DRINKING WATER FROM FLOWER VASES
THE STORY OF A CRISIS IN THE NHS

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ABSTRACT

Drinking water from flower vases – the story of a crisis in the NHS

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The present study examines the storytelling surrounding the organisational crisis at the Mid-Staffordshire NHS Foundation Trust over the period from March 2009 to November 2010, based on the data collected from twelve sources and 1274 documents relevant to the case.

The study addresses three core questions: How does storytelling relating to one event unfold into multiple stories? How do the roles of storyteller and audience change over time? How does the evolution of storytelling bring about the unintended consequences?

The study is grounded in the critical management studies and “managerialist” literatures on stories and storytelling in organisation and derives from these three main elements of its theoretical framework: ante-narrative, poetic delivery, and message simplification. The study suggests that these elements share a unifying notion of speculation. Speculation here is seen as an antidote to the potential stultification of the relationships between the storyteller and the audience in the accounts of storytelling. To counteract such stultification, the study brings the dynamic nature of storytelling to the fore and examines the evolution of storytelling over time using the methodology of frame analysis.

Frame analysis identified and traced seven frames that emerged as the storytelling surrounding the crisis evolved. The study found the role of the storytellers and audience became mutually dependent and blurred as the events unfolded. The storytellers and audience were intertwined through a need to maintain a shared account of the events at MSFT. They were bound together through their speculative storytelling in order to answer the questions of “did it really?” and “so what?”

The analysis has also identified two unintended consequences of the storytelling surrounding the crisis: sacralisation and memorialisation. Together, these consequences have produced a shield (metaphorically speaking) that has served to protect the organisational structures of the NHS from a more radical questioning.
ACKNOWLEDGEMENTS

The shortness of this acknowledgement is no measure of the very great respect I hold and debt of gratitude I owe to Dr. Olga Suhomlinova for her time, patience, challenge and support over many years, as I juggled the PhD alongside a full time job and family commitments. Thank you for your part in my journey. Also to Professor James Fitchett who supported me at the outset of my journey. I would also like to thank Mrs Teresa Bowdrey, who has always provided valuable guidance and administrative support from the outset.

Finally, no duty is more urgent than that of returning thanks to my wife, Helen, which is where I must now focus my attention.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>2</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>3</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>4</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>7</td>
</tr>
<tr>
<td>LIST OF APPENDICES</td>
<td>8</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>9</td>
</tr>
<tr>
<td>LIST OF ABBREVIATIONS</td>
<td>10</td>
</tr>
<tr>
<td>CHAPTER 1. INTRODUCTION</td>
<td>11</td>
</tr>
<tr>
<td>RESEARCH QUESTIONS</td>
<td>12</td>
</tr>
<tr>
<td>THEORETICAL BACKGROUND</td>
<td>13</td>
</tr>
<tr>
<td>THEORETICAL FRAMEWORK</td>
<td>14</td>
</tr>
<tr>
<td>Research question 1</td>
<td>14</td>
</tr>
<tr>
<td>Research question 2</td>
<td>16</td>
</tr>
<tr>
<td>Research question 3</td>
<td>17</td>
</tr>
<tr>
<td>RESEARCH CONTEXT</td>
<td>18</td>
</tr>
<tr>
<td>STRUCTURE OF THE STUDY</td>
<td>20</td>
</tr>
<tr>
<td>CHAPTER 2. LITERATURE REVIEW AND THEORY DEVELOPMENT</td>
<td>22</td>
</tr>
<tr>
<td>STORY AND STORYTELLING LITERATURE</td>
<td>23</td>
</tr>
<tr>
<td>Defining a story</td>
<td>25</td>
</tr>
<tr>
<td>Storytelling organisations</td>
<td>28</td>
</tr>
<tr>
<td>The contribution of story and storytelling literature to the research questions</td>
<td>38</td>
</tr>
<tr>
<td>FRAME ANALYSIS</td>
<td>47</td>
</tr>
<tr>
<td>MEMORIALISATION AND SACRALISATION</td>
<td>64</td>
</tr>
<tr>
<td>Memorialisation</td>
<td>64</td>
</tr>
<tr>
<td>Sacralisation</td>
<td>70</td>
</tr>
<tr>
<td>THEORETICAL FRAMEWORK</td>
<td>73</td>
</tr>
<tr>
<td>CHAPTER 3. METHODOLOGY</td>
<td>83</td>
</tr>
<tr>
<td>RESEARCH DESIGN</td>
<td>83</td>
</tr>
<tr>
<td>DATA COLLECTION</td>
<td>85</td>
</tr>
<tr>
<td>DATA SOURCES</td>
<td>88</td>
</tr>
<tr>
<td>Data sources: Mass media</td>
<td>88</td>
</tr>
<tr>
<td>Data sources: Formal inquiries</td>
<td>89</td>
</tr>
<tr>
<td>Data sources: Organisational sources</td>
<td>89</td>
</tr>
<tr>
<td>STORYTELLERS</td>
<td>90</td>
</tr>
<tr>
<td>KEY EVENTS DURING THE TIMELINE</td>
<td>91</td>
</tr>
</tbody>
</table>
CHAPTER 7. ANALYSING THE ROLES OF THE STORYTELLER AND THE AUDIENCE. 191
Identifying the audience .............................................................................................. 191
Considering the audience over time .......................................................................... 191
Research question 2: Changing roles of storytellers................................................. 206

CHAPTER 8. CONSEQUENCES OF THE STORYTELLING ......................................... 209
INTENDED CONSEQUENCES ..................................................................................... 209
UNINTENDED CONSEQUENCES OF THE STORYTELLING ............................................. 212
Memorialisation of the stories...................................................................................... 212
Sacralisation of the NHS .............................................................................................. 220
Research question 3: Intended and unintended consequences of storytelling ........ 225

CHAPTER 9. DISCUSSION AND CONCLUSIONS ................................................... 230
REVISITING THE PURPOSE OF THE STUDY ............................................................... 230
THEORETICAL CATALYST .......................................................................................... 231
IMPLICATIONS FOR THEORY .................................................................................... 233
Research question 1 ..................................................................................................... 235
Research question 2 ..................................................................................................... 238
Research question 3 ..................................................................................................... 239
DIRECTIONS FOR FUTURE RESEARCH .................................................................... 240
PRACTICAL IMPLICATIONS ....................................................................................... 242
LIMITATIONS OF THE STUDY .................................................................................. 243
QUESTIONS FOR FUTURE RESEARCH ...................................................................... 244
CONCLUSION ............................................................................................................. 247

APPENDIX 1. THE FIRST SIGNATURE MATRIX FOR EACH FRAME .................... 248
APPENDIX 2 – THE FIRST ELABORATION MATRIX FOR EACH FRAME ............. 257
APPENDIX 3 – INTENDED AUDIENCE FOR EACH FRAMES ............................. 265
APPENDIX 4 – INTENDED CONSEQUENCES: AN EXAMPLE OF FRAME MOTIVATION OVER THE SIX EVENTS ................................................................. 273
BIBLIOGRAPHY ........................................................................................................ 274
LIST OF TABLES

Table 1. Comparing Managerialist and Critical Management approaches to storytelling 40
Table 2. Examples of coding text fragments into data items 97
Table 3. Examples of coding data items into key themes 99
Table 4. Example of signature matrix constructed for one of the frames in the study 103
Table 5. Identification of the event at which the key theme emerged, and from which a signature matrix and analysis of the functions of the frame were created 104
Table 6. Example of the frame functions developed for one of the frames 106
Table 7. The presentation of “depictions” in the signature matrix for the Justice frame over the six key events 107
Table 8. The presentation of “prognostic function” in the elaboration matrix for the Justice frame over the six key events 108
Table 9. The presentation of intended audience and data items 110
Table 10. The data sources and the documents extracted from those sources 131
Table 11. The number of documents and data items associated with the storytellers 133
Table 12. The number of data items associated with the four key storytellers 138
Table 13. The number of data items associated with each event 146
Table 14. Key words and phrases identified through the data analysis 148
Table 15: The frame and identified frame sponsor 156
Table 16: Example fragments of text from the Justice Frame illustrating an amplification of a single issue over the six events 186
Table 17: Example fragments of text from the Learning Frame illustrating an amplification of a multiple issue over the six events 187
Table 18: Escalation of the stories illustrated by the Justice and Learning frames. 188
Table 19: Blurring of roles between storytellers and audience using examples of the Improvement and Leadership frame 208
Table 20: Illustrating the unintended consequence of sacralisation and memorialisation on story work through the frames 228
LIST OF APPENDICES

APPENDIX 1. THE FIRST SIGNATURE MATRIX FOR EACH FRAME
Table a1.1 The signature matrix for the Justice frame
Table a1.2 The signature matrix for the Learning frame
Table a1.3 The signature matrix for the Improvement frame
Table a1.4 The signature matrix for the Leadership frame
Table a1.5 The signature matrix for the Distress frame
Table a1.6 The signature matrix for the Blame frame
Table a1.7 The signature matrix for the Defence frame

APPENDIX 2. THE FIRST ELABORATION MATRIX FOR EACH FRAME
Table a2.1 The elaborative functions of the Justice frame
Table a2.2 The elaborative functions of the Learning frame
Table a2.3 The elaborative functions of the Improvement frame
Table a2.4 The elaborative functions of the Leadership frame
Table a2.5 The elaborative functions of the Distress frame
Table a2.6 The elaborative functions of the Blame frame
Table a2.7 The elaborative functions of the Defence frame

APPENDIX 3. INTENDED AUDIENCE FOR EACH FRAMES
Table a3.1 Justice frame and the intended audiences
Table a3.2 Learning frame and the intended audiences
Table a3.3 Improvement frame and the intended audiences
Table a3.4 Leadership frame and the intended audiences
Table a3.5 Distress frame and the intended audiences
Table a3.6 Blame frame and the intended audiences
Table a3.7 Defence frame and the intended audiences

APPENDIX 4. INTENDED CONSEQUENCES: AN EXAMPLE OF FRAME MOTIVATION OVER THE SIX EVENTS
## LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Areas of theoretical development and the research questions</td>
<td>15</td>
</tr>
<tr>
<td>2</td>
<td>Key contribution of storytelling literature to this research</td>
<td>42</td>
</tr>
<tr>
<td>3</td>
<td>The relationship between events, accounts, and framing</td>
<td>63</td>
</tr>
<tr>
<td>4</td>
<td>Theoretical framework – research question one.</td>
<td>79</td>
</tr>
<tr>
<td>5</td>
<td>Theoretical framework – research question two</td>
<td>80</td>
</tr>
<tr>
<td>6</td>
<td>Theoretical framework – research question three</td>
<td>81</td>
</tr>
<tr>
<td>7</td>
<td>Theoretical framework</td>
<td>82</td>
</tr>
<tr>
<td>8</td>
<td>The structure of the National Health Service</td>
<td>115</td>
</tr>
<tr>
<td>9</td>
<td>Mid-Staffordshire NHS Foundation Trust Management Structure</td>
<td>119</td>
</tr>
<tr>
<td>10</td>
<td>Defining the scope of analysis and data set</td>
<td>147</td>
</tr>
<tr>
<td>11</td>
<td>The evolution of the frames over time</td>
<td>182</td>
</tr>
<tr>
<td>12</td>
<td>The evolution of the storytellers over time</td>
<td>183</td>
</tr>
<tr>
<td>13</td>
<td>Ms Bailey’s café and memorial wall</td>
<td>217</td>
</tr>
<tr>
<td>14</td>
<td>Snapshots taken from the Independent Inquiry volume two</td>
<td>218</td>
</tr>
<tr>
<td>15</td>
<td>Movement within the theoretical framework</td>
<td>234</td>
</tr>
<tr>
<td>16</td>
<td>Illustrating the novelty in the theoretical approach of the study</td>
<td>237</td>
</tr>
</tbody>
</table>
LIST OF ABBREVIATIONS

CCG – Clinical Commissioning Group
CEO – Chief Executive Officer
CHI – Commission for Healthcare Improvement
CQC – Care Quality Commission
DoH – Department of Health
HCC – Health Care Commission
LAT – Local Area Team
MP – Member of Parliament
MSFT – Mid Staffordshire NHS Foundation Trust
NHS – National Health Service
PALS – Patient Advice and Liaison Services
PCT – Primary Care Trust
QC – Queens Counsel
SHA – Strategic Health Authority
UHNS – University Hospital of North Staffordshire
UK – United Kingdom
CHAPTER 1. INTRODUCTION

Mrs F then received a call from the hospital to tell her that her husband had died. The family returned to the hospital and found [her] husband ... lying on a bed in the ward, disconnected from equipment with no one attending to him and without a sheet covering him (Francis, 2010b, p. 291)

I had been thinking again about the [2012 Olympic] opening ceremony, and wondering how it must have felt watching that mawkish pageant if you had been one of the victims – one of the survivors, that is – of Stafford hospital. Is it possible that some degree of embarrassment regarding the egregious failings of this health service that we love too much explains why the full, almost indescribable horror of that scandal seems not to have fully sunk in? (Wheatcroft, 2013)

Achieving change within organisations is a complex and contested process. I have worked in the UK National Health Service for 10 years, and my personal experience suggests that even when change is absolutely necessary – when it is, as the case in healthcare often could be, literally a matter of life and death – the change is usually far from straightforward.

My concern with the challenges of organisational change has combined in this thesis with my interest in storytelling in organisations. The link between change and stories is fairly explicit. Thus, the impetus for change is often derived from the stories that highlight the dissatisfaction with the present state of affairs and call for change. The programmes for change are often articulated – and debated – in the form of stories that take the storyteller and the audience from the past into the present and the future.

In the context of the National Health Service, storytelling appears particularly important as it gives the voice not only to the organisational members but also to the patients and the general public. Further, the NHS is not only a large and prominent organisation and a public service about which the general population cares deeply, but also a “cultural icon” of the UK society, and hence the storytelling in and around the NHS has a strong social resonance.
To illustrate, the opening ceremony of the London 2012 Olympic Games featured a section celebrating the National Health Service as one of the UK’s core achievements. It offered an emotive and triumphant story – a story that stands in a marked contrast to the accounts reflected in the epigraphs to this Chapter. The first extract/epigraph comes from the Independent Inquiry (Francis, 2010a) (Francis, 2010b) into the events at the Mid-Staffordshire NHS Foundation Trust (MSFT) and was presented to the Inquiry by a wife of a patient who died at the MSFT hospital. The second extract/epigraph links the account presented in the Olympics opening ceremony with the views of “the survivors of Stafford hospital” and highlights the significance of our individual and collective representations of the NHS through stories.

RESEARCH QUESTIONS

The present study is set in the context of an organisational crisis at MSFT and encompasses the events that occurred between March 2009 and November 2010. Briefly, the crisis erupted when the Healthcare Commission had uncovered the multiple failings in patient care at the Hospital in 2009 (Healthcare Commission, 2009). The crisis led to two Government inquiries, the first started in 2009 and was published in February 2010 (Francis, 2010a) (Francis, 2010b) the second started in 2010 and was published in February 2013 (Francis, 2013).

Although it has been nearly ten years since the problems at the Mid-Staffordshire Hospital occurred and five years since the publication of the findings of the Healthcare Commission inquiry into “apparently high mortality rates in patients admitted as emergencies to Mid-Staffordshire NHS Foundation Trust since April 2005” (Healthcare Commission, 2009, p. 3), the wider issues reflected in the Mid-Staffordshire case remain current, as the recent reviews (e.g., the 2013 review by the NHS Medical Director for England, Sir Bruce Keogh (Keogh, 2013) and the 2014 Care Quality Commission review (Care Quality Commission, 2014)) indicate that inadequate care continues to be a serious problem in the NHS. Hence, an investigation into the Mid-Staffordshire Hospital crisis is not only of “academic” interest, but has a potential practical significance for the on-going organisational changes across the NHS.
Incidentally, the NHS has seen a growing prominence of storytelling, amidst the increasing role and voice (especially since the Bristol Inquiry (Kennedy, 2001)) of the hitherto near-silent public. There are examples of the NHS organisations and the local communities embracing storytelling to challenge the official line and to achieve some control of the situation that affects them.

The ultimate aim of this study is to investigate the potential contribution of storytelling surrounding an organisational crisis to the solution of the problems underlying the crisis. Gauging this contribution, however, would be impossible without understanding how the stories from the crisis emerge and unfold and without considering how the “active elements” of storytelling – the storytellers and their audience – evolve over time. The study, therefore, poses the following three research questions:

**Research question 1:** How does storytelling unfold and escalate from one event into multiple stories?

**Research question 2:** How do the roles of the storyteller and audience become defined and re-defined over time?

**Research question 3:** Within this process of unfolding stories, what are the intended and unintended consequences of storytelling?

**THEORETICAL BACKGROUND**

The research conversation I want to embrace throughout this study relates to the storytelling literature. From the literature review, I identified two approaches to storytelling: (1) a managerialist approach and (2) a critical management studies approach. The managerialist approach provides practical advice to practitioners on how to use stories to drive transformational change. The critical management approach, in contrast, focuses on the complexity, plurivocality and poetic interpretation in storytelling and emphasises the notions of power and transformation embodied in storytelling. The very definition of story has been widely contested; yet, amidst the debate, some general themes can be detected,
such as: stories are not coherent, stories are distinct from narrative, stories are a product of performance, stories can offer local and intimate accounts of events.

In this study, I both build upon the above approaches and question them. In particular, I depart from the dominant approaches to storytelling, where storytelling is used as a tool, either to influence organisations (as in the managerialist approach) or to understand/interpret various organisational processes (as in the critical management approach). Rather than treating storytelling as an instrument for examining something else, I take storytelling as the focal object of my study.

THEORETICAL FRAMEWORK

In the following section I briefly outline my theoretical framework with regard to the three research questions. Figure 1 graphically depicts the relationship between the research questions and the areas where the study integrates and further develops the extant theories.

Research question 1

The first research question asks how storytelling stemming from one event unfolds into multiple stories. I begin answering this question with a definition of story. I interpret the concept of a story to mean, not an historical account, but an opportunity to “re-narrate” events (as per Cunliffe, Luhman and Boje (2004: 265)). Next, I prioritise the need for a story to be believable, rather than “real.” Story is a product of its presentation, in which “readership and interpretation are as important as structure and authorship” (Barry & Elmes, 1997, p. 431) and in which a story needs to “seduce” in order to engage the audience (Gabriel, 2008). Finally, stories are temporal events; and this opens up opportunities for re-telling and re-presentation of the previously told stories.

From such a definition of story, I derive and bring to the fore the concept of speculation as a key notion underpinning the act of storytelling. I argue, following Gabriel (2008: 195) that, since the accuracy of stories is not important, it is the speculative choices of purposeful or accidental inaccuracy that have the potential to identify something of significance. In methodological terms, frame analysis is well
Figure 1. Areas of theoretical development and the research questions

- **Research Question One**: Storytelling unfolding (Speculation)
- **Stories**
- **Memorialisation**
- **Sacralisation**
- **Storytelling**
- **Research Question Two**: defining roles of storytellers and the audience (Stultification)
- **Frame Analysis**
- **Research Question Three**: Storytelling consequences
equipped to deal with the speculative element of storytelling because frame analysis allows for stories to exist in their fragmented forms. Fragmentation, in turn, allows to develop “a retrospective explanation of storytelling’s speculative appreciations” (Boje 2001, p. 3) suggested for. The notion of speculation is further explored in Chapter 2.

To capture and analyse how the storytelling unfolded over time, I identified, through frame analysis, seven frames that encapsulated the multitude of stories surrounding the crisis. I compared and contrasted these frames as they emerged, developed and changed over the course of twenty-two months and then mapped the evolution of storytelling. The examination of storytelling through the lens of these frames allowed me to trace how storytellers used speculation and amplification to develop their stories and to attract new audiences to maintain the momentum of storytelling.

**Research question 2**

The second research question asks how the roles of the storyteller and the audience become defined and re-defined over time. What particularly interested me was to discover, whether the storytellers hold their role indefinitely and whether the audience maintains its role. Stories do not exist in just the “here and now” of an individual act of storytelling. Instead, stories develop across time and space as they are told and re-told by the storytellers, and as they are picked up and carried on by the audiences. The present study demonstrates that storytelling reaches far beyond organisational boundaries, and involves various organisational stakeholders, including local and national communities. Storytelling research commonly limits the boundaries of storytelling to a finite number of actors, usually those within the organisation, and focuses on the transmission of the story to the intended audience. To illustrate this point here, I shall use, as a story, the Mrs F’s account, related in the Mid-Staffordshire Hospital Inquiry (Francis, 2010b, p. 291) and presented as the first epigraph to this Chapter. A managerialist approach to storytelling would use Mrs F’s story to highlight the known weaknesses of the system and consider an opportunity to learn from the actions that led to such a
significant breakdown, while emphasising the need to ensure that this does not and cannot happen again. A critical management approach to storytelling would focus on the multiple meanings and interpretations of Mrs F’s experience. It would highlight how the complexity of the systems (such as the NHS) seeks to control and/or cover up the events. Despite significant differences between the two approaches, in both of them the story itself constitutes the focal point, whereas the storyteller – Mrs F - is relegated to the background. Such prioritisation of the story over the storyteller misses an opportunity to consider the relationship between the storyteller and the audience - and to fully investigate the act of storytelling. Further, the prioritisation of the story over the storyteller creates the effect of stultification. The concept of stultification comes from Ranciere’s work “Ignorant Schoolmaster” (Ranciere, 2007). For Ranciere, stultification occurs when the students’ intelligences are linked with the intelligence of the schoolmaster in such a way that the students have to rely on the schoolmaster to explain what the students have learned. The process of stultification binds the storyteller to the audience and thus masks the relationships between the storyteller and the audience. The notion of stultification and the impact on the relationship between the storyteller and audience informs the theoretical framework and the data analysis pertaining to Research question 2.

Research question 3

The third research question asks about the intended and unintended consequences of storytelling. The intended consequence of storytelling in each of the seven frames identified in the study was to ensure that the events at the Mid-Staffordshire Hospital do not happen again. The stories were crucial to both the Independent Inquiry into the crisis (see volume two of the Independent Inquiry into events (Francis, 2010b)) and to the Patient’s Association’s report calling for change within the NHS (Patients Association, 2009).

There were, however, also two unintended consequences. The first unintended consequence was sacralisation of MSFT and the NHS. The results of the frame analysis showed a lack of argumentative devices to drive real change. Rather than producing the impetus for a radical change, the storytelling stopped short of
questioning the core values of the NHS and instead focused on repairing the “sacred institution”. The second unintended consequence of storytelling was memorialisation. The frame analysis uncovered the lack of substantive audience engagement, despite the fact that public debate and involvement were encouraged – and outwardly visible. The memorialisation of the events, similar to the sacralisation of the NHS as an institution, served to protect the NHS organisations from further scrutiny. Although there were several key storytellers with widely different positions and the storytelling was truly “plurivocal”, all storytellers ultimately tried to avoid “estrangement, the unknowable, acquiescence to transitoriness and a multiplicity of possible interpretations” (Bull, 2005, p. 48). In short, they sought to avoid the emergence of what Nicholls (2006, p. 2) would call the “anti-memorial”, because such anti-memorial could lead to a breakdown of trust in the established healthcare system.

The unintended consequences of storytelling were uncovered through the theoretical framework that prioritises the process of storytelling and the relationship between the storyteller and the audience. I argue that these unintended consequences could not have been discovered through the traditional approaches to storytelling that prioritise the story rather than the act of storytelling. The investigation following the traditional approaches to storytelling would have led either to establishing one set of stories as “the dominant narrative” and then attributing the failure to instigate change to the problems of change implementation or, alternatively, to considering the multiple positions expressed in different stories and then attributing the failure to instigate change to the complexity of the multiple interpretations.

RESEARCH CONTEXT

My research takes place within the context of an NHS organisation going through a crisis. An organisational crisis has been chosen as a “critical incident” that brings storytelling into focus and to the fore. My research investigated storytelling surrounding an organisational crisis in MSFT. MSFT was at the centre of a series of inquiries into the quality of care delivered at the Hospital between 2005 and 2009.
It is suggested that during this time, the lack of appropriate care contributed to between 400 and 1200 patient deaths.

The study focused on the period from March 2009 to November 2010. In March 2009, the first report into the Hospital was published, which raised the impact of the crisis in the public domain. By the time of the opening of the Public Inquiry into events at the Hospital (November 2010), a series of reviews had been undertaken and published. During this period I identified six key events. The events were selected as having the most or a notable increase in data items recorded over the period of the study. An analysis of these events produced 1274 documents from which 2905 data items were identified and attributed to nine key storytellers. The storyteller was defined as someone having a significant role in creating and recreating frames through a demonstrable relationship, involvement and role in the crisis at MSFT. In order to create a manageable yet significant data set, I focused on three events that accounted for over 80% of the data items identified.

A detailed analysis of the data items established key words and themes, which could be clustered into seven areas. Using a signature matrix (Creed, Langstraat, & Scully, 2002) and an elaboration matrix (Snow and Benford (2000)), seven frames were developed: Learning; Justice; Improvement; Leadership; Distress; Blame, and Defence. The frames were created, recreated and presented in a signature matrix and elaboration matrix for each event during the time period of the study. Some frames were present throughout the period in question (for example Justice and Learning); others were identified during the period of the study. The frames and matrices were reviewed in detail for each event. The study also identified a frame owner (or sponsor). In assigning ownership, I was able to test the frame and the relationship between the storyteller, and eventually the audience to which the frame is intended to move. Finally the analysis considered how the frames, storytellers and frame owners (sponsors) changed over the period of the study and throughout each event.
This study acknowledged the paradigmatic issues in the construction of stories and storytelling. It used frame analysis not to redefine stories, but to identify the consequences of storytelling across organisational and community boundaries in the UK’s NHS. The study has developed a methodological approach to capture and analyse storytelling over time. Within an organisational theory’s approach to storytelling, the study demonstrated the significance of speculation within storytelling which contributes to an on-going development of storytelling as a valuable tool to understand the intimate accounts within organisations. Finally the study identified and developed the notion of sacralisation and memorialisation within the NHS as an unintended consequence of stories – even when there is a shared and urgent, or life threatening, need to change.

STRUCTURE OF THE STUDY

There are eight chapters that follow this introduction. Chapter 2 Literature Review contrasts the managerialist and the critical management studies literatures on storytelling, and derives from these literatures three main elements of the theoretical framework (ante-narrative, poetic delivery, and message simplification), and highlights the common thread uniting these element, namely, the concept of speculation. The chapter also considers frame analysis as a tool to understanding storytelling. Finally, the chapter covers the literature on sacralisation and memorialisation. These concepts emerged as crucial to the understanding of the unintended consequences of storytelling in the process of empirical analysis. Therefore, they derive from rather than predate the analysis. For consistency sake, however, the associated literatures are presented in this chapter.

Chapter 3 Methodology presents the research design and methods and discusses the use of frame analysis as a methodological tool to examine storytelling.

Chapter 4 Case Study provides the background information on the empirical case. It describes the structure of NHS and of the Mid-Staffordshire Foundation Trust Hospital and provides a brief overview of the crisis and its aftermath.
Chapter 5 Data Analysis analyses the empirical data using the frame analysis approach.

Further analysis and the results pertaining to the three research questions are presented in Chapters 6, 7 and 8 respectively.

Finally, Chapter 9 Discussion and Conclusions pulls together the key findings, areas of concern and areas for potential future development.
CHAPTER 2. LITERATURE REVIEW AND THEORY DEVELOPMENT

The following chapter provides an overview of the relevant literatures and develops a theoretical framework for the study.

As noted in Chapter 1, the present study aims to examine the process and the consequences of the evolution of stories and storytelling surrounding a significant organisational event. In Chapter 1 (Introduction), Figure 1 summarised the areas of theoretical development and the research questions. There are four areas of literature that are relevant to this study. (1) Story and storytelling. Understanding the literature relating to story and storytelling provided an opportunity to explore how the notion of speculation is a consistent thread throughout the conflicting literature – which influences the evolution of storytelling over time. (2) Frame analysis: with the speculative nature of storytelling prioritised, a frame analysis method provided an opportunity to capture and analyse storytelling as it evolved. This method allowed me to understand the process of storytelling and importantly the stultified and mutually dependent relationship between the storyteller and the audience.

Both (3) sacralisation and (4) memorialisation were identified as unintended consequences from the analysis. These were identified through an analysis of the evolution of storytelling and understanding the roles of storyteller and the audience. Of significance was that these two phenomena were not a product of storytelling (for example, the story of the memorial), but were a part of the storytelling process, whereby the storyteller and audience were bound by the other to continue telling the story.

Accordingly, this chapter opens with the discussion of the core concepts and phenomena under consideration, namely “story” and “storytelling”. The chapter then proceeds to examine the ways in which the evolution of storytelling can be theorised using “frame analysis”. Frame analysis has hitherto been used primarily as a data analysis method in research on social movements; I expand on how frame
analysis informed theory development and, through an appreciation of the effects of stultification, how it informed the theoretical framework of this study. Next, the chapter considers the consequences from the evolution of storytelling, which the present study theorises in terms of “memorialisation” and “sacralisation”, and reviews the relevant literatures. Finally, the chapter identifies a theoretical framework for the study, and its relationship to the research questions.

**STORY AND STORYTELLING LITERATURE**

An interest in storytelling places this research within a field that considers language and the use of language. Discourse analysis has become a ubiquitous description for an interest in language (Alvesson and Karreman (2000:1126) and one with no consistent definition (Potter and Wetherell, 1987: 6). Alvesson and Karreman (2000: 1126) differentiate between discourse as the “study of social text” and discourse as the “study of social reality as discursively constructed and maintained”. Discourse analysis is an approach that can be applied to speech and text beyond naturally occurring dialogue. Within this study I included newspaper articles, press releases and formal inquiry reports, as well as examples of naturally occurring text where it is recorded in videos and transcribed conversations. An interest in storytelling, however, extends beyond an interest in the specific use of language and seeks to understand how individuals make sense of their worlds. Narrative analysis is an approach that is “sensitive to the stories that people tell about their lives or events around them” Bryman and Bell suggest (2007, 551).

Discourse and narrative approaches emerged across social sciences (see Alvesson and Karreman, 2000) and are now widely used as a method to study organisation (Boudes and Laroche, 2009). Czarniawska (1998, p. 13) suggests narrative approaches “provid[e] an opportunity for organisation theory to “reinvigorate itself”. However, an interest in language, or linguistic turn within organisational studies, was not a straightforward step. Rhodes and Brown (2005) illustrated the tension identified in the early 1990s, within which the significance of the story was considered:
“Dyer and Wilkins argued that, not only was the point of case research to produce an ‘exemplar’, ‘a story against which researchers can compare their experiences and gain rich theoretical insights’ (p. 613), but that the ‘classics’ in organization studies ‘are good stories’ (p. 617). In reply, Eisenhardt (1991) contended that stories are not theories, and while ‘[g]ood storytelling may make ... studies entertaining to read ... their theoretical impact comes from rigorous method and multiple-case comparative logic’” (p. 621).” (in Rhodes and Brown (2005, p. 167))

Boje’s (1991) study of story performance in an Office-Supply Firm was a point in time from which the narrative analysis within organisation studies developed. The value of narrative analysis in organisation theory was contested (Rhodes and Brown 2005, p. 168), although as Stutts and Barker (1999, p. 213) suggested “organisational story and storytelling research has produced a rich body of knowledge unavailable through other methods of analysis.”

Although the early 1990s represented the period from which the pace of narrative in organisational research increased I would suggest there are three stages of development, starting in the 1970s. Mitroff and Kilmann’s (1976) study of organizational myths and stories, found “stories gave the researcher access to the unconscious yet projective images of what the organization meant to the managers” (in Rhodes and Brown, 2005, p.169). This emerged from the dominant theory that marginalised storytelling as not a “proper focus of studies of the social sciences” (Mitroff and Kilmann, 1976, p. 191). The second stage developed during the 1990’s and emerged from the growing body of research in organisational culture (e.g. Peters and Waterman 1982); narratives were increasingly used as data, in order to provide researchers the opportunity to examine emotional and symbolic lives. In Gabriel (1995, p. 479) he investigates “the unmanaged organization” through stories, fantasies and subjectivity. Furthermore, during this stage, the literature re-considered the history of organisation theory and recognised it “had long been founded on the ability to tell a good story” (Rhodes and Brown. 2005:
The third stage emerged in the 2000s and recognised the multifaceted nature of the research. Building on narratives, not only as a form of data, but also as a theoretical lens, and a methodological approach. Rhodes and Brown (2005, p. 170) illustrate the significant breadth of narrative and “its near conceptual neighbours” listing some eighteen different strands of narrative development, including sensemaking, community mediation and learning, the cumulative impact of these strands being “indicative and constitutive of narrative’s impact” (p 170).

Therefore, an interest in language, or linguistic turn within organisation studies presented an opportunity not only to “provide negative critique of other methodologies, it also demonstrates real alternative with substantive analytical benefit” (Rhodes and Brown 2005, p. 179).

Defining a story

The concept of a “story” has been extensively discussed and contested in the literature, and my aim here is not to comprehensively survey the relevant debates but rather to collate a composite definition that highlights several important aspects of the concept material to my study.

A useful starting point, from which the complexity of this concept can be explored, is provided by a definition of a story as a sequence of events presented in a linear fashion, i.e. with a beginning, middle and an end. Such a “structuralist” approach to defining a story (Barry & Elmes, 1997, p. 431) can be illustrated by Gergen’s (1999); (quoted in Cunliffe, Luhman and Boje, (2004, p. 263)) list of the “characteristics” of a story: “a valued endpoint or goal; relevant causally linked events ordered in a linear, temporal sequence; demarcation signs (the beginning and ending of the story); and characters with stable, coherent identities”.

This notion of a story as a coherent and sequential set of events has, however, been challenged on several grounds, leading to a more complex conceptualisation of the story. I highlight several important aspects of this conceptualisation below.

Firstly, a story is not necessarily coherent, but may be fragmented (Boje (2001, p. 2)). Boje challenges the modernist narrative of order and plot and argues that the
“folk of organisation[s] inhabit storytelling spaces outside of plot, not tidy rationalised narrative spaces” (2001, p. 2). In Boje’s text he introduces the notion of “terse fragments” (1991, p. 10), in which he suggests “A terse telling is an abbreviated and succinct simplification of the story in which parts of the plot, some of the characters, and segments of the sequence of events are left to the hearer’s imagination” (p. 10).

Similarly Gabriel (2000, p. 1) suggests storytelling “is a delicate process, a process that can easily break down, failing to live up to its promise, disintegrating into mere text”. Secondly, a story is distinct from narrative (see Gabriel (2000, p. 26) and Boje (2001, p. 2)) in that it is not found everywhere and the ability of a story to determine meaning anywhere is contested. Both Boje and Gabriel complain that it can be difficult to unearth good stories and talented storytellers in organisations (Collins, 2008, p. 320). Gabriel suggests that the increasing academic interest in organisational storytelling has been facilitated by post-modern scholarship and its tendency to see stories (as generators and creators of meaning) everywhere (Gabriel, 2000, p. 5).

Boje (2001, p.1) highlights the “chaotic soup” of a critical management approach to storytelling, one that is “self-deconstructing and flowing”. Both argue that story has a definite definition, which is distinct from narrative. For Boje, it is the “ante-narrative” (Boje, 2001, p. 2), which Gabriel describes as a “proto-story” (2000, p. 26), while for Gabriel it is the poetic story (2000, p. 83). For Boje, stories are too unconstructed and fragmented to capture and therefore cannot be everywhere. He suggests story is “ante-“ or before the story and narrative is “post story”. The ante (or ante-narrative) story is the account of incidents, and resists narrative (P2). Post-story is the after-effects of the story, “once coherence has been rendered” (Boje, 2001, p. 4) – the narrative adds “plot and coherence to the story line” (PP 1). Ante-narrative focuses on the flow of storytelling.

Boje highlights that it is difficult to analyse speculative appreciations as “people are always in the middle of living and tracing their storied lives” (p 5). This contrasts to the managerialist perspective through the existence of stories and can be captured
and understood (see, for example story as text research in Boje (1991, p. 107)).

Whilst Gabriel does not draw a stark distinction between narrative and story, he is clear that “not all narratives are stories”; he emphasises that those that focus on “descriptive accounts of events that aspire at objectivity” must not be considered stories (Gabriel, 2000, p. 5). He continues to suggest that stories should not be assumed as the only vehicle to generate meaning, and importantly that “not all stories generate or sustain meaning” (Gabriel, 2000, p. 5).

Thirdly, a story is a product of its performance. Gabriel (1995) suggests that rather than performance being distinct from the story – it is a central characteristic of the story. This reinforces the relationship between the story and the act of storytelling. Gabriel asserts the importance of plots; staging and casting are central characteristics of stories (Collins, 2008, p. 320). Both Gabriel and Boje agree that the performance, flow and delivery of storytelling are as significant as the content. What is important is the sequencing of events through the performance and re-enacting of the story (Ricoeur, 1984, p. 150). Boje suggests stories are temporal, flowing, emerging [and] not at all static (Boje, 1991, p. 1), whereas traditional accounts of storytelling remove the subjectivity and complexity of the story in order to demonstrate the effectiveness of the message (Boje, 2006). As Gurbium and Holstein (1998, p. 165) note, stories are “not complete prior to their telling but are assembled to meet the situated interpretative demands”.

Fourthly, stories offer local and intimate accounts of situations, events and predicaments within which exist multiple meanings (Gabriel, 2000, p. 1). Gabriel describes the process of story work as a delicate woven product of intimate knowledge. The nature of the intimate accounts and multiple meanings emphasises the delicate and changing nature of stories. Boje (2001, p. 18) and Gabriel (1995, p. 496) develop the notion of a story and highlight that the story can and will have multiple meanings that co-exist. Extending that further therefore suggests that with the acceptance of multiple meanings for a story, accuracy is not important (see Brown, Gabriel and Gherardi (2009, p. 326)).
I propose an emerging and revised definition of story for the purpose of this study. The story is one that is not an historical account, but an opportunity to re-narrate events (for example “they offer a way to invent the future and to re-narrate organizational life” (Cunliffe, Luhman, & Boje, 2004, p. 265)). This definition of story led me to prioritise the need for a story to be believable, rather than “real” as a product of its structural presentation; “readership and interpretation are as important as structure and authorship” (Barry & Elmes, 1997, p. 431). This also led me to the development of the definition of “story”, where in order to promote and engage readership and interpretation of the story, the seductive powers of storytelling need to be understood (Gabriel, 2008). The final development of the definition of “story” is that given the interpretative nature of stories, they are temporal events. To use Boje’s description, stories “self destruct” (Boje, 2001, p. 18). This opens up opportunities for further re-telling and re-presentation of the event and/or previous stories.

The challenge therefore for this research and its conception of the story, which was explored through question one, is an understanding of the evolution of storytelling through the recalcitrant nature of facts, rather than truths (Gabriel, 2008, p. 162). This then led me to consider research question two, the role of the storyteller and their audience and experiences on which the story is told. Here I intend to explore the case study and research material, and consider research question three – the intended and unintended consequences of storytelling.

**Storytelling organisations**

The literature on storytelling could be divided into two streams: (1) an applied, practitioner-orientated or “managerialist” stream and (2) a critical management stream.

**Managerialist approach**

Managerialist authors aim to offer practical advice to managers on how to best use stories to enhance their effectiveness. Stories are recognised and used in many organisational settings such as “annual reports, speeches, training programs, audits,
Boje describes practitioner orientated material as a consulting industry (Boje, 2006, p. 219). This differentiates the style, approach and purpose of these texts from academic text. The history of the development of both styles is set out below. It is interesting to note that in 2006 Boje found a search on Amazon.com that would yield 1,103 storytelling books, of which about 50 apply to leadership and management (Boje, 2006, p. 219). Today, in 2014, the same search yields 147,677, of which over 7,000 related to business, management and leadership.

Practitioner-orientated, or “managerialist” approach to storytelling can be traced back to the work of Peters and Waterman (1982), which has been extensively examined and criticised in the academic literature by Child (1988), Collins (2008), and Parker (2000)). The book was based on research (funded by McKinsey and Company, the large US consulting firm) into excellence in organisations (Peters & Waterman, 1982, p. 13). The conclusion of the book found that “as it turns out, the excellent companies are unashamed collectors and tellers of stories, of legends and myths in support of their basic beliefs. Frito-Lay tells service stories. J&J tells quality stories. 3M tells innovation stories...” (Peters & Waterman, 1982, p. 282). Boje paraphrases the book into one recommendation, which is: “CEOs learn three-minute stump speeches to spur employees on to greater acts of customer service, devotion, and quality” (Peters & Waterman, 1982, p. 13).

Parker (2000) acknowledges that Peters and Waterman (1982) “opens up some intriguing questions about the use of terms like myth, ritual, language and so on within the description of organisation” (Parker, 2000, p. 13). Managerialist authors, or the consulting industry of storytelling, focus on where they can support the development of storytelling in speeches, training material and, following Peters and Waterman (1982), the role of the chief executive as a key storyteller. With this emphasis there is a broad range of potential literature from which to pull, but based on a consultancy model of material that focuses on and commits to adding
organisational value, Boje (2006) identifies six variations across the literature; (1) a CEO turned storyteller, sharing advice and experience (see (Armstrong, 1992)), (2) a consultant pitching advice to CEOs, supporting the development of key stories (see (Peters & Waterman, 1982) and (Denning, 2001)), (3) a strategic use of storytelling to support organisational change initiatives, (see (Gargiulo, 2002), (4) providing a catalogue and broad range of stories to be used by CEOs and leaders, (see (Parkin, 2004), (5) a coaching guide to CEOs and leaders in the complexity of storytelling, (see (Simmons, 2001)) and (6) maximising transformational impact through ‘in situ’ stories rather than imported stories (Kaye, 1996).

Boje suggests that that the managerialist literature provides academically testable propositions across “story leadership, story training, story consulting, and storytelling organisation systemics” (Boje, 2006, p. 219). The literature search highlights a number of key points that can be observed; (1) story telling is very important to organisations to support the delivery of change; (2) the story should focus on happy endings in order to engage the audience; (3) a single account of the story helps to ensure the story is clear and understood; (4) Keep it simple – storytelling is a way of making the complex simple; (5) storytelling and the transformational powers are a tool that can be taught and learnt. These themes can be traced back to Peters and Waterman (1982), and although there are variations and nuances to these themes, the literature returns to these fundamental principles.

At first point, the importance of storytelling to leaders, is well documented; stories are the most important tool a leader can possess (Boje, 2006, p. 219). For example, Armstrong’s collection of stories he has amassed to aid training (1992); or Denning’s springboard story to support transformational change (2001). As the tale started, Peters and Waterman highlight “the excellent companies are unashamed collectors and tellers of stories” (1982, p. 282).

From this recognition of the transformative value of stories and storytelling, the second point refers to how the literature moves to identify how to deliver the perfect story. The literature tended to, although not exclusively, focus on the
transformative powers of a happy ending. For example Denning’s springboard stories (Denning, 2001, p. xix); However, there is acknowledgement that unhappy endings have value, for example Simmons (2001) acknowledges the need to recognise and articulate stories that are positive and negative.

The third point focuses on the predominant approach to the telling of the story is one that is based on a monological account. Denning (2000, p. xix) sets out the characteristics: “(1) it is a story from the perspective of a single protagonist in a prototypical business predicament; (2) it is an explicit story familiar to the audience; (3) it stimulates their imagination; (4) it must have a positive or happy ending”. Gargiulo (2002) does take this further and cautions the audience to the potential risks that a good storytelling approach can bring, which can be a tool for the con-artist. In his account he highlights stories as a potential “weapon and acts of propaganda” (2002, p. 35). His solution, in line with the fundamental principles identified above, is to develop a wide database of stories, and to “use them contingently” (2002, p. 101).

The fourth point that can be highlighted from the literature is that stories are a vehicle to make the complexity manageable. Peters and Waterman (1982, p. 9) highlight how important it was to create “memory hooks provided by alliteration… our stuff was just too hard to explain, too easily forgettable”. From this approach, they highlight the potential of storytelling (1982, p. 11):

“All that stuff you have been dismissing for so long as the intractable, irrational, intuitive, informal organisation can be managed. Clearly, it has as much or more to do with the way things work (or don’t) around your companies as the formal structures and strategies do. Not only are you foolish to ignore it, but here is a way to think about it. Here are some tools for managing it. Here, really, is the way to develop a new skill.”
Following this lead, Denning (2000: xviii) suggests that such a story “enables a leap in understanding by the audience so as to grasp how an organisation or community or complex system may change”. Parkin (2005) provides the tools from over fifty example stories. These stories are broken down into a simplified linear account (Boje, 2006, p. 220), and makes the suggestion that storytelling is an easy approach to support the implementation of change.

Finally, the fifth point concludes that story telling can be learnt and developed as a tool by any leader. Gargiulo (2002) is cited as a typical example of this type of presentation of storytelling. The text moves on from Armstrong’s (1992) training for staff, to a more complex presentation of the story. Authors such as Simmons (2001) develop methods as to “how to sell a good story”. This form of text has an academic structure and remains popular. Simmons, like Gargiulo, highlights the subtle and complex nuances of storytelling.

From the publication of Peters and Waterman in 1982, Peters has continued to build on the research. Peters (2003) in (Collins, 2008, p. 218), argues twenty years after the original publication that stories have the capacity to create the “wave of lust” that throw buyers and sellers together (318):

“Those organisations with the best stories, he insists, will have faithful employees, excellent products and ardent customers”.

Whilst the conceptual, methodological and editorial issues within Peter and Waterman (1983) have been well documented (Collins, 2008), and the growth and interest in providing advice and guidance to organisations remains voluminous and present today. Organisations, including the NHS (based upon personal experience) are engaging management consultants to support the organisation’s management teams in order to embrace dialogue with staff. Generally, the managerialist literature simplifies the complexity of storytelling (e.g., overlooking multiple voices and locations of storytelling) and focuses on storytelling as an aid to managing and changing organisations. Such an approach does acknowledge the role of the storyteller and audience, but one that has a traditional sense of pedagogy, with a separation between the storyteller and the audience.
Kaye’s (1996) and Simmon’s work (2001) do acknowledge the complexity and potential for resistance between the storyteller and audience. The principle focus of managerialist literature is to support, encourage and deliver transformational change through engagement within the organisation. Managerialist literature focuses on describing a future state, and the intended position (Parker, 2000, p. 13). This focuses on how effectiveness and commitment can be achieved through engagement rather than control (Parker, 2000, p. 13).

Research question one sought to understand how storytelling evolved over time through using the definition of “story” as discussed previously, and an appreciation of the distinction between narrative and story, alongside the managerialist literature which articulates the processes through which (in this one discrete area of CEO/Leadership storytelling) narrative (or emplotment) is developed, as opposed to stories. Drawing from Cunliffe, Luhman and Boje (2004) and illustrated by Ricoeur, emplotment is the process through which “we try to make sense of our experience; we organise actions and events around plots or themes, that is, the ‘active sense of organising the events into a system’ (Ricoeur, 1984, p. 33).

Therefore, I wish to develop from the managerialist literature an understanding of the simplification of messages and speculative appreciation used to silence/exclude complexity and the consequences of such an approach. Consequences such as providing structure and a voice to the elite are that which “heroises the manager, while leaving the labour without a voice” (Boje, 2008, p. 1456). However, the assertion that other approaches to storytelling can side-step and avoid the silencing of voices would be a grand statement, and one I cannot accept. Therefore, this study takes forward an appreciation of the art and approach to simplifying the story – in turn, making it memorable – as a basis for achieving transformational change. The residual question that will require on-going understanding is: at what cost?

**Critical management studies approach**

A brief description of the critical management studies approach to storytelling leads to “a concern with themes ranging from fictionality, plurivocity and reflexivity to
temporality, intertextuality and voice” (Brown, 2006); which is enforced as “all of which are suffused with power” (Brown, Gabriel, & Gherardi, 2009).

As a tool to analyse organisations, the research on stories-as-text can be traced back to Gouldner (1954) who collected stories from an employee and the employee’s predecessor. The interest in storytelling has increased over the last 20 years. An interest in storytelling by critical management scholars tends to come as a supporting or secondary area of interest to subjects such as culture or folklore. The body of literature relating to storytelling is significant, and includes notable contributions to this field of research by Boje, Brown, Czarniawska, and Gabriel. For example, Brown’s interest is in organisational culture, identity, sense making, leadership and change (Brown, 1998; 2000; 2006; 2009); or Czarniawska’s work relating to storytelling highlights that stories occur across multiple sites and often simultaneously; furthermore stories are rarely told with a complete plot, even though in the most un-story like tales an underlying plot can be identified (see Czarniawska, 1997; 1999; 2004). I focused on David Boje and Yiannis Gabriel, whom are considered two leading commentators in this area (Collins, 2008, p. 318). David Boje has been one of the most prolific contributors to the discussion of storytelling (Boje, 1991; 1994; 1995; 2001; 2006). Yiannis Gabriel has developed a significant body of research on storytelling, narrative and folklore as a means of studying organisational symbolism, culture and politics (e.g. Gabriel, 1991a; 1991b; 1995; 2000; 2004; 2008).

I started with the areas of agreement between the two authors. Firstly, stories are important tools to understand the complexity and ambiguity in organisation (Collins, 2008, p. 318). Secondly, narrative accounts (which are represented largely by managerialist literature (see (Boje, 2008)) replay the facts of a situation, whereas stories have embellishments and speculative appreciations (Brown, Gabriel, & Gherardi, 2009, p. 324). Thirdly, the post-modern turn to investigate stories presents them as omnipresent, a point both authors challenge (see (Gabriel, 2000)). Fourthly, they argue against “so much of what passes for academic narrative analysis in organisational studies seems to rely upon sequential, single-voiced
stories” (Boje, 2001, p. 9). Both authors highlight that stories are susceptible to translation, and that they have a “polysemic” quality” (Collins, 2008, p. 319). Fifthly, stories are fragile and subject to translation (Gabriel, 2000, p. 239). Finally, the content and performance of the story is as significant, if not more so, than the facts upon which the story is based (see (Gabriel, 2000, p. 20), and (Boje, 2001) in (Brown, Gabriel, & Gherardi, 2009, p. 234)), and it is this focus on performance rather than fact that underscores the importance of stories in understanding the complexity and ambiguity in organisations.

The approach to storytelling between the two authors does vary. For Boje, the purpose of stories work as a sense-making device in organisations (Boje, 2001, p. 79); Boje is influenced by Weick’s view: “retrospective sense-making is an activity in which many possible meanings may need to be synthesised, because many different projects [stories] are under way at the time reflection takes place” (Weick, 1995, p. 27) in (Boje, 2001, p. 3)). They are tools and approaches to understand the ambiguity within organisational life (Collins, 2008). For Gabriel, stories and storytelling provide an intimate account of events, and breathe life into the communication experience. Gabriel suggests “storytelling is an art of weaving, of constructing the product of intimate knowledge” (Gabriel, 2000, p. 1); (see also (Collins, 2008, p. 319)).

For Boje the sense-making process uncovers worlds of experience, while the stories emerge as flowing and not static, and otherwise denied in official corporate (hi)stories: he suggests that “stories in organisations are self-deconstructing, flowing, emerging and networking, not at all static” (Boje, 2001, p. 1). Boje is influenced by the notion of sense-making and sees stories as an approach to understand the ambiguity by “retracing their lives, retrospectively through stories” (Collins, 2008, p. 322). Boje (1991) has argued that people use stories as a sense-making device, and as a tool to gain political advantage in a conversation, an appraisal of which is made available through Boje’s notion of the “ante-narrative” (2001, p. 9). Boje suggests ante-narrative has two interpretations, the first being that story comes before the staging and directing which he argues “lead to the
development of sequential, single-voiced, top-down narratives” (2001, p. 9). The second interpretation is “ante”-narrative acting as a bet that retrospective sense-making may emerge in the future from: “the fragmented, nonlinear, incoherent, collective and unploted” stories, which come before narrative accounts (Collins, 2008, p. 320). To illustrate this further Boje highlighted:

“Tracing a story into its inter-story context (into the Tamara of many pre-narrated stories and ante-narratives) also invites a political reading of the text in to its inter-textual relation with other texts. How a the story references a context within other ante-narratives, self destructing one meaning in a web or network of stories of other meaning” (Boje, 2001, p. 27)

This is best illustrated in the Boje assertion that “the terse narrative which announces, ‘you know the story’ should be regarded as a story in its own right” (Collins, 2008, p. 320). Later in a more radical move, Boje (2001, p. 9) argues that stories are those special forms of narrative that exist prior to the crystallising processes of casting and plotting. It is therefore the speculative approach of the storytellers and how a political reading of these approaches informs the emerging narrative.

For Gabriel, stories are based upon intimate knowledge and accounts of experience, and it is the performance, poetic and ingenuity used in the intimate accounts that are revealed through storytelling about organisations. More specifically it is the “performativity, memorableness, ingenuity and symbolism” (Gabriel, 2000, p. 20). Gabriel describes narrative as “opinions” or “reports”, the former containing facts, but no plot, and the latter offering an historical rendering of the facts providing a “stubbornly factual and causative, as opposed to, symbolic account” (Collins, 2008, p. 320). What distinguishes story from narrative is described by him as proto-stories and poetic stories (Collins, 2008, p. 321). In response to Boje’s ante-narrative (2001, p. 9), Gabriel suggests these are proto-stories – which are incomplete, and with no satisfactory ending. It is the poetic that both distinguishes stories from narrative for Gabriel and is the key focus around which Gabriel
develops the story. For Gabriel it is the chain of events that reflects the structure of the plot.

In addition to the chain of events, it is the traits and approaches used by the storytellers, including the use of symbolism, embellishment, and a focus on enduring truths rather than simple facts (see (Collins, 2008, p. 321), (Gabriel, 2000), and (Gabriel, 2004)). Gabriel describes eight “poetic tropes” (Gabriel, 2000, p. 36); this includes emotion, motivation and connections. He suggests the poetic tropes “breathe life into stories and give them capacity to communicate experience” (Collins, 2008, p. 321). Gabriel best articulates the value of such an approach as:

“[t]he realisation that, far from being an obstacle to their use in social research, this poetic license enhances their usefulness and has been one of the major changes in researchers’ attitudes. A story, even if inaccurate and maybe especially if inaccurate, opens windows into an organisation’s narrative universe, its clashes and contradictions, its fantasies and fictions – in short, into the meaning systems that people in organisations construct, sustain and inhabit.” (Gabriel, 2008, p. 154)

Of interest is the development of an appreciation for the intimate nature of story-work and performance influenced by poetic license. Story-work is the fragile process of developing plots, staging and direction through the chain of events – it is a focus on enduring truths rather than simple facts (Collins, 2008, p. 321).

To recap, stories are not found everywhere. Both agree that stories are important tools to understand the complexities of organisations. Both agree that stories are hard to find in organisations (Collins, 2008, p. 321). Gabriel focused on understanding the specialty and rareness of the story, whereas Boje refined the meaning of story. Critical management scholars identify that storytelling occurs across many areas within the organisation, and are told with a multi-vocal and un-unified view (Boje 2006). These authors also acknowledge that stories are used by individuals and can be loaded for political gain (Boje, 2001) and power (Brown, Gabriel, & Gherardi, 2009). As Collins highlights, Gabriel (2000) (2004) and Boje
(1991) (2001) identify that managerialist accounts of stories “too often, represent partisan projections of a top management world-view that jar with the everyday stories which people tell one another at, or about, work” (Collins, 2008, p. 323). Boje and Gabriel offer an opportunity to consider a more complex, or speculative appreciation of the storytelling.

Critical management literature highlights the importance of multi-vocal and competing voices. In a challenge to managerialist literature, critical management contemplates that achieving commitment is another version of control, as highlighted by Boje and Gabriel’s identification of a dissonance between the storytelling elite and the everyday experience of organisation Parker (2000).

The contribution of story and storytelling literature to the research questions

This review of story and storytelling literature was undertaken to establish how the existing literature approached storytelling. Of specific interest is how the literature contributed to understanding the evolution of storytelling as set out in research question one. In Table 1 below, I present a comparison of managerialist and critical management literature, influenced by Boje (2006, p. 216).

This presents a binary separation between managerialist text and critical management text; the literature review also identified differences within the two approaches. For example, I acknowledge that Denning (2001) and Simmons (2001) have conflicting views regarding whether a story should or should not have a happy ending. What is clear is the paradigm of managerialist literature focuses on the simple, ordered and stylistic delivery of stories. Similarly the varying positions highlighted within the literature of Boje and Gabriel are examples of variation within critical management studies, Boje focusing on fragmented and distributed pre-story, whilst Gabriel emphasises the poetic approach to delivery. The paradigm of critical management literature emphasises the complexity, the political nature, and champions the subjective rather than factual nature of stories.
There is a risk inherent in both managerialist and critical management literature, the former ensuring the story has a beginning, middle and an end, the later focusing on the poetic embellishments. This could mean both literatures ignore the terser, boring stories (Boje, 2006). I suggest that an opportunity exists to consider storytelling in action, looking at “the dynamics of the storytelling organisation from a complex system standpoint” (Boje 2006, p. 224) and understanding how stories evolve over time. Of interest to this particular thesis, and one that broadens the complex system, is the relationship with factors “outside” the organisation. In Parker (2000, p. 22) he describes the approach of managerialist literature (and specifically Peters and Waterman (1982)) as:

“Attempts to generate belonging might itself be symptomatic of the Durkheimian diagnosis in terms of its search for communitas or Tonnies’s Gemeinschaft against the anomic or alienating tendencies of the modern Gesellschaft. ...we are encouraged to worship within the evangelising organisation, to find our devotions in work.”

Whilst critical management studies highlight the development of counter stories from internal and external sources: “it is virtually impossible to sustain monological accounts of social reality” (Oswick & Keenoy, 2001) in Bryant & Cox (2004), and “stories are quickly opposed by counter stories” (Boje, 2006, p. 218). Rather than focus on stories as a single event existing within the organisation, research question one sought to follow the opportunity to consider how stories move and change between the organisation (internal) and communities (external) as one story, rather than two distinct or opposing positions. Research question two focused on the roles of the storyteller and audience that supported its evolution, therefore rather than focus on the singular elite story teller and mass audience, or a focus on the multiplicity of voices and interpretations, an opportunity exists to understand how the roles of the storyteller and audience are created and defined, and how this changes over time.
Table 1. Comparing Managerialist and Critical Management approaches to storytelling

<table>
<thead>
<tr>
<th>Managerialist</th>
<th>Critical Management Studies</th>
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<tbody>
<tr>
<td>Teleological approach: focus on “story endings” and in particular, “happy”/positive endings. (Denning, 2001)</td>
<td>Evolutionary approach: focus on “unfolding”; no clear end point (Boje, 1991) (Gabriel, 2000)</td>
</tr>
<tr>
<td>Emphasis on simplification (e.g., simple story lines are considered more useful to cope with organisational complexity) (Gargiulo, 2002)</td>
<td>Emphasis on complexity (Boje, 2001) (Brown, Gabriel, &amp; Gherardi, 2009)</td>
</tr>
<tr>
<td>Elite and transformative (see (Denning, 2001) and (Peters &amp; Waterman, 1982)). Stories are created and delivered with the desire to implement significant change, and specifically through the will of the leader (often in the singular) (Parker, 2000, p. 17)</td>
<td>Storytelling is a tool for sense-making rather than purely transformation (Boje, 2001), and for Gabriel it is based upon the intimate knowledge and account of anyone. (Gabriel, 2000, p. 20).</td>
</tr>
<tr>
<td>Tacit knowledge is said to be captured and retrievable in story databases (Parkin, 2004)</td>
<td>Stories cannot be captured (Gabriel, 2000) (Collins, 2008) (Boje, 2001)</td>
</tr>
<tr>
<td>Stylising the presentation (see (Peters &amp; Waterman, 1982, p. 11)) and practicing the telling of simple stories is said to improve leadership effectiveness (Simmons, 2001).</td>
<td>Stories are difficult to “capture”, therefore avoid repetition and practice in the delivery. However poetic delivery, engaging delivery is a component of a story. In its briefest form “You remember that story...?” for Boje is the act of speculative sense-making that attempts to engage, with stories told as tersely and fragmented (2001). For Gabriel the poetic tropes, fundamental to a story, are “distinct ways of turning facts into meaningful, emotionally charged stories” (2000, p. 83).</td>
</tr>
<tr>
<td>Factual accounts perform well (Armstrong, 1992)</td>
<td>Factual accuracy has no primacy, the performance is key. (Brown, Gabriel, &amp; Gherardi, 2009) (Gabriel, 2008)</td>
</tr>
</tbody>
</table>
The research will seek to identify the managerialist turns of single univocal presentations, whilst simultaneously understanding the acts of interpretation – through the development and analysis of a story, the storyteller and the audience. The concern remains with: “accounts of sequenced events, and with plots that weave together complex occurrences into unified wholes that reveal something of significance” (see Brown (1998); (2000); and Gabriel (2008)). I argued that the opportunity to do this can be taken forward through the development of frames and frame analysis. Such an approach seeks to avoid being “seduced by the story” (see Gabriel (2008)) or to finding “terse fragments” (Boje, 2001, p. 5), it instead focuses on the complexity of constructing and delivering the tale, and understanding what, how and why the story is more or less believable. In order to bring the key opportunities together, I set out in figure 2 below the key components I took forward from the first section of the theoretical framework for this study.

I have identified three key features that I wish to draw from the literature for this research. All three are in conflict, but equally are mutually dependent on one another. The sum of these three elements provided an opportunity to explore the evolution process and acts of storytelling, rather than purely the content of the story (be that from a managerialist (single account) or critical management perspective (multiple accounts)). The concern would be with how the story comes about, as the “story work” which is “literally the art of constructing meaningful stories” (Collins, 2008, p. 320) is developed. Rather than restate the definitions of ante-narrative, poetic delivery and a managerialist approach to the simplified message, I would like to articulate the relationship between the components of the model. I will consider each in turn.

The first component is ante-narrative. In short, I am interested in Boje’s notion of ante-narrative as a refusal to be coherent (Boje, 2001, p. 2), and its primary function as one of sense-making. Stories are “ante-narrative”, in that they come before the processes of staging and directing. In contrast, the ante-narrative preceding such structure represents “a bet” (or “an ante”) that retrospective sense-making may emerge in the future. Ante-narrative is not narrative, and Boje is concerned to
Figure 2. Key contribution of storytelling literature to this research

Unfolding stories/evolving storytelling

Ante narrative
The speculative appreciations and political approach to sensemaking
Speculation is the interest in the flow of storytelling

Poetic delivery
The chain of events and intimate knowledge that develops poetic tropes to deliver the story
Speculation is the distortion and omission which serve a deeper process

Simplified Message
Making the complex manageable
Speculation is an account of the future
emphasise that people inhabit a space that is “messy and outside of plot” (Boje, 2001, p. 2); it is therefore of importance to understand story before the application of the order. However, this means for Boje that stories cannot be retrospectively captured, as they are too unconstructed and therefore consist of “retrospective sense-making symbolism”. Consequently, they “amount to little more than delicate fragments of sense, communicating metonymically, as if they were product brands” (Gabriel, 2000, p. 20). Boje’s notion of ante-narrative is in contrast to Gabriel (2000) and the notion of plot. For Boje, the development of the plot is an application of order that closes down the speculative ability of the story, and elevates it to a narrative account of facts.

Of interest therefore, from an understanding of ante-narrative, is Boje’s notion of speculation. Speculation is the interest in the flow of storytelling (over time). Boje describes speculation as identified through the ante-narrative, where the individual is still chasing stories, considering “many different logics for plotting on-going events” (Boje, 2001, p. 4). Although Boje’s and Gabriel’s relationship with plot contrasts is integral, Gabriel’s definition of story (poetic tales) does seek to emphasise the “sense of folkeness or disorder”; in this example plot is not and cannot be considered a single constraining entity. That means to say, the notion of ante-narrative and poetic tales arguably resist a sense of order, the simplified and/or imposed view. Ante-narrative is described as the living experience, whereas narrative is the “meta-level understanding” (Boje, 2001, p. 3). Boje argued that in the shift from ante-narrative to narrative, the speculative process ceases – and this is where I turn to Gabriel’s poetic tales.

If ante-narrative focuses on speculation and sense-making, I suggest the second component – poetic delivery – focuses on interpretation (Gabriel, 2000, p. 35). Whereas sense-making is a personalised focus on the individual (or collective) making sense of accounts and experience, interpretation is a broader relationship of the understanding of the acts of storytelling. Poetic delivery (or more specifically poetic licence) is a narrative contract between the storyteller and the audience. As Gabriel suggests:
“Poetic licence forms part of a psychological contract between the storyteller and his/her audience, that allows a storyteller to twist the material for effect, to exaggerate, to omit, to draw connections where none are apparent, to silence events that interfere with the storyline; to embellish, to elaborate, to display emotion, to comment, to interpret, even as s/he claims to be representing reality” (Gabriel, 2008, p. 158).

Poetic licence is not a novel or film account of events, nor is it a rhetorical or stylistic presentation of fact; it is experience. Through poetic licence Gabriel differentiates between facts as experience and facts as information (Gabriel, 2008, p. 158). I suggest that this also differentiates critical management and managerialist accounts of storytelling, with the former emphasising experience, and the latter emphasising facts as information (albeit delivered in a rhetorical/stylised form).

What is of interest here is how poetic licence enables the storyteller to buy the audience’s suspension of “critical judgement in exchange for pulling of a story which is at once meaningful and verisimilar” (Gabriel, 2008, p. 159). Treading a tightrope between two questions (Gabriel suggests that the primary focus of the story teller is to answer in their story the “so what?” and “did it really?” questions), which threaten to undermine the narrative contract of experience, is the key function of poetic license. Whereas managerialist approaches to storytelling focus on the delivery of the information rather than the verisimilitude of the account, I would suggest that poetic license offers a similar notion of speculation as seen with the ante-narrative. Poetic license speculates through accounts that support (or undermine) the truth and accuracy of the account. Gabriel’s poetic licence allows for a similar level of (speculative) appreciation and re-writing of plot as it forms part of the story work.

Gabriel suggests that poetic license is not to develop an untruth, but instead suggests that “it may be that distortions, omissions and exaggerations serve a deeper purpose” (Gabriel, 2008, p. 159). Poetic license and managerialist stories of
simplified accounts share a relationship with truth (or more accurately a lack of prioritisation of truth) and accuracy of reporting (Gabriel, 2008, p. 159). Presenting critical management and managerialist accounts together highlights that stories “may have different symbolic resonances with different listeners, as for some it is a protostory to others it is a story” (Gabriel, 2000, p. 26). Therefore, whilst the three components discussed here contest and contradict, the opportunity to understand a connection between them exists.

The third area is that of the ‘simplified message’. This is the process through which the account or story is developed, coached, attuned and to be delivered by an individual leader. It is not purely a communication strategy or the improvement of the grammatical presentation of the story. In similar terms to Gabriel’s (2008) poetic licence, it is about the crafting of events and facts into a story to be delivered to the audience. However, unlike poetic licence and its focus on interpretation, the focus of the simplified message is one of transformation. The approach is informed by the relationship and psychological contract between the storyteller: in this case, predominantly the individual (and often white, male, chief executive or senior leader in the organisation) and the audience (predominantly the wider organisation and lower levels of staff).

The story attempts to realise a change. It is not (necessarily) a tool for interpretation or sense-making. It is an account of the future, delivered in a way that can be, or at least assumed to be, assimilated by the audience. In this case it is the objective expert (the senior leader) presenting their view in the language and experience of the audience (see for example Denning (2001)). It is this relationship that is of interest to this study. The process of emplotment in the story, making the account memorable, is crucial. The relationship between the storyteller and audience isn’t one seeking to suspend belief and critical judgement, but one that seeks movement and change. The story is delivered in univocal format and from an elitist position (Boje, 2008, p. 1456). The size of the consultancy business associated with organisations and storytelling highlights that delivering this simplified message and achieving movement and change is not straightforward.
would argue that such an approach requires the same speculative approach that we perceive in Boje’s account of ante-narrative and Gabriel’s poetic license. To bring these three components together, the ante-narrative exists before plotting, whilst the poetic licence is building on the plot, casting and performance; what connects these two elements is the speculative nature of the process. The simplified message is similarly a speculative approach, which seeks to silence the complexity in order to “hook” the listener, reader or audience to the message. Therefore, although the three components and the literature describe stories from individual paradigms, the notion of speculation is a theme that pulls them together. Returning to my definition of story, I highlight that the accuracy of stories is not important – and therefore the speculative choices of purposeful or accidental inaccuracy are a source of investigation that has the potential to identify something of significance (Gabriel, 2008, p. 195).

However, from these three approaches I want to ensure that I do not promote speculation and inaccuracy at the expense of fact. An opportunity exists with all three approaches to understand the relationship each has to the storyteller, audience, and their psychological contract. The grounding of the three approaches – and a move away from defining story and narrative to one focusing on the relationships, allows for the ability to recognise the complexity and multivocality of storytelling, while avoiding an argument “for the non-existence or irrelevance of facts or celebrating the infinity of interpretations and symbolic constructions.” (Gabriel, 2008, p. 162). Clearly, in the context of the case at the centre of this research, in which many people died at MSFT, this study acknowledged this fact and through the research questions and theoretical framework, investigates how the deaths and accounts of the deaths are speculated, generated and replayed and evolve over time. As Gabriel (2008, p. 162) suggests, there “are no virtual deaths, irrespective of whether the dead are symbolically constructed as victims, martyrs, heroes or collateral damage. Facts are recalcitrant – they cannot be modified at will, although they may be contested, interpreted or explained.”
A path through the critical management studies approach would potentially prioritise experience and multivocality, whereas the managerialist prioritises the presentation of “fact” in a clear manner – both offer opportunities to understand the “possibility [of] grave breaches of the psychological contract between author and reader” (2008, p. 160). This approach can identify and acknowledge that in a contested environment of storytelling where every terse fragment is challenged, experience (over fact) as a position of authority offers a “shelter from criticism, an oasis of trust, an island of tranquillity, where a person can speak with incontestable authority and expect, if not being respected, at the very least being to be believed” (2008, p. 162).

Accepting this allowed me to develop a theoretical framework to understand the process of storytelling through the three research questions. Rather than seek to promote experience over fact (and/or visa versa) – I found they were faces of the same coin, each dependent on the other. A relationship exists between individual or collective experience (particularly in the cases of suffering and victimisation) and the knowledge of the detached and objective expert (Gabriel, 2008, p. 164); both are mutually dependent on the other. I have described the effect of this relationship as stultification. I explored how frame analysis provided a theoretical framework to analyse this position.

**FRAME ANALYSIS**

Methodological approaches used in narrative and storytelling research within organisation theory included a wide range of tools; Boudes and Laroche (2009) use narrative semiotic approach informed by semionarrative theory (see for example Greimas (1983)), Boje’s (2004) use of grotesque method (informed by Bakhtin, 1968)). Frame analysis is a not a method that has been explored through storytelling and narratology within organisation theory. I selected frame analysis as the methodology in order to support the research questions of: How does storytelling unfold and escalate from one event into multiple stories? How do the roles of the storyteller and audience become defined and re-defined over time?
Within this process of unfolding stories, what are the intended and unintended consequences of storytelling?

Frame analysis, as suggested by Creed, Langstraat and Scully (2002, p. 35) offered a research strategy to capture “the role of societal culture in the workings of organizations and institutions”. More specifically they suggest that frame analysis can sort out underlying topics; situate frames in context, surface politics, subjugated voices, and support organizational researchers to make mindful choices. Frame analysis has been developed across a range of fields within social science, as I will illustrate below. Of specific interest to narrative and storytelling within organisation theory there are a number benefits frame analysis offers, and three specific examples I would like to consider here.

Firstly, frame analysis provided a method in order to make sense of “societal and contextual issues” (p. 36). Of particular interest is the development of framing within social movement theory, where “meaning is pivotal” (Benford, 1997, p. 410). Where frame analysis was applied at a defined set of points over the timeline of a story it provided an opportunity to consider how and why stories unfold and escalate.

Secondly frame analysis provided an opportunity to develop a richer depiction of the environment at the heart of the study. Frame analysis, again influenced by social movement theory, provided a “model for its use in understanding the strategic, regulatory, and culture dimensions of both intraorganisational and extraorganisational policy debate” (Creed, Langstraat and Scully, 2002, p. 35). Of significance is the value frame analysis added to an understanding of how storytelling unfolds, within, outside and between the organisation and communities. Frame analysis provided a grounded way to look at the content of institutional forces and stakeholder claims (see Friedland and Alford, 1991).

Finally, Goffman suggested (1974, p. 25) the notion of multiple and intersecting frames was key to informing analysis – frame analysis methods have previously underplayed this value. In this study, and through the application of frame analysis over the course of the study, the dynamic acts of the storytelling were considered
through an appreciation of the intersections that were made, developed and broken between frames. Such an approach provided an opportunity to consider the intended and unintended consequences of storytelling, through an appreciation of how the multiple and intersecting frames developed over time.

Frame analysis therefore provided the ideal method to support an analysis of the data and address the three research questions. I found that frame analysis literature constituted a source of insight and challenge. I suggested that speculative appreciations of storytelling (identified through the storytelling literature) could be presented and understood through signification steps of frame analysis. Frame analysis allows for stories to exist in their fragmented forms. This fragmentation allows for, as Boje (2001, p. 3) suggested, “a retrospective explanation of storytelling’s speculative appreciations”. For poetic delivery, frame analysis focuses on the “reality construction” or “meaning generation” (Benford & Snow, 2000, p. 625), and the process through which the frames (and plots) are set out. Finally, frame analysis offers an opportunity to categorise and connect pieces of information and by doing so reduce complexity into single coherent story whilst carrying ideological and political implications (Gamson, 1992).

The concept of frame analysis is credited to Goffman’s (1975) description of frames as a "schemata of interpretation" that enables individuals "to locate, perceive, identify, and label occurrences within their life space and the world at large" (p. 21). Inspired by James’ question (1950) “under what circumstances do we think things are real?” Goffman’s interest in sense-making (Creed, Langstraat, & Scully, 2002, p. 35) focuses on “what is it that is going on here?” (Goffman, 1975, p. 8). From Goffman’s work frame analysis has developed across many disciplines, Benford and Snow (2000, p. 611) highlight the development of frame analysis across psychology, linguistics, discourse analysis, communication, media studies (Tversky & Kahneman, 1981) (Tannen, 1993) (Scheufele, 1999) (Triandafyllido & Fotiou, 1998) and finally within sociology as a tool to study social movements and collective actions (Benford & Snow, 2000, p. 612). With this research focused on the events of a crisis at MSFT and understanding how the different storytellers and audiences reacted to events...
relating to the crisis, it is a sociological application of frame analysis informed by social movement that I primarily wanted to consider.

Although the term ‘framing’ has been used within sociology (see for example Bateson (1955)) since the 1950’s, it gained ground following on from the complex text of Goffman in 1975. A review of the literature finds that Goffman provided little guidance for the use and applications of frame analysis (Benford, 1997, p. 412): “It has abundant implications for what it is that we should attend to, but the methodological implications are only suggested and not developed at this point”. Framing was then taken forward in a range of fields (Vliegenthart & Zoonan, 2011), but most notably three areas. Firstly psychology; see for example Tversky & Kahneman (1981). Secondly media and communications; see Gitlin (1980) and Entman (1993). Thirdly for sociology and social movement; see Gamson ((1975); (1992)) and Snow and Benford (2000).

To consider frame analysis as an analytical tool, within the psychology literature (see Tversky & Kahneman (1981)), the authors consider the “framing effect” (Tversky & Kahneman, 1981, p. 453) in terms of understanding the way individuals react to or make decisions dependent on how the question or problem is framed as either loss or a gain. To consider examples of media and communications, Gitlin (1977) (1980) first researched how mass media in the 1960’s framed movements. Gitlin opens with “how TV flattens consciousness about movements, and within movements; how it backfires, how for a time it amplifies opposition, certain types of opposition, and then how it ends up devouring movement” (1977, p. 789). His analysis uncovers a request, whereby he asks the readers not to be blinded by the spotlight of mass media, but to “understand how it is to live in a floodlit world” (1977, p. 800).

It was Entman however who significantly moved the analysis onwards by using the term “framing as a fractured paradigm” (Entman, 1993). Entman argues that the discipline of communication can “contribute something unique” (1993, p. 51) through the development of frame theory. Entman continues to highlight that the
point of his analysis in 1993 “despite the omnipresence across the social sciences and humanities, nowhere is there a general statement of framing theory that shows exactly how frames become embedded within and make themselves manifest in a text, or how framing influences thinkers” (Entman, 1993, p. 51). Vleuglenthart and van Zoonan track, from Entman, a significant rise in research and the use of framing in research regarding news and journalism outlets (Vleuglenthart & Zoonan, 2011, p. 102).

Vleuglenthart and Zoonan (2011, p. 102) echo this lack of consistency in their application almost 10 years later. These authors, in their review of frame analysis in communications, distinguish between frame analyses as either frame building (how does the frame come about?) or frame effects (what consequences does the frame have?) (2011, p. 103). They highlight that Gitlin’s approach emphasises the frame building processes (in his case the framing of the US student movement in 1960s) as the “principles of selection, emphasis and presentation composed of little tacit theories about what exists, what happens, and what matters” (Gitlin, 1980, p. 7). For frame effects they draw from the work of Gamson relating to social movements, but also his interest in movements and news coverage (Vleuglenthart & Zoonan, 2011, p. 103). Gamson’s analysis of collective action frames identified that frames “offer ways of understanding that imply the need for and desirability of some form of action” (Gamson, 1992, p. 7).

In the social movement literature, frame analysis was moved forward by a range of authors, but primarily Gamson (1975; 1992; Gamson & Lasch 1983; Gamson, Fireman, & Rytina; 1982) and Benford and Snow (Snow, Rochford, & Worden, 1986); (Snow & Benford, 1992); (Benford, 1993); (Benford & Snow, 2000). As with communication theory, the analysis is influenced by framing and framing effects. Frames were described as “collections of idea elements tied together by a unifying concept that serve to punctuate, elaborate, and motivate action on a given topic” (Snow & Benford, 1988).

Within social movement Creed, Langstraat and Scully emphasise frame analysis as a
“tool for sorting out many viewpoints and stances as the objects of inquiry” (Creed, Langstraat, & Scully, 2002, p. 38). This allows for the acknowledgement of the role of the researcher in the construction and reconstruction of the frames – rather than a frame being presented as ontologically “out there” and capable of being captured. Of interest to the study is the manner by which frame analysis moves from purely being a tool for analysis, to tool of development or expanded theory. In 2000, Snow and Benford’s review of the emerging literature highlighted the potential of frame analysis to support the theory development in the area of framing processes, and the identification of hitherto hidden dynamics within social movement (2000, p. 633).

What this analysis highlights is that there are similarities in the approaches and at a meta-level; the consistent tie-back to Goffman exists. Vliegenthart and Zoonan best summarise where there is consistency (2011, p. 105):
- That frames are multiple and can be contradictory or oppositional
- That frames are part of a struggle for meaning between different actors that have unequal material and symbolic resources;
- That news frames are the result of situated social and routinised processes in which the agency of the individual journalists is relative;
- That frames used by audiences are the result of socially situated articulations between particular issues, individual and collective differences, experiential knowledge, popular wisdom and media discourse.

In order to identify the opportunity frame analysis presents, I would like to consider what the purpose of this study is and summarise the definition of the story. The purpose of this study is to establish authorities on the phenomenon of storytelling through the examination of 1) how storytelling unfolds and escalates, starting from a single event and generating into multiple stories; 2) how the roles of the storyteller and the audience are defined, redefined and become blurred in the process; 3) how the stories reach intended and unintended audiences and how this might create “unintended consequences” of storytelling.
Having established the definition of story as one that is not an historical account, but an opportunity to re-narrate events, it must be believable, rather than “real” as a product of its structural presentation; therefore the seductive powers of storytelling need to be understood. The final development of the definition of “story” is that given the interpretative nature of stories, they are temporal events. To use Boje’s description, stories “self destruct” (Boje, 2001, p. 18). This opens up opportunities for further re-telling and re-presentation of the story. The opportunity frame analysis, and a sociological approach informed by social movement theory, offers is articulated by Creed, Langstraat and Scully (2002, p. 37):

Frame analysis, then, is a technique for approaching a text by attending to its diverse idea elements with the following question: What holds these elements together? The goal of frame analysis is understanding how certain idea elements are linked together into packages of meaning, potentially encoded into sound bite like signifiers that stand for those packages of meaning, and deployed in situated discursive activity.

Within social movement, frame analysis highlights the significance and relationship between “frame processing and goal attainment” (Benford & Snow, 2000, p. 632). Creed, Langstraat and Scully (2002, p. 39) suggest that “one goal of frame analysis, and of a signature matrix as a particular technique is to direct careful attention to how these diverse idea elements are deployed in integrated ways”. The signature matrix developed by Gamson and Lasch (1983, p. 399) and the functions of the frame that Snow and Benford articulate as punctuation, elaboration, and motivation functions (Snow & Benford, 1988) are presented in a simple elaboration matrix by Creed, Langstraat and Scully (2002, p. 41). It provides a clear approach for analysing frames, and ordering different fragments of text. Together, these two approaches help to identify the framing, and process of framing, through the signature matrix. The signature matrix provides an opportunity to understand the definition, through the differentiation and similarities evident between the storyteller and the audience. The frame effects, through the elaboration matrix,
offer the opportunity to identify the intended (or unintended) consequences of the frame and allow for an opportunity to identify how the stories unfold.

In this section I have presented three components of frame analysis. Firstly frame analysis provides a structure to support the uncovering of the components and presentation of accounts, enabling an understanding of where and how connections are made/not made; secondly, through the presentation of connections and the weaving of these accounts together, it provides an opportunity to “reveal something of significance” (Brown, Gabriel, & Gherardi, 2009, p. 324), and in doing so frame analysis offers an opportunity not only to re-present accounts, but to present opportunities to develop theory. However, of most interest is that thirdly, frame analysis, if applied over the course of an event, provides an opportunity to observe how the accounts and connections change over time – it presents an opportunity to consider not just movement organisations, but the organising of movement.

The functional approach that frame analysis provides is a structure that states: “all texts, regardless of how clear or abstruse they may be, are comprised of packages of integrated idea elements held together by some unifying central concept, called a frame” (Gamson & Lasch, 1983). The building and identification of plot, delivery and performance also support Gabriel’s definition of the “poetic story” (2000, p. 83).

Despite the significant literature and material relating to frame analysis it has not “produced a coherent and cumulative understanding of where and how particular frames affect particular responses of individuals in particular circumstances, under particular conditions” (Vliegenthart & Zoonan, 2011, p. 111). As Vliegenthart & Zoonan (2011) suggest, from the limitations they observe from critical studies of media and news, they have emphasised the frame of the text itself, rather than the frame building. They suggest there is more “to offer for understanding how frames come about, than much of current frame research itself.” (p. 108).
Examples such as McCammon’s analysis of social movement organisations and Women’s citizenship in the US (McCammon, 2012); Noy’s analysis of frames and homeless policy in San Francisco (Noy, 2009); and Jones and Livne-Tarandach’s analysis of frames used by architects (Jones & Livne-Tarandach, 2008), continue to base their analysis on the approach set out by Benford and Snow (2000).

As highlighted, the signature matrix (Gamson & Lasch, 1983, p. 399), which is also set out by Creed, Langstraat and Scully (2002, p. 42) is used to sort what are described as “idea elements of a set of texts into categories such as metaphors, exemplars, catchphrases, depictions, visual images, roots, consequences, and appeals to principle.” (2002, p. 39). This provides an opportunity to explore how the data items (terse fragments (Boje, 1991)) are used in integrated ways to create sequence and plot, the outcome of which provides an opportunity to develop theory through the identification of new connections, explanations and account for story work (Collins, 2008, p. 320), which hitherto remained hidden. Instead of becoming the master discipline that Entman wished for, Benford suggested (1997, p. 415): “the bulk of empirical work has tended to accomplish more toward yielding a morphology of frames rather than producing a sociology of movement framing processes”. Applying frame analysis over a period of time provides an opportunity to develop a greater appreciation of the processes of building the “frame” as well as the process of framing over time, which is an area in which the current literature requires further development (Vliegenthart & Zoonan, 2011, p. 106).

The case at the centre of this study, the crisis at MSFT, has taken place within the context of an “active multimedia culture in which citizens nowadays operate and compile their political information.” (Vliegenthart & Zoonan, 2011, p. 111). Therefore the development of frame analysis must take account of these fragments of political information that build and develop over time. Whilst considering the movement and changing connections within and between frames, it is important to consider who is moving. In this case, it is to understand the storyteller and the
audience. Frame analysis therefore supports and generates a structure to address research question one (the evolution of storytelling).

In order to consider research question two, the application of frame analysis over time provides further opportunity to understand the storyteller and audience and thus I wish to consider, in concise terms, the literature’s definitions. Consistent with the definition of frame analysis, there is no single definition of the storyteller found across the text. Terms that are introduced within the frame analysis literature include organisational actors (Creed, Langstraat, & Scully, 2002, p. 35), sponsors (Gamson & Lasch, 1983, p. 6), and movement activists (Benford & Snow, 2000, p. 614).

In chapter 3 (Methods) I will set out the storytellers identified. However it is perhaps important to consider the definitions. Creed Langstraat and Scully (2002, p. 35), drawing from Hoffman and Ventresca suggest, “Existing institutional arrangements shape how organisational actors frame, respond to, and solve their problems” (Hoffman & Ventresca, 1999). Gamson and Lasch (1983, p. 2) place the sponsor as the creator of packages and frames: for example, “Strips of events exist in a particular symbolic environment or culture. A variety of organisational sponsors offer interpretive packages that give meaning to these events as they unfold over time” (p. 2). Finally Benford (1993) identifies four groups involved in social movement framing a) the activist; b) rank and file supporters; c) recruits; and d) significant others. Of interest to this study, is the activist: for example, student activists in the Chinese democracy movement (Zuo & Benford, 1995) were leaders, proactive and vocal individuals that were identified as defining, constructing and altering frames in order to attract and recruit new supporters. There is therefore similarity across these definitions, with a significant role of creating and re-creating frames overtime.

It is also important to consider to whom the storytelling is delivered. Goffman (1975, p. 124) devotes time to the development of the theatrical frame, in which he sought to illustrate the intertwined relationship between the onstage and offstage
actor and the audience. As highlighted through the definition of stultification, it was recognised that both the actor and audience were mutually dependent on one another; Goffman wrote about the nature and dynamic of the meeting between one and the other person. He compared social interaction to theatrical performance, and distinguishes between the public “front region” (the front of the stage between the actor and audience) and the “back region” (the private space) (Goffman, 1959).

It is through movement theory that I wish to connect to and consider the audience. It has long been taken as a given in communication studies that the target of the message can affect the form and content of the message; for example, in the social movement literature, activists targeted audiences to interact with. Moreover, movement organisations find it necessary to appeal to multiple audiences who vary in terms of the relative interests, values, beliefs and knowledge, as well as with respect to which of the various movement or counter movement roles they can potentially play (Benford & Snow, 2000, p. 630).

From their analysis of the literature, Benford and Snow (2000) suggest that there are three ways the relationship between the storyteller and the audience is contested: “counter-framing by movement opponents, bystanders, and the media; frame disputes within movements; and the dialectic between frames and events” (p. 625). Counter-framing activity challenges the diagnostic and prognosis positions. This can lead to natural development and evolution of the frame responding to those challenges, but can also lead to framing contests. Counter-framing is the attempt of those who do not support the movement to undermine the alternative beliefs and its version of reality; hence, when the storyteller develops their frame to avoid or respond to these challenges a framing contest occurs (Ryan, 1991).

Frame disputes (developed in Benford (1993)) within movements are “intramovement disagreements over the diagnostic and prognosis stage” of the core tasks (Benford & Snow, 2000, p. 626). Diagnostic and prognosis stages form part of the elaborative function of a frame and “serve to attribute responsibility for
the issue and to prescribe potential solutions to it” (Creed, Langstraat, & Scully, 2002, p. 40). The diagnostic and prognosis stages are dialectic between frames and events. This step seeks to understand the tension or agreements between the frames and the actual action undertaken, and how or if, the action redefines the very frame that provided the opportunity for action (Benford & Snow, 2000, p. 627).

Although a review of the literature relating to frame analysis, culture and politics did not provide a consensus or structure for the method, it did provide insight into the forms culture and politics can take (Beamish & Luebbers, 2009); (Jones & Livne-Tarandach, 2008); (McCammon, 2012); (Nord & Olsson, 2013); (Noy, 2009); (Polletta, Chen, Gardner, & Motes, 2011); (Roy, 2010); (Vicari, 2010); (Vliegenthart & Zoonan, 2011). I do not intend to divert this study into the depths of literature relating to culture and politics. However what I did want this study to do was to uncover the “meaning work” (Benford & Snow, 2000, p. 613) and understand how this might change, develop over time, and influence the relationship between the storyteller and audience. In McCammon (2012), she develops Benford and Snow’s work to consider the organisational influences and identities that exert influence upon frame development; for example by using Gamson (1975), she highlights that he “distinguishes between social movement organisations with the goal of displacing opponents—that is, removing elites from power—and those with more moderate demands calling for reform of existing policies and institutions.” McCammon highlights further research that emphasises the need to understand the organising work of framing – the doing (Carmin & Balser, 2002); (Haines, 2006); (Polletta, 2005) suggests “that a social movement organisation’s ideological orientation is a primary force shaping the group’s tactics and framing” (McCammon, 2012, p. 43). This study has identified Cure the NHS as a group established to create pressure to realise change within the NHS. Other organisations such as Monitor also have a role to facilitate and deliver a movement or a change in practice.

To explore this notion of ‘meaning work’ further, Benford and Snow identified three contextual/constraining factors that affect the framing processes: a) political
opportunity; b) cultural opportunity and c) audience effects (2000, p. 628). Political opportunity refers to changes in the structure that facilitate or constrain the development of frames. The authors highlighted the work of Mooney and Hunt’s (1996) historical analysis of agrarian mobilisation, and highlight how the resonance of frames changes over time, suggesting that “movements are shaped by a repertoire of interpretations in which the alignment of master frames varies with changing socioeconomic and political contexts” (1996, p. 188). Cultural opportunity refers to valuable and “extant stock of meanings, beliefs, ideologies” (Benford & Snow, 2000, p. 629) and represents a “cultural resource base” (p. 629) from which, where opportunity allows, new cultural meaning can be generated by framing activity.

Benford and Snow (2000, p. 629) highlight the literature in this field by identifying framing processes as “typically reflecting wider cultural continuities and changes”. Finally, audience effects refer to the nature and relationship between the movement or storyteller and the audience, and again how frames develop and respond to these wider changes. Benford and Snow suggest that there is opportunity to understand further the dynamic relationship between the frame and audience (2000, p. 630), which is a key research question of this study. The literature review started with the founding principles of frame analysis (Goffman, 1975), (Gamson & Lasch, 1983), which developed the notion of framing activity as a tool to understand sense-making. I found these principles had been taken and developed across a wide field of interest, however whilst a basic structure of analysis could be articulated through Gamson and Lasch’s (1983) signature matrix and Benford and Snow’s (2000) development of frame analysis and social movement, the literature did not identify a single unified approach to developing or applying frame analysis. That said, the value of frame analysis, as a tool to understand storytelling and sense-making activity, was clear. Of particular importance is the value of frame analysis to traverse the complexity in defining storytelling, through a structured understanding of the sequencing and presentation of the story.
The development of media and communication frame analysis, and examples found in social movement present frames as “out there” waiting to be discovered, or as a pre-defined frame which can be applied to a pre-existing position. This can then account for the connections and approach (see, for example Vliegenthart & Zoonan’s (2011, p. 105) review of the literature and identification of a range of frames including “protest frame”, “conflict frame” etc.). Whilst there is value in testing a predefined notion of a frame to the events as they are presented, the approach and definition of a story I have set out above focuses on issues of speculation, the temporal nature of stories, and the poetic delivery. I am therefore less interested in a story’s accuracy and/or empirical fit with a predefined “narrative”, but more so in the relationship and exchanges between the storyteller and the audience. A predefined frame by its very nature will embed a sense of opposition between the storyteller and audience from the outset. This would limit the ability of the analysis to understand how the roles of the storyteller and audience emerge and change over time. The literature review identifies significant opportunities to apply frame analysis as a tool to understand the organising of movement, rather than movement organisations.

This study’s use of frame analysis does not see frames as available to be found. Frames therefore cannot be imposed; the frame does not create the effect; the frame is not fixed or permanently bounded. To do so would impose a relationship between the storyteller and audience, and one that creates mutual dependency, one that stultifies. This study frame analysis is seen as a tool to create frames by the researcher, through both dynamic and ambiguous means, the frame is loaned or tested on/with/by the sponsor, the storyteller and audience. The frame is temporarily fixed and bound by the researcher in order to understand how idea elements are deployed, and how connections are made and what holds them together. The frame does not produce this effect, but may account for or explain why the effect happened or did not happen.

Figure 3 clarifies the relationship of framing and frame analysis to the events at MSFT. Given the significance of providing care – and the failings of that provision in
care – it is important to identify the relationships between events, framing and the accounts of events. The purpose of this study was focused on the accounts of events, and consequently how these events are rendered and presented. The accounts of events are presented through the data items identified in written documents; the frames are created, by me as the researcher, and in themselves will therefore provide a further account of the event. The re-ordering and presentation of the data items will create a new account.

However, the data items used to create the frames were based solely on the data items identified in the existing accounts of events. The frames are not built on my direct experience of the events at MSFT, although it would be inappropriate to suggest the frames are developed without being influenced by my perception of the events and experiences of working in NHS hospitals. Furthermore, frame analysis was not an analysis of the events themselves, frame analysis is concerned with relationships between accounts of events, and the events themselves – how the connections are made, ignored and lost over time. Frames and framing is used as a tool to suspend the accounts for comparison and analysis.

**Summary**

Frame analysis literature provided an opportunity to support the research questions one and two: (1) evolution of storytelling - frame analysis provided an opportunity to capture and suspend the terse fragments and present them for analysis over time. The speculative appreciations could be understood through the presentation of the elaboration function and signature matrix (these will be defined in more detail in chapter three (Methods)). (2) Roles and relationships of storytelling and audience are prioritised through testing the frames; this avoided the effects of stultification. I have summarised the theoretical frame of frame analysis in Figure 3 below, which presents frame analysis as a suspension between the event, frames, and accounts. What this means is frame analysis allows for the foregrounding of “the struggle for meaning between different actors that have unequal material and symbolic resources” (Vliegenthart & Zoonan, 2011, p. 105). This provides an
opportunity to answer research question two; how do the roles of the storyteller and audience become defined and redefined over time?
Figure 3. The relationship between events, accounts, and framing
MEMORIALISATION AND SACRALISATION

Memorialisation

The notion of memorialisation came to the fore as a result of the application of frame analysis to the data items identified in this study. It was therefore important to consider the literature in this field in order to understand the relationship between storytelling and frame analysis.

I have focused on memorialisation literature based on disaster, as the case for this study and subsequent memorialisation is based on disaster incidents at MSFT. To provide a definition, Perry (2004) undertakes a detailed review of the history and development of the definitions of disaster. From this review, he suggests that “the disaster is characterised as a social disruption that originates in the social structure and might be remedied through social structural manipulations” (2004, p. 11). A dictionary definition of memorialisation is to preserve the memory of; or commemorate memories. Placing such a definition on disaster within a sociological interpretation of it provided an opportunity to recognise the socially constructed nature of memorialisation as the response to that disruption; it is a part of the structural manipulation. Literature into post-disaster societies highlights that “memorialisation can be used as a form of social remembering and forgetting, often selecting and distorting memory to serve present needs” (Davis & Bowring, 2011, p. 380).

The literature relating to memorialisation is broad, with themes such as holocaust memorialisation (Magilow, 2007); memorialisation in post war Germany (Niven, 2013); roadside memorialisation (Klaassens, Groote, & Huiden, 2009); and government memorialisation (Nicholls, 2006) for example. Memorialisation literature focused on major geo-political events such as Northern Ireland, South Africa, Africa, Middle East (see for example (Marschall, 2010); (Feldman, 2008)). The notion of memorial mania describes a change in the landscape that saw increased frequency and exposure to memorials. Memorialisation is not new, but it is recognised that post Princess Diana’s death in 1997, the notion of ‘memorial
mania’ was introduced by Doss in a description of the contemporary, global penchant for conspicuous displays of public mourning (2008, p. 7), (or “mourning sickness” as West (2004, p. 7) suggests). It is certainly a phenomenon which has captured the attention of the scholarly community, with geography, criminology, sociology and anthropology all represented within a burgeoning interdisciplinary literature (see (Hartig & Dunn, 1998) (Collins & Rhine, 2003) (Ferrell, 2004) (Clark & Franzmann, 2006) (Owens, 2006)).

In order to constrain and focus the scope of the literature I will consider government and disaster memorialisation. This field draws together the analysis of the public and governmental reaction to a major catastrophic event. The literature relating to political or war events, whilst valuable, are driven by significantly different contextual actions and responses; disaster memorialisation responds to an event that is unique, often a natural occurrence, or tragic events as a result of unforeseen or unexpected circumstances. An understanding of the literature into disaster memorials identifies firstly the structure, types and forms of memorials that have developed over the last hundred years, examples of which include attendance at religious places, formal memorial services, anniversary events, and post-disaster rituals (Eyre, 1999).

The process of identifying forms of memorials, when driven by a desire for remembrance and rehabilitation is not straightforward. In Eyre’s (1999) analysis she refers to the UK’s decade of disaster (1999, p. 23). This included twelve disasters between 1985 and 1989, examples of which include the Bradford Stadium fire, Zeebrugge Ferry disaster, Piper Alpha oil rig explosion, Lockerbie air crash, and Hillsborough stadium. She highlighted the four stages of response. Firstly “spontaneous and unplanned expression in the first few hours and days, are followed by funerals, official memorial services and anniversary events” (1999, p. 23). An important reflection on the learning from the responses to disaster and memorialisation were illustrated in, and for example, the “large influx of toys was an impressive but inappropriate arrival into the village of Aberfan which had just lost a generation of children” (Eyre, 1999, p. 26). Eyre says disaster memorials take
many forms, but all are ‘collective symbols commemorating the event and its significance’ (Eyre, 1999:28); but they are not without issue, for example, the memorial hall in Aberfan which is little used, influenced the group responding to the Bradford fire disaster in the process to determine their response:

What form should a memorial take? For my part I would have liked some kind of a garden, which could be used as a place of peace for those who suffered. But this has complications: someone has to maintain it. It might not be wanted (the thought of a hall at Aberfan, which is I understand little used, loomed in front of us) or it might be vandalised. We all felt that whatever shape our memorial took, it was important that it commemorated the generosity of people contributing to the fund. So in the end, after some fascinating discussions, we all were happy to suggest a memorial plaque. Although gardens would have been nice, nonetheless here is a plaque which will be in a safe place, a thing of beauty and something which those who are still distressed from that tragic day may come and see in peace, quiet and privacy. We hope that it will give them comfort” (Suddards, 1987)

Secondly the literature considers the impact and consequences of the creation of memorials. This is where the literature is more widely contested. From the literature, I identified two contrasting views: (1) memorials provide an opportunity for recognition, reflection, rehabilitation and recovery or; (2) memorials are vehicles to control, silence or remove the need for a response to the disaster. For example for the former, and particularly around rehabilitation, Carden-Coyne (The Ark, 2005) refers to the vision of wholeness and restoration that war memorials provide. In addition to providing a constant reminder, they also recommend that they provide a legacy with the ambition to avoid future disasters (Carden-Doyle, 2005) (see also McGee & Young, 2000). On the other hand, the latter, Eyre (2004b) suggests “remembering is an inherently political activity, which can be manipulated for the
purposes of socially constructing a community’s past and design of its future” (p. 455).

Ware presents a challenge to the conventional view of the benefits of memorials by suggesting that ‘they ameliorate the situation and alleviate our guilt so we can let go of the past. They promote collective amnesia’ (Ware, (1997, p. 12)). A socially constructed understanding of disaster and memorialisation as structural manipulations presents a context where, for example, ‘Memorials...help us to mourn victims of tragic circumstances, both natural and human induced; but how we choose which victims, which circumstances and which events are worthy of memorials is quite significant’ (Ware, (1997, p. 12)). I suggest that when coupled with a frame analysis method that identifies the speculative appreciations of stories and storytelling, an appreciation of memorialisation offers a possibility to articulate consequences of the storytelling surrounding MSFT.

From this review of the literature I can see that the process of memorialisation is a contested and complex process. The memorialisation literature found that government-led disaster memorials often ‘are served up in an unquestioned and unproblematic way ... symbols are ... insufficient, and when deployed in a way where easy reading dislocates the beholder from any real appreciation of the tragic, they shield ourselves from ourselves’ (Bowring, 2005, p. 8). The consequences of memorialisation were articulated as rather than compelling action or movement, memorialisation and the structure of remembering can “encourage forgetting; that, instead of representing the past, they may in fact mystify and displace it” (Tumarkin, 2005). It raises the question of who needs rehabilitation, or to have guilt alleviated and who helps to achieve either or both of these ends. For this I find in the literature a description of the community, and also the sponsor or owner of the memorial.

Herman suggests, “Recovery requires remembrance and mourning.... Restoring a sense of social community requires a public forum where victims can speak their truth and their suffering can be formally acknowledged” (1997, p. 242). The
community in the context of disaster or emergency management needs further clarification. Recognising that the community in which the disaster takes place, e.g. Ladbrooke Grove; or the World Trade Centre, is fundamental as that community may have no or limited connection to the disaster, as much as those with a connection to the disaster have limited or no connection to the local community (Marsh & Buckle, 2001, p. 5). Eyre, drawing from Gordon (2004) suggests that community is made up of open-ended groupings “defined by organising cultural beliefs and practices” (2004, p. 20). Such a definition of community presents a structural notion and a broad definition of community with a relatively stable social structure of authority, power and prestige and with a common culture” (2004, p. 20). This definition is challenged in Sullivan’s (2003) work, presenting community in a more negotiated sense, in which community “will be bounded by the impact of the emergency” (Sullivan, 2003, p. 19). Nicholls emphasises the complexity of community with the context of disaster, she highlights that such communities or “social grouping which interacts, albeit inconsistently, on a number of levels... and characterised by a self-recognised and self-defined commonality of experience which changes over time” (2006, p. 3).

In terms of the sponsor or owner of the memorial, Eyre (2004a, p. 27) draws from the 9/11 commission and other post-disaster inquiries, and the importance of “giving survivors an opportunity to tell their story”. It is also about putting in place legal and political processes such as investigations and inquiries to address objectively, openly and honestly the causes of man-made events and the accountability of all involved. Eyre argues that if this does not occur the ability to learn and develop does not begin. Nicholls (2006, p. 4) highlights that memorials and memorialisation “carry messages of complex components”, for example overt messages include the naming of individuals. Nicholls continues to question the covert messages that develop while challenging the position articulated by Eyre (2004a, p. 27), which is that communities are, and “should be allowed to talk openly and honestly”. It is the process of permission and enabling to talk that has the potential to be manipulated and challenge the memorialisation process. Nicholls suggests that the sponsor or owner of the memorial can be complicit in the creation
of the memorial, but more problematically, the sponsor can be complicit in the actual disaster that is memorialised. Nicholls (2006, p. 4) highlights:

“By taking responsibility for the creation of a memorial, governments may tacitly recognise (if not acknowledge), to a greater or lesser extent, their ‘implicatedness’ in, and even responsibility for, the ills that befall their communities.”

The literature review identified the complexity in the development of a response to disasters. The memorialisation literature provided a socially constructed definition of disaster. However, it is the socially constructed nature of the disaster – and therefore the response – that provides a valuable contribution to this study, and shares a familiar theoretical ground that was identified in the frame analysis literature. It demonstrated a speculative approach, such as the consideration of the past. Similarly the act of the memorialisation creates an affect of stultification between the delivery of the memorial and the community to which it is placed. Such a relationship and the affect of stultification is illustrated through the community “being allowed” to share their story – which was found to be a significant feature of memorialisation.

Memorialisation literature also highlights the complexity in the way messages and groups of individuals join up (or not) and how the messages are developed inconsistently. As such social phenomenon (memorialisation) is placed in the context of the community and sponsor; it has a clear parallel to the definitions of the storyteller and the audience. It also highlights that a traditional approach to memorialisation will see a standard set of steps – initial response, funerals, memorials and anniversaries; the literature acknowledges these steps, and highlights the increasing occurrences of “memorial mania”. It also opens an opportunity to explore the how and why certain memorials are created (or not) and how and by whom these are influenced over time.
**Sacralisation**

A definition of sacred and sacralisation started with an acknowledgement of the theistic relationship (towards a god or spiritual ideal). But through the development of literature in the 80’s and 90’s, it became emphasised by the secular symbolic nature of sacred. In Harrison, Ashforth, & Corley (2009, p. 229) they consider the etymology of sacred and highlight sacred developments out of the notion of the “untouchable” or “set apart”, which leads them to highlight the development of a non-theistic definition of sacred (Pargament, Magyar, Benmore, & Mahoney, 2005). With a secular, symbolic and non-theistic construct of sacred, the move to defining sacred as relevant to organisations is influenced by Harrison, Ashforth, & Corley’s (2009, p. 229) definition:

“When something is so deeply meaningful as to be seen as sacred – whether it be an ideal, behaviour, or other target – then emotionally charged psychological and perhaps institutional borders are erected around it to protect it from “secular” (non-sacred) contamination. It becomes inviolable.”

In addition to the creation of “institutional borders”, Harrison, Ashforth and Corley state that such a process generates “normative control ... generating a set of unique structural relationships among the individuals, organisations, and institutional context (2009, p. 225). Therefore, I suggest sacralisation is a socially constructed process of protecting an organisation that involves the organisation (and its staff), the community and the context in which it operates.

In Pargament and Mahoney’s analysis of the breadth of the literature relating to sacred and sacralisation in a secular sense, they have investigated areas as broad as an individual’s bodily perceptions (Mahoney, Carels, Pargament, Wachholtz, Leeper, & Kaplar, 2005), sexual behaviours (Murray-Swank, Mahoney, & Pargament, 2005), perceptions of marriage (Mahoney, Paragement, Jewell, Swank, Scott, & Emery, 1999), parenting behaviours (Murray-Swank, Mahoney, & Pargament, 2006), and
pursuit of life dreams (Phillips & Pargament, 2002). The conclusion of the analysis found that “given the breadth of ways in which the sacred can be manifested, it is not surprising that individuals often seek the sacred at work” (2009, p. 225). This emerging interest in the sacred has led to a body of literature investigating similarities between secular and religious organisations, for example “religio-economic corporations” (Bromley & Shupe, 1990), “para-religions” and “quasi-religions” (Greil, 1993), “organisational exaltation” (Khandwalla, 1998), and “secular religions” (Ashforth & Vaidyanath, 2002). This research concludes that secular organisations are introducing theistic principles into the development of structures and meaning.

Such a theistic connection is interesting, but to return to Harrison, Ashforth and Corley’s etymology (2009, p. 229); the scared is to set aside and make untouchable. Such a definition has parallels to frame analysis – in essence the act of setting aside, constructing a boundary, follows a similar process to framing. Therefore the value of understanding sacralisation in an organisational or management context is to understand how, what and why identity is socially constructed and importantly, “what we value and believe” (2009, p. 227). Sacralisation and the process of generating the inviolable appear interchangeable, an organisation’s identity promoted to the inviolable means by which the identity can become an end in itself – over and above the products or services the organisation delivers. (Harrison, Ashforth, & Corley, 2009, p. 227). The literature provides a structure and mechanism to understand this:

“Virtues and ideals become integrated into the normative fabric that binds organisations to individuals and institutions to create connections that are so deeply meaningful that they are seen as sacred. (Harrison, Ashforth, & Corley, 2009, p. 227)

The value of the definition of sacralisation provides an alternative perspective and structure to analysis when an event occurs (such as the disaster at MSFT) that can be described, in this context, as sacrilegious. Harrison, Ashforth, & Corley use the
term sacrilege to define an event that has “torn the ideological fabric that ties the organisation to both the institutional environment and those individuals who have chosen to value the organisation’s normative system” (2009, p. 229). Harrison, Ashforth and Corley (2009) suggested there are four stages of response to a sacrilegious event that impacts a sacred organisation. (1) Discovery, individual disbelief, and organisational denial; (2) perceived breach of covenant and convention; (3) labelling and institutional punishment; (4) repentance.

The definition of story discussed above emphasised three key issues: (1) a need for a story to be believable, rather than “real” as a product of its structural presentation; (2) the seductive powers of storytelling need to be understood (Gabriel, 2008); and (3) the interpretative nature of stories means they are temporal events. The challenge I set is to understand the recalcitrant nature of facts, rather than truths (Gabriel, 2008, p. 162), which took me to understand the role of the storyteller and their audience and experiences on which the story is told. I therefore suggest that the sacralisation literature helps to identify the significance of what individuals believe and value. Importantly, the sacralisation literature offers an opportunity to question how these constructed rules and normative systems might spill over, exerting an influence beyond the organisation’s boundaries to foster relationships with broader organisational audiences” (Harrison, Ashforth, & Corley, 2009, p. 228).

Where stories are understood as temporal events, sacralisation and an understanding of a response to a sacrilegious event, from the literature, will provide an opportunity to understand any enduring consequences of storytelling (when accepting that the endurance is not permanent). Where sacralisation is identified it does suggest a degree of an enduring relationship with the organisation – even when the story and storytelling fluctuates. Of significant value and contribution is that where sacrilege occurs, the literature identified the notion of repentance, which then moves to reparation. As Harrison, Ashforth, and Corley (2009, p. 248) suggest:
“It would not be too much of an exaggeration to say that the safest time to say, invest in a bank, is after the bank has been vilified for defrauding its customers and then gone through the reintegration process. Indeed, by precipitating a clear break with the sacred, sacrilege may bring to a head – and foment a resolution of – organisational pathologies that might otherwise have continued on indefinitely.”

Through an application of frame analysis to the case (MSFT) the notion of sacralisation was identified from the data. Such an understanding will support the development of accounts of storytelling and their development over time.

**Summary**

Research question three asked, within this process of unfolding stories, what are the intended and unintended consequences of storytelling? The identification of memorialisation and sacralisation from the original analysis, and the subsequent literature review, brought forward and questioned the relationship between the audience and storyteller, defining them not by the relationship but defining them by their outcomes. The learning from the literature and application to this study helped to articulate the consequences – and more particularly – the unintended consequences of storytelling.

**THEORETICAL FRAMEWORK**

Research into storytelling has established the socially constructed nature of stories and storytelling. This material has provided a valuable contribution to organisational theory, generating credibility to storytelling within the social sciences as a valuable tool to the practitioner in order to understand the organisations and relationships with staff and customers. However the literature review has identified a number of limitations in the approach taken to presenting stories and storytelling. From the story and storytelling literature, a traditional approach would presuppose the knowing teller and the waiting-to-be-enlightened audience, or the active actor and the passive spectator. This study emphasised the dynamic aspect of storytelling
– that the stories do not just exist in the “here and now” as an individual act of storytelling, but develop across time and space as they are told and retold by the storytellers, as well as picked up and carried on by the audiences.

A critical management studies approach prioritises experience and multivocality, whereas the Managerialist prioritises the presentation of “fact” in a clear manner – both offer opportunities to understand the “possibility [of] grave breaches of the psychological contract between author and reader” (Gabriel, 2008, p. 160). I developed a theoretical framework to understand the process of storytelling through the three research questions. The framework, rather than seeking to promote experience over fact (and/or visa versa), recognises that they were faces of the same coin, each one dependent on the other. A relationship exists between the individual or collective experience (particularly in the cases of suffering and victimisation) and the knowledge of the detached and objective expert (Gabriel, 2008, p. 164), both whom are mutually dependent on the other. The literature review identified the significance and role of speculation as a theoretical framework drawing from both critical management studies and managerialist literature using the components of ante-narrative (which exists before plotting), and the poetic (which is the building on the plot, casting and performance).

Finally the simplified message is similarly a speculative approach, which seeks to silence the complexity in order to “hook” the listener, reader or audience to the message. Returning to the definition of story, I highlighted that the accuracy of stories is not important – and therefore the speculative choices of purposeful or accidental inaccuracy are a source of investigation that has the potential to identify something of significance (Gabriel, 2008, p. 195). An opportunity exists within all three approaches to understand the relationship each has to the storyteller, audience, and their psychological contract. The theoretical framework is a move away from defining story and narrative to one focusing on the relationships, which allows for the ability to recognise the complexity and multivocality of storytelling but avoids making an argument “for the non-existence or irrelevance of facts or celebrating the infinity of interpretations and symbolic constructions” (Gabriel,
The framework investigates how the accounts of the events at MSFT are generated, speculated and replayed over time.

As presented above, Vliegenthart and Zoonan best summarise where there is consistency in the frame analysis field (2011, p. 105):

- That frames are multiple and can be contradictory or oppositional.
- That frames are part of a struggle for meaning between different actors that have unequal material and symbolic resources.
- That news frames are the result of situated social and routinised processes in which the agency of the individual journalists is relative;
- That frames used by audiences are the result of socially situated articulations between particular issues, individual and collective differences, experiential knowledge, popular wisdom and media discourse.

The opportunity from the frame analysis literature emerged from placing frame analysis within the context of the definition of story used in this study which was one that is not an historical account, but an opportunity to re-narrate events. It must be believable, rather than “real”, as a product of its structural presentation; therefore the seductive powers of storytelling needed to be understood, and given the interpretative nature of stories they are therefore temporal events. To use Boje’s description, stories “self destruct” (Boje, 2001, p. 18). This opened up opportunities for further re-telling and re-presentation of the story. The opportunity provided by frame analysis captured and analysed the terse fragments.

The traditional approach to storytelling commonly limited the boundaries of storytelling to a finite number of actors within an organisation. Through an application of frame analysis to understand the storytelling process, the frequent switching of roles between the storyteller and the audience can be observed.

A consistent theme in the literature on storytelling is the development of socially constructed boundaries. These boundaries separate stories from narratives, audience from the storyteller, and experience from fact. An opportunity existed to
understand further how these boundaries (frames) are reinforced, broken, and other connections are ignored. Frame analysis is the key component of the theoretical framework, as frame analysis is seen as a tool to create frames by the researcher as dynamic and ambiguous, while the frame is loaned or tested on/with/by the sponsor, the storyteller and audience. The frame is temporarily fixed and bound by the researcher in order to understand how idea elements are deployed and how connections are made, with reference to what holds them together. The frame does not produce the effect, but may account for or explain why the effect happened or did not happen.

The memorialisation literature provided a socially constructed definition of disaster. However, it is the socially constructed nature of the disaster – and therefore the response – that provides a valuable contribution to this study, and shares a familiar theoretical ground that was identified in the frame analysis literature. It demonstrated a speculative approach, such as the consideration of learning from the past to influence future actions. Similarly, the act of the memorialisation creates an affect of stultification between the delivery of the memorial and the community to which it is placed. The literature identifies the contested possibilities for the development of memorials. In doing so the hitherto implicit needs of those involved in the disaster become exposed through a structured understanding of the construction and their relationship to the disaster and the memorial.

This sacralisation literature demonstrated that organisational theory has identified the role and impact of sacralisation on organisations – however, the consequences of sacrilege need further development and research. The value of the sacralisation literature to this research is it provides an alternative perspective to the theoretical framework and structure to analysis when an event occurs (such as the disaster at MSFT), that can be described (in this context) as sacrilegious.

**Summary**
I have set out the theoretical framework in figures 4 – 7 below and identified how these relate to and support the analysis of the research question.
Figure 4 – Research question one: How does storytelling unfold and escalate from one event into multiple stories? A key outcome from frame analysis as an analytical tool was the structure applied over time to consider how the stories unfolded, were told and re-told. Frame analysis is grounded in the notion of meaning – that is not to suggest frame analysis can find, or becomes the custodian of “truth”. Rather, it provides an opportunity to understand the processes of generating, repeating and silencing meaning. Recognising the role of speculation identified through the storytelling literature, the structure of the frame analysis provided an opportunity to test (or even to speculate) with the frames and the building of frames over time. The theoretical framework was informed by the three conflicting elements of the ante-narrative, poetic tales and simplified messages (as identified in figure 2). This approach considers the relationship and tension between experience, fact and the processes of storytelling. From the literature review I highlighted three key attributes of a story which will be used to inform the definition moving forward: (1) believable rather than real; (2) seductive; and (3) temporal. Frame analysis provides a structured approach to identify actions that the storyteller undertakes to deliver the believable story – this is not at the expense of reality. Through an application of the signature matrix and elaboration matrix over time, this study will observe how storytelling evolves. Frame analysis develops, as a part of the theoretical framework, the ‘story work’ which is the fragile process of developing plots, staging and direction through the chain of event – it is a focus on enduring truths rather than simple facts (Collins, 2008, p. 321).

Figure 5 – Research question two: How do the roles of the storyteller and audience become defined and re-defined over time? An opportunity exists, through an application of frame analysis, to emphasise the relationship between the storyteller and the audience, to consider how both the facts and experience are presented through storytelling and over time, rather than emphasising one at the expense of the other. Frame analysis focused on storytelling as a tool to traverse the questions of “so what?” and “did it really?” The posing of and response to such questions requires a relationship between the storyteller and audience. Frame analysis, whilst
establishing a sponsor of the frame, allows for the role(s) of storytellers to grow, change and adapt over the course of the story. With the temporal nature of the story, the audience and storyteller distinction identified within the literature review becomes blurred. The story is told and re-told by many different individuals. Whilst the sponsor has a role in structuring the dialogue, this approach does not and cannot assume that from that position the story is narrated accurately. The current literature overlooked the significance of the relationship between the storyteller and the audience, placing a defined separation between them; between which the story is analysed, rather than storytelling itself. I suggest that such an approach constricted the ability to understand the roles between the storyteller and the audience. Frame analysis provided a structure to analyse and account for these relationships, which was mindful of the effects of stultification.

Figure 6 – Research question three: Within this process of unfolding stories, what are the intended and unintended consequences of storytelling? Finally memorialisation and sacralisation literature provides a greater understanding of the relationship between the organisation and communities over time.

Figure 7 provides an overview of each of the theoretical components of the framework.
Figure 4. Theoretical framework – research question one.

Research question 1 – how does storytelling unfold?
Figure 5. Theoretical framework – research question two

Research question 2 – defining the roles of the storyteller and the audience

- Events
- Framing
- Frame Analysis
- Accounts of events
- Audience
- Storyteller
Figure 6 Theoretical framework – research question three

Research question 3—what are the intended and unintended consequences of storytelling?

- Sacralisation
- Events
- Framing
- Accounts of events
- Memorialisation

Frame Analysis
Figure 7. Theoretical framework
CHAPTER 3. METHODOLOGY

This chapter presented the research design, the data collection and analysis methods I employed in my investigation of storytelling.

The challenge for any research methodology is to ensure a certain rigor and quality. This challenge is particularly strong for qualitative research as illustrated by Pratt’s (2008) metaphor of fitting oval pegs (qualitative methods) into round holes (criteria for rigor developed for quantitative research). Pratt (2008); cited in (Gibbert & Ruigrok, 2010, p. 725) advised the researchers using qualitative methods to focus “on the process of fitting” rather than on “making oval pegs seem rounder, or by making round holes bigger or more oval friendly”. In practical terms, this implies the need to be aware of and take into account the methodological choices and decisions to be concerned with, and assure quality of such decisions, and to explicitly document those. I have endeavoured to do so in the following chapter.

My aim here was to demonstrate “research competence”, as defined by Buchannan and Bryman (2007, p. 483) to involve “addressing coherently the organisational, historical, political, ethical, evidential and personal factors relevant to an investigation.”

The chapter began with establishing case study as the research design, then it set out the criteria used to identify the chosen case study’s organisation. The chapter then identified the approach to data collection, and identification of data sources. Finally it set out the approach to data analysis.

RESEARCH DESIGN

The research design is a case study. The case study allows an examination of storytelling in a “real-life” setting, “where boundaries between context and phenomenon tend to be blurred” (Stake, 1995) in (Gibbert & Ruigrok, 2010, p. 712). The case study design allowed me the flexibility to move between context and
phenomenon, which is particularly fitting for my investigation of the roles of actor and audience.

The choice of domain for the case study has been determined by my work experience. I have worked in senior management roles in the NHS and publicly funded health organisations outside of the UK. My roles have focus on working with staff to look at and improve the way they deliver services to patients. I have chosen to undertake the case study of a single organisation rather than to do a comparative case analysis of two (or more) organisations for two reasons. Firstly, the research into a single organisation would provide the ability to deliver a greater depth of analysis. The NHS has an impressive ability to generate documents, reports, or accounts from interested parties, and many other people who engage with the organisation. Therefore the quantity of research data is significant, and the need to analyse the data would be restricted to a limited level if data for multiple organisations were collected. Secondly, the NHS is a complex organisation and has a complex relationship with the communities it serves. Therefore, the specific and local variations between sites would always generate questions of comparability, whilst at the same time reducing the ability to achieve a valuable depth of analysis in one or both organisations.

I have chosen to concentrate on the case study of an organisational crisis as a “critical incident”, which brings storytelling to the fore. A crisis presents an opportunity to consider the relationships between the actor and the audience at a time when the storytelling becomes overt, documented and visible. Therefore the research design purposefully sampled NHS organisations with extreme crises in order to assess and select the most appropriate case for this research. The choice of a specific crisis site was based on the criteria of scale (for example, the crisis must be greater than a one off event impacting on a small number of people), time frame and data availability. I have developed the following criteria for choosing a specific incident: (1) the incident must be of significance to the organisation, (2) the incident should have been reported in local and national media; (3) the incident has taken place in the last three years and continues to
surface in the media; (4) there are materials about the incident available for investigation. These criteria have been developed to provide a broad scale of storytelling (reporting in the local and national media) and to ensure the feasibility of the study (time limits and availability of data).

Out of the prominent incidents such as that of Bristol Hospital, Alder Hey Children’s Hospital, Maidstone and Kent NHS Trust, I have chosen the case of Mid-Staffordshire NHS Foundation Trust (MSFT) as an incident that satisfies all the criteria. The case of Mid-Staffordshire NHS Foundation Trust concerns the poor provision of emergency care to patients visiting the Accident and Emergency Department at the hospital and the resulting high number (c1200) of avoidable deaths between 2005 and 2008 (Healthcare Commission, 2009). The report into the events at MSFT, published within the three years since commencing this study, had a significant impact on the hospital, leading to the resignation of the Chief Executive and Chairperson (Express and Star, 2009h). The initial findings did not confirm the number of deaths, but inferred the number to be between approximately 400 and 1200. These figures and the reaction to the findings were widely reported locally and nationally (Express and Star, 2009a), (BBC News, 2009c) (Guardian, 2009a). The data analysis identified 1274 documents available to support the study and that referred directly to the crisis at MSFT.

Storytelling within the NHS has taken an increasingly important role and voice (especially since the Bristol Inquiry (Kennedy, 2001)) with respect to the hitherto nearly silent public in this storytelling. It can be argued that the staff of local NHS organisations and the relevant local communities have embraced storytelling to challenge the official line and to achieve some control of the situation that affects them.

DATA COLLECTION
The case study design offers an opportunity to generate a significant amount of data. This opportunity is crucial to the success of a qualitative study. As Janesick
(2000) noted, “qualitative researchers should gather extensive amounts of rich data with thick description”; as “thick description makes thick interpretation possible.” The most pertinent data for the study of storytelling as a performance would be those derived from the direct observation and/or video-recording of the acts of storytelling. My study, however, has been retrospective rather than prospective, therefore such data have not been available, with the exception of limited video footage e.g. (BBC News, 2009c), all the available footage relates to comments on the crisis rather than the crisis itself. Increasingly covert footage is being collated by patients/carers and journalists in an attempt to highlight the crisis or issues within the hospital before the event is acknowledged and more publicly understood. For example, the Dispatches investigation for Channel 4 into the care of the dying, while providing families and carers with cameras to record their experiences (Dispatches, 2011), or Panorama’s report following the story of undercover nurse Margaret Haywood (BBC Panorama, 2009) are significant to this investigation.

There are a number of issues in using such primary data: firstly the ethical issues of covert data collection and investigation would prohibit such activity; secondly any investigation would be speculative and the resource, time and effort may not deliver the data required; thirdly, within the constraints of a part-time PhD to take on an undercover role would not be possible alongside a full-time job. The only final opportunity would be to become a “whistle blower” myself, and document my observations from my own experience. Thankfully, to date, I have not found myself in a position that would justify such an approach.

I have, therefore, chosen instead to collect the data from the accounts of the events presented by various individuals (on their own behalf, or on behalf of a group or an organisation). Such accounts could be elicited in an interview or taken from the written sources. The problems inspired by access and personal constraints have precluded me from collecting the data through personal interviews. Specifically, in terms of access, the NHS has a rigorous ethical review process for any research to be conducted in its organisations. Since the case study organisation has been an organisation in crisis and has been subject to an on-going (at the time of this study)
inquiry, the permission to undertake a study of the events surrounding the crisis would unlikely to have been granted. Even if such permission had been granted, the logistics of working full-time and conducting the research on a part-time basis whilst residing 250 miles away from the research site would have made this data collection method unfeasible. Interviewing in a structured or unstructured manner has its own limitations: for instance the characteristics of the interviewer, acquiescence of the interviewee, social desirability – and in particular, in light of the subject matter, the challenge between values and actual experience in the responses is a significant risk (see Bryman and Bell (2007)).

I have, therefore, chosen to collect the data from the publicly available written accounts. Studying a public sector organisation has its advantages, as there is a statutory requirement on such organisations to provide extensive reports of its activities and make those available in the public domain. Furthermore drawing from public accounts also provides access to the making of the story, and any consequences for the audience. Moreover, the nature of the case study events has also generated a considerable amount of attention from various organisations and media, as well as from individuals and groups. Hence, there has been an abundance of information sources regarding the case study. These included the accounts published by the Trust itself, its regulatory body, the Department of Health, the NHS-associated organisations (e.g., NHS Institute for Innovation, NHS Confederation, Health Care Commission, Care Quality Commission); professional organisations (e.g., Royal College of Nursing), local, regional, national, and international press and associate sector publications (e.g., Health Service Journal), as well as the accounts provided in the Internet blogs and network sites (e.g., www.silobreaker.com). Indeed, the potential data sources have been too numerous rather than too few.

Furthermore, the number of individuals involved in the case study organisation and events has been significant; for example, the Public Inquiry quoted among the core participants 8 large organisations and included over 75 witnesses at the Public
Inquiry (Francis, 2011). The challenge, therefore, has been to reduce the number of sources and actors in order to provide a feasible scope for the data collection. I document the procedures I followed in limiting the number of data sources and actors/storytellers in the following two sections.

DATA SOURCES
To limit the number of data sources, I have split the sources into three categories: (1) mass media, (2) formal inquiries into the crisis, and (3) organisational sources. I have selected the data sources from each category in the way described below:

Data sources: Mass media

There are three main local newspapers, a large number of national newspapers, and a range of media organisations, all of which have produced significant output. I have selected the following publications, one local, three national, and one mixed media:

Express and Star (local)
Guardian (national)
Daily Mail (national)
Sun (national)
BBC (mixed media)

The Express and Star newspaper was selected specifically as it was primary-based and focused on Stafford; other local newspapers, whilst including Stafford, reported on stories across the whole of Staffordshire. Three national newspapers were identified from three categories – (1) broadsheet; (2) middle market tabloid; and (3) tabloid. Although the Guardian is printed in a Berliner format, it fits within the category of broadsheet. The Guardian is referred to politically as a centre-left newspaper; the Daily Mail however is considered as politically Conservative; whilst the Sun is considered populist. Therefore, the three titles present a spectrum across the political environment.

The time frame for the crisis under investigation is from November 2007 to November 2010. However, in order to constrain the data collection period, articles
will be reviewed between the periods March 2009 - November 2010. In March 2009 the Chief Executive of Mid Staffordshire NHS Trust resigned, and at which point the volume of stories and data increases significant. By October 2011 the formal public inquiry was opened into events at MSFT.

**Data sources: Formal inquiries**

There are seven formal reports on the crisis at Mid-Staffordshire NHS Foundation Trust. The research will focus on 1) Healthcare Commission (HCC) (Healthcare Commission, 2009), which is the report first undertaken into the events at the hospitals; 2) two inquiries undertaken into events by Mr Robert Francis QC, both compiled as a request for the Secretary for State for Health (Francis, 2010a); (Francis, 2010b). The four remaining reports were reports conducted on specific components of the organisation and/or crisis (see Chapter 4 for further information).

**Data sources: Organisational sources**

Organisational sources will constitute this section. All the organisations involved (of which there are more than ten, for example: Department of Health; Monitor; Staffordshire PCT; West Midlands SHA; Mid Staffordshire NHS Foundation Trust; Care Quality Commission; Cure the NHS; Leigh Day Solicitors; Action against Medical Accidents; National Patient Safety Agency; The Royal College of Physicians). This group would provide a significant body of data for analysis; however, this research will focus on formal reports of events and surrounding reactions to and preparation for those reports. Therefore the research constrains the data analysis for this group to press releases from the following organisations:
Mid-Staffordshire NHS Foundation Trust
Leigh Day Solicitors
Cure the NHS
Monitor

This selection represents two organisations who are “organisation-side” (the Hospital and Monitor (the Hospital’s regulator)) in which these two organisations
have a vested interest in managing the organisation; and two organisations that are public/patient side (Cure the NHS (the patient body set up to raise awareness of the crisis) and Leigh Day Solicitors (the legal representation for many of the relatives and patients at the hospital)).

**STORYTELLERS**

In order to conduct the data analysis of the significant body of material identified above, the research identified a cohort of key individuals/roles throughout the course of the crisis and responses to the crisis. In analysing the data I used nine characters to support the search, collection, collation and analysis of the data. Without this filter the data analysis would have been unmanageable within the time constraints; and would have suffered from excessive data to establish a valid and meaningful depth of analysis. By identifying the following individuals it attempts to provide a focus to ensure that rich descriptions and deep analysis can be delivered.

Three roles (as distinct to individuals that held the roles) were identified that are connected to running and regulating the organisation. The roles were:

1. Mid-Staffordshire NHS Foundation Chief Executive – four individuals held this post during the period of analysis
2. Monitor Chief Executive
3. Chairman of the Public Inquiry

Three roles were identified that were users of, or representing the users of, the services provided by the Hospital

1. Lead for Cure the NHS
2. Director of the Patients Association
3. Lead advocate for Leigh Day and Co Solicitors

The act of promoting/profiling these individuals above others presented risks to the data analysis. However, this approach helped to cut through the data.

From this approach, the method identified nine individuals that had a significant role within MSFT. The method constrained the data sources to secondary sources
and I did not elect to interview the nine individuals in order to record their account of events. The primary focus of the study is not the storytellers or the story. This study focused on the act of storytelling itself; I am not (primarily) concerned with how this story ended, tragic as the outcome was. Whilst it would be valuable to review the frames and my account of storytelling with the individuals identified, it was important that my analysis was not directed or emplotted by a personal interaction or interview with some or all of the storytellers. The potential to be seduced by the story, in itself would be of interest, but secondary to the focus of this study. It would be a valuable exercise on completion to seek the reflections of each storyteller on the accounts, which would offer future opportunity for research.

**KEY EVENTS DURING THE TIMELINE**

In the preliminary examination, I identified six main events that occurred during the timeframe under analysis. These events were identified as producing more data items than other events over the timelines. These will be explored in more detail in Chapter 5 (Data Analysis).

**Publication of the Healthcare Commission Report, 17th March 2009**

Event 1 was the publication of the Healthcare Commission report into the events at MSFT (Healthcare Commission, 2009) was the starting event in the timeline.

**Resignation of Martin Yeates as Chief Executive of the Hospital: 15th May 2009**

Event 2, on this day, the Chief Executive, Martin Yeates formally resigns from his post as CEO of MSFT.

**Announcement by Health Secretary Andy Burnham of the independent inquiry: 21st July 2009**

Event 3, four months after a debate in the House of Commons regarding a public inquiry into events at the hospital, the Secretary of State for Health, Mr Andy Burnham MP announced an Independent (but not public) Inquiry was to be held into events at the Hospital.
Publication of the independent inquiry into care provided at the hospital: 24th February 2010

Event 4. The final report was published in two volumes (Francis, 2010a) (Francis, 2010b), and is addressed to the Secretary of State for Health. The first volume sets out the main findings of the report across eight sections: The patient experience; The culture of the Trust; The experiences and perceptions of staff; The management of significant issues; Governance; The Board; Mortality Statistics; and External Organisations. This is supported with an executive summary, conclusions and recommendations. The second volume sets out quotes and case studies given as evidence to the Inquiry.

Announcement by the Prime Minister David Cameron that a public inquiry into the events at MSFT will take place: 9th Jun 2010

Event 5. This inquiry would be heard in public and chaired by Mr Francis. He set out the scope of the second inquiry:

“a. To investigate the role of the commissioning, supervisory and regulatory organisations and systems, and the attendant culture in relation to their monitoring role at the Trust between January 2005 and March 2009.

b. To identify the lessons to be learned as to how the deficiencies of the sort identified in my first report can be identified and acted upon earlier than they were. In doing this, I must bear in mind the changes that have been made to the regulatory arrangements since then, and make the consequent recommendations” (Francis, 2010c, p. 2).

Opening statement at Public inquiry by Robert Francis QC: 8th November 2010

Event 6. This was the closing event in the timeline. Mr Francis QC commenced his opening statement after a delay in the start of the first session.
DATA ANALYSIS

I use frame analysis as the method to analyse the data. Chapter 2 (Literature Review) sets out the detailed context of the literature relating to frame analysis. To recap the key context, frame analysis has its origins in the work of Goffman (1975), particularly his description of frames as "schemata of interpretation" that enable individuals "to locate, perceive, identify, and label" occurrences within their life space and the world at large (Goffman, 1975, p. 21). Frames help to render events or occurrences meaningful and thus function to organise experience and guide action (Benford & Snow, 2000). Goffman, however, provided little guidance on how to conduct a frame analysis (Benford, 1997, p. 412). As Gamson noted (1975, p. 607), Goffman’s work “has abundant implications for what it is that we should attend to, but the methodological implications are only suggested and not developed.”

Since the publication of Goffman’s work, frame analysis method has undergone considerable development and has been widely employed in psychology, linguistics, discourse analysis, communication and media studies (cf. Benford and Snow (2000, p. 611); Oliver and Johnston, (2000, p. 3)). Yet my review of the literature suggests that no unified model for frame analysis has emerged (Benford, 1997) (Benford & Snow, 2000) (Vicari, 2010)) and that many particulars of the method have not been sufficiently explicated to provide clear guidelines on the method’s application.

I have therefore opted to develop my own model of frame analysis, which pulls together the disparate contributions from existing studies, with particular reference to recent literature on social movements (see Benford & Snow, 2000); (Creed, Langstraat, & Scully, 2002): (Vliegenthart & Zoonan, 2011)). Briefly, the model includes the following five steps:

1. Coding text fragments as data items
2. Develop a provisional frame
3. Construct a signature matrix for the frame
4. Analyse the functions of the frame
5. Analyse the processes of framing and frame change
In the subsections below, I describe these steps in greater detail and explain how I analysed the data. Before I proceed, I define three key concepts used in the analysis: story, storyteller, and audience.

**Story**

The frame analysis method recognises that the essence of work into framing is “not within us, but between us” (Medvedev and Bakhtin (1978), as cited in Snow and Benford (2000, p. 4)). In the literature review (see Chapter 2) I provide a more detailed definition of a story, which distinguishes between the concepts of narrative and story. Unlike narratives, stories exist in fragmented forms, and it is this fragmentation that allows for “a retrospective explanation of storytelling’s speculative appreciations” (Boje, 2001, p. 3). These fragments can be pieced together by using a frame – a “unifying central concept” that holds together “packages of integrated idea elements” (Gamson & Lasch, 1983). In my study, I approach a story not as something that is presented for analysis, but as something that emerges as a result of the analysis (through the application of the frame analysis method to the empirical data).

**Storyteller**

The frame analysis literature uses various terms related to the concept of the storyteller, namely: organisational actor (Creed, Langstraat, & Scully, 2002, p. 35), sponsor (Gamson & Lasch, 1983, p. 6), and movement activist (Benford & Snow, 2000, p. 614). The definitions of these terms vary, but all of them highlight the role of these “agents” in defining, constructing and altering frames. Rather than using any of these terms, I use the term “storyteller”. The storyteller is defined as someone having a significant role in creating and recreating frames, through a demonstrable relationship, involvement and role in the crisis at MSFT. A more detailed definition of a storyteller is set out in Chapter 2 (Literature Review).

**Audience**

Goffman (1959) (1975) used theatre metaphors, such as “actor”, “audience”, and “front region” (the front of stage between the actor and audience) “back region”
(the private space), to describe social interaction. I concur with Goffman in highlighting the importance of the audience, but I also draw upon the literature on social movements to define what audience is. As Benford and Snow (2000, p. 630) note, “it has long been taken as a given in communication studies that the target of the message can affect the form and content of the message. In the social movement arena, activists and targeted audiences interact... Movements find it necessary to appeal to multiple audiences who vary in terms of their relative interests, values, beliefs, and knowledge, as well as with respect to which of the various movement or counter-movement roles they can potentially play.” I define audience as, drawing from Goffman, one that engages with the storyteller directly (either positively or negatively). The audience is defined in more detail in Chapter 2 (Literature Review). The following section presents the five steps of frame analysis this study applied:

**Coding text fragments into data items**

*Data item* is defined here as a text fragment that is either a quotation from, or a reference to, a particular storyteller. As noted earlier in this Chapter, I identified nine individuals that played an important role in the case study events as storytellers.

From the data sample, which identified 859 documents I used a key word search on all files I had previously selected for analysis. The key word was the surname of the storyteller; each item was then validated to ensure the correct storyteller was identified. I then coded each relevant text fragment as a data item and assigned numbers to the data items. The examples of coding are presented in Table 2 below.

**Developing a provisional frame**

In order to develop a provisional set of frames, I established the underlying problem areas and themes from the data items. A data item is the fragment of text that is taken and used to construct the frame. I have included this step as a bridge to pulling together the data items that form packages that will provide the structure for the frame. Creed, Langstraat and Scully (2002, p. 40) ask the question “what
holds these diverse elements together?” and move to label the frame provisionally. However, this suggests that the frame is understood before they are grouped together – in presenting the signature matrix in its ordered fashion, that question must have been answered. Therefore, with a frame analysis approach grounded with social movement theory, and to draw from Benford and Snow (2000, p. 615):

Collective action frames are constructed in part as movement adherents that negotiate a shared understanding of some problematic condition or situation they define as in need of change, make attributions regarding who or what is to blame, articulate an alternative set of arrangements, and urge others to act in concert to affect change.

I suggest that in order to understand what the key themes to be articulated are, it is crucial to clarify before progressing towards the building of the signature matrix and moving on through the frame analysis method. This process included: 1) reviewing the data items that have emerged from the texts; 2) functional key word searches – looking at particular problems that emerge. The data items can then be categorised into themes. The data items packaged within that theme were then reviewed to establish if a narrative consistency or connection exists. 3) All data items were connected (where appropriate) to a key theme. The themes can be reviewed and compared through the perspective of the data items they may share; 4) this then allows for the themes and provisional frames to be established. The examples of data items and key themes are presented in Table 3 below.
Table 2. Examples of coding text fragments into data items

<table>
<thead>
<tr>
<th>Text file</th>
<th>Text file source</th>
<th>Text file date</th>
<th>Text fragment</th>
<th>Storyteller</th>
<th>Data item</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><a href="http://newsvote.bbc.co.uk/mpapps/pagetools/print/news.bbc.co.uk/hi/england/staffordshire/8179701.stm?ad=1">http://newsvote.bbc.co.uk/mpapps/pagetools/print/news.bbc.co.uk/hi/england/staffordshire/8179701.stm?ad=1</a></td>
<td>1 August 2009</td>
<td>The hospital's former chief executive, Martin Yeates resigned in March before a damning report into the hospital was published.</td>
<td>Mr Yeates</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td><a href="http://www.expressandstar.com/latest/2009/08/01/hospital-boss-starts/#ixzz1k6zX0UQO">http://www.expressandstar.com/latest/2009/08/01/hospital-boss-starts/#ixzz1k6zX0UQO</a></td>
<td>1 August 2009</td>
<td>Mr Sumara is a former director of turnaround at NHS London.</td>
<td>Mr Sumara</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td><a href="http://www.expressandstar.com/latest/2009/08/01/hospital-boss-starts/#ixzz1k6zX0UQO">http://www.expressandstar.com/latest/2009/08/01/hospital-boss-starts/#ixzz1k6zX0UQO</a></td>
<td>1 August 2009</td>
<td>Antony Sumara is taking over as chief executive of Mid-Staffordshire NHS Foundation Trust from interim chief executive Eric Morton, who was drafted in following the departure of chief executive Martin Yeates.</td>
<td>Mr Yeates</td>
<td>4</td>
</tr>
<tr>
<td>14</td>
<td><a href="http://www.bbc.co.uk/news/uk-england-stoke-staffordshire-12683426?print=true">http://www.bbc.co.uk/news/uk-england-stoke-staffordshire-12683426?print=true</a></td>
<td>8 March 2011</td>
<td>Stafford Hospital gets new chief executive. A new chief executive has been appointed to lead Mid Staffordshire NHS Foundation Trust which manages Stafford Hospital. Lyn Hill-Tout will succeed Antony Sumara in mid June. She has been chief executive of Great Western Hospitals NHS Foundation Trust for the past eight years. Mr Sumara is understood to be retiring at the end of his two-year contract after he was brought in to troubleshoot at the hospital. He oversaw a transformation programme of 100 planned improvements.</td>
<td>Ms Hill-Tout</td>
<td>2</td>
</tr>
<tr>
<td>128</td>
<td><a href="http://www.midstaffspublicinquiry.com/hearings/session-448/week-thirty-four-26-28-september-2011">http://www.midstaffspublicinquiry.com/hearings/session-448/week-thirty-four-26-28-september-2011</a></td>
<td>28 September 2011</td>
<td>It is your exhibit 51, dated 19 October 2007, addressed to you on Monitor headed paper, and it is signed by Dr Bill Moyes. The bottom paragraph of the first page he writes: &quot;What causes me discomfort is the fact that you have written direct to the chief executive. The current chief executive has been appointed to lead Mid Staffordshire NHS Foundation Trust which manages Stafford Hospital. Lyn Hill-Tout will succeed Antony Sumara in mid June. She has been chief executive of Great Western Hospitals NHS Foundation Trust for the past eight years. Mr Sumara is understood to be retiring at the end of his two-year contract after he was brought in to troubleshoot at the hospital. He oversaw a transformation programme of 100 planned improvements.&quot;</td>
<td>Dr Moyes</td>
<td>15</td>
</tr>
</tbody>
</table>
executives of foundation trusts expressing expectations in terms which will be interpreted as instructions. This approach cuts straight across the accountability of foundation trusts, which is well illustrated by the National Audit Office in their report of June 2006."

<table>
<thead>
<tr>
<th>Source</th>
<th>Date</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>215</td>
<td>30 Septem</td>
<td>Cure the NHS, founder Julie Bailey said: “We are very unhappy with the comments. It is fundamental that Martin Yeates appears at the public inquiry. There were people going through intense psychiatric treatments who attended the Francis inquiry earlier this year.” She continued: “We know just one person was not responsible for what has happened. That’s why we did not want to engage with them — it is the role of our MPs to do that.”</td>
</tr>
<tr>
<td>262</td>
<td>13th Decem</td>
<td>Sources close to the inquiry have revealed chairman Robert Francis has been forced to use his powers to compel some witnesses to come and give evidence to the hearing in Stafford.</td>
</tr>
<tr>
<td>313</td>
<td>21 Septem</td>
<td>Representations will be made on behalf of Leigh Day &amp; Co’s clients to Mr Francis that public servants, including those who ran the hospital over the past few years, should have to justify the way they conducted themselves as well paid public servants, in public.</td>
</tr>
<tr>
<td>420</td>
<td>17 March</td>
<td>Katherine Murphy, director of the Patients Association. How can any patient have trust in the managers and systems that have allowed this disaster to run and run? It is not enough for the chairman and chief executive to take the fall for this.</td>
</tr>
</tbody>
</table>
Table 3. Examples of coding data items into key themes

<table>
<thead>
<tr>
<th>Text file number</th>
<th>Data item</th>
<th>Text file source</th>
<th>Text file date</th>
<th>Text fragment</th>
<th>Storyteller</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td><a href="http://newsvote.bbc.co.uk/mpapps/pagetools/print/news.bbc.co.uk/1/hi/england/staffordshire/8179701.stm?ad=1">http://newsvote.bbc.co.uk/mpapps/pagetools/print/news.bbc.co.uk/1/hi/england/staffordshire/8179701.stm?ad=1</a></td>
<td>1 August 2009</td>
<td>Mr Baggs said Mr Sumara’s appointment should establish a platform of certainty so the hospital could continue to improve. &quot;It is important the improvements continue and there is no complacency on the issues which still remain to be addressed,&quot; he said.</td>
<td>Mr Sumara</td>
<td>Certainty</td>
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<td></td>
<td></td>
<td>Improvement</td>
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<td>Complacency</td>
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<td>Organisation</td>
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<td>Distress</td>
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<td></td>
<td></td>
<td>Rescue</td>
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<td></td>
<td></td>
<td></td>
<td>Learning</td>
</tr>
<tr>
<td>15</td>
<td>2</td>
<td><a href="http://www.bbc.co.uk/news/health-11696735">http://www.bbc.co.uk/news/health-11696735</a></td>
<td>8 November 2010</td>
<td>In setting out the public inquiry framework, Mr Francis said he would not revisit the harrowing cases of deceased patients brought to light in the fourth inquiry. This inquiry was held in private. Instead he said he wanted to look at the structure of the NHS and the actions and inactions of management to see how the failings had come about and why they had remained undetected for so long.</td>
<td>Mr Francis</td>
<td>Blame</td>
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<td></td>
<td>Manager</td>
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<td>Complaints</td>
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<td></td>
<td>Death</td>
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<td></td>
<td>Patients</td>
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<td></td>
<td>Listening</td>
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<td></td>
<td></td>
<td>Distress</td>
</tr>
</tbody>
</table>
They just need better management, better customer focus and better training." Sir, that concludes the statement.

Ms Bailey, founder of Cure The NHS, said: “We have written to Andrew Lansley to express our concern that no decision on funding has been made. We can’t afford the costs ourselves.”
Seven key themes were identified at this stage: (1) Justice; (2) Learning; (3) Improvement; (4) Leadership; (5) Distress; (6) Blame; and (7) Defence. These concepts will be explored in more detail in Chapter 5 (Data Analysis). They were indicated through the identification of clusters around seven themes. From these themes it was possible to develop a provisional sense of the seven problems or opportunities that the data items were seeking to develop. One further provisional frame relating to management was identified at this stage, but discounted. Although an emerging focus on management both at the hospital and outside of the hospital is under question, I did not see a sufficient thread or movement that justified grouping these together.

To illustrate this further, there was a significant quantity of data items that referenced Mr. Yeates and his suspension from his role as Chief Executive of MSFT; the commentary at this stage is seen as focusing on the functional acts of either a) the past or b) his resignation. There was not a frame or consistent set of data items that stood alone that could be tested against the components of a signature matrix or an elaborative function. A review of data items referring to management could establish a range of examples of the signature matrix steps, and although the elaborative functions could support a management frame, its articulation of the problem, elaboration and consequences would be narrowly focused to Mr. Yeates. There is a connection to poor management and what happens to Mr. Yeates in both the Justice Frame (holding people to account) and the Learning frame – via understanding what happened and why.

**Constructing a signature matrix for the frame**

*Signature matrix* is a set of categories that help to organise the data items into a description of a frame. The structure of a signature matrix has been developed within the research on social movements and I followed the Creed, Langstraat and Scully (2002, p. 36) model of signature matrix development here. Signature matrix consists of eight categories. The first five categories, namely: metaphors, exemplars, catchphrases, depictions and visual images, accentuate the frame,
rendering a situation quickly interpretable. The last three categories – roots, consequences, and appeals to principle – serve to justify and demonstrate the argument made within the frame. Each category is populated with the relevant data items. Table 4 below provides an example signature matrix.

In my analysis, I went beyond developing the frames and describing them using signature matrices (i.e. beyond treating the frames as static), as I am particularly interested in the evolution of the frames over time. Therefore, I construct a set of the signature matrices for the frames for each of the six key dates identified in the study. It should be noted that, in principle, the number of frames may increase or decrease over time, as some new frames may emerge and old frames may be discarded. The themes emerged over the course of events and were not all present at the outset. Table 5 below identifies when, during the timeline, the themes were identified. For each of these themes, a signature matrix and analysis of the functions of the frame were created, and set out below.
Table 4. Example of signature matrix constructed for one of the frames in the study

<table>
<thead>
<tr>
<th>Category</th>
<th>Text file number</th>
<th>Data item</th>
<th>Justice Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metaphors</td>
<td>394</td>
<td>1</td>
<td>It was like a Third World country hospital. It was an absolute disgrace. This is an outrage that which has been happening at Stafford Hospital (Basford, 2009).</td>
</tr>
<tr>
<td>Exemplars</td>
<td>370</td>
<td>3</td>
<td>Investigating individual claims of negligence, abuse and/or degrading treatment that has occurred and that are still continuing in the Hospital at the present time. (Leigh Day &amp; Co Solicitors, 2009a)</td>
</tr>
<tr>
<td>Catch phrase</td>
<td>153</td>
<td>4</td>
<td>Drinking water from flower vases (Boseley, 2010b)</td>
</tr>
<tr>
<td>Depictions</td>
<td>153</td>
<td>4</td>
<td>What we saw will haunt us forever. (Symons, 2009)</td>
</tr>
<tr>
<td>Visual Images</td>
<td>153</td>
<td>4</td>
<td>(Symons, 2009) (Image - Ms Bailey and her mother)</td>
</tr>
<tr>
<td>Roots</td>
<td>402</td>
<td>2</td>
<td>Bailey says her attempts to improve hospital care were stymied by local bureaucracy and obfuscation (Gould, 2009).</td>
</tr>
<tr>
<td>Consequences</td>
<td>370</td>
<td>2</td>
<td>Leigh Day &amp; Co Solicitors have been instructed by Julie Bailey and Christine Dalziel of Cure the NHS regarding the Healthcare Commission’s investigation into Mid Staffordshire NHS Foundation Trust to call for, and to challenge, any refusal to hold a public inquiry, and to consider issues about the past and on-going patient care within the Trust (Leigh Day and Co, 2009a).</td>
</tr>
<tr>
<td>Appeals to principle</td>
<td>420</td>
<td>2</td>
<td>How can any patient have trust in the managers and systems that have allowed this disaster to run and run? It is not enough for the chairman and chief executive to take the fall for this (Guardian, 2009b).</td>
</tr>
</tbody>
</table>
Table 5. Identification of the event at which the key theme emerged, and from which a signature matrix and analysis of the functions of the frame were created

| Event 1 | Learning | Justice |  |  |  |  |
|---------|----------|---------|  |  |  |  |
| Event 2 | Learning | Justice | Improvement |  |  |  |
| Event 3 | Learning | Justice | Improvement | Leadership |  |  |
| Event 4 | Learning | Justice | Improvement | Leadership | Distress |  |
| Event 5 | Learning | Justice | Improvement | Leadership | Distress |  |
| Event 6 | Learning | Justice | Improvement | Leadership | Distress | Defense | Blame |
Analysing the functions of a frame

According to Snow and Benford (1992) a frame has three tasks/functions: diagnostic, prognostic and motivational. *Diagnostic* function refers to defining the problem, apportioning the blame and establishing relationships of cause and effect. *Prognostic* function refers to identifying the strategies required to achieve the desired solution to the problem. *Motivational* function refers to providing a rationale for action and issuing a “call to arms”.

The three functions provide a structure for further analysis of the frame. In practical terms, with similarity to signature matrices, the three functions offer a set of categories for examining the frame and these categories are populated with the relevant data items. Table 6 illustrates the frame function categories developed for one of the frames identified in my study.

Following the same rationale as described above for the signature matrices, I developed the set of frame functions for all frames. Consequently, the outcome of this step was the seven sets of frame function analyses as schematically depicted for each event, illustrated in table 5 above.

Analysis of the processes of framing and frame change

In this step the attention of frame analysis switches from describing a frame (through signature matrix and frame functions) to examining how a frame is constructed – and reconstructed over the course of the crisis.

Using the data presented within the first five stages, I compared how the frames changed and developed through the six key dates identified. I compared each category of the signature matrix and elaboration matrix over time. In Table 7 below I have set out how, in this example, the depictions from the signature matrix are presented over the six key events. Similarly in Table 8, I have set out the prognostic functions from the elaboration matrix as presented over the six events.
Table 6. Example of the frame functions developed for one of the frames

<table>
<thead>
<tr>
<th>Category</th>
<th>Text file number</th>
<th>Data item</th>
<th>Learning Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic function “What is the problem?”</td>
<td>376</td>
<td>2</td>
<td>Mrs Bailey said that an inquiry needed to address a number of questions – including exactly how many deaths had there been and why did Health Secretary Alan Johnson and his predecessors fail to prevent these deaths? (Express and Star, 2009b)</td>
</tr>
<tr>
<td>Prognostic function “Who is responsible? What outcomes can be predicted with or without intervention”</td>
<td>376</td>
<td>3</td>
<td>“We demand a full statutory inquiry in order to compel witnesses to appear and to answer questions on oath. Because the Healthcare Commission has done so much preliminary investigation the timescale can be shorter than normally and it will, anyway, be an excellent investment in the future healthcare of everyone. “The number of deaths involved is very large and they continue nonetheless.” (Express and Star, 2009b)</td>
</tr>
<tr>
<td>Motivational function “What action should be taken?”</td>
<td>159</td>
<td>1</td>
<td>Eric Morton, has now pledged that meetings would be arranged for all concerned patients and relatives about the &quot;quality of care they have received&quot;. (BBC News, 2009c)</td>
</tr>
<tr>
<td></td>
<td>395</td>
<td>1</td>
<td>The Tory leader promised a Conservative government would make huge changes to the NHS during his visit to Stafford late yesterday by slashing targets and focusing on patient feedback. He spent more than an hour listening to members of Cure the NHS in campaign group founder Julie Bailey’s cafe on Newport Road, before saying an investigation “absolutely independent” from the hospital, the Government and “the whole system” was needed. (Express and Star, 2009e)</td>
</tr>
<tr>
<td></td>
<td>420</td>
<td>1</td>
<td>The trust now has the strong leadership it needs to respond to the report’s recommendations, but we'll be monitoring what happens next very closely – and we won't hesitate to step in again if the trust doesn't continue to build on the progress already made. (Guardian, 2009a)</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------</td>
<td>---------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Depictions</td>
<td>What we saw will haunt us forever. (Symons, 2009) (Speaker - Ms. Bailey) (Text file number: 153) (Data item: 4)</td>
<td>None</td>
<td>Often left in soiled bedclothes, being given inadequate food and drink, having repeated falls, suffering from late diagnosis, cancelled operations, bungled referrals and misplaced notes (Boseley, Patients 'demeaned' by poor-quality nursing care, 2009) (Speaker - Ms Murphy) (Text file number: 424) (Data item: 1)</td>
</tr>
</tbody>
</table>
Table 8. The presentation of “prognostic function” in the elaboration matrix for the justice frame over the six key events

|--------------------|----------------|--------------|---------------|-------------------|--------------|------------------|
| Prognostic function| What had become clear was that official channels for their concerns were either ineffectual or hopelessly complex. (Gould, 2009) (Speaker – Ms Bailey) (Text file number: 402) (Data item: 1) | Former hospital boss Martin Yeates could finally face questions over his leadership of Stafford Hospital after it emerged he may be called to give evidence to an influential group of MPs. (Express and Star, 2009) (Speaker – Unknown Journalist) (Text file number: 223) (Data item: 1) | Commenting on the former chief executive Martin Yeates, who stepped down days before the damning Healthcare Commission report in March that revealed the extent of the hospital’s failings, Mr Kidney said: “Of course he should give evidence – he is the most crucial witness.” (Express and Star, 2009p) (Speaker – Mr. Kidney M.P.) (Text file number: 236) (Data item: 1) | In his view it was not fair to impose all the responsibility for what went wrong on Mr Yeates’ shoulders, and that the other executive officers should share in it. (Midstaffs Public Inquiry, 2010j) (Text file number: 64) (Data item: 57) | Despite two previous inquiries campaigners demanded a public inquiry which would compel witnesses to attend and be cross-examined. (BBC News, 2010h) (Speaker – Ms Bailey) (Text file number: 39) (Data item: 3) | Were they talking about prosecuting Mr Yeates? A. We were talking about -- Q. Yes. 1A. -- the intended possible prosecution -- Q. Okay. -- in other words, calling to account. Q. Yes. All right. A. I asked why, and he said because he was no longer at the trust, and he explained that any negotiations or investigations that he might wish to continue with them could only be on a voluntary basis on the part of the trust. (Midstaffs Public Inquiry, 2010k) (Speaker – Street) (Text file number: 94) (Data item: 10) |}

They demanded a full public inquiry with stronger legal powers. (Speaker – Unnamed Journalist) (BBC News, 2010g) (Text file number: 15) (Data item: 7)
Finally I consider the individual storyteller and how their role is represented and changes through data items and over time. For example, Ms Bailey's profile changes over the course of events. Using the frames I was able to identify the storytellers, data items and frames relevant to each individual. This then allowed me to identify themes, connections and omissions.

In order to present the movement of frames and storytellers, I plotted the findings on two simple 2 x 2 matrices. Both matrices are considered in more detail in Chapter 5 (Data Analysis). In chapter 5 figure 11 presents the movement of frames over time against two continuum. The vertical continuum considers the presentation of the frame as either aligned to existing beliefs, or aligned to recruiting new supporters; the horizontal continuum considers the presentation of the frame, while either articulation suggests the construction and frame content is focused on connections between events. Comparitively, at the other end of the continuum, frame amplification focuses on specific items and raising them above others within the frame. Figure 12 below presents the movement of storytellers over time against two continuum.

The horizontal continuum identifies the level to which the storytellers were vocal, with regard to the tone and emphasis of their messages. The vertical continuum considers the nature and structure of their stories in either formal or informal terms. The final stage of the data analysis was to identify the audiences for each frame, and identify how the individual data items are mapped to the the audience.

From the data items, the audience can be identified as the existing storytellers, consisting of the local community in Staffordshire, the wider community across the United Kingdom, the MSFT, other NHS organisations, local and national political parties and politicians, and the UK Government. Table 9 provides an example of the intended audience illustrated by using the data items.
Table 9. The presentation of intended audience and data items

<table>
<thead>
<tr>
<th>Intended audience</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Politicians/ political parties</td>
<td>Mrs Bailey said that an inquiry needed to address a number of questions – including exactly how many deaths have there been and why did Health Secretary Alan Johnson and his predecessors fail to prevent these deaths? (Express and Star, 2009b)  &lt;br&gt;&quot;The committee members were very civilized but there was no real scrutiny. The questioning was so bland and two committee members even dropped off to sleep during the meeting. (Midstaffs Public Inquiry, 2010q)  &lt;br&gt;Rebecca, my daughter, stood up and outlined what had happened to my mum. The councillors had no idea what was going on. &quot;Philip Jones drew breath when he saw the photos of my mother, as did the lady with him. But these were the same people who sat on the scrutiny committee and were used to just nodding their heads ... As a group we decided to lobby support from Andy Burnham but he didn't want to do anything because he had given them Foundation Trust status. He said he would come to Stafford. He in fact promised on radio that he would come to meet Cure the NHS, but he cancelled in December 2009. (Midstaffs Public Inquiry, 2010q)</td>
</tr>
</tbody>
</table>
Using this analysis of the audience I was then able to identify theme issues, omissions and contradiction between the audience, and storytellers over the course of the timeline.

**SUMMARY**
From the literature review I identified frame analysis as a qualitative tool to analyse a complex set of data. The initial challenge was to ensure the scope of the study was appropriate in order to generate a sufficient and analysable body of data. Whilst the literature review identified the value of frame analysis and confirmed the opportunity frame analysis offers to consider the research questions this study seeks to address, there was no formal structure or definition of the method. That said the literature review identified a sufficient body of material to support the development of the signature and elaboration matrices as the central device to analyse the data.

From the literature review, the understanding of the data set identified, and following an initial analysis of the data, I was able to identify a need to structure the process of manipulating the data items into the matrices, and then once in the structure, identify a process through which to consider what the matrices presented. These steps are set out above, and include the identification of themes, mapping data items and the generation of provisional frames in order to populate the signature and elaboration matrices. Applying the frame analysis at six key events during the period of the study provides an opportunity to understand and analyse the movement of frames, and storytellers over time, the outcome of which was presented across two matrices (see figure 11 and 12). These were support by the textual presentation of the seven frames over six events, which provided twenty six signature matrices and twenty six elaboration frames. Finally with the identification of the audience that were supported by the data items, the final stage was to review and identify the significant items from this analysis. This led to the development and exploration of the unintended consequences of storytelling.
CHAPTER 4. CASE STUDY

This chapter presents the case study used to provide the context and data for this research. Through this chapter I identified my own personal background and relationship to the provision of healthcare services in the UK. I then moved to provide a summary account of the structures of the NHS and Foundation Trusts for whom the responsibility to “manage” hospitals rests. Next, the organisation, MSFT, at the centre of this study is introduced. I provide an account of the purpose and structure of the organisation, which then moves into an explanation of the crisis at MSFT. Finally the chapter sets out a summary of the individual and key reports into the crisis at MSFT.

BACKGROUND

I have worked in Healthcare for more than ten years, in both the UK and Middle East. I have worked in six different organisations; together they have employed nearly 50,000 people. The industry, its people, customers, policy makers, critics and supporters always have an interesting story to tell – whether an employee, employer, a patient, relative or carer. We all, at some point rely on the services of these people, delivered in the various different NHS organisations. In many cases a trip to the hospital can leave us stripped naked, given an armband with basic information and (sometimes) left for many hours. Healthcare has the ability to make people’s day, to make them happy beyond all imagination – supporting the birth of a child, or curing a previously deadly illness, allowing us one more day/week or month with our loved ones – at other times it breaks us, it can end a life, or while lending support with great dignity, a death.

In the UK over the last 20 years, the NHS structures for delivering increasingly complex and highly sophisticated care have been ordered into “organisations”. Each organisation has a recognisable brand, look and feel. It is in this emotive, exciting and challenging environment I placed the research. In order to limit the scope of the research I restricted the area of focus to the United Kingdom, and in particular the NHS. This therefore excludes my experience in the Middle East, and private sector healthcare organisations.

The private health sector in the UK, in comparison to the NHS is relatively small, and often provides a limited range of services. With respect to the relationship between the Private Hospital, the Doctor and the Patient, it can become influenced by the transactional and
“purchase” issues – that is not to say all of the emotive issues identified earlier do not exist. This led me to focus on the National Health Service and the United Kingdom; this does not imply that the context or “field” of analysis is any more straight forward – however, the access and opportunities of the NHS provided the most appropriate area to start the research.

Within the National Health Service I chose to concentrate on a crisis as a “critical incident” that brings storytelling to the fore. A crisis presents an opportunity to consider the relationships between the storyteller and the audience at a time when the storytelling becomes overt, documented and visible. It is of interest to this study that, as mentioned above, the NHS has recently started to promote storytelling as a technique with which to engage organisational members in the change process.

**CONTEXT**

**The UK National Health Service**

The NHS was founded in the United Kingdom on 5th July 1948, when the then Health Secretary, Aneurin Bevan, opened Park Hospital in Manchester. For the first time, hospitals, doctors, nurses, pharmacists, opticians and dentists were brought together under one umbrella organisation to provide services that were free for all at the point of delivery. The central principles were clear: the health service would be available to all and financed entirely from taxation, which meant that people would pay into it according to their means. During the 1960’s, The Hospital Plan was introduced with the aim of separating the NHS into three parts – hospitals, general practice and local health authorities. During the 1970’s, the then Health Secretary David Ennals, commissioned a review of the NHS to investigate the inequality of healthcare that still existed despite the foundation of the NHS. The Whitehead Report in 1987 and the Acheson report in 1998 reached the same conclusions, highlighting the persistent health inequalities.

Throughout the 50 years of the NHS notable medical and clinical advancements were significant; including organ transplants, the first full hip replacement, and improved diagnosis through CT and MRI Scanning. But in organisational terms the 1990’s and 2000’s saw significant change in the structure and management of all aspects of the National Health Service. These changes were embodied in the NHS Community Care Act 1990. The
impact was to allow Health Authorities to manage their own budgets and buy health care products from hospitals and other health organisations on behalf of the local population. In order to be deemed a 'provider' of such health care, organisations became NHS Trusts, i.e. independent organisations with their own management. The changes within the NHS then took a significant step forward through the publication of the NHS Plan in 1999 (Department of Health, 2000). The NHS Plan brought about the biggest change to healthcare reform in England since the NHS was formed in 1948. It set out how increased funding and reform would eliminate geographical inequalities, improve service standards and extend patient choice. It outlined the vision of a health service designed around the patient.

With the notion of “organisation” embedded in the structure of the National Health Service, the concept of Foundation Trusts was introduced in 2004. Foundation Trusts were given more financial and operational freedom than other NHS trusts and represented the Government’s move towards the decentralisation of public services. Like other trusts, Foundation Trusts are assessed by the NHS performance inspection system. Figure 8 below sets out the different organisations that currently make up the structure of the NHS. The organisation at the centre of this research is an NHS Trust (and more specifically an NHS Foundation Trust) delivering Secondary (acute, complex) healthcare. It is perhaps important to consider what a Foundation Trust is, and why this is important.

**Foundation Trust and Monitor**

NHS Foundation Trusts are not-for-profit, public benefit corporations. Foundation Trusts (in principle) are not directed by Government thus have greater freedom to decide their own strategy and the way services are run. Traditionally NHS services and Trusts were accountable through a Strategic Health Authority to the Department of Health. Foundation Trusts are not directly accountable to the Strategic Health Authority or the Department of Health. Monitor is the organisation with statutory responsibility to regulate the performance of said Foundation Trusts.

Monitor is the independent regulator of NHS Foundation Trusts, and was established in January 2004 to authorise and regulate NHS Foundation Trusts. It is independent of central government, the Department of Health and directly accountable to Parliament. Monitor undertakes three main areas of work: 1) determining whether NHS trusts are ready to
Figure 8: The structure of the National Health Service. (NHS, 2011)
become NHS Foundation Trusts; 2) ensuring that all NHS Foundation Trusts comply with the conditions they signed up to – that they are well-led and financially robust; and 3) supporting NHS Foundation Trust development.

The assessment process is standardised for all organisations and includes: 1) how is the Trust currently governed and what are the plans to improve care? 2) Is the Trust financially viable? 3) Is the Trust legally constituted? The Trust in turn focuses primarily on the membership and ensuring it represents the local community it serves. Once established as a Foundation Trust, Monitor’s role focuses on regulating the organisation to ensure that the leadership, quality of care and finance are appropriate. Monitor, as a regulator rather than a hierarchical line manager, establishes a governance process that focused on, and allows for “earned autonomy”. The principle of this approach means that those organisations that could demonstrate their performance across a relatively small set of targets (compared to previous Department of Health measures), would be rewarded with greater freedom and less scrutiny. For those organisations that start to demonstrate a significant or catastrophic failure, Monitor has the power to intervene in the respective Foundation Trust in the event of failings in its healthcare standards, or other aspects of its leadership which may result in a significant breach of its terms of authorisation. This could include the removal of key staff and the replacement with interim staff until the issue can be addressed.

Finally Monitor is responsible for the development of the existing Foundation Trusts. Monitor has identified three key areas: it has focused on 1) Service-line management, which in short develops a profit and loss account for each service. The emphasis on such an approach is to allow Clinicians (Doctors and Nurses) to understand the true cost of their service delivery and how they influence (increase or reduce) the profitability of their service. 2) Non-Executive Director Development influences how each Foundation Trust is run and governed by a Board of Directors and a Board of Governors. Foundation Trusts are urged and required to ensure the Non-Executive representation on the Board is diverse, strong, and of a highly experienced nature. Foundation Trusts often manage income of several million pounds, and can employ thousands of staff (the organisation I currently work for has an income of £1bn and employs 12,000 people). 3) The development of strong financial leadership.
Foundation Trusts deliver healthcare services to local (and sometimes regional or national) populations through a contract agreed between the Foundation Trust and the Primary Care Trust (at the time of writing (2012)). The Primary Care Trust is responsible for identifying the needs of their population and “purchasing” services from a range of different providers. Through the contract between the Primary Care Trust and the Foundation Trust, there are significant and wide ranging contractual performance requirements placed on the Foundation Trust. The contracts are developed by the Department of Health and implemented through the Strategic Health Authority, and into the Primary Care Trust. Therefore, although there is no hierarchical relationship between the Foundation Trust and the Department of Health, there remains a very clear connection between the needs of the Department of Health and the requirements and expectation placed on the Foundation Trust. Furthermore, each Foundation Trust must lay its annual report and accounts before Parliament for scrutiny.

The Foundation Trust is accountable to their local communities through members and governors – the objective of this principally being that NHS Foundation Trusts can be more responsive to the needs and wishes of their local communities. Anyone who lives in the area, works for a Foundation Trust, or has been a patient or service user there, can become a member of the Trust and influence the way the organisation is run. The Foundation Trust membership and elected governors have the authority to appoint (and terminate the employment) of the Chairperson and Chief Executive of the organisation.

It is worth noting that from 2013, the Strategic Health Authorities and Primary Care Trusts were disbanded and replaced by Local Area Teams (LATs) and Clinical Commissioning Groups (CCGs); this has not fundamentally changed (at the time of writing) the contractual relationships set out in this document.

**MID-STAFFORDSHIRE NHS FOUNDATION TRUST**

Mid-Staffordshire General Hospitals NHS Trust was established in 1993, and then authorised as a Foundation Trust in 2008, at which point it became known as Mid-Staffordshire NHS Foundation Trust.
The principle purpose of the organisation is to provide acute (complex) hospital services for
the local populations living in Stafford, Cannock, Rugeley and the surrounding areas, which
includes around 325,000 people. Services are provided from two Hospitals, one located in
Stafford and another in Cannock. The hospitals are based in the south of the County of
Staffordshire. The broad services provided include medical and surgical specialties to adults
and children; in addition the Trust runs an Accident and Emergency Service. Each year the
hospital will see around 250,000 patients, with around 63,000 patients being admitted for
treatment, and around 74,000 patients attending the Accident and Emergency department;
the Hospital delivers around 2,000 babies each year. The organisation employs 3,000 staff
and is governed by a Board of Directors, including six Non-Executive Directors, a Chief
Executive and seven Executive Directors. Figure 9 sets out the Management structure of
the organisation in June 2011 (Mid-Staffordshire NHS Foundation Trust, 2010).

The Trust Board oversees and seeks assurances regarding the performance of the Trust
through the corporate governance arrangements. This, in short, is a set of seven
committees including:

1) Workforce Committee
2) Finance and Performance Committee
3) Equality and Diversity Committee
4) Donated Funds Committee
5) Healthcare Governance Committee
6) Audit Committee
7) Remuneration/Terms of Service Committee

Each of the Committees has Executive and Non-Executive representation plus appropriate
staff and public. These committees report to, and are documented in, the formal and public
Board meetings. Board meetings are held each month and consist of a public/open session
and a private/closed Session. Items not discussed in public are considered private on the
basis of a) commercially sensitive information; b) personal/staff information; or c) patient
related information.
Figure 9. Mid-Staffordshire NHS Foundation Trust Management Structure

Trust Chair
Sir Stephen Moss

Associate Director
(Corporate Governance)
Trust Secretary
David Haycox

Chief Executive
Lyn Hill-Tout

Head of Communications
Deborah Neal

Director of Finance and Performance
Darren Cattell

Deputy CEO / Medical Director
Mr. Manjit Obhrai

Chief Operating Officer
Maggie Oldham

Deputy Chief Executive
Beccy Fenton

Director of Nursing and Midwifery
Colin Ovington

Director of Quality and Patient Experience
Julie Hendry

Director of Human Resources
Christine Lloyd-Jennings

Head of HR Operations
Chris Plant

Head of OD & Training
Mike Barnett

Head of Medical Staffing
Derek Thomas

Occupational Health & Safety Manager
Peter Morton

Manager of Recruitment & Retention
Jo Holmes

Acting Deputy Director of Finance
Sarah Preston

Clinical Lead Clinical Audit
Research & Development
Dr. Tom Sheeran

Clinical Lead Clinical Audit
Research & Development
Dr. Tom Price

Clinical Lead Cancer
Dr. Paul Hiley

Clinical Lead Clinical Effectiveness
Vacant

Deputy CEO, Urgent Care
Chris Holt

Deputy COO, Planned Care
Claire Braithwaite

Head of Performance
Warren Shaw

Associate Director (Medicine)
Claire Mackirdy

Associate Director (Surgery)
Steve May

Associate Director (Clinical Support Services)
Karen Bourne

Associate Director (Facilities)
Louise Kiely

Head of Governance
Paul Archer

Deputy Director of Nursing (Quality & Service Improvement)
Suzanne Banks

Head of Nursing (Medicine)
Karen Kelly

Clinical Lead Infection Control
Vacant

Night Matron
Laura Griffiths

28th June 2011
To understand the management structure that supports the Board, the majority of the 3,000 staff are managed by the Chief Operating Officer. This role has responsibility for the day-to-day operational running of all services across the two hospital sites. This includes 1) “Urgent Care”, as in any patients visiting the hospital through the Accident and Emergency, and 2) “Planned Care” of patients who “elect” or choose to visit the hospital because they need to stay in hospital or require surgery; all of these activities are referred to as “Planned Care”. In this structure the Chief Operating Officer will have responsibility for all staff – administrative, Doctors (of all levels), Nursing Staff and Allied Health Professionals (e.g. Physiotherapists).

Functions such as Medical Director and Director of Nursing and Midwifery provide support to the Chief Operating Officer. These two roles are responsible for maintaining the clinical and professional standards of their respective staff groups. The Director of Quality and Patient Experience works with these two roles and the Chief Operating Officer to consider how the operational systems and process might change to improve the experience for patients and improve clinical outcomes. Furthermore, this role will have responsibility for monitoring and assuring the quality of the services provided and the health/clinical outcomes from them. Finally the Deputy Chief Executive, Director of Human Resources and Director of Finance and Performance manage the corporate agenda in their respective areas, whilst providing operational support to the clinicians and management delivering services.

The Council of Governors (elected representation) work with the Trust’s Board of Directors to ensure that the Trust acts in a way that is consistent with its terms of authorisation. In this way, the Council of Governors plays an important role in helping to set the overall direction of the organisation. There are thirteen elected public governors, five members of staff elected as governors, and seven governors appointed by key local organisations (e.g. the local Universities, local Government etc.).

At the time of writing, South Staffordshire PCT was responsible for Commissioning (buying) the Healthcare services for the population of South Staffordshire (which includes Stafford and Cannock). The PCT will contract for services from Mid-Staffordshire NHS Foundation.
Trust, and represent other PCTs whose population use the Hospital. The income value of all contracts (led by the PCT) was £152m (2010/11); during 2010/11, additional activity was delivered resulting in the contract/income at the end of the year amounting to £157m. However the pay and other costs exceeded the additional income and at the end of 2010/11, the organisation was predicting a loss (deficit of £13.86m).

From April 2010, a new system of regulation for health and social care in England came into force which required the Trust to register with the Care Quality Commission (CQC). The Trust had to submit evidence to the CQC in order to show that they were compliant with the regulations. Normally, CQC formally review a Trust when they receive information that is of concern and, as a result, decide whether the Trust is still meeting one or more of the essential standards. The CQC also formally review services at least every two years to check whether they are meeting all of the essential standards in each of the locations. The reviews include checking all the available information and intelligence the CQC holds about a Trust. The CQC may seek more information by contacting people who use services, public representative groups and organisations such as other regulators. They may also ask for more information from the provider, and carry out a site visit with direct observations of care.

In 2010, upon the Mid-Staffordshire NHS Foundation Trust’s submission for CQC Licence across seventeen essential standards, the CQC found the organisation compliant in five areas with the remaining twelve being marked as either of minor or moderate concern. Examples (taken from CQC Compliance Report October 2010) of compliance included consent for treatment and meeting nutritional needs. Examples of minor concerns include relating to the care and welfare of people who use services – in this area progress had been made but not all areas identified by the Trust had been implemented. Examples of moderate cause for concern included the management of medicine, where the CQC found inconsistency in practice and policy within the organisation. Therefore, in 2010, Mid-Staffordshire NHS Foundation Trust found areas that required further investigation, but did not prevent it from continuing with its daily delivery of services. The issues raised would be managed through the formal governance structure referred to above.
Monitor, as already highlighted, is the regulator for Foundation Trusts. In 2010 Monitor published two risk ratings for each NHS foundation trust: 1) a financial risk rating (rated 1-5, where 1 represents the highest risk and 5 the lowest); and 2) a governance risk rating (rated red, amber-red, amber-green or green). The assessment of Mid-Staffordshire as at March 2011 was a financial risk rating of 1, meaning there is a high probability of significant breach of authorisation in the short-term, e.g. less than 12 months, unless remedial action is taken, and a governance risk of red, this pertains that there exists a likely or actual significant breach of terms of authorisation. Out of 136 Foundation Trusts there were three organisations (including Mid-Staffordshire NHS Foundation Trust) with this lowest rating for both measures. Monitor has formally intervened in the organisation due to its performance previously (in 2009), and the details will be set out below; but as of 2011, there was no formal intervention.

In summary, Mid-Staffordshire is a small to midsized acute hospital. It has established a management structure that supports, as a Foundation Trust, the demands of Monitor and the Care Quality Commission.

**THE CRISIS**

Mortality rates report the level of deaths experienced by a hospital and the surgical and medical specialties. This information allows for hospitals to recognise that there is a standard level of death related to any given procedure, from which a “norm” for a given set of circumstances can be established. It was the identification of apparently high mortality rates in patients admitted as emergencies to the Hospital since April 2005, and the care provided to these patients that the crisis centres around.

The Healthcare Commission (HCC as the predecessor to the CQC) identified the high rate of mortality in autumn 2007, and the Commission contacted the Trust to raise an ‘alert’ which resulted in a review of the mortality data to ensure this was accurate. The primary responses by the organisation to the Commission related to matters of data accuracy. The organisation asserted that the high rates were principally related to poor data collection. The Commission challenged the evidence presented by the organisation, and in light of significant public pressure and feedback regarding quality, a full investigation was launched.
by the HCC. Between March 2008 and October 2008, the HCC carried out an investigation into Mid-Staffordshire NHS Foundation Trust.

The findings of the investigation concluded that the standardised mortality rate was found to be high across a range of conditions which subsequently led [the Health Care Commission] to conclude: “there were systemic problems across the trust’s system of emergency care” (Healthcare Commission, 2009, p. 4). In short, a significantly higher number of deaths were occurring than would normally be expected. The reaction to such a finding was compounded by the report identifying that this was related to poor standards of care, including insufficient staff on the ward that led to patients being left in soiled sheets, unfed and without medication. At the point of the publication of the Healthcare Commission’s report in March 2009, the Chief Executive and Chairperson of MSFT resigned. An interim Chief Executive was announced during this phase.

The crisis is defined through 1) the catalyst – public concern about their experience at the Trust; 2) the trigger – the high standardised mortality rate confirmed through the initial investigation by the Healthcare Commission; and 3) the identification of cause – the systemic failure in A&E and exceptionally poor standards of care. The event (i.e. the higher than expected levels of death) occurred between 2005 and 2008, however the crisis relates to the responses that followed between March 2009 and October 2011.

**INVESTIGATING THE CRISIS**

As a result of the report from the Healthcare Commission (Healthcare Commission, 2009) a series of formal and further investigations into the causes of the crisis were initiated.

**Formal investigations into the Trust and the crisis**

The purpose of this section is to present the key investigations into the crisis. These will also form part of the data set analysed in chapter 5 (data analysis). The key/formal investigations into MSFT were:

- Learning and Implications from Mid Staffordshire NHS Foundation Trust 1st October 2007 to 30th April 2009: KPMG (on behalf of Monitor) – September 2009 (KPMG, 2010).
- Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009: Robert Francis QC – February 2010 (Francis, 2010a); (Francis, 2010b).
- Mid-Staffordshire NHS Trust Public Inquiry: Robert Francis QC (Francis, 2013).

Of these seven reports three were reviewed in detailed as part of the research. Those were: 1) The Health Care Commission Review (Healthcare Commission, 2009); 2) The first inquiry into the Hospital (Francis, 2010a); (Francis, 2010b) and 3) The transcripts from the public sessions ahead of the publication of the public inquiry (Francis, 2013); the actual published report was outside the scope/time period of this study. The other four investigations are significant, but largely refer to or were referred by these three significant reports. A summary of the remaining four reports is as follows:

**Dr. David Colin Thomé investigation** (Thome, 2009)

The author of this investigation and report, Dr. David Colin Thomé, was National Director for Primary Care and worked for the Department of Health. This report was commissioned by the Secretary of State for Health, and focused on the role of the Primary Care Trust and Strategic Health Authority through the period of the events preceding the investigation by the Healthcare Commission. This was considered necessary as the Healthcare Commission (HCC) investigation focused almost entirely on the internal hospital processes and people within MSFT.
The Department of Health was concerned that the Hospital had been able to perform so poorly (as described in the HCC report (Healthcare Commission, 2009)) for such a prolonged period of time. The Department of Health was concerned that this had not been highlighted or addressed by the organisations with the mandate and responsibility to performance manage the Hospital – that being the local Primary Care Trust (South Staffordshire PCT), and the Strategic Health Authority (West Midlands SHA). The investigation’s objectives were:

1. understand why the PCT and SHA were not aware of failings;
2. to complement a review being undertaken by Professor Alberti (see below);
3. make recommendations on what commissioners across England could learn;
4. set out what steps commissioners (PCTs, those responsible with purchasing healthcare) should reasonably expect to take in assessing risks.

The investigation largely involved one to one meetings with staff across the Hospital, PCT and Strategic Health Authority. This investigation reviewed information from 2002 (whereas the Healthcare Commission investigated from 2005 only). This investigation highlighted a review by the Commission for Health Improvement (CHI), which preceded the Healthcare Commission, and itself was preceded by the Care Quality Commission. This review identified and requested action plans by the Hospital to improve the level of emergency admissions and address the quality of care at the hospital. Prior to 2005, the CHI awarded stars based on the performance as judged by CHI. Trusts were awarded zero, one, two or three stars. In 2002/3 CHI awarded MSFT three stars in response to the quality of the action plan the Trust had implemented. The following year 2003/4 for the Trust was awarded zero stars, largely due to poor performance against access/national targets.

The investigation (Thome, 2009, p. 14) “found that no concerns about the hospital came to light through the local reporting system”. Information now available and collected long after the event was not requested or available at the time. There were indicators – such as the zero star rating and poor patient survey results, however poor care was able to go undetected. It is worth noting that the recommendations are made to the National Health Service as a whole and are not targeted at the South Staffordshire PCT or West Midlands.
SHA alone. The investigation identified four key areas of improvement for all PCTs, and I have summarised the recommendations:

1) Involving patients and public – PCTs would be held to account by ensuring and demonstrating that patients are involved in the process of managing the performance and quality of care.

2) Commissioning for outcomes – this tasks PCTs to focus on the “broader picture” (Thome, 2009, p. 15) and not focus on process measure alone. What this means is – rather than just focusing on the national target of the 4 hour wait in Accident and Emergency, PCTs should also ensure the end experience, the outcome of the system should be measured. In short, this relates to the consequences for the patient – i.e. did they get better or not? Not just were they seen in time.

3) Ensuring governance and clarity of accountability – PCTs must take ultimate responsibility for ensuring safe services are delivered. PCTs must be supported by all organisations to ensure they can discharge this obligation.

4) Clinical leadership – ensure that PCTs have the right clinical leadership with the ability to act and to challenge poor performance when it is identified.

The significance of this investigation is that it highlights a) additional history and context that preceded the Healthcare Commission review, but also b) it demonstrates how the many organisations (see the NHS Context section above) all failed to take action to or be aware of any issues at the Hospital.

**Professor Sir George Alberti investigation** (Alberti P. , 2009)

The author is a Senior Research Investigator at Imperial College London and was also asked, like Dr David Colin Thomé by the Secretary of State (and by Monitor), to:

1) review the procedures for emergency admissions and treatment at Mid Staffordshire NHS Foundation Trust

2) to review the Trust's (MSFT) progress against the recommendations in the Healthcare Commission’s report

3) to collaborate with the investigation of Dr. David Colin Thomé
In this review the author made twenty three recommendations and thirteen key observations. The most notable being that, in the opinion of the author, the Accident and Emergency department was now “providing safe, good quality care” (Alberti P., 2009, p. 6). The review went on to highlight other evidences of positive progress in recruitment, staffing and processes. However the author highlighted there were still significant issues relating to patient flow, staff shortages in other support areas, equipment, nursing, patient involvement and the culture of staff at the hospital.

Finally, the report recommended that the establishment of networks should support emergency and care of the elderly services, to involve staff from across the multiple organisations involved in delivering care. This investigation has no formal connection to the regulatory or contractual relationships within the NHS; however it is important as it identifies the progress and areas of development after the publication of the Healthcare Commission investigation.

**KPMG (on behalf of Monitor)** (KPMG, 2010)

If the Healthcare Commission (2009) and Professor Alberti’s report (2009) focused on the Hospital itself, and Dr. David Colin-Thome focused on the PCT and Strategic Health Authority, this report focused on the role of Monitor (the regulator for Foundation Trusts). The report was Commissioned by Monitor and they requested their internal auditors (KPMG) to “assess lessons for both the assessment process of applicant NHS foundation trusts and the ongoing compliance of NHS foundation Trusts” (KPMG, 2010, p. 2). The report made fourteen recommendations which were accepted by Monitor’s Board, and following this implementation plans were put in place.

The fourteen recommendations were high-level statements, such as “obtain stronger assurances” or “stronger focus”, “redefine quality governance”, and “enhance stakeholder information flow” (KPMG, 2010, p. 3). The recommendations were grouped into four categories: 1) Assessment; 2) Compliance; 3) Intervention; 4) Structural Matters. At this stage the report provides little additional information regarding the context of the crisis. The significance or intention of the report is largely constrained to Monitor itself.
**Professor John Wallwork** (Wallwork, 2010)

This investigation was the fourth Investigation commissioned by a Secretary of State. Professor John Wallwork is a Senior Cardiac Surgeon from Papworth Hospital, UK. It was initiated in order to consider the clinical services provided at the Hospital. It was commissioned to identify if the current range of services should continue. Seventeen recommendations were made, and following the themes and key areas identified in the original Healthcare Commission investigation, this was a more “technical” investigation and written firmly in the language of the NHS – making reference to pathways, networks and clinical outcomes. The outcomes, or recommendations, were that the Hospital continues to operate the services it currently delivers, but does so in a different way. The investigation suggested two changes to certain clinical services; they should be 1) delivered in partnership with other hospitals, and/or 2) services should be more integrated with primary care.

**SUMMARY**

This review provides an introduction to the key structure of the NHS within the UK, and focuses on the particular role of Monitor (as a regulator of) and Foundation Trusts. This was a significant Political and strategic change to the way the NHS was managed, and the failures identified in the Healthcare Commission’s report (Healthcare Commission, 2009) were the first public failure of this new system. The consequences of poor care had led to a higher than expected level of deaths and very real, and personal, accounts of poor experiences of patients and their carers at the hospital. The reaction to this report and the events that followed during the period of March 2009 to November 2010 were the focus of this study.
CHAPTER 5. PRELIMINARY ANALYSIS

This chapter provides the preliminary analysis of the data and the construction of the frames for further consideration in chapters 6, 7 and 8. A frame focuses attention on a particular aspect of the problem. It provides the tentative answers to the questions: “What is the problem?”, “Who is responsible?” and “What is to be done?” In other words, a frame articulates what the problem is, attributes the responsibility, and identifies the course of action. The ultimate outcome of the analysis is an overarching picture that pulls the multiple frames together and identifies the key themes in the interpretation of the problems and consequences.

As discussed in Chapters 1 and 2, frame analysis was the key component of the theoretical framework of the study. In the following section I set out the start and end point for the timeframe to be analysed; I identified, using the data sources from Chapter 3, (Methods) the volume of documents relevant to this Case. I then described how these documents were analysed and broken down into individual data items. From this data set I also identified nine storytellers and six events which took place during the timeline. I then presented how the data items are coded to events and to storytellers. In order to focus the research, I highlighted how four storytellers and three events are prioritised for further, more detailed analysis.

TIMEFRAME

The timeframe of the analysis covers the period from March 2009 until November 2010.

The starting point

The starting point of the timeframe, March 2009, corresponds to the publication of the Healthcare Commission’s report “Investigation into Mid Staffordshire NHS Foundation Trust” (Francis, 2010a). The report identified several problems at MSFT, including high mortality rates, poor nursing care and staff shortages (Healthcare Commission, 2009, p. 134). At the launch of the report, the outcome of the report was summarised by the Chairman of the Healthcare Commission. This summary was repeated in a number of different texts:

“This is a story of appalling standards of care and chaotic systems for looking after patients. There were inadequacies at almost every stage in the care of
emergency patients. There is no doubt that patients will have suffered and some of them will have died as a result." (BBC News, 2009c) (Leigh Day and Co, 2009a) (BBC News, 2009d) (Carvel, 2009).

The end point

The end point, November 2010, corresponds to the opening of the public inquiry, chaired by Mr Francis Q.C. The opening day of the Inquiry, held in Stafford was on the 8th November 2010. The accounts of the day highlight a tense start, with the Inquiry taking place in two rooms in the local council offices. Mr Francis QC framed the opening based on his experience of the previous inquiry:

“Last year, in my first inquiry, I sat and listened to many stories of appalling care. As I did so, the questions that went constantly through my mind were: why did none of the many organisations charged with the supervision and regulation of our hospitals, detect that something so serious was going on, and why was nothing done about it? That question was one which many patients and their families – and, it is fair to say, healthcare professionals as well – wanted to be answered." (Midstaffs Public Inquiry, 2010c, p. 2).

DATA

The data was collected from twelve sources. The rationale for the choice of these sources was presented in Chapter 3. The search through these data sources identified 1274 documents relevant to the case. The details are provided in Table 10.
Table 10. The data sources and the documents extracted from those sources

<table>
<thead>
<tr>
<th>Source</th>
<th>Number of documents extracted from the source</th>
<th>Examples of documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Express &amp; Star</td>
<td>166</td>
<td>(Burnham under fire on hospital inquiry, 2009q)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Former nursing boss still on payroll, 2010b)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Hospital's £628,000 spin shock, 2010c)</td>
</tr>
<tr>
<td>2. Guardian</td>
<td>55</td>
<td>(Outrage greets Mid Staffordshire hospital report, 2009b)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Stafford hospital inquiry findings due, 2010a)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Mid-Staffordshire inquiry: Unhealthy system, 2010b)</td>
</tr>
<tr>
<td>3. Daily Mail</td>
<td>2</td>
<td>(NHS rewards bosses after 1,200 'excess' deaths at scandal-hit hospitals, 2011)</td>
</tr>
<tr>
<td>4. The Sun</td>
<td>8</td>
<td>(PM's vow on death hospital, 2010d)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Ward deaths shame Labour, 2010b)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Chaos kills 'up to 1,200' in one hospital, 2009)</td>
</tr>
<tr>
<td>5. BBC</td>
<td>84</td>
<td>(Failing hospital to review cases, 2009c)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(NHS trust inquiry chiefs resign, 2009a)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Stafford Hospital public inquiry welcomed, 2010d)</td>
</tr>
<tr>
<td>6. Care Quality Commission</td>
<td>1</td>
<td>Investigation into Mid Staffordshire NHS Foundation Trust (Healthcare Commission, 2009)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009 Vol 2, 2010b)</td>
</tr>
<tr>
<td>8. Public Inquiry</td>
<td>908</td>
<td>(Key document - Terms of Reference, 2010f)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(11 November 2010 Transcript, 2010g)</td>
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<tr>
<td></td>
<td></td>
<td>(9 December 2010 Transcript, 2010r)</td>
</tr>
<tr>
<td>9. MSFT</td>
<td>6</td>
<td>(Statement by Chief Executive re Public Inquiry, 2010)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Press Releases, 2010)</td>
</tr>
<tr>
<td>10. Cure the NHS</td>
<td>1</td>
<td>(Bower and Mid Staffs Inquiry, 2011a)</td>
</tr>
<tr>
<td>11. Leigh Day and Co</td>
<td>15</td>
<td>(Leigh Day instructed over Mid-Staffordshire NHS Foundation Trust, 2009a)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Update on Mid Staffordshire NHS Foundation Trust, 2009b)</td>
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<td></td>
<td></td>
<td>(Leigh Day instructed over Mid-Staffordshire NHS Foundation Trust, 2009a)</td>
</tr>
<tr>
<td>12. Monitor</td>
<td>15</td>
<td>(Monitor appoints Chief Executive at Mid Staffordshire NHS Foundation Trust, 2009b)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(National Health Service Act 2006 (“the Act”) NOTICE of exercise of intervention powers under section 52 of the Act, 2009a)</td>
</tr>
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<td></td>
<td></td>
<td>(Monitor welcomes CQC’s 12 month progress report into Mid Staffordshire NHS Foundation Trust, 2010)</td>
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<tr>
<td>Total</td>
<td>1274</td>
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In the first stage of preliminary analysis I read all 1274 documents to familiarise myself with the particulars of the case and to identify the main storytellers. In the second stage of preliminary analysis the individual storytellers were referred to singly 859 times of the 1274 documents. Taking into account documents where more than one storyteller is referred to, I was able to single out 425 individual documents that included all the references to each storyteller. In the third stage of preliminary analysis, I broke the 425 documents into data items. A data item is a fragment of the text that provides a quotation from a storyteller or refers to a storyteller. The following example illustrates the procedure I followed.

Example of coding

The article “MP angers hospital deaths campaigner” (Express and Star, 2010f) was broken down into seven data items, of which three data items were coded to Ms Bailey, and four data items were coded to Mr Francis. For instance, the text “Ms Bailey added: ‘The number of deaths expected and observed stands, the ratio stands and the appalling care stands’” was coded as a data item for Ms Bailey, because this text is a direct quote from Ms Bailey (Express and Star, 2010f).

The text “Mr Francis was following the views of Professor Brian Jarman that conclusions on the cause of the death of an individual patient or number of patients cannot be drawn from the statistics themselves” was coded as a data item for Mr Francis, as this text refers directly to Mr Francis and represents his views. (Note that the coding of this text as a data item for Mr Francis does not entail any judgement as to the accuracy of the text and the extent to which it reflects Mr Francis’ views). Finally, the text “She [Ms Bailey] said she had received assurances from Mr Francis that it had not been his intention to discredit the mortality statistics” was coded both to Ms Bailey and Mr Francis.

I stored the data items in an Excel spreadsheet and attributed each item to a particular storyteller. Table 11 presents the list of storytellers and the number of documents and data items associated with each storyteller.
Table 11. The number of documents and data items associated with the storytellers

<table>
<thead>
<tr>
<th>Storyteller</th>
<th>Number of documents</th>
<th>Number of data items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Bailey</td>
<td>155</td>
<td>482</td>
</tr>
<tr>
<td>Mr Yeates</td>
<td>178</td>
<td>1152</td>
</tr>
<tr>
<td>Mr Morton</td>
<td>52</td>
<td>122</td>
</tr>
<tr>
<td>Mr Sumara</td>
<td>130</td>
<td>334</td>
</tr>
<tr>
<td>Ms Hill-Tout</td>
<td>14</td>
<td>23</td>
</tr>
<tr>
<td>Dr Moyes</td>
<td>74</td>
<td>346</td>
</tr>
<tr>
<td>Mr Francis</td>
<td>209</td>
<td>385</td>
</tr>
<tr>
<td>Leigh Day and Company</td>
<td>33</td>
<td>49</td>
</tr>
<tr>
<td>Ms Murphy</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>859</td>
<td>2905</td>
</tr>
</tbody>
</table>
STORYTELLERS AND EVENTS

Storytellers

The question “What is a storyteller?” has been addressed in Chapter 2. Briefly, the storyteller is defined here as a person who has a significant role in creating and recreating frames, through a demonstrable relationship with and involvement in the crisis at MSFT. My preliminary examination of the full set of the documents (1274 documents) identified nine storytellers. I describe these storytellers below.

Ms Bailey, the founder and leader of Cure the NHS

Ms Julie Bailey was the daughter of Mrs Bella Bailey, a patient at MSFT, and established the campaign group Cure the NHS. Ms Bailey was driven to establish Cure the NHS after the death of her mother at MSFT. The group was established in November 2007 to support carers and patients who experienced poor care at MSFT (BBC News, 2010g). Cure the NHS is “committed to [changing] the management and ethos of the trust so we may all feel safe and secure if admitted to the Hospitals.” (Cure the NHS, 2011b).

Ms Bailey, through Cure the NHS, was persistent in her calls and lobbying to ensure that a public inquiry was undertaken into events at the Hospital. The group would not accept the previous reports published into the Hospital. Their consistent challenge was to ensure Managers, Politicians, Clinicians and other decision-makers were interviewed in public. The problem Ms Bailey identified that needed to be addressed was to ensure that no one could hide, that it would uncover failings, and it would ensure that accountability and openness takes place.

Mr Yeates, the CEO of MSFT (August 2005 – May 2009)

Mr Yeates was Chief Executive of MSFT between August 2005 and May 2009. In August 2005, Mr Yeates was recruited on an interim basis; in February 2006 his position was confirmed as permanent. Mr Yeates was Chief Executive during the period under investigation by the Healthcare Commission. Mr Yeates stepped down as Chief Executive on 3rd March 2009, but formally resigned from the post in May 2009. Mr Yeates did not attend the Private or Public Inquiries, but did provide written statements. Mr Yeates was considered medically unfit to give evidence.
**Mr Morton, the CEO of MSFT (May 2009 – July 2009)**

Mr Morton was Chief Executive at MSFT between May 2009 and July 2009. Monitor used the statutory power to recruit Mr Morton into his post. Mr Morton was employed on an interim basis. Mr Morton was the Chief Executive of Chesterfield NHS Foundation Trust, and continued in this role whilst also acting as interim Chief Executive at Mid-Staffordshire. For a short period in May both Mr Morton and Mr Yeates were employed in the role of Chief Executive of MSFT at the same time. At the end of Mr Morton’s tenure at MSFT, he continued his full-time role as Chief Executive of Chesterfield NHS Foundation Trust.

**Mr Sumara, the CEO of MSFT (August 2009 – July 2011)**

Mr Sumara was Chief Executive of MSFT between August 2009 and July 2011. Mr Sumara was employed and placed into the role of Chief Executive by Monitor (the Regulator) and not interviewed or recruited by the Hospital Board or staff members. Monitor used the formal powers, under section 52 (4) of the National Health Service Act 2006 to appoint Mr Sumara due to the Hospital’s lack of recruitment of an appropriate permanent candidate (Monitor, 2009a).

Mr Sumara had worked in senior roles within the NHS for twenty-five years (Monitor, 2009b), including most recently as NHS London Director of Turnaround. Prior to that, he was recruited into University Hospital of North Staffordshire (UHNS) as Chief Executive in order to improve the hospital, which at that moment was considered to be failing financially. Mr Sumara was also Managing Director of the local Strategic Health Authority in 2005; a role which involved him in the process to review Mid-Staffordshire NHS Hospital Trust ahead of their application to become a Foundation Trust (Francis, 2010a, p. 327). Mr Sumara retired on completion of his contract with MSFT in July 2011.

**Ms Hill-Tout, the CEO of MSFT (June 2011 – May 2013)**

Ms Hill-Tout was appointed as Chief Executive of MSFT in June 2011 and retired from the post in May 2013. The Hospital Board recruited Ms Hill-Tout as the permanent Chief Executive for the hospital. Ms Hill-Tout joined in June 2011 and had only limited exposure during the period of data analysis. Prior to assuming the role of Chief Executive, Ms Hill-Tout was Chief Executive of Great Western Hospitals NHS Foundation Trust for eight years (Guardian, 2011).
**Dr Moyes, Executive Chairman of Monitor (February 2008 – January 2010)**

Dr Moyes was the Executive Chairman of Monitor from February 2008 and January 2010. Monitor is responsible for the accreditation and regulation of NHS Foundation Trusts. Monitor was established through Government legislation. Dr Moyes was appointed as Executive Chairman in February 2008, and subsequently retired in January 2010. Dr Moyes was responsible for the final authorisation of Mid-Staffordshire Hospital as a Foundation Trust on the 1st February 2008.

**Mr Francis Q.C., Chairman of the Independent and Public Inquiries in MSFT**

Mr Francis is a barrister and “undertakes clinical negligence actions on behalf of claimants and defendants, including NHS bodies, private healthcare providers, all the medical defence organisations, and insurers” (Serjeants’ Inn Chambers, 2013). He has had involvement in a number of inquiries into the NHS, these include Bristol Royal Infirmary (Unexplained high levels of infant death) (Kennedy, 2001); and Alder Hey Hospital (Retention of body parts from deceased children without consent) (Redfurn, 2001). He also chaired the inquiry into the events and care provided to a patient found guilty of murder (Michael Stone, while suffering from severe mental health issues, found guilty of murder after indicating to his carers his intention to commit murder) (Francis, 2006); Mr Francis also chaired the first inquiry into events at Mid-Staffordshire – an inquiry undertaken privately, and the findings of which were published (Francis, 2010a) (Francis, 2010b). Mr Francis also chaired the public inquiry into events at Mid-Staffordshire. Mr Francis has therefore represented the organisations’ management as well as the patients and victims.

**Leigh Day and Co Solicitors, legal representatives for Cure the NHS**

Leigh Day and Co Solicitors are a specialist law form and experts in clinical negligence (Leigh Day and Co, 2013). They were initially appointed in March 2009 by Ms Bailey to represent Cure the NHS. They also were able to represent patients in their claims for compensation against the Trust (BBC News, 2011a).

**Ms Murphy, CEO of the Patients Association**

The Patients Association is “a healthcare charity which for nearly 50 years has advocated for better access to accurate and independent information for patients and the public; equal access to high quality health care for patients; and the right for patients to be involved in all aspects of decision-making regarding their health care” (Patients Association, 2013). Ms
Murphy was appointed Chief Executive of the Association in 2008. Their involvement in the hospital included developing, in partnership with Cure the NHS, a petition calling for a public inquiry into events at the hospital (Campbell, 2010b). The Association had representatives attend and provide evidence to the Public Inquiry. In 2009, the Patients Association released 'Patients not Numbers, People not Statistics' a collection of sixteen firsthand accounts of patient care (Patients Association, 2009). This included the story of Ms Bailey’s mother at MSFT.

After further investigation and to reduce the complexity, I identified that out of the nine storytellers, five of the storytellers accounted for 93% of all the data items coded. On further analysis and identification of the number of data items coded to each of the six events, I identified that Dr Moyes did not attract a significant volume of data items. I therefore chose to proceed with four key storytellers. The chosen four storytellers were Ms Bailey, Mr Sumara, Mr Francis and Mr Yeates. Table 12 below sets out the four storytellers and the number of data items coded to them in total and for the six events. The following four storytellers accounted for 85% of data items identified during the six key events. Mr Yeates had 31.8% (308) of data items coded; this can be attributed to the fact that Mr Yeates was chief executive of MSFT during the crisis, and widely cited as a principle contributor or cause of the crisis.

Ms Bailey had 27.2% (264) of data items coded. Ms Bailey came to the fore from the publication of the report by the Healthcare Commission, and as the representative of Cure the NHS. Mr Francis had 13.6% (132) of the data items coded to him. As Chairman of both the independent and public inquiries, Mr Francis was placed as a high profile individual, with responsibility refined by Government to investigate the crisis. Finally, Mr Sumara had 12.4% (120) of the data items coded. During his time as CEO of MSFT, Mr Sumara was outspoken in his views of MSFT and the NHS, attracting a high level of interest.
Table 12. The number of data items associated with the four key storytellers

<table>
<thead>
<tr>
<th>Storyteller</th>
<th>Total number of data items (n 2906)</th>
<th>Total number of data items coded during the 6 key events (n 969)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Bailey</td>
<td>482</td>
<td>264</td>
</tr>
<tr>
<td>Mr Yeates</td>
<td>1151</td>
<td>308</td>
</tr>
<tr>
<td>Mr Sumara</td>
<td>334</td>
<td>120</td>
</tr>
<tr>
<td>Mr Francis</td>
<td>385</td>
<td>132</td>
</tr>
<tr>
<td>Total</td>
<td>2352</td>
<td>824</td>
</tr>
</tbody>
</table>
It is worth noting that for each event identified and discussed below, data items were coded to the event if they were considered data up to one month before, or one month after the date of the key event. This approach was taken to ensure the context leading up to and beyond the event could be analysed, as expanding the analysis beyond the single day of the event created a meaningful data set.

**Events**

In the preliminary examination I identified six main events that occurred during the timeframe under analysis.


As presented above, the publication of the Healthcare Commission report into the events at MSFT (Healthcare Commission, 2009) was the starting event for the crisis. The Healthcare Commission’s investigative team spoke to 103 patients, 99 of whom were critical of the care provided (p. 4). The Healthcare Commission review team also undertook interviews with staff, relatives and patients, reviewing patient case notes and complaints. They made their own direct observations on the Hospital and reviewed external reports.

The report drew a set of conclusions about MSFT, the other local NHS organisations and the wider NHS overall. It made a set of specific recommendations for the Accident and Emergency Department, for the Board of MSFT, staffing and capacity, and standards of care. It also made reference to concerns in the quality of mortality data and variations in the data across the NHS (p. 13). A summary of the key areas of concern is (Healthcare Commission, 2009, p. 7):

“Patients arriving in A&E were assessed by unqualified receptionists to determine whether they needed urgent attention. One patient with an open fracture of the elbow had to wait for more than four hours, covered in blood and with no pain relief, because the receptionist failed to give the case priority.

There were too few consultants in A&E to provide on-call cover all day, every day, and junior doctors were not adequately supervised.

There were not enough nurses to care for emergency patients. A review of staffing levels in 2007/08 found the trust was short 120 nurses, of which 17
were needed in A&E, 30 in the surgical division, and 77 on the medical wards.

Nurses in the emergency assessment unit were not trained to read cardiac monitors and sometimes turned them off. Patients did not always get the correct medication. Nurses on the wards were not always able to identify when patients were deteriorating after an operation, for example, by monitoring vital signs.

Call buttons were not always answered when patients were in pain or needed the toilet. Relatives claimed patients were left, sometimes for hours, in wet or soiled sheets, putting them at increased risk of infection. Patients at risk of developing pressure sores did not get appropriate care. In one ward, 55% of patients were found to have pressure sores when only 10% had sores on arrival.

Delays in operations were commonplace, especially for trauma patients at weekends. Sometimes a patient’s operation might be cancelled four days in a row, and they would receive “nil by mouth” for most of the day, four days running.”

**Event 2: Resignation of Martin Yeates as Chief Executive of the Hospital: 15th May 2009**

On this day, the Chief Executive, Martin Yeates formally resigned from his post as CEO of MSFT. Within the data sample and analysis there is no recorded data on the 15th May 2009. On the 16th May 2009 there is one article that refers to Mr Yeates and Ms Bailey. During the two-month period covering May and June 2009 there are 56 data items. Although the formal resignation of Mr Yeates is a significant event, rather than marking the end of the story, this period saw the story develop still further. The local newspaper, the Express and Star, headlines the news of Mr Yeates’ resignation with “Scandal-hit hospital boss quits at last” (Express and Star, 2009h). The paper continues to suggest that Mr Yeates has escaped disciplinary action and describes the Hospital’s statement as “terse”. Ms Bailey is clear in her response to the news of Mr Yeates’ resignation:

“It is an absolute disgrace. Who is responsible for all those deaths? He should be brought to book, and held to account for what he did. The hospital board
should be ashamed for how they have allowed him to avoid answering any questions” (Express and Star, 2009h).

The events of Mr Yeates’ resignation coincided with a formal discussion in Government about the need for (or against) a public inquiry into the MSFT. “This only strengthens the need for a public inquiry. The only way Martin Yeates will be held to account for his decisions is if he is called to give evidence to an inquiry under oath” (Express and Star, 2009i). Mr David Kidney MP, the MP for Stafford decided to engage in a debate about whether a Public Inquiry would be held into events at the hospital. Mr Kidney MP had stated he would not follow the Party line and would vote for a public inquiry, as the Government at the time were making a case to refuse the public inquiry (Express and Star, 2009i).

**Event 3: Announcement by Health Secretary Andy Burnham of an independent inquiry: 21st Jul 2009**

Four months after the Healthcare Commission’s report was published, and two months after the formal resignation of Mr Yeates, the Secretary of State for Health, Mr Andy Burnham MP announced an Inquiry was to be held into events at the Hospital.

An independent inquiry was to be held, the findings of which would be shared publicly. The focus of the inquiry was to examine “what went wrong at the hospital – where hundreds of patients are believed to have died needlessly over a three-year period – and also look at learning lessons for the future.” (Express and Star, 2009p). The inquiry was not constituted under the Inquiries Act 2005, and therefore could not compel witnesses to attend. Staff, managers, patients and relatives would be asked to give evidence.

Mr Burhnam MP suggested that the inquiry was structured in this way, so as not to “unduly distract the new staff and management from improving services today” (Express and Star, 2009p). It was acknowledged that although the inquiry was to be undertaken in private, Cure the NHS (and therefore Ms Bailey) would be able to observe the Inquiry. The concern, stated by the local MP Mr David Kidney, was “witnesses may be excused if they were deemed not competent enough to appear” (Express and Star, 2009p). This led to a concern that this would allow Mr Yeates to not present evidence to the inquiry. The data reference
to Mr Yeates at this time related only to Mr Kidney MP’s view that “Of course [Mr Yeates] should give evidence – he is the most crucial witness” (Express and Star, 2009p).

It is also worth noting that Mr Sumara commenced his role as CEO of MSFT in August 2009, and therefore the data items coded to this event include references to this appointment.

**Event 4: Publication of the independent inquiry into care provided at the hospital: 24th February 2010**

The final report was published in two volumes (Francis, 2010a) (Francis, 2010b), and is addressed to the Secretary of State for Health. The first volume sets out the main findings of the report across eight sections: The patient experience; The culture of the Trust; The experiences and perceptions of staff; The management of significant issues; Governance; The Board; Mortality Statistics; and External Organisations. This is supported with an executive summary, conclusions and recommendations. The second volume sets out quotes and case studies given as evidence to the Inquiry.

Volume 1 restates (Francis, 2010a, p. 7) the purpose of the inquiry as:

> “Concerns about mortality and the standard of care provided at the Mid Staffordshire NHS Foundation Trust resulted in an investigation by the Healthcare Commission (HCC) which published a highly critical report in March 2009. This was followed by two reviews commissioned by the Department of Health. These investigations gave rise to widespread public concern and a loss of confidence in the Trust, its services and management.”

The Inquiry contacted directly (or indirectly) nine hundred and sixty-six individual members of the public and eighty-two members of Trust staff. The inquiry was supported by a panel of specialist advisers including Cure the NHS, Primary Care Trusts (PCTs) and Counsel to the Inquiry (Francis, 2010a, p. 6). It was noted that all members of staff invited to attend did so, with the exception of Mr Yeates. Written material was provided, but Mr Yeates was excused from attending the inquiry personally on medical grounds. The report established eighteen recommendations.
Event 5: Announcement by Prime Minister David Cameron that a public inquiry into the events at MSFT will take place: 9th June 2010

Following the announcement on the 9th June 2010, the procedural hearing for the Public Inquiry was held in July 2010. The procedural hearing considered the practical issues of undertaking the inquiry. It also confirmed those individuals and groups considered as Core Participants in the inquiry. Awarding Core Participant status allowed those individuals or groups to submit questions to witnesses. It also enabled them to claim support for legal costs and their representation at the inquiry.

This inquiry would be heard in public and chaired by Mr Francis. He set out the scope of the second inquiry:

“a. To investigate the role of the commissioning, supervisory and regulatory organisations and systems, and the attendant culture in relation to their monitoring role at the Trust between January 2005 and March 2009;
b. To identify the lessons to be learned as to how the deficiencies of the sort isolated in my first report can be identified and acted upon earlier than they were. In doing this, I must bear in mind the changes that have been made to the regulatory arrangements since then, and make the consequent recommendations” (Francis, 2010c).

The inquiry was established under the Inquiries Act 2005, and therefore Mr Francis QC could compel witnesses to attend. At this stage the Chairman was seeking to confirm who wanted to, or would seek to step forward and be heard at the Inquiry, before considering who would be compelled to attend. He was also looking at the location and venue to ensure access to the inquiry was possible. The Chairman was also clear to highlight that the Inquiry “cannot reinvestigate matters already dealt with in the first Mid Staffordshire Inquiry, or look into complaints about other NHS Trusts or NHS Foundation Trusts” (Francis, 2010c). Ms Bailey was pleased with the scope of the inquiry:

“The terms of reference and scope are just what we wanted. Former health ministers, Department of Health executives in Whitehall and in Staffordshire will now have to explain why they did not stop this disaster” (Triggle, 2010b).
Over the following few days significant positive comments were made about this announcement, including a visit to Stafford by the then Secretary of State for Health, Andrew Lansley MP, to Cure the NHS, where the “group planned to ask Mr Lansley to give more support to hospital boss Antony Sumara in his efforts to turn the hospital around” (Express and Star, 2010i).

There was no comment or confirmation at this time as to whether Mr Yeates would be compelled to attend the Inquiry.

**Event 6: Opening of the Public inquiry by Chairman Robert Francis: 8th November 2010**

This was the closing event in the timeline of this study. The inquiry was published in February 2013 (Francis, 2013). Mr Francis QC continues to emphasise that his remit is to look forward and learn lessons. Re-iterating this will not re-examine what happened at the hospital, as Mr Francis QC commenced his opening statement after a delay in the start of the first session. A number of relatives raised their concerns at being kept in a separate room from those giving evidence, one relative “shouted angrily that he wanted to "see the faces" of those who were giving evidence.” (BBC News, 2010g). In his opening speech, Mr Francis acknowledged those who campaigned for the Inquiry, and the significance of this as a milestone.

Mr Francis was also keen to “pay tribute to the determination and courage of those who have campaigned for the inquiry” (Midstaffs Public Inquiry, 2010c, p. 2). He explicitly thanked Ms Bailey for her work in ensuring that issues will be exposed that would otherwise have been hidden (p.3). Mr Francis continued to set out what he intends to do throughout the inquiry. He emphasises and focuses on the need to learn lessons. He highlights that the inquiry “will talk to 150 witnesses, and read one million pages of documentation” (Midstaffs Public Inquiry, 2010c, p. 6). He finally sets the expectation of how the press should behave, making it clear any queries of the inquiry were to be directed to Mr Francis’ assistant. At this point Mr Francis handed over to the Counsel of Inquiry, who led an opening statement for the rest of the day.

The Inquiry operated for six weeks during November and December 2010. It delivered the key opening statements and received a range of witnesses over that period. The transcripts
of their sessions were the source of data items coded to the storytellers for the period of November and December 2010.

After the preliminary analysis of these events, I singled out three events for further analysis: events 1, 4 and 6. I chose these events because, when identifying the volume of data items coded to the day of the event and one month before and after, the three events chosen accounted for 83% (809) of the 969 data items identified within the criteria. Table 13 presents the number of data items identified for each event. It is worth noting that these three events relate to an inquiry into events at the hospital, be they the publication of the Healthcare Commission report (2009), the Independent Inquiry (Francis, 2010a) (Francis, 2010b), or the opening of the public inquiry.

**Summary**

Within the study time frame (March 2009 – November 2010), I reviewed 1274 documents from 12 data sources. Based on this review, I identified nine storytellers and six events. I further reviewed a subset of 425 documents associated with these storytellers, broke these documents into 2905 data items, inputted the data items into an Excel spreadsheet and linked each data item to a storyteller. I then reviewed the data items, the storytellers and the events and, based on the storyteller’s prominence and the event’s significance (both in conceptual terms and in terms of the data items these had attracted), narrowed the number of storytellers down to four and the number of events down to three for further analysis.

In the following analysis, with the purpose of identifying the frames (see section “Identifying the Frames” below) I use the data from all nine storytellers and all six events. In order to examine the evolution of the frames (see section “Movement”), the storytellers, and the audiences, I focus on just four storytellers: Ms Bailey, Mr Sumara, Mr Francis and Mr Yeates; and three events: Event 1, Event 4, and Event 6.

In figure 10 below, I have provided a summary overview of the approach taken to manage the significant body of data. The process set out above, refined and reduced the scope of the analysis in order to establish a manageable data source, whilst maintaining the ability to undertake a detailed analysis in order to develop a thick description of the case study at the heart of this research.
Table 13. The number of data items associated with each event

<table>
<thead>
<tr>
<th>Storyteller</th>
<th>Total number of data items coded during the 6 key events (n 969)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Event 4: The independent inquiry into care provided at the hospital is published, 24th February 2010</td>
<td>218</td>
</tr>
<tr>
<td>Event 6: Public inquiry chairman Robert Francis gives his opening statement, 8th November 2010</td>
<td>544</td>
</tr>
<tr>
<td>Total</td>
<td>809</td>
</tr>
</tbody>
</table>
Figure 10. Defining the scope of analysis and data set

Stage 1:
- Significant range of data sources
- It was necessary to limit the sources to provide a meaningful data set, but with sufficient size to support rich analysis

Stage 2:
- Significant range of data Defined the role of the storyteller which limited the research to 9 individuals
- Sampled media sources and limited to 8 forms
- Identified three category of organisations involved and identified one organisation from each
- Using volume of documents identified, established 6 key events across the timeline

Stage 3:
- Scope of the research was refined further and focused on 3 events representing 83% of all data items, and 4 storytellers that accounted for 85% of all data items
IDENTIFYING THE FRAMES

Identifying the frames involved the detailed analysis of the documents identified, and data items identified. This included, from that detail, rebuilding the text to identify a set of themes running through the fragments of text. This allowed me to identify a set of seven provisional frames. With these seven frames, I was able to using the signature matrix and elaboration frames to create the initial frames.

Finally, with the initial frames completed, I identified a sponsor for each frame. The sponsor is a storyteller, to whom the shaping and owning of the development of the story from within the frames can be attributed.

Identifying the themes for provisional frames

As the first stage of frame identification, I examined the data items to spot the different themes. Specifically, I looked for words or phrases most commonly occurring in their description of the MSFT case. I read each document identified in the data analysis, and identified the data items. From a reading of each of the data items I was able to identify a code, a theme, or key word for each data item where appropriate. Table 14 highlights the list of such words/phrases:

Table 14. Key words and phrases identified through the data analysis

<table>
<thead>
<tr>
<th>Certainty</th>
<th>Distress</th>
<th>Money</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>Sustain</td>
<td>Staff</td>
<td>Cleanliness</td>
</tr>
<tr>
<td>Improvement</td>
<td>Inquiry</td>
<td>Complaints</td>
<td>Governance</td>
</tr>
<tr>
<td>Complacency</td>
<td>Action</td>
<td>Death</td>
<td>Information</td>
</tr>
<tr>
<td>Organisation</td>
<td>Regulators</td>
<td>Patients</td>
<td>Blame</td>
</tr>
<tr>
<td>Leaving</td>
<td>Legal</td>
<td>Failing</td>
<td>Honesty</td>
</tr>
<tr>
<td>Apology</td>
<td>Nursing</td>
<td>Listening</td>
<td>Loss</td>
</tr>
<tr>
<td>Survivors</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
It is worth highlighting that one data item could relate to more than one theme. For example:

“Mr Sumara stated: “Robert Francis said he didn’t want the public inquiry to detract or to get us away from the main focus of continuing to improve the hospital. It has created an enormous workload. We believed we would not necessarily have a great deal of involvement because it is an inquiry about the external regulators. The costs of employing counsel are going to have to be paid by the trust. It is extremely expensive. It is public money that would be better spent caring for patients. He said the trust had no alternative but to spend the cash, adding: “It’s not what we would want to do”" (Express and Star, 2010c).

From this example the data item has been coded against Improvement; Inquiry; Regulators and Legal themes.

Establishing themes and identifying key words is a subjective process of labelling text, and through such a process I made conscious decisions to include the twenty-nine items above, as well as exclude others. With infinite possibilities for establishing idea elements, it was important to provide some level of test for the choice of these – this included (a) the frequency the word itself appeared in the text (i.e. “manager” was a frequent word and subject matter of the data items); (b) the number of times the description of the idea element for example “manager” is described as something else e.g. “The new boss brought in to help transform the troubled trust running Stafford Hospital was due to start work today” (Express and Star, 2009r) was included; (c) whether other items were sub-sets of the same definition; and finally (d) does the idea element allow for a broad description or interpretation? Whilst undertaking the data analysis I identified these themes, and tested them against the first 1,000 items. In each case they were relevant and notable words found within the data items; they also had resonance with my own experiences of managing within NHS organisations.

The identification of these themes allowed me to ask the question: “what holds each of the idea elements together? This approach enables the analyst to discern the connections among these elements, and to identify and distinguish the different unifying structures or
frames that hold them together” (Creed, Langstraat, & Scully, 2002, p. 39). Each theme in the text is connected to other themes. For example, the idea element “manager”, is connected to the organisation, through employment. In turn, the organisation is connected to the inquiry through seeking to learn lessons. The inquiry is connected to action, through a desire to see managers “own up” and hence reconnects the idea element back to manager. The mapping processes tested and redefined these themes, helping to ensure the validity of them. The process of mapping the themes and connections highlighted their inherent complexity and multiple connections between them. The idea elements and relationships highlight conflicting views and contradicting relationships, as well as similarities – and through the themes and their connections, I was able to start developing provisional frames.

From this process of mapping, I was able to see a set of emerging key themes, those being: a) staff; b) governance; c) nursing; d) organisation; and e) patients.

After investigating the clusters, I singled out the following seven areas to develop provisional frames:

(1) **Justice.** This theme is driven by data items that emphasise the need for justice as a result of the decisions taken that led to poor care at the hospital.

(2) **Learning.** A focus on what can be learnt as a result of the failings at the hospital, and reinforcing the importance of understanding how the crisis occurred.

(3) **Improvement.** The importance of demonstrably improving the way care is delivered for patients and families.

(4) **Leadership.** The right leadership makes the difference.

(5) **Distress.** Data items emphasise and remind others of the real pain and suffering experienced by patients and their families at the hospital.

(6) **Blame.** Highlights a need to identify and attribute blame for what went wrong.

(7) **Defence.** In response to the need to blame, generates a need to respond and defend what, how and why individuals and organisations responded.
Developing the signature matrices and elaborative functions for each frame

In the second stage of frame identification, I analysed the data items in relation to the seven themes and used the data items to populate the signature matrices and identified the elaborative functions for each frame. For the seven provisional frames, Appendix 1 provides the initial signature matrix; whilst the first five elements of the signature matrix are the accentuating data items rendering the situation quickly interpretable; the last three serve to justify the argument made. Appendix 2 provides the initial elaboration functions using Snow and Benford’s (1988, p. 199) framework that distinguishes between the functions of diagnosis, prognosis and motivation of a given frame. As highlighted above, the elaboration function “serves to attribute responsibility for the issue and to prescribe potential solutions to it” (Creed, Langstraat, & Scully, 2002, p. 40).

Note that the frames change over time and that my main interest lies within the evolution of the frames over the timeline of the events I identified in the case. A signature matrix and the elaboration functions were developed for each frame and for each event. The evolution of the frames is, in turn, presented in the next section (“Analysing the Evolution of Frames and Storytellers”). A brief description of the signature matrices and elaboration functions for each frame follows this.

The Justice frame emerged during the first event (Event 1: Publication of the Healthcare Commission Report, 17th March 2009). This first frame emerges from the data items in relation to the failure, at that time, to hold individuals to account for what happened. Although a series of reviews were undertaken (see for example (Alberti G. A., 2009) (Healthcare Commission, 2009) (Colin-Thomé, 2009)) no individual had been held to account. For example, the loss of the Chairperson and Chief Executive were not considered sufficient an outcome to assure this could not happen again. Ms Bailey was calling for them to be held to account in public (Express and Star, 2009b).

A further example is the management’s culpability: e.g. “poor, abysmal management” (BBC News, 2009c). Finally Ms Bailey expressed a need to quantify how many patients died as a result of the failings, which led to an internal review being established (BBC News, 2009c) (Express and Star, 2009b). At this stage the signature matrix accentuates the impact the failing had, such as various levels of incidents: “haunting”, “third world”, “drinking water
from flower vases” (Boseley, 2010b), whilst the justification for such accentuation is that attempts to fix this had failed, and the need for a public inquiry was necessary. The elaboration functions diagnosed failings in management that led to the issues (see (Symons, 2009) (Gould, 2009)). The output from which was the development of the “rallying point” (Gould, 2009) and call for public inquiry in order to realise justice for those that had died.

The Learning frame emerged during the first event (Event 1: Publication of the Healthcare Commission Report, 17th March 2009). The second fundamental problem was a perceived failure, at this point, to learn why and how events had been allowed to happen (Express and Star, 2009b) and furthermore to identify if this could still be occurring (Express and Star, 2009b). At this stage the signature matrix data items opens with a “vacuum” in oversight and patient involvement (Gould, 2009), and an acknowledgement that lessons need to be, and have been learnt (BBC News, 2009a). The accentuation is justified on the basis that more should be done to understand what happened and why events took place at the hospital. The elaboration functions diagnosed the problem as a lack of awareness within the NHS structure of the problems and therefore it was crucial that lessons were learnt.

The Improvement frame emerged during the second event (Event 2: Martin Yeates resigns as Chief Executive of the Hospital: 15th May 2009). The frame, as described in table 16 in appendix 1, is not complete. From the data items and key words during this event there were sufficient references to identify an Improvement frame; however, at this stage the matrix could not be completed. In order to understand how the provisional frame would develop over time, it was therefore appropriate to identify the frame in its form at that moment. I identified an accentuating theme that was focused on improvement. In an article titled “Troubled Stafford Hospital Shake Up” (Express and Star, 2009r), Mr Morton launched his improvement plan. Mr Morton emphasises the need “to draw a line in the sand” (Express and Star, 2009e) which I suggest is a conscious step to create an alternative forward focus rather than the retrospective speculations of the Justice and Learning frames.

Although the signature matrix is not complete for this frame, there are sufficient data items for a unifying concept. Mr Morton’s plan for improvement with an eight month deadline (Express and Star, 2009n) as well as public support for allowing the hospital time to improve (Express and Star, 2009n) creates a contested view from the Justice frame. This concept is couched in negative terms (as well as Mr Morton’s positive frame, see (Express and Star,
The elaboration diagnosis was to ensure how the hospital by moving forward, could provide safe care. The outcome to address this diagnosis was a set of actions that Mr. Morton outlined (See Appendix 2 table a2.3).

The Leadership frame emerged during the third event (Event 3: Health Secretary Andy Burnham announces an independent inquiry, 21st Jul 2009). During the third event the signature matrix accentuation presents a shift from describing leadership (or more specifically, Mr Yeates) as the problem, to good leadership being the solution. This starts a movement to seek support for management that hitherto had been thought of as self-interested, career-minded bureaucrats – for example “The report which was released under the Freedom of Information Act blames Mr Yeates for a series of failures, errors and misjudgements. The document painted the picture of a hospital whose management, in an effort to balance the books and hit targets, made stinging cuts in nursing staff without considering how this might affect the patients” (Express and Star, 2009s). The signature matrix for the frame is constructed almost entirely using the data items from Dr Moyes. In his written correspondence (Monitor, 2009a) (Monitor, 2009b) (Monitor, 2009a), what particularly struck me were two key points; the first was the role of leadership to build trust and confidence, and the second was Ms Bailey’s description of Mr Sumara as having “vision” and "strength" (BBC News, 2009f). This contrasted strongly with the descriptions of Mr Yeates. I therefore suggest leadership is a significant theme over the course of the timeline. From the introduction of Mr Sumara, who was considered a good leader and a contrast to Mr Yeates as a bad manager, there was an emerging need to create a movement in the audience’s view of leadership. The elaboration functions perceive the failure of MSFT to identify and recruit an appropriate CEO as key, and the outcome of which was the recruitment of Mr Sumara.

The Distress frame emerged during the fourth event (Event 4: The independent inquiry into care provided is published, 24th February 2010). An increase in published patient stories supported the development of the Distress frame and the apparent broader story of the experiences of distress contrasted to the focus of the Justice frame. With the focus of the independent inquiry on learning, and the separation of patient stories from the lessons identified as part of the report from the inquiry (Francis, 2010b), this is a body of text that created a Distress frame. A video interview with a carer set out their experience, and
highlighted their distress, including: “I could hear my mum screaming…I dropped my bag and ran to her…please don’t let me die here” (Triggle, 2010a, p. 1min 30secs). At this stage the signature matrix accentuates the distress (for example “sobbing and humiliated” (Triggle, 2010a)) whilst the justification for such accentuation was that the distress was extreme and avoidable. The elaboration functions diagnosed the problem or cause of distress due to a lack of resources and money. The proposed actions at this stage were not clear.

The Blame frame emerged during the sixth event (Event 6: Public inquiry chairman Robert Francis gives his opening statement, 8 Nov 2010). In previous events blame had been used to illustrate examples and focused predominantly on Mr Yeates. However, during this event a significant body of data items was identified that supported the construction of a frame where blame was apportioned to a much wider set of individuals and organisations. The public inquiry, by its legal structure, establishes and recognises witnesses and the accused, and a forum to accuse (blame) and defend that had not been openly or previously structured. The initial investigation and the first inquiry were undertaken in private and the findings were then published – therefore a structured presentation of the case, defence of the case and argument was not evident.

I specifically saw the construction of both the Defence and Blame frames as vehicles to challenge and/or protect the existing bureaucracy (the NHS, Monitor etc.) rather than a representation of the individual complaints and responses from the individuals involved. Ms Bailey and Mr Lownds were focused on ensuring that the blame sat with Mr Yeates and the wider system of regulation. At this stage the signature matrix accentuates the failings of management at MSFT, and the impact or realisation of this fact on individuals providing evidence to the Inquiry. There was a significant body of data items that provided justification for such an accentuation (see Appendix 1 table a1.6). The elaboration functions diagnosed the problem as existing before Mr Yeates took over at MSFT, and that Mr Yeates did not understand the scale of the issues. As with the Distress frame, at this point there was no illustration of the solution to this problem.
The Defence frame emerged during the sixth event (Event 6: Public inquiry chairman Robert Francis gives his opening statement, 8th November 2010). A narrative establishing a defence had been identified in previous events, and as highlighted above (see Blame frame), the structure of the public inquiry developed formal roles of blame (accuse) and defence. The defence promotes the complexity between the different NHS organisations (for example, Monitor; CQC; DoH etc.), I would go on to suggest that the Defence frame would overlap with the Blame – as one organisation makes a defence it is often through blaming another organisation. At this stage the signature matrix accentuates the complexity of events at and around the organisations surrounding MSFT, and highlights particularly the relationship between Monitor and the Care Quality Commission. The elaboration functions diagnosed some of the decisions that led to the crisis, including the decision to authorise MSFT as a Foundation Trust and other roles in supporting the hospital (see appendix 2, table a2.7). At that stage in the timeline there was no clear output of what should occur to address this problem.

**Frames and storytellers**

I would like to consider the relationship between the storytellers identified and the frames constructed. Recognising that I have constructed the frames, and that these are not “out there” to be identified, I place the frames around a strategic idea that is owned or apportioned to a storyteller. I describe this ownership as a “frame sponsor” (Creed, Langstraat, & Scully, 2002, p. 43). In assigning ownership I can test the frame and the relationship between the storyteller, the frame, and eventually the audience to which the frame is intended to move.

The table 15 below identifies the sponsors allocated to each frame. With Mr Yeates represented by the third hand reports and letters, he does not sponsor or lead a frame.
I have allocated ownership of the Justice, Distress and Blame frames to Ms Bailey, and the Learning and Defence frames to Mr Francis. Mr Sumara is sponsor of the Improvement frame and replaced Ms Bailey as the sponsor of the Leadership frame.

I allocated the Justice frame to Ms Bailey because the frame and data items were predominantly involving Ms Bailey. The Justice Frame is motivated to recruit individuals who support the aim of publicly holding individuals to account. This is founded upon a significant effort by Ms Bailey to raise the profile and complain about what she saw at the hospital. The steps taken included complaints on the ward to the Chief Executive, to CQC, to the local PCT, local MP, and finally a formal letter to CQC (Midstaffs Public Inquiry, 2010e). The audience for Justice had therefore gone beyond the hospital staff and the local community. The ability to deliver Justice would sit at a national Government level. Ms Bailey’s primary audience was the local population of Stafford, and Cure the NHS was an effective group that recruited significant volumes of patients and carers in order to challenge at the national level the need for action at the hospital.

The Learning frame focused and emphasised the need to stop, reflect and learn from the events in order to move forward (Mid Staffordshire NHS Foundation Trust, 2010). Mr Francis
is placed as the sponsor of this frame, his explicit role and remit was to learn from events and was governed by the terms of reference for the two inquiries undertaken; the terms of reference were established by the Government at the time. The audience is therefore the Government, to whom ultimately the inquiries’ findings are directed, but similarly the audience was the wider community, staff and organisations associated with the NHS.

I have placed Mr Sumara as the owner of the Improvement frame. Although initially the frame drew data items from the improvement plans set out by Mr Morton, the frame and the development was significantly expanded upon once Mr Sumara was appointed as CEO at MSFT, as is reflected in the data items presented in the frame. The Improvement frame was predominantly focused on the staff, relatives and patients within MSFT; Mr Sumara’s communication largely referred back to one of these two groups (BBC News, 2010d). Although as already highlighted, with the attention on the hospital and Mr Sumara, Mr Sumara on a number of occasions used this opportunity to raise the profile of issues within the NHS (Express and Star, 2009t).

Initially I suggested that Ms Bailey was the owner of the Leadership frame, with data items coded to Ms Bailey at the outset focusing on and describing the failings of leadership. However, as Mr Sumara joined MSFT, the definition and emphasis of leadership changed. The motivation was to describe successful leadership for staff and the local community (BBC News, 2009i). The motivation, as I perceived it for Mr Sumara, was to build (or re-build) trust in the leadership, and more importantly within the hospital (Monitor, 2010). The Distress frame includes references from the second volume of the independent inquiry (Francis, 2010b). Before that time, Ms Bailey had shared the distress experienced by the local community with the local community and also nationally (Francis, 2010a, p. 30). A key role Ms Bailey undertook (which later became the function of Cure the NHS (Gould, 2009)) was to collect the stories and experiences of distress from the patients and relatives within Stafford.

Therefore, although the second volume (Francis, 2010b) is authored by Mr Francis, I suggest the Distress frame is owned and structured from the focus of Ms Bailey wanting to raise the
profile of the distress experienced. The publication by Mr Francis helped to confer legitimacy on those claims.

The Defence and Blame frames are closely connected, however the Defence frame is owned by Mr Francis as I have suggested, whilst Ms Bailey is the owner of the Blame frame. The significance is that the motivation and focus of the two frames are similar. However the approach and audience to which they are targeted is different, with Mr Francis couching his statements within a Learning frame, and Ms Bailey placing hers within a Justice frame. Both are developed through the public inquiry, the audience for which is the general public.

Summary

By using the analysis of the data items to build themes, I identified seven frames. I then used the data items to build the frames. Finally, I was able to suggest a frame sponsor for each frame, providing an opportunity to test who influences the frames and story over the course of the timeline.
CHAPTER 6. ANALYSING THE EVOLUTION OF THE FRAMES

Throughout the subsequent three chapters (chapter 6, 7 and 8) I set out the analysis for each of the research questions. This chapter considered: How does storytelling unfold and escalate from one event into multiple stories? Chapter seven considered: How do the roles of the storyteller and audience become defined and re-defined over time? And finally chapter eight considered: Within this process of unfolding stories, what are the intended and unintended consequences of storytelling?

For each of the three key events identified above I reviewed the data items, signature matrix and elaboration frames. I also considered all the data items coded to each of the key storytellers. To analyse the evolution of the frames and the storytellers over time, I focused on the changes within the frames between the three pivotal events. I considered each event in turn; for each event I identified the frames and storytellers at that time. I then analysed the evolution of the storytellers and frames chronologically. Using the frames and data items, I then illustrated the changes over time, and finally identified the speculative appreciations that influence the storytelling evolution.


The Justice and Learning frames were present at this stage. Of the key storytellers identified, two storytellers were present: Mr. Yeates and Ms. Bailey. The signature matrices and the elaborative functions of these frames are presented in Appendix 1: tables a1.1 and a1.2, and Appendix 2: tables a2.1 and a2.2.

Frames

At this stage the difference between the two frames, Justice and Learning, are limited. There is consensus in a need for additional further action around what happened at MSFT over and above the recommendations in the Healthcare Commission report (Healthcare Commission, 2009).

To consider the Justice frame, the first five elements of the signature matrix accentuated the frame (Creed, Langstraat, & Scully, 2002, p. 40). The data items attributed to Ms. Bailey focused on impactful statements, which personalised the scale of the issues that necessitate a response – Justice. The catch phrase of “drinking water from flower vases” established an
enduring mental association with the events at the hospital. The last three elements of the signature matrix were the argumentative devices (Creed, Langstraat, & Scully, 2002, p. 40). The argumentative devices in the initial Justice frame focused on the fact that problems had been raised – but no action was taken. This created a movement demanding a public inquiry as the only basis on which the events can be understood. The elaboration frame develops the understanding of the problem and causes, including a focus on managers’ lack of response to the issues raised.

In considering the Learning frame, although not identified as a key storyteller, this event underpinned Mr. Morton in the establishment of this provisional Learning frame. He was appointed to the Trust during the period this frame was constructed. The accentuation of the frame focused on the need to ask questions – to understand what has happened, in order to move forward. From the two data items selected for the signature matrix, he was quoted as highlighting that improvements were made and lessons had been learnt. Mr. Morton did not acknowledge or respond to the calls for a further inquiry. However, Mr. Morton did agree to establish a retrospective review of patient notes in order for carers and relatives to understand if they or their relatives experienced inappropriate care. Therefore, the argumentative device at this stage in the frame was to contain the next steps to this review in order to satisfy the local community.

The argumentative tools between the frames are similar, with a desire to understand what happened and why. The application of frame analysis identified emerging tensions. The first tension was between a) is this a local issue? or b) is this a national/systemic issue? To illustrate, the data items for this period largely focused on the events at the Hospital, however there are two data items that open the question of whether the problems lay beyond MSFT. For example: “This is an outrage that this has been happening at Stafford Hospital. Where else is it happening? Who has been monitoring this situation?” (Basford, 2009). The leader of the opposition, Mr. David Cameron M.P, said “an investigation “absolutely independent” from the hospital, the Government and “the whole system” was needed” (Express and Star, 2009e). The second tension was between regulatory organisations a) Monitor and b) Healthcare Commission. Within this data set, Dr. Moyes’ (representing Monitor) data items were limited to the immediate action they had taken to recruit the temporary Chairperson and Chief Executive (Guardian, 2009a), whereas in the
Healthcare Commission report (Healthcare Commission, 2009), it was noted that they had to advise Monitor of the concerns with regard to the leadership at MSFT (p. 12).

The Commission’s report also placed the responsibility with Monitor for ensuring the actions from the report were followed through (p. 15). What the frame analysis identified was that, in light of this relationship it was surprising to find that there was no public articulation or acknowledgement of Monitor’s role in addressing the issues. The third area of tension was between a) Government set targets and b) Managers (as a collective group rather than individuals), and the role and consequences of targets. Such findings in the Healthcare Commission report highlighted a focus on targets over care at MSFT (p. 133). The analysis suggested that this tension created a need to answer the question of responsibility for actions. Furthermore, I found that through the presentation of accounts at this stage, the Government is transferring the responsibility to the manager entirely as highlighted in the "poor, abysmal management" which was to blame, and not the targets or any other "excuse" (BBC News, 2009c).

**Storytellers**

At this stage, of the four storytellers used in the analysis, only Mr. Yeates and Ms. Bailey were present. I did not include any data items relating to Mr. Yeates in the signature or elaboration matrix, as there were no direct quotes from Mr. Yeates at this stage. He was referred to in the media in relation to his stepping down from the role of Chief Executive at MSFT. There were also four data items that referred to written exchanges that were undertaken during the investigation by the Healthcare Commission. These references highlighted how the Commission engaged with Mr. Yeates during the investigation, as well as the need to force Mr. Yeates to respond. He apologised at the time for not engaging earlier (Healthcare Commission, 2009, p. 28). In a video interview with the Secretary of State for Health, Mr Johnson directly blamed abysmal management for the failings at the hospital, although he stopped short of specifically naming Mr. Yeates (BBC News, 2009c).

At this stage in the story’s timeline, the narrative Ms. Bailey presented was rich with sound bites, for example “haunt us for the rest of our lives” (Symons, 2009), “drinking water from flower vases” (Boseley, 2010b). Ms. Bailey used a metaphor of a “third world hospital” (Basford, 2009) when describing MSFT. Ms. Bailey’s focus was to find out if this was
happening elsewhere and to make it stop (Triggle, 2010b). At this stage Ms. Bailey’s experience at the hospital was just one of several cases highlighted, but is represented across many other stories. Ms. Bailey focused her attention on the Government and the Secretary of State for Health at the time, Mr. Alan Johnson MP (Express and Star, 2009b). Ms. Bailey uses language that is legalistic/bureaucratic rather than emotional in her first data reference, (Express and Star, 2009b), for example “We demand a full statutory inquiry in order to compel witnesses to appear and to answer questions on oath”.

Those data items recorded to Ms. Bailey that are not specifically included in the signature matrix and elaborative functions set the context of Ms. Bailey and Cure the NHS; for example, Ms Bailey criticising the local M.P for fence sitting (Express and Star, 2009d). Also in the data items not included at this stage was a counter challenge by Ms. Bailey where she dismissed the argument for not holding a public inquiry, suggesting the review that was to be undertaken by Mr. Morton was to try and appease any calls for further action (Express and Star, 2009b). The data items also highlighted that the Leader of the Opposition (at the time) visited Ms. Bailey and Cure the NHS during which he spoke and gave a commitment to significant changes in the NHS if his party were elected to Government (Express and Star, 2009e). Finally the data items highlighted that both Ms. Bailey and Cure the NHS had continued to investigate and record the details of cases which “she presented dossiers of evidence to the Healthcare Commission” (Gould, 2009).

Publication of the independent inquiry into care provided at the hospital: 24th February 2010

The following five frames were present at this stage: Justice, Learning, Improvement, Leadership, and Distress. All four key storytellers were also present at this stage: Mr. Yeates, Ms. Bailey, Mr. Sumara and Mr. Francis. The signature matrices and the elaborative functions of these frames were presented in appendix 1 and 2: tables a1.1 to a2.7.

Frames

I found that it was appropriate for Ms. Bailey to continue as sponsor of the Justice frame. During this event the data items used in the frame accentuated that the initiation of the independent inquiry worked as confirmation and acknowledgement that the claims Ms. Bailey, other patients and relatives made were legitimate. The argumentative devices focus
on the need for further action. The report, the data items in the Justice frame suggested, did not hold individuals to account. The Justice frame identified that there was increasing political movement/momentum supporting a call for a public inquiry (BBC News, 2010a). The motivation that underpinned the Justice frame was a perceived need to address the public concern (Francis, 2010a, p. 31) through a public inquiry; Mr. Francis highlighted that previous reports, including his own, did not address these concerns. During this event, and contrasted with the Justice frame presented in event one, I found that the frame is moving from one based upon emotion and individual accounts, to one that focused on and addressed the wider public. As Ms. Bailey and Cure the NHS sought to represent the concerns of a wider group, connections were sought for wider national opportunities to raise the profile of the need for change. These were afforded further legitimacy by the support for a further public inquiry from the leader of the Conservative Party.

The Learning frame data items accentuated the notion that patients and people were ignored. The argumentative devices focus on the issue that individuals were not held to account, but also highlights the pressure under which MSFT and the NHS operate. The argumentative devices challenged managers of other NHS organisations (Vize, 2010) to question the structures in which they operate. There was an implied criticism of the NHS’s wider system, highlighting “excellence is not guaranteed by the star system” (Boseley, 2010b), which provided a sense of legitimacy to the NHS managers to challenge their organisations. The publication of the independent inquiry was structured and focused:

Primarily to give those most affected by poor care an opportunity to tell their stories, and to ensure that the lessons to be learned from those experiences were fully taken into account in the rebuilding of confidence within the Trust.

(Francis, 2010a, p. 7)

The inquiry, under Mr. Francis’ chairmanship, was therefore not focused on bringing individuals to justice; it was only, in a limited sense, interested in the role of other organisations. The inquiry did have a role to play in clarifying the significance of mortality information within hospitals. Mr. Francis, in the main body of Volume 1 (Francis, 2010a), distilled the stories down to eleven key themes and included in Volume 2 (Francis, 2010b) a wide selection of patient stories. Separating out the “un-validated” patient stories into
volume two of the inquiry (Francis, 2010b), he emphasised or de-cluttered the objective nature of findings in volume one of the report.

The Improvement frame data items emphasised the progress made to address the issues at MSFT. The data items within the frame created an acknowledgement, through the fact of needing to improve, that the hospital was in difficulty; however improvement had been documented and evidenced. The accentuating elements of the frame focused on making a difference – not thinking, saying or talking about change, but real demonstrable change (Francis, 2010a, p. 182). The arguments used a focus on the connection to staff and patients as the only test of the success (or otherwise) of making that difference (Francis, 2010a, p. 183).

The Leadership frame was developed during the third event as a product of the introduction of Mr. Sumara as the interim CEO at the Trust. This frame included data items that focused on a forward movement, or a call for change rather than a retrospective analysis of what has gone before (Francis, 2010a, p. 376). The Leadership frame during this event used the data items to contrast “poor” leadership (for example, a sense of denial (Francis, 2010a, p. 18); or wrong priorities (Francis, 2010a, p. 348)) with “excellent” leadership (for example, demonstrable progress, and a desire for more (Francis, 2010a, p. 179)), with Mr. Yeates cast as the poor leader, and Mr. Sumara as the excellent. Mr. Sumara, as the Chief Executive of MSFT at the time the report was published, remained focused on improving the hospital (Francis, 2010a, p. 367). At this point the role of good leader (future) and bad leader (past) is best illustrated with two data items used in the Leadership frame. The first related to the ability of managers to blame another part of the organisation; “a sense of denial in the organisation, characterised by “It’s not our fault, it is somebody else’s” (Francis, 2010a, p. 18). The second highlighted the need for the leader to identify and solve the problems: “Approbation by external regulators is no substitute for direct knowledge of what is actually being done within a trust” (Francis, 2010a, p. 179).

Within this event, the frame analysis identified an interesting set of moves. Firstly, Mr. Sumara and MSFT are acknowledged by the regulator for making significant improvements (Francis, 2010a, p. 179). The regulator was the organisation that has the power and authority to remove the leader, however, Mr. Sumara, represented in the Leadership frame, dismissed the positive feedback (Francis, 2010a, p. 179). With such a move the Leadership
frame presents Mr. Sumara’s denial of the value of the regulators. The rejection of the
regulators was a move that attracted support from individuals and campaigners such as Cure
the NHS; however the focus Mr. Sumara prioritised was “direct knowledge of what is
actually being done within a trust” (Francis, 2010a, p. 179). This, paradoxically, is one that
would be wholly supported by the regulators. This is an interesting “jujitsu move” (Creed,
Langstraat, & Scully, 2002, p. 42), with Mr. Sumara adopting the very same language of Ms.
Bailey and Cure the NHS to co-opt, redefine, or reclaim leadership. Such a move sees both
the Leadership frame and the Justice frame recruiting, or seeking out supporters in order to
deliver a change in the way MSFT operates, whilst creating a connection to justice in a call to
hold previous leadership to account.

The Leadership frame had a relationship with distress, with Mr. Sumara building his vision
around one simple statement: “that is what the hospital is for, to treat patients. That is all
there is to it” (Francis, 2010a, p. 182). A statement based on the stories of distress and
complaints that Mr. Sumara observed, and for which he apologised (Express and Star,
2010k). The data items suggested a move to close the discussion on the past –
acknowledging the investigation, whilst driving a story that highlighted the improvement
and on-going care (Monitor, 2010). What is unusual, but not explored by any storytellers, is
that the investigation has highlighted that there were problems at the hospital before the
period Mr. Yeates took over as CEO (Boseley, 2010b). It is also acknowledged that Mr.
Yeates improved MSFT in some areas – through the acknowledgement that he inherited a
hospital that was failing (Francis, 2010a, p. 345). However there were no references or data
items seeking to understand what happened prior to his appointment as CEO; the
Healthcare Commission’s own data identifies a higher than average mortality rate in 2004

Mr. Sumara had a role in assessing the capability of the MSFT leadership prior to the
application for Foundation Trust status being submitted. In his previous role, he challenged
Mr. Yeates and his leadership of the organisation: “a strategic-free zone”, that was one
comment I remember being said, in the sense that they didn’t have a clear sense of where
the organisation was going” (Francis, 2010a, p. 328). In hindsight, he confirmed his concerns
were right, and demonstrated his superior leadership capacity (Francis, 2010a, p. 179). Of
significant interest was that there were no data items identified that challenged or
questioned Mr. Sumara’s complicity in authorising MSFT. Based on Mr. Sumara’s view of leadership, “Mr. Sumara ... reviewed the performance of Mr. Yeates and concluded that there was a case to answer in disciplinary proceedings for potentially serious failings in leadership” (Francis, 2010a, p. 343). This creates a further link between the Justice and Leadership frame.

The Distress frame was formed out of the move by Mr. Francis and through the publication of patient stories in volume two of the independent report (Francis, 2010b). This move to separate out the formal learning from the distressing story provided a discrete and lasting record – a memorial of the stories largely told by the carers of family members about those patients that had died. In creating the separate section, it also provided the ability to remove the need for editorial rigour in the confirmation of cases, that “[t]he Inquiry has not sought to confirm the facts or information provided” (p. 2). There was editorial input by Mr. Francis in order to select a balance of good and bad accounts. The document presented short excerpts of text of around fifty words. The stories included positive comments about the hospital as well as negative. Within the text, Mr Francis presented positive and negative comments about the same area, for example:

“Following a GP referral the patient attended the hospital for an X-ray; however she was shocked to be left in a cold waiting area wearing only a gown for thirty minutes” (Francis, 2010b, p. 4).

“A patient who was admitted to the day unit at Stafford Hospital on five occasions was always treated by staff in a ‘caring and compassionate way’, and the ward was ‘clean, bright and airy’. The staff in the X-ray department were very reassuring and explained everything to him simply” (Francis, 2010b, p. 5).

Along with the detailed accounts, the document included key “sound bites” that were lifted from the narrative and promoted within the document. The presentation of these sound bites focused predominantly on the individuals and the relationship between the nurse or doctor, and the patient or carer.

The argumentative devices in the Distress frame at this stage were limited; the data items used emphasised and articulated the level of distress experienced (Triggle, 2010a).
suggested that the argumentative devices are limited within this frame because, through prioritisation of articulation data items in the frame, the Distress frame becomes an argumentative device in its own right that underpins the Justice, Leadership and Improvement frames (Boseley, 2010b) (Francis, 2010b, p. 298). To illustrate this within the improvement frame, Mr. Sumara in his approach to improve MSFT is clear that “any staff members found to be “a perpetrator of harm or poor care” would "not be working at my hospital anymore" (BBC News, 2010b).

To explore the link between the Justice and Distress frames, I took the creation of Cure the NHS by Ms. Bailey, and how it sought to document the experiences and suffering of patients (Cure the NHS, 2013). Through “discussing the horror”, Cure the NHS supported fellow carers and relatives (Cure the NHS, 2013); the experience of distress drove the group to seek justice. The presentational style of volume two provided many sound bites, predominantly of poor or distressing care, and also uses stories and accounts from Cure the NHS members (Francis, 2010b, p. 7) (p. 10) (p. 59). Using the output from volume two (Francis, 2010b), Triggle (2010a) sets out the events at the hospital and the findings of the report. The article emphasised the distress experienced by patients and carers alike. The website article included a video interview with a carer where they set out their experience and highlight their distress, including: “I could hear my mum screaming…I dropped my bag and ran to her… she said – ‘please don’t let me die here’” (Triggle, 2010a, p. 1min 30secs). Ms. Bailey replays this significant representation of distress and uses it to reinforce her desire for justice, which will only be achieved through a Public Inquiry (Francis, 2010a, p. 31).

*Storytellers*

As the CEO of MSFT during the period under investigation, Mr. Yeates was referred to in forty-eight data items and was presented as a speaker in both matrices. Mr. Yeates did not make any comment publicly, other than written communication presented to the inquiries. There were limited direct quotes made by Mr. Yeates as a speaker; therefore data items were predominantly references to Mr. Yeates. Of the data items where Mr. Yeates is presented as a speaker, two items highlighted the challenge that Mr. Yeates saw on joining MSFT. The challenges included the complex financial climate, a lack of desire to change and the acceptance of poor standards (Francis, 2010a, p. 339) (Boseley, 2010b). This highlighted how poorly MSFT was performing at the point at which Mr. Yeates took his role. There are
examples of quotes supporting the improvements Mr. Yeates had achieved during his time, for example from the Inquiry it was identified (Francis, 2010a):

“Before Martin Yeates was appointed, there was no systematic system of governance” (p. 245);

“she described him as good Chief Executive” (p. 335);

“the persistence and willpower required to make the changes Mr. Yeates made should not be underestimated” (p. 341);

“he had been doing his best to put them right when he ran out of time” (p. 345);

“referred to praise of Mr Yeates, and himself thought that if he had been given longer he would have addressed the problems” (p. 346);

“many staff welcomed the arrival of Mr Martin Yeates as someone who would address the problems that had developed previously” (p. 397);

A further group of data items referred to the nature and timing of Mr. Yeates’ departure, for example:

“One had to decide whether to follow the logic of the report and start disciplinary proceedings against Mr. Yeates or to seek a negotiated departure. They chose the latter course, having received legal advice” (p. 344).

“In March last year the trust put out a press release announcing that former chief executive Martin Yeates had stood down from his role. In fact he was still employed on his £169,000 salary but was not fulfilling any of his duties” (Express and Star, 2010b).

An area of discussion was whether Mr. Yeates was retiring or stepping aside:

“Mr. Carder told me that he thought that it had been assumed that Mr. Yeates was not coming back, thus the use of the word “retiring” in the minutes of the Board. A letter was sent to Mr. Yeates on the 17th March giving him notice of the decision to suspend him “pending an investigation
into the serious failings of the Trust whilst you were Chief Executive Officer, as identified in the Healthcare Commission report.” He was also notified of the intention to appoint an external investigator” (Francis, 2010a, p. 343).

Finally, within the data set coded to Mr. Yeates was a summary that presented his view of events:

“He had “been appointed to a failing organisation lacking in any governance arrangements and suffering from poor leadership. It had become apparent there was a “major underlying financial deficit” in 2006/07, a year in which the NHS was required to balance its books. He asserted that over his period in office “the organisation had been turned around to one with a sustainable future, through embedding robust governance arrangements and improving quality and standards of care.” He accepted that there were “examples of poor care subsequently identified as being delivered in some of the hospital services, primarily during the course of 2006/07”. However, this should be put in context of an organisation where at the point of the Chief Executive’s appointment there were no systems or processes, a lack of standards and protocols, no training and development, patchy and inconsistent staffing arrangements and no performance controls or management. Remedial action was required in all of these areas and action either has been taken or is a work in progress.” (Francis, 2010a, p. 339).

Mr. Sumara was coded in twenty-six data items for this period of the story. Through these data items, Mr. Sumara asserted his views of the organisation and is quoted in sound bites: for example, “they hated it” (Francis, 2010a, p. 221); “absolutely useless” (Francis, 2010a, p. 259); “real, serial and had a devastating impact” (Francis, 2010a, p. 183); “that is what the hospital is for, to treat patients. That is all there is to it” (Francis, 2010a, p. 182); “Mr. Sumara also said any staff members found to be "a perpetrator of harm or poor care" would "not be working at my hospital anymore" (BBC News, 2010b). Mr. Sumara was notable for his bluntness on a number of occasions, for example “the current Chief Executive told me in blunt terms what he perceived about the organisation when he arrived” (Francis, 2010a, p. 170). Mr. Sumara was referred to positively: “Antony [Sumara] is a good figurehead up there and people will see him like this; but he has only been in there a short time” (Francis, 2010a, p. 168). What was important to consider at this stage was not
uniquely Mr. Sumara’s perception of the Trust, and management of it after the event, but to consider Mr. Sumara’s involvement before the crisis. Specifically, Mr. Sumara was involved in the process and decision to promote the Hospital to become a Foundation Trust. For example:

“The encouragement included a ‘rehearsal’ in 2005 for the Board-to-Board meeting with Monitor, which was conducted by Mr. Nicholson and Mr. Sumara, then Managing Director of Shropshire and Staffordshire SHA. Mr. Sumara remembered the occasion and described it as “pretty challenging”. He pointed out that a similar process at a neighbouring trust had resulted in the departure of the whole Board. Mr. Sumara recalled having concerns” (Francis, 2010a, p. 327).

In addition to Mr. Sumara’s involvement in the authorisation of MSFT as a Foundation Trust, and at a similar time, as Chief Executive of Shropshire and Staffordshire SHA (Strategic Health Authority), he was engaged in a dialogue with the Board of Directors at the University Hospital of North Staffordshire. During this engagement he was identified as being “very preoccupied during our board interview and spent a lot of time getting up and going out and taking phone calls; that was because the North Staffs had said that it had refused to break even at the end of the financial year and the entire non-executive team and chair were being removed that afternoon” (Francis, 2010a, p. 225). This story was used to highlight the pressure on all hospitals to deliver financial performances, and the consequences of failure were consequently made clear. Therefore there was an emerging and complex set of stories relating to Mr. Sumara, initially as a leader to fix the problems, but with a level of culpability for the decisions to authorise MSFT as a Foundation Trust. While it is accepted that Mr. Sumara raised concern, he did have the capacity to prevent the authorisation in the first place as he demonstrated behaviour of prioritising financial performance, for which he was then critical of others.

With ninety-six data items coded to Ms. Bailey, it was worth highlighting that eighty of these data items were patient stories developed and presented by Cure the NHS, which Ms. Bailey founded. I included these and coded them to Ms. Bailey due to the significant contribution she made to these stories coming to be presented and of most significance to Ms. Bailey, the story of her own mother that launched the Campaign group:
Calling itself Cure the NHS, this group was led by Julie Bailey, the daughter of Isabella Bailey, an elderly patient who died in Stafford Hospital. Ms Bailey was concerned and aggrieved by the care that she saw being provided there. She launched the campaign with a letter to the Staffordshire Newsletter in December 2007, and the Cure the NHS group ensured that the issue of the standard of care provided by the Trust remained in the public consciousness. The group mounted a campaign for a public inquiry into the failings, as it saw them, not only of the Trust’s management but also of the wider NHS and its regulatory framework (Francis, 2010a, p. 30).

The remaining data items highlighted Ms. Bailey’s response to the publication of the independent inquiry (Francis, 2010a), where Ms. Bailey suggested the report was “outrageous” (Express and Star, 2010d) (Boseley, 2010b), and continued to assert her position (and that of Cure the NHS) that a Public Inquiry was necessary (Boseley, 2010c) (Triggle, 2010a). This led to two responses, both referring to Ms. Bailey, one from the then Leader of the Opposition (only a few months ahead of a general election) and one from the Secretary of State for Health at that time. The former referred to Ms. Bailey and committed his Party to a Public Inquiry should they be elected at the next general election (BBC News, 2010h). The Secretary of State for Health set out the reasoning for the decision, with reference to the Opposition party, to not proceed with a Public Inquiry (Francis, 2010a, p. 31). This period further illustrated Ms. Bailey’s profile and engagement with senior politicians at the time.

Mr. Francis had thirty-six data items coded during this event. These data items were used disproportionately in the frames compared with the other storyteller evaluated, with twenty-two items in the signature matrix and six in the elaboration matrix. The data items highlighted that Mr. Francis is a medical legal expert (Guardian, 2010c) (Express and Star, 2010a), and his authorship of the report possessed highlighted findings from it (Boseley, 2010c). Mr. Francis introduced the patient stories collected, which were included in a separate volume; the purpose of which Mr Francis states is that:

“I [Mr. Francis] am extremely grateful to everyone who has contacted me, and to those who gave their time to attend an oral hearing; I appreciate that
for many this has involved reliving painful memories. The stories they have
told me deserve to be read by anyone seeking to understand the impact of
poor care on those who seek help in hospital and on their families. I have
therefore included them in this separate volume” (Francis, 2010b, p. 1).

Throughout the frames, quotes from Mr. Francis were used to create legitimacy to certain
claims, for example “Mr. Francis QC refers to "denials of dignity" (Leigh Day, 2010b),
"unnecessary suffering" (Leigh Day, 2010b) and described the impact of the appalling care
and treatment on the patients and also family members as being "almost unimaginable"
(Campbell, 2010b).

Opening of the Public inquiry by Robert Francis: 8th November 2010

All seven frames were present at this stage: Justice, Learning, Improvement, Leadership,
Distress, Blame and Defence. The signature matrix and elaborative functions are set out in
appendix 1 and 2. All four storytellers were present at this stage: Ms. Bailey, Mr. Yeates, Mr.
Sumara and Mr. Francis.

Frames

Using the data items coded I suggested the emphasis of the Justice frame at this stage was
on finding the “truth” (Midstaffs Public Inquiry, 2010j). There were data items used from
Leigh Day and Co (the firm of solicitors representing Ms. Bailey and Cure the NHS) that
highlighted the volume and value of claims settled (BBC News, 2010f). This argumentative
device (the fact that legal claims confirm and are settled on the basis of accepting
negligence), developed the legitimacy of the claims for justice that the truth emphasised by
Ms Bailey and Cure the NHS was correct. With this legitimacy of justice, Cure the NHS is
now represented as a large group, alongside a body of experience that it was capable
through the platform and visibility created over the timeline of the story of challenging large
organisations such as the Department of Health, and the Health Ombudsman (Midstaffs
Public Inquiry, 2010e). The data items emphasised accounts of individuals attending
meetings individually and experiencing limited response or engagement (Midstaffs Public
Inquiry, 2010q), but also provided accounts of the individuals returning as part of the Cure
the NHS; the reaction, response and outcome is demonstrably different (Midstaffs Public
Inquiry, 2010q). Such a move highlighted the significance of engagement created by the
group – which continued to return to the argumentative device and account of one story – that of Ms. Bailey’s mother (Midstaffs Public Inquiry, 2010h).

This recruitment of support for Cure the NHS and/or a call for justice did not appear to be a product of a static story (the story of Ms. Bailey’s mother, Bella). What was evident in the data items for the Justice frame was a change in response to the events. That is to say that rather than singularly focus on a response to the events that led to the death of Ms. Bailey’s mother, the Justice frame had evolved, and responded to the context that has emerged.

Ms. Bailey, as recognised through acknowledgement by Mr. Francis (BBC News, 2010g), was credited with driving and ensuring a public inquiry. Hence, the public inquiry focused on the broader issues and operation of the wider NHS (Campbell, 2010b). Cure the NHS and Ms Bailey adjusted the approach to respond to and focus on these matters. For example, “The story of Stafford Hospital is more complicated than one bloke sitting in an office asleep on the job [he said]” (Midstaffs Public Inquiry, 2010e).

The Learning frame represented the key points taken from all the previous inquiries. The argumentative devices were limited, but the emphasis focused on and extended beyond the scope of MSFT. I suggested that there were three significant points that were emphasised: 1) Mr. Francis highlighted that “there is no statutory obligation to be honest within the NHS” (Guardian, 2010e); 2) the speed and nature of change of learning is slow (Francis, 2010a, p. 315); and 3) The NHS cannot admit to making a mistake (Guardian, 2010e). I suggest that this is another example of a “jujitsu move” (Creed, Langstraat, & Scully, 2002, p. 42), on this occasion by Mr. Francis. Through these statements they appear to strike at the heart of the issues – summarising hundreds of statements and evidence, they captured the emotive essence of the Justice and Distress frames, but equally have very little demonstrable connection to improvement, leadership or outcomes.

The Leadership and Improvement frames, during this event, had limited data items associated with them. The Improvement frame is dominated by Mr. Sumara, who sets out clearly his improvements, both made and planned (Express and Star, 2010l). Furthermore he used assertive language that he will “clear out” anyone, or “close” wards that fail to meet the standards required. I suggested that this was an attempt to stop talking about individual improvement tasks – which reminds us of the failure from which MSFT must improve – and move to a dialogue about building confidence. Mr. Sumara is challenging and allowing the
Community to believe the local hospital is “normal”. This move placed the Improvement frame in contrast to the Justice frame. Moving away from a sense of being in a state of perpetual complaining to one that persuades the community to move forward and trust the hospital again. This focus on confidence and trust was also highlighted through the data items used to construct the Leadership frame. Dr. Moyes, Mr. Yeates and Mr. Morton were all underlined as examples of poor leadership, with the central theme focused on a lack of communication skills – be that Dr. Moyes (and Monitor) not communicating at all (Midstaffs Public Inquiry, 2011b), Mr. Yeates refusing to communicate (Midstaffs Public Inquiry, 2010h) or Mr Morton communicating poorly (Midstaffs Public Inquiry, 2010i). In contrast, again Mr. Sumara is highlighted as a demonstrable example of good leadership through communication (Midstaffs Public Inquiry, 2010m).

The data items that populate the Distress frame during this event focused on emphasising and articulating distress – for example, the legal confirmation of the claims of suffering included in the Justice frame (BBC News, 2010f), and an apology clearly articulating and accepting the distress experienced at MSFT (Mid-Staffordshire NHS Foundation Trust, 2010). This point was vital, as the distress appears to be contained to and within MSFT. Although the scope of the inquiry looks at the systemic issues within the NHS, there was no comment on wider examples of poor service. In this event a conflict between the Improvement frame and Distress frame was highlighted – with the Improvement frame highlighting positive progress; the Distress frame possessed data items that clearly articulate that the distress and pain continues today (Midstaffs Public Inquiry, 2010r).

I suggest that Mr Sumara used the notion (based on the reality he experienced at MSFT when he spoke to relatives that complained about their care) of distress and developed a policy called “zero harm” (Midstaffs Public Inquiry, 2011a), which he used to tackle and challenge the way care was provided. Such a public acceptance and acknowledgement that the NHS, and MSFT did/does cause harm was a significant move to rebuild trust with the local community – and in the context of blame, distress, defence, carries a level of honesty that hitherto had not been accepted. I would go further to suggest, and in light of some of the criticism of Cure the NHS and Ms. Baileys as creating victims, that such a move has greater ability to generate support and movement than the continued focus on justice.
From my construction of both the Blame and Defence frames, they became vehicles to challenge and/or protect the existing bureaucracy (the NHS, Monitor etc.) rather than illustrate a representation of the individual complaints and responses from the individuals involved. Whilst consensus existed that Mr. Yeates had a significant responsibility for the crisis (Ms. Bailey and Mr. Lownds (Midstaffs Public Inquiry, 2010m), were focused on ensuring that the blame sat with Mr. Yeates), the Blame and Defence frames used data items to demonstrate the complexity in the system surrounding MSFT. With Monitor suggesting that quality of care was not their responsibility, and as such, belonged to the CQC (Midstaffs Public Inquiry, 2010d); Cure the NHS and Mr Francis highlighted that the focus was on “system and not care” (Francis, 2010a, p. 341).

The relationship between Monitor and Government was also questioned; while Monitor accepted responsibility for the decision for MSFT to become a Foundation Trust (BBC News, 2010h), it too blamed the Department of Health (Midstaffs Public Inquiry, 2011b). The frames continued the steps of moving the problem away from a specific focus on MSFT (Midstaffs Public Inquiry, 2010e). The data items emphasised that the initial responses to the crisis were a PR operation, and that trust between the community and the Hospital was lost (Midstaffs Public Inquiry, 2010j); Cure the NHS was suggested to be a part of the problem, slowing down the improvements, and positioning themselves as “victims” (Midstaffs Public Inquiry, 2010q). Such an approach of generating a sense of victimisation creates a division between the community (of which Cure the NHS considered themselves representatives) and the staff within the hospitals, whom, by default are the perpetrators of harm. What is important to note is that in the articulation, emphasis, roots and solutions highlighted through the frame analysis, at no stage has the political, local or clinical challenge focused on the need to stop the NHS in its current structure and form. This creates a relationship between each of the storytellers and raises a question about their ownership and relationship with the NHS.

A final reflection regarding the final event in the story timeline is that the Justice and Learning frames dominated the movement during the process, with the other frames supporting or providing additional context and challenge. Event 1 opened with the Justice and Learning frame, with Ms. Bailey leading the Justice frame and Mr. Francis the Learning. That said, the nature of the stories by the sixth event were markedly different from the first.
The key points from the frames during this event were that Blame and Defence frames were created to protect the on-going bureaucracy (e.g. the NHS, Monitor, Foundation Trusts). There is a consistent thread and consensus across the frames of Mr. Yeates’ failings at the hospital, but little else; the public inquiry represents the end of the campaign for Cure the NHS. The Justice frame considered the future role for Ms. Bailey (her potential as M.P. and making her campaign national).

**Storytellers**

Mr. Yeates had the most data items coded to him (two hundred and twenty three) for this period. It is important to highlight that Mr. Yeates did not attend the public inquiry in person, but did provide a detailed written statement which was read to the inquiry in week 35 (3rd – 7th October 2011) and therefore outside the scope of this study. In the data items coded during the scope of the study, family members and relatives developed an account of Mr. Yeates’ response to their complaints. In many cases the view expressed was that Mr. Yeates did not engage well with relatives (Midstiffs Public Inquiry, 2010n); (Midstiffs Public Inquiry, 2010c); (Midstiffs Public Inquiry, 2010h); (Midstiffs Public Inquiry, 2010m); (Midstiffs Public Inquiry, 2010l).

There was support for Mr. Yeates at the time from staff, but the experience of trying to get in contact with him was well documented as being difficult (Midstiffs Public Inquiry, 2010l). The reduction in nursing numbers in order to achieve financial balance was attributed to Mr. Yeates and contributed to the events at the hospital (Midstiffs Public Inquiry, 2010c). Governance (or a lack of governance) is also identified as a major contributing factor to poor care (Midstiffs Public Inquiry, 2010d), and the Chief Executive has a key role in ensuring that appropriate governance is in place. Mr. Yeates, and others, highlight that on his taking over as Chief Executive, there had been no previous governance arrangements, and improvement had to be, and was being made (Francis, 2010a, p. 245).

Mr. Sumara provided his evidence to the trial in week 15 (14th-16th March 2011). Although primarily Mr. Sumara’s involvement as Interim Chief Executive was after the period of crisis, Mr. Sumara was involved in the process that allowed MSFT to progress towards Foundation Trust status, which preceded the crisis period. Mr. Sumara was involved in a Board-to-Board meeting – where the Board of the Strategic Health Authority met the Board of MSFT to scrutinise, in detail, the plans for the Hospital (see (Midstiffs Public Inquiry, 2010q) and (BBC
News, 2010h)). Through the data items, there were several references to the real and tangible improvements that Mr. Sumara had made, and the focus he had demonstrated, including the threat to close wards that do not improve (see (BBC News, 2010g) (Express and Star, 2010l); (BBC News, 2010g)).

In the BBC News (2010e), Mr. Sumara set out his improvement plan for the Hospital. He is regularly referred to as the ideal Chief Executive (Midstaffs Public Inquiry, 2010p). As highlighted above, Mr. Sumara developed the zero harm principle that was widely adopted by the rest of the NHS (Midstaffs Public Inquiry, 2010q). Mr Sumara’s involvement in the local hospital University Hospital of North Staffordshire (UHNS) was also used to highlight that UHNS had a whole team involved when in financial difficulty, yet no team was brought into MSFT even when it lost its quality star rating (Midstaffs Public Inquiry, 2010q). Mr. Sumara is critical of the regulators and colleagues in the NHS. Such frankness in the nature of his comments about other NHS organisations is not seen from any other NHS employee. Finally Mr. Sumara’s opinion is afforded status and recognition by Mr. Francis, who allowed Mr. Sumara’s list of the problems to be set out in the final report (Midstaffs Public Inquiry, 2010d).

Ms. Bailey gave her evidence on week 3 of the inquiry, from the 22nd – 25 November 2010, therefore her evidence was included within this data set. Ms. Bailey gave evidence over two days and thirty-two data items were coded to her from this period. In addition to this, Ms. Bailey submitted three sets of written evidence, which were explored as a part of the Public Inquiry. The opening day of the Public Inquiry was, by coincidence, the third anniversary of the death of Ms. Bailey’s mother at the hospital. This day reinforced her role as the central campaigner, in as much as she is the daughter who lost her mother at the Hospital. Ms. Bailey was defined by the death of her mother, with “Julie, whose mother died at the hospital” often cited (Lissaman, 2010); (BBC News, 2010g); (BBC News, 2010h) and from this platform, Ms. Bailey highlighted the consequences the hospital had on people (Lissaman, 2010). Ms. Bailey, and Cure the NHS, were praised at the outset of the Inquiry (Midstaffs Public Inquiry, 2010h); (BBC News, 2010g); (Midstaffs Public Inquiry, 2010c). With Ms. Bailey’s profile already significant in relation to the Hospital, this opening day provided a platform nationally to restate the concerns and the need for continued interest in the events at the Hospital, for example:
"These people have been damaged by the system," she said. "They have been left so upset and pained by the NHS complaints procedure. I'm quite a strong person but I know I will never get all the answers about my mum's death. It's there daily, a horrible feeling that will never, ever go away. It's the knowledge that people have died needlessly." She said the public inquiry was important because people would be compelled to give evidence under oath. "We want to know what happened and why," she said (Lissaman, 2010).

Not only did the events of this day reinforce Ms. Bailey's role as campaigner it also affirmed the value of the Cure the NHS group, which corroborated a role beyond the campaign, personally helping the relatives of those who suffered in the hospital (Midstaffs Public Inquiry, 2010e). The data items coded to Ms. Bailey also drew attention to the routes through which Ms Bailey complained about the service, including: the Royal College of Nursing (Midstaffs Public Inquiry, 2010i), the independent case note review (Midstaffs Public Inquiry, 2010i), via Patient, Advice and Liaison Service (PALs) (Midstaffs Public Inquiry, 2010h), the Healthcare Commission (Midstaffs Public Inquiry, 2010e); (Midstaffs Public Inquiry, 2010h), the Health Service Ombudsman assessment panel (Midstaffs Public Inquiry, 2010i); (Midstaffs Public Inquiry, 2010e), the Secretary of State for Health (Midstaffs Public Inquiry, 2010e), complaints to the PCT Chief Executive (Midstaffs Public Inquiry, 2010i), and finally through raising the complaint publicly (Midstaffs Public Inquiry, 2010i).

Ms Bailey was of the belief that the problems were not solved after the first review – and thus she persisted with evidence nonetheless (Midstaffs Public Inquiry, 2010e). The use of their stories to highlight wide spread issues (Midstaffs Public Inquiry, 2010g) and illustrate in personal detail the problems she observed (Midstaffs Public Inquiry, 2010h); (Express and Star, 2010m), all led to Ms. Bailey’s confidence in that complaining was the best method to get the answer (BBC News, 2010g).

A number of data items from the formal notes of the Public Inquiry during this period were coded to Mr. Francis, highlighting Francis' recommendation for a review in the governance arrangements of the NHS (272:1). There are several references to the themes and actions from the previous Independent Francis Inquiry (Francis, 2010a) (Francis, 2010b) (Midstaffs Public Inquiry, 2010n); (Midstaffs Public Inquiry, 2010o); (Midstaffs Public Inquiry, 2010p); (Midstaffs Public Inquiry, 2010r) (Midstaffs Public Inquiry, 2010s). The Inquiry examinations
were by Counsel, but on occasion, Mr. Francis would ask questions of witnesses or the Counsel themselves (Midstaffs Public Inquiry, 2010h). An example of this is presented at the end of Ms. Bailey’s evidence:

Thank you, Mr. Hyam... Miss. Bailey, thank you very much indeed for your evidence and the considered manner in which you have given it, and I know how -- although we've met before and you've given evidence before this will have been a difficult experience for you. I just would like to again express my appreciation for everything you've done through your organisation to help my first inquiry and this one, and for the help you generally have given. Thank you very much (Midstaffs Public Inquiry, 2010i).

A number of data items coded to Mr. Francis included questions that Mr. Francis posed, for example: what were the effects of NHS marketisation (Guardian, 2010e)? Or the negative role of auditing and a lack of statutory obligation (Guardian, 2010e). Procedural issues were highlighted, such as Mr. Francis’ power to legally force people to attend (Express and Star, 2010o). With regard to the specific issue of compelling Mr. Yeates to attend, Mr. Francis had agreed, following legal and medical advice not to call Mr. Yeates, and to allow Ms. Brisby (the then Chair of MSFT) to appear via video link (BBC News, 2010h), and that he would protect those who were named in public for giving poor care (Express and Star, 2010m); and (Express and Star, 2010m).

**Analysing the evolution of the frames and storytellers: A summary**

Figure 11 below highlighted the movement of the frames over the timeline of events. An arrow for each frame illustrated the movement; the blue circle indicated the event number in which the frame was created. The horizontal axis took into account articulation and amplification: at one end of the scale, articulation suggested the construction and frame content is focused on connections between events that are collated and packed in the frame, whereas at the other end of the continuum, frame amplification focused not on connections, but on the focusing of specific items and raising them above others within the frame (Benford & Snow, 2000, p. 623). The vertical axis considered the strategic approach and goal of the frame construction; at one end of the continuum, alignment focused on existing beliefs and values and engaging through a shared understanding. The other end of
the continuum, recruitment, focused on recruiting new connections through different values/ideas in order to broaden the appeal of the frame.

From this analysis, I suggest that the Justice frame was considered over time to be singularly emphasising the need for justice, with justice being defined as managers involved forced to talk publicly and subsequently held to account. However at the outset, the frame focused on the emotive need for justice, with one focusing on punishment; but as each inquiry and report was published the opportunity for justice as defined at the outset was reduced or removed – to which end the frame adjusted and connected to wider agendas and concerns.

The Learning frame has a more complex set of movements over the course of the timeline. Starting with the connection of lessons from the hospital reports in order to inform learning, the frame is pegged within existing structures of managing healthcare organisations. However, as the profile of the hospital events and the prevalence of problems increased, the frame starts to become much clearer in attributing where specific learning was necessary. As with the Justice frame, by the time of the sixth event improvements had materialised, as the need and opportunities to learn from the events were restricted, and the notions of learning begin to connect to broader issues of improvement and leadership.

The Improvement frame moved from organisationally-owned problems and improvement plans (for example, Mr Morton’s plans to improve the hospital), to a much wider ownership and view of improvement: for example Monitor’s intervention and Cure the NHS’ plan for improvement – which were based on the success of improvements so far. What is curious is the absence of any dialogue regarding the problems or improvement that preceded this investigation, which itself identified and confirmed that problems existed prior to Mr. Yeates joining the organisation. The frame then returned to a functional focus on where and how the hospitals could improve.

As a frame, Leadership is best described as building new dimensions that seek to engage with the wider audience. The frame moved from examples of what bad/poor leadership is, through to powerful examples and role modelling of real leadership, as embodied by Mr. Sumara. This returns to the sixth event, a subject that appeals in general terms to the importance of good leadership.
The Distress frame was constructed and remained consistent throughout the timeline, with a clear emphasis on distress, pain and the emotional representation and consequences of them. Of significance through said timeline was the function of distress and the strategies to connect to other frames and audiences. Distress was used predominantly as a part of the Justice frame, and similarly was used in the Leadership, Improvement, and Learning frames to underpin the argumentative devices of those frames.

Finally, the two frames of Defence and Blame were introduced during the final event. The function of those frames were, like the Distress frame, significant catalysts that served other frames – the formal articulation of blame and defence provided a role that propelled the Justice frame (and Ms. Bailey) forward and forced the Learning frame (Mr. Francis) to respond and manage the consequences of the complexity.

Figure 12 below illustrated movement in the way the storytellers presented themselves through the course of events. An arrow for each storyteller illustrates the movement; the blue circle indicates the event number in which the storyteller joined the timeline. I have mapped the movement on two axes. The first identified the level to which the storytellers were vocal, with respect to the tone and emphasis of their messages. The second axis considered the nature and structure of their stories in either formal or informal terms. From this analysis, I suggested that Ms. Bailey remained vocal throughout the events. By the sixth event the emphasis and tone as well as the formal structure of the stories told by Ms. Bailey mirrored Mr. Francis’ style.

In contrast, Mr. Sumara joined during the third event and was vocal and formal in his presentation. However, as the events and timeline passed, Mr. Sumara became more informal in the structure and the emphasis intersected with Ms. Bailey’s style and shared similar examples. By the end of the sixth event, Mr. Sumara was less vocal and had returned to a more formal structure in the stories he told. Mr. Francis, during the stories, was largely presented formally. However, through the development of the inquiries, his style and presentation aligned to Ms. Bailey’s level of informality. Increasingly, as the inquiries were completed, Mr. Francis became more vocal in his stories. Finally Mr. Yeates’ position remained consistent throughout the events, remaining formal in all communication, telling no stories directly, and was represented only through others.
Figure 11. The evolution of the frames over time
Figure 12. The evolution of the storytellers over time

Identifies the first event the storyteller was present

Quiet

Represents the movement over the series of events

Informal

Formal

Mr. Yeates

Mr. Francis

Mr. Sumara

Ms. Bailey

All storytellers were present during the sixth event
Answering Research question 1: Evolution of storytelling

The first research question was: How does storytelling unfold and escalate from one event into multiple stories? The study identified the starting point as the publication of the HCC report into events at MSFT (Healthcare Commission, 2009). From the report, I identified the emergence of seven frames. Two initial frames were identified at the outset (Justice and Learning frames) while the remaining five frames emerged throughout the period of the study. Frame analysis provided an opportunity to identify the components of the story and to track the changes overtime; this is identified in figure 11 above. This identified how, for example, the Justice frame started with the single focus of wanting to force managers at MSFT to talk publicly and be held to account (for example, “It is not enough for the chairman and chief executive to take the fall for this.” (Guardian, 2009b); “Mrs. Bailey said that an inquiry needed to address a number of questions” (Express and Star, 2009b)).

Thus, the data items placed into the frame emphasised the emotive accounts for punishment and justice (see for example “Investigating individual claims of negligent, abuse and/or degrading treatment that has occurred and that are still continuing in the Hospital at the present time” (Leigh Day & Co Solicitors, 2009a); “The only way Martin Yeates will be held to account for his decisions is if he is called to give evidence to an inquiry under oath” (Express and Star, 2009i)). However, as time progressed and further reports were published (Francis, 2010b), and the support from the original audience (the community) was limited (for example “it’s about time Ms. Julie Bailey now can see That NO INQUIRY WILL GO AHEAD and go back to her café (Express and Star, 2009j)), the development of the frame through the data items sought new audiences in order to maintain momentum. For example: “should the Government continue to refuse to hold a public inquiry, the lawyers will apply for permission to hold a judicial review which could see judges order an inquiry to take place” (Express and Star, 2009f); and “his [the Secretary of State for Health] decision not to hold a public inquiry into the Trust was unlawful under Article 2 and 3 of the Human Rights Act” (Leigh Day & Co, 2009b).

The frame now shifts to a formal, legal dialogue that is familiar to a national audience. Of particular importance, frame analysis identified that throughout the period the data items in the frame focused on amplification, specific discrete and singular messages of a call for
justice through a public inquiry, raising them above other items. These are illustrated in Table 16 below.

In contrast to the Justice frame, the Learning frame followed a more complex set of movements. During the early events, the Learning frame connected the lessons from the emerging reports (see for example (Healthcare Commission, 2009); (Thome, 2009); (Alberti P. , 2009)). The approach focused on broad and general learning for NHS organisations. However, as the complexity of issues identified emerged over the course of events, the frame moved to become more specific in the areas in which it attributed specific learning. By the final event the apparent specific opportunities to learn or share learning had regressed to more general opportunities, which were communicated to a wider audience. These changes are summarised in Table 17 below.

These examples illustrated how using frame analysis can provide a structure to identify the changes in emphasis and purpose of stories. I highlighted the adaptive nature of storytelling that continued and sought the on-going escalation of the story. It also identified that from the single account of the HCC report (Healthcare Commission, 2009) there were multiple responses and stories that grew from the initial account.

As identified in Chapter 2 (Literature Review) and set out in Figure 1, stories and storytelling presented through frame analysis provide a structure to analyse the events, accounts of events and the frames developed from the data items. This relationship between events, accounts of events and frames were highlighted in Figure 4 and provided the central component of the theoretical framework. Tables 16 and 17 below illustrate how the data items and frames created the account and demonstrated the movement over time. Also of importance was the definition of storytelling and the opportunity to develop the literature further. This was illustrated in Chapter 2 (Literature Review) and figure 2; I identified the opportunity to consider speculation (and more specifically ante-narrative, poetic tales and simplified messages) over the course of the events. What was clear from the analysis was that the stories were developed from both a clear and univocal approach, but were equally supported by speculative approaches. Table 18 below illustrates the escalation of the story and its relationship to speculation.
Table 16: Example fragments of text from the Justice Frame illustrating an amplification of a single issue over the six events

<table>
<thead>
<tr>
<th>Event</th>
<th>Item</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Event 1</td>
<td>Investigating individual claims; to call for, and to challenge any refusal to hold a public inquiry.</td>
<td>(Leigh Day &amp; Co Solicitors, 2009a)</td>
</tr>
<tr>
<td></td>
<td>It is not enough for the chairman and chief executive to take the fall for this.</td>
<td>(Guardian, 2009a)</td>
</tr>
<tr>
<td>Event 2</td>
<td>“It’s not over; it’s all just started over again now that we are campaigning for the public inquiry. It’s about justice.”</td>
<td>(Express and Star, 2009g)</td>
</tr>
<tr>
<td>Event 2</td>
<td>We want people from that trust to be held to account.</td>
<td>(Express and Star, 2009k)</td>
</tr>
<tr>
<td>Event 3</td>
<td>They did not agree with its recommendation of private hearings to allow staff to give evidence confidentially followed by a public report of findings.</td>
<td>(Express and Star, 2009o)</td>
</tr>
<tr>
<td>Event 3</td>
<td>Continue to lobby Health Secretary Andy Burnham for a public inquiry, because they needed “honest answers”.</td>
<td>(Express and Star, 2009o)</td>
</tr>
<tr>
<td>Event 3</td>
<td>&quot;We want to know why this happened to our loved ones?</td>
<td>(BBC News, 2009c)</td>
</tr>
<tr>
<td>Event 4</td>
<td>The report as &quot;absolutely outrageous&quot;. &quot;All he's done is recommended another independent inquiry,&quot;</td>
<td>(Boseley, 2010c)</td>
</tr>
<tr>
<td>Event 4</td>
<td>None of these reviews or reports satisfied the public concerns as represented by Julie Bailey and Cure the NHS, who continued to demand a public inquiry.</td>
<td>(Francis, 2010a, p. 31)</td>
</tr>
<tr>
<td>Event 6</td>
<td>I felt the hospital were responsible for my mum's death.</td>
<td>(Midstiffs Public Inquiry, 2010h)</td>
</tr>
</tbody>
</table>
Table 17: Example fragments of text from the Learning Frame illustrating an amplification of a multiple issue over the six events

<table>
<thead>
<tr>
<th>Event</th>
<th>Item</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Event 1</td>
<td>There has been a &quot;vacuum&quot; in oversight and patient involvement in the NHS.</td>
<td>(Gould, 2009)</td>
</tr>
<tr>
<td>Event 1</td>
<td>“For all of us and for all NHS patients now and in the future, we need to learn all of the lessons from Stafford Hospital.”</td>
<td>(Express and Star, 2009b)</td>
</tr>
<tr>
<td>Event 2</td>
<td>There are, however, lessons for all of us and it is important that these are learned. So once again let me say how important it is that you, the Board of Directors, the Board of Governors and senior clinical leaders all study these reports carefully and ask honestly whether any of the issues or lessons might apply to your organisation. If that question is addressed honestly and openly, lessons will be learnt and we will avoid a repetition of what were truly terrible failures in the care of patients.</td>
<td>(Moyes, 2009)</td>
</tr>
<tr>
<td>Event 3</td>
<td>&quot;We need him to lift the lid off that hospital and see what’s been going on.&quot;</td>
<td>(BBC News, 2009f)</td>
</tr>
<tr>
<td>Event 3</td>
<td>&quot;We want to know why this happened to our loved ones? Why nobody listened to us for so long after we told so many people?&quot;</td>
<td>(BBC News, 2009c)</td>
</tr>
<tr>
<td>Event 3</td>
<td>&quot;This report removes any doubt and makes this clear to all. Two of the accounts come from Stafford, and they sadly fail to stand out from the others,&quot; she said.</td>
<td>(Boseley, 2009)</td>
</tr>
<tr>
<td>Event 4</td>
<td>Francis warns other trusts that the Stafford board – whose chair, executive and non-executive members are responsible for all its activities – were oblivious to most of the failings.</td>
<td>(Vize, 2010)</td>
</tr>
<tr>
<td>Event 4</td>
<td>I have, however, investigated the process that surrounded [Mr Yeates’] departure from the Trust and have found that it was inappropriate and took insufficient account of the public interest.</td>
<td>(Francis, 2010a, p. 410)</td>
</tr>
<tr>
<td>Event 6</td>
<td>It is vitally important that the NHS listens to what people have to say so that the mistakes of the past are not repeated.</td>
<td>(Mid Staffordshire NHS Foundation Trust, 2010)</td>
</tr>
</tbody>
</table>
Table 18: Escalation of the stories illustrated by the justice and learning frames.

<table>
<thead>
<tr>
<th></th>
<th>Ante-narrative Speculative appreciations</th>
<th>Poetic tales Intimate tales</th>
<th>Simplified messages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Justice frame</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>How can any patient have trust in the managers and systems that have allowed this disaster to run and run? (Guardian, 2009b).</td>
<td>4: “Money and greed have taken priority over patients’ lives.” (Symons, 2009).</td>
<td>6: “Drinking from flower vases” (Symons, 2009).</td>
</tr>
<tr>
<td>2</td>
<td>“It’s not over, it’s all just started over again now that we are campaigning for the public inquiry. It’s about justice” (Express and Star, 2009g).</td>
<td>5: “The Healthcare Commission report is the worst report in the history of the NHS and we are still here now fighting to get patients treated properly. It is an absolute disgrace that we are still having to fight everyone” (Express and Star, 2009m).</td>
<td>7: “What had become clear was that official channels for their concerns were either ineffectual or hopelessly complex” (Gould, 2009).</td>
</tr>
<tr>
<td>3</td>
<td>“there should be no reward for failure.” (Express and Star, 2009l).</td>
<td>8: “how many deaths have there been and why did Health Secretary Alan Johnson and his predecessors fail to prevent these deaths?” (Express and Star, 2009b).</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>10: &quot;We need him to lift the lid off that hospital and see what's been going on&quot; (BBC News, 2009f).</td>
<td>11: &quot;This report removes any doubt and makes this clear to all.” (Boseley, Patients 'demeaned' by poor-quality nursing care, 2009)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>12: “There are also worrying instances of cruel and callous attitudes from staff towards vulnerable and sometimes terminally ill patients” (Boseley, Patients 'demeaned' by poor-quality nursing care, 2009).</td>
<td>13: “The new inquiry will be chaired by Robert Francis QC, who will hear evidence from patients and families and identify lessons for the future, the government said.” (BBC News, 2009g)</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>14: “On Tuesday, we announced a further, independent, inquiry chaired by Robert Francis QC to hear evidence from patients and families – building on the reports to date and the Independent Clinical Reviews under way – and identify lessons for the future (Express and Star, 2009q).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning frame</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>“how many deaths have there been and why did Health Secretary Alan Johnson and his predecessors fail to prevent these deaths?” (Express and Star, 2009b).</td>
<td>9: “we all know that the Healthcare Commission’s report leaves many questions unanswered. It looked at what happened but not the reasons why. “For all of us and for all NHS patients now and in the future we need to learn all of the lessons from Stafford Hospital” (Express and Star, 2009b)</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>10: &quot;We need him to lift the lid off that hospital and see what's been going on&quot; (BBC News, 2009f).</td>
<td>11: &quot;This report removes any doubt and makes this clear to all.” (Boseley, Patients 'demeaned' by poor-quality nursing care, 2009)</td>
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<td>11</td>
<td>14: “On Tuesday, we announced a further, independent, inquiry chaired by Robert Francis QC to hear evidence from patients and families – building on the reports to date and the Independent Clinical Reviews under way – and identify lessons for the future (Express and Star, 2009q).</td>
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</table>
The exemplified texts shown in table 18 above are identified from the frame analysis. The speculative appreciations for the Justice frame (sponsored by Ms. Bailey) included questions placed in the public domain, setting challenges such as “no reward for failure” that were then followed through later in the story. The poetic tales use emotive language to engage the audience, as illustrated by example two in Table 18 above: (“It’s not over, it’s all just started over again now that we are campaigning for the public inquiry. It’s about justice” (Express and Star, 2009g)). Furthermore the simplified accounts and stories were illustrated through frame analysis; the phrase “drinking water from flower vases” captures the story and need for change (irrespective of the truth – which was never confirmed through the various inquiries) in the most powerful of short sentences. In example two Table 18, a functional analysis and conclusion of the issues was provided – without compromise – with an attribution of accountability.

For the Learning frame (sponsored by Mr. Francis), the simplified message is found throughout the Learning frame and across events, with measured and considered positions presented. That said, the flexibility of the frame analysis methodology, whilst attributing Mr. Francis as sponsor, did not preclude other actors (and Mr. Francis himself) making speculative appreciations and poetic tales. Again, the speculation came from placing questions within the public domain, searching for a response (which can be identified through the connections between the frames). While the poetic tales were highlighted, even where a frame is largely governed by structure (the public inquiry), poetic and emotive development still took place. The careful use of language, for example “cruel and callous” has an impact beyond the structure of the public inquiry. The remaining five frames, using frame analysis were tracked over the course of the study. Of significance was the relationship between the storyteller and audiences that influenced the cause and direction of stories – this will be considered in more detail in Chapter 7 below.

Summary

Chapter 2 (Literature Review) figure 4, sets out the theoretical framework used to consider the research question of how storytelling unfolds and escalates from one event into multiple stories? I found that the informality of stories served to engage movement in their respective cases, but it was a consistent relationship with formality that legitimised the individual’s position. Formality became a key theme for the storytellers. Ms. Bailey gained
legitimacy and authority through a formalisation of her previously informal and challenging stories. Mr. Francis managed and maintained the relationship between the formalities of his inquiries with the informal stories, constantly protecting the formal process. Mr. Sumara ensured his focus to lead and improve MSFT was delivered through informal storytelling and sound bites, however, ultimately Mr. Sumara’s messages were included in and structure into the wider formality of the events.

From this analysis I concluded that frame analysis did provide an opportunity to consider how storytelling unfolds and escalates from one event into multiple stories. I observed that the frames did not develop into a consistent pattern. In addition to the findings above three key observations were noted:

(1) Although four frames (Justice, Defence, Blame and Distress), by event six, were focused on specific aspects of the frame for amplification, they also sought to connect to other frames rather than maintaining a singular focus and definition. For example, the Justice frame focused and amplified the search for truth (Midstaffs Public Inquiry, 2010) whilst over the course of events, it moved from emotive language to a more formal dialogue engaging with legal and political systems.

(2) There was, between the frames, a difference between Justice, Distress and Learning frames that sought to develop new connections; and Leadership and Improvement frames that were appealing to existing audiences based on a return to existing beliefs and values.

(3) Furthermore there were important intersections worthy of further understanding between the frames – for example, the Improvement and Leadership frames became aligned during the early events, but then became disconnected and disparate by the sixth event. Learning and Justice shared a similar movement: from a focus on existing values and beliefs moving to a more ‘connection seeking’ frame, during the sixth event the Learning frame became focused on new areas of development and recruiting new audiences, while the Justice frame remained firmly rooted the original audience and the same reasons why a call for justice was necessary.
CHAPTER 7. ANALYSING THE ROLES OF THE STORYTELLER AND THE AUDIENCE

In the previous chapter I considered: How does storytelling unfold and escalate from one event into multiple stories? This chapter (seven) now moves to consider: How do the roles of the storyteller and audience become defined and re-defined over time? Finally, in chapter eight, I will consider the third research question: Within this process of unfolding stories, what are the intended and unintended consequences of storytelling?

For each of the three key events identified in chapter five above, I reviewed the data items, signature matrices and elaboration frames. I also considered all the data items coded to each of the key storytellers. To analyse how the roles of the storyteller and audience became defined I focused on the audience and their relationship to the storyteller. I began by identifying which individuals and/or groups can be considered as audience and then examined the relationships between the frames and the audience.

Identifying the audience

From the data items the audience can be identified as the existing storytellers, the local community in Staffordshire, the wider community across the United Kingdom, the MSFT, other NHS organisations, local and national political parties and politicians, and the UK Government. In appendix 3, tables a3.1 to a3.7 below, I have set out each of the seven frames and data items as examples of dialogue with the intended audience.

Considering the audience over time

Justice frame

As identified in the Frames and Storytellers section of chapter 5, Ms. Bailey was presented as the sponsor of this frame. I suggest that Ms. Bailey and the construction of the frame were motivated to recruit support for a public inquiry. This drive was consistent throughout the six events. The audience of the Justice frame began with the local community, and moved to a national audience that included Government representation. The key question found in the data was whilst an audience may have been present, the relationship and communication was predominantly one direction – from the storyteller to the audience.
To consider the audience over time, the audience was initially considered the local community, and Ms. Bailey established Cure the NHS as a campaign group to recruit further members. Ms. Bailey’s café was used as the base for meetings (Gould, 2009). Ms. Bailey and Cure the NHS appeared successful in recruiting members. Although there is no documented count of members, the evidence suggested that the group secured a significant number of members (see “there were queues of people coming in who were worried about the care of relatives who died in January and February” (Gould, 2009)). As early in the timeline as the first event, Ms. Bailey and the Justice Frame focused on raising the profile of the cause – which continued to call for a Public Inquiry into events at MSFT.

The construction of the frame highlighted how the messages of Ms. Bailey and Cure the NHS were played to a national, as well as local audience: for example “like a third world country hospital” (Basford, 2009) and “Drinking water from flower vases” (Boseley, 2010b) were replayed locally and nationally. The framing process also draws out the early and emerging relationships with politicians (for example, Mr. Johnson has apologised for the fiasco and described the failings at Stafford Hospital as “inexcusable” (Express and Star, 2009a)). This appears to be based on Ms. Bailey’s failure to receive a satisfactory solution to her issues prior to Event 1, where she had engaged the entire local and associated NHS Organisations (see: “Bailey says her attempts to improve hospital care were stymied by local bureaucracy and obfuscation” (Gould, 2009)).

During the analysis of the evolution of the frames and storytellers’ section of chapter 5, I highlighted the movement over time presented in the Justice frame by emphasising emotional and existing beliefs. One can emphasise a need for punishment, for example “Investigating individual claims of negligent, abuse and/or degrading treatment that has occurred and that are still continuing in the Hospital at the present time” (Leigh Day & Co Solicitors, 2009a). Comparatively, one can actively recruit and focus on a broader agenda for change within the NHS (see “Cure the NHS and other Leigh Day & Co clients objected to the Francis Inquiry on a number of grounds. Two of the main objections to the Inquiry were, firstly that it was to be held in private and secondly that its scope was to be limited to what happened within the hospital” (Leigh Day, 2010a)). Also highlighted in the same section was the development of Ms. Bailey’s style over time; at the outset of the events her approach was informal, however, by the final event Ms. Bailey was using a formal style of narrative.
This style echoed Mr. Sumara and Mr. Francis, to the point it was difficult to distinguish the three storytellers, Mr. Francis, Ms. Bailey and Mr. Sumara from one another; for example, the first quote below is Ms. Bailey, the second Mr. Francis and the third is Mr. Sumara:

“This will get to the truth. We really believe this will be a full examination of what went wrong” (BBC News, 2010g).

"Routinely neglected", endured "unimaginable" distress and suffering, and were left "sobbing and humiliated" by staff” (Campbell, 2010b).

“I offer our sincerest apologies to the families concerned, for the distress caused by the poor care their relatives received” (Express and Star, 2010l).

Ms. Bailey and the Justice frame remained visible, vocal and present throughout each event.

During the first event, the two frames identified were the Justice and Learning frames. There was consensus that action was required to respond to the findings of the Healthcare Commission report (Healthcare Commission, 2009), with both Mr. Morton (BBC News, 2009b) and Ms. Bailey (Guardian, 2009b) agreeing that further action was necessary.

Both the Learning and Justice frames shared ground in terms of the need for further action, and both frames focused on the transmission of knowledge, marking out two closely related approaches. That is to say that the dialogue is one way, with no response identified in the data items. For the Justice frame Ms. Bailey provides example after example (Symons, 2009); (Basford, 2009); (Gould, 2009); (Express and Star, 2009m) of her experience, which is picked up and shared locally and nationally. The Justice frame addressed the local community and beyond, with rhetorical questions such as: “How can any patient have trust in the managers and systems that have allowed this disaster to run and run?” (Guardian, 2009b). It argues that the formal structure of the organisation is “ineffectual and hopelessly complex” (Gould, 2009), suggesting that the organisation is not the vehicle to resolve matters on behalf of the community.

Of importance was the function of Cure the NHS as a focus for community action “Gradually, it [Ms. Bailey’s coffee shop] became a memorial and a rallying point, and Cure the NHS was formed” (Gould, 2009).
During the fourth event, the publication of the independent inquiry, Ms. Bailey had the opportunity and the national audience to compose the structure and actions that need to follow as a result of the publication (Triggle, 2010a). Mr. Francis highlighted the significance of Ms. Bailey and Cure the NHS: “she launched the campaign with a letter to the Staffordshire Newsletter in December 2007, and the Cure the NHS group ensured that the issue of the standard of care provided by the Trust remained in the public consciousness. The group mounted a campaign for a public inquiry into the failings, as it saw them, not only of the Trust’s management but also of the wider NHS and its regulatory framework” (Francis, 2010a, p. 30). The publication of the first report (Healthcare Commission, 2009), and the recommendation by Mr. Francis that a further review was required (Boseley, 2010b), provided the legitimacy and permission to Ms. Bailey that she proceed with the calls to the national community and politicians for a public inquiry (BBC News, 2010a). The outcome and response from this approach was the support of Rt. Hon. David Cameron M.P (then, Leader of the Opposition); he pledged his support for a public inquiry in the event of his political party being elected to Government (BBC News, 2010a).

The theme of a unidirectional dialogue presented by the Justice frame to the audience continued through this event, with the exceptions being: 1) the response from the Rt. Hon. Mr Cameron (BBC News, 2010a); and 2) an exchange of views in response to a local newspaper article (Express and Star, 2009j). To consider the latter, the relationship between the unfolding stories and the community remained complex and not without conflict in the approach (see “it’s about time Ms Julie Bailey now can see that NO INQUIRY WILL GO AHEAD and go back to her café” (Express and Star, 2009j)), much of which gains only limited space and response in the unfolding story. What was of interest is that during the first event, the data items focused on asking rhetorical questions (Triggle, 2010a); (Francis, 2010a, p. 31); (Leigh Day, 2010b).

Although the Political audience had responded in the commitment to deliver a public inquiry (if elected to Government) (BBC News, 2010a), there remains very little public reaction identified by the data analysis, beyond Ms Bailey and Cure the NHS to the unfolding events. The independent report (Francis, 2010a) did include the comments from staff and the local community; however there is no supplementary dialogue, support or challenge from these
groups outside of the report. The public reaction extends to only limited responses from existing or previous members of staff, who had experienced significant criticism identified especially in the Justice Frame (and Distress Frame). These criticisms were highlighted in appendix 3, table a3.1. It is worth noting that beyond the personalisation of the issues to Mr. Yeates, criticism was largely levelled at groups of staff such as “nursing”, “doctors” and “managers”; therefore, this may account for the silence. To raise an objection to the presenting stories would be to identify yourself publicly; something Ms Bailey herself, as sponsor of the Justice Frame, highlighted: “Instead of making our hospitals safe, they try to shoot the messenger” (Express and Star, 2010f).

By the final event, the opening of the public inquiry, Ms. Bailey and the Justice frame had achieved the goal set from the initial objectives, which was to have a public inquiry into events at the hospital (Leigh Day and Co, 2009a). It is worth acknowledging however, that the inquiry was not to reinvestigate ground covered by previous reports/inquiries (Midstaffs Public Inquiry, 2010f, p. 2). Furthermore, Ms. Bailey’s desire to see Mr. Yeates questioned publicly about his role at the hospital did not happen; Mr. Francis confirmed this would not happen (BBC News, 2010h). Ms. Bailey, and the Justice frame, used the Public Inquiry “stage” and national profile to recount the detailed events that they witnessed – even though this covers the ground previously discussed in the first inquiry (Francis, 2010a) (Francis, 2010b). What was considered significant was the continued lack of local community engagement or response to this performance, and the inquiry as whole. Of interest is the relegation of staff and the public to a silent and unresponsive audience, with little or no involvement as the story unfolds. The audience at the Public Inquiry reduced significantly, and would regularly include the same Cure the NHS members (BBC News, 2010h).

Learning frame

As identified in the Frames and Storytellers section (chapter 5), Mr. Francis was presented as the sponsor of this frame. Mr. Morton was the sponsor of the frame prior to Mr. Francis’ engagement with MSFT. Mr. Morton established, and Mr. Francis continued across all six events, an identified need to learn from events in order to move forward (Mid Staffordshire NHS Foundation Trust, 2010). The primary audience relationship was between Mr. Francis and Government, although I found a relationship with the local community and other NHS
organisations. The relationship with Government was less obvious from the frame analysis, but can be identified through the setting of the Terms of Reference for both the Independent Inquiry and the Public Inquiry. The Terms of Reference required the findings and recommendations to be presented to the Secretary of State for Health.

In the Analysis of the Evolution of the Frames and Storytellers: a summary section of chapter 5, I identified the development of the Learning frame. Focusing initially on accepting that there were issues at the hospital, and that action had been and was being undertaken to improve care provided, the frame evolved over the period of events presented. It moves from the first event, connecting the findings from the various reports into MSFT (Alberti G. A., 2009) (Colin-Thomé, 2009), and providing assurance (for example: “Mr. Morton said lessons had since been learned and that staffing levels had been increased” (BBC News, 2009c)) to a clear attribution of the problems and presents a set of recommendations (Francis, 2010a) in event four.

The latter generated significant national profile, and repetition of data items through the media (see: “Mid Staffordshire NHS Foundation Trust, the hospital’s parent body, lost sight of its responsibility to provide safe care after managers became preoccupied with cost-cutting and government targets, his report found” (Campbell, 2010a)). The intended audience moved from providing assurances to the local community, to presenting to other NHS organisations and the wider national community (for example, “It is vitally important that the NHS listens to what people have to say so that the mistakes of the past are not repeated” (Mid Staffordshire NHS Foundation Trust, 2010)). By the sixth event, the opening of the Public Inquiry, the frame had a high profile and provided a vehicle for storytellers to present their views (see Justice Frame and Ms Bailey above).

The frame analysis highlighted that politicians used the story of learning as a feature of their engagement with events at MSFT, for example “Health Secretary Alan Johnson pledged that the roles of all senior managers would be investigated but would not condone “knee-jerk” sackings” (Express and Star, 2009c). The commissioning by Government of the Independent and Public Inquiries was founded on learning lessons.

The style of transmission of knowledge as a unidirectional approach was set during the first event by Mr. Morton addressing the local community, staff and local and national press in
order to provide assurance that improvement has been made and will be made (BBC News, 2009c). During the first event, the Learning frame, as did the Justice Frame, addressed the local community and beyond (for example, “For all of us and for all NHS patients now and in the future we need to learn all of the lessons from Stafford Hospital (Express and Star, 2009b)). The frame emphasised, to the wider audience, the need to find answers to a number of questions, for example “exactly how many deaths have there been and why did Health Secretary Alan Johnson and his predecessors fail to prevent these deaths?” (Express and Star, 2009b); “We demand a full statutory inquiry in order to compel witnesses to appear and to answer questions under oath” (Express and Star, 2009b).

The fourth event was significant for the construction of the Learning frame, and provided the publication of detailed findings, recommendations and stories of the experiences of patients, relatives and staff (Francis, 2010a) (Francis, 2010b). The Independent Inquiry report provided the most significant set of responses from relatives and the staff at MSFT to the events that had taken place. Mr. Francis highlighted that although the majority of the public raised concerns about care provided, he also highlighted that a “substantial minority had only positive comments to make” (Francis, 2010a, p. 8). It was through the accounts in volume two shared in the report that were then shared with the wider audiences by the local and national press (for example, the failure at Mid Staffordshire NHS Foundation Trust was real, serial and had a devastating impact on the way patients were cared for (Francis, 2010a, p. 183)). The accounts of staff were best summarised in two sections – “the culture of the Trust” (Francis, 2010a, p. 15) and “perceptions of staff” (Francis, 2010a, p. 16).

In this report Mr. Francis highlighted the significance of undertaking the inquiry in private and in doing so Mr. Francis asserted: “I am confident that many of the witnesses who have assisted the Inquiry by written or oral evidence would not have done so had the Inquiry been conducted in public” (Francis, 2010a, p. 33). Mr. Francis discussed the low level of attendance at inquiry meetings in the hospital in the report, and he suggested a significant contributing factor to this low level of engagement was the fear that the views of individual staff members “might be considered disloyal to their employer, if those views came to the Trust’s attention” (Francis, 2010a, p. 34). Acknowledging the methodology employed by Mr. Francis was in support of staff in raising their concerns, there remained a notable absence of significant and serious concerns raised by staff and professional bodies in the data items.
identified. This meant there was no challenge or counter stories to the frames which prevailed and silenced the contextual or mitigating issues and actions taken by individuals and the organisation.

For the Learning frame, the sixth event, the opening of the Public Inquiry provided a structure that brought together the local and wider community to see and hear the Inquiry. Mr. Francis’ role as Chair of the Inquiry required him to oversee the order, presentation and structure of the events in the inquiry. It is important to highlight that the structure and requirements of the inquiry were largely predetermined by the Terms of Reference set by Government; the Terms of Reference proposed that the inquiry must focus on commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role at MSFT (Midstaffs Public Inquiry, 2010f, p. 1). However, it was also clear that the public inquiry will not duplicate the inquiry previously undertaken (p. 2). This latter component of the scope appears to have been ignored, as identified through the Justice Frame, Ms. Bailey, Cure the NHS and other associated members of the campaign group proceed to provide detailed accounts of their experiences at the hospital. For example:

“I just wanted justice. If he had said 'Hands up it is bad', but could demonstrate in a robust way that it wouldn't happen again, I would have walked away, secure in the knowledge that vulnerable people were not at risk." A. Yes -- Q. That's paragraph 25. A. -- if Mr. Yeates had said, "Yes, your mum has died of C.diff and, yes, she should have been buried in a body bag", I would have walked away. All I wanted was the truth” (Midstaffs Public Inquiry, 2010j).

Perhaps this is best illustrated in Ms. Bailey’s opening comments, "When I gave evidence to the first inquiry, I felt the chairman was sympathetic. However, I think he was strictly constrained by the setup of the first inquiry, and I will explain later in my view that the government did not want a public inquiry” (Midstaffs Public Inquiry, 2010k).

The audience to the Public Inquiry remained a small group of individuals that had campaigned since the publication of the first report; the involvement of professional bodies, other NHS organisations, politicians and public was limited to the written evidence and/or their presentation of evidence to the inquiry. The press coverage of the proceedings was
limited to tracking progress (BBC News, 2010e), and replaying existing lessons learnt (Guardian, 2010f).

*Improvemenet frame*

Mr. Sumara sponsored the Improvement frame. This frame had examples of a two-way dialogue between Mr. Sumara, the relatives and patients, staff and Ms. Bailey. The frame addressed primarily the local community. The movement of the Improvement frame over the course of the events was significant, starting with Mr. Morton’s improvement plan (for example, the action plan would be “a line in the sand” to allow the hospital to move forward (Express and Star, 2009r)). His plan responded to existing recommendations and provided a structured approach to engaging with the relatives and patients affected by MSFT.

Discussing Mr. Sumara’s very vocal challenges to the NHS, which were replayed publicly (for example, “I am not aware of any external body, a regulator, that has that sort of capability, and certainly the Foundation Trust process wouldn’t give you any assurance about the quality of patient care and safety. In fact I think Monitor are only now just trying to build upon that expertise” (Francis, 2010a, p. 379)). Finally I suggest that Mr. Sumara presented in such a way as to recruit support from the local community for forward movement and improvement – rather than solely a retrospective analysis of what went on previously.

Finally the sixth event, dominated by the opening of the public inquiry, which was a review of the events of the past, meant that dialogue about past and future improvements was not present or presented in the frames.

Mr. Sumara decided to address the local community and the formal NHS structures (see, Mr. Sumara questions the ability of Monitor to understand the clinical issues at MSFT (Francis, 2010a, p. 379); and Mr. Sumara highlighted and acknowledged the real, and devastating impact MSFT had on its community (Francis, 2010a, p. 183)). Mr. Sumara’s relationship with the audience(s) as a storyteller was complex; he was detached from the audience of other NHS organisation (including Monitor) because of his criticisms of the system. This allowed him to build a relationship with the local community (for example, Mr. Sumara is the first and only CEO to apologise directly to the local community and acknowledge the distress and pain they suffered (Express and Star, 2010l)). He also challenged the system and the organisation of the NHS, (see (Midstaffs Public Inquiry, 2010b)). Mr. Sumara achieved this
whilst being firmly embedded in the structure and culture of the NHS; this occurred via his involvement in the decision previously to authorise MSFT as a Foundation Trust (Midstaffs Public Inquiry, 2010a) and through his appointment and continued employment by Monitor, where he was acknowledged as a successful leader.

Of interest, and unlike the other frames, there was a level of challenge to the progress and improvement made. However, Mr. Sumara consistently responded to this challenge with an equivalent emotive response, for example: “Antony Sumara threatens to close wards at the hospital if they fail to make the grade” (BBC News, 2010g). Such an approach used the same style and approach composed by campaigners, including Ms. Bailey. The confidence and trust in Mr. Sumara from the local community was identified through the data items and represented in the Leadership frame discussed below.

**Leadership frame**

Ms. Bailey was initially identified as the sponsor of this frame, defining what poor or bad leadership was (for example, "I left the meeting feeling very angry. Then I remember crying with frustration. I had expected to see Mr. Yeates and the consultant at the meeting. After all, my husband had gone to hospital with a backache and had come out dead. He had lost his life and our family had suffered terribly as a result" (Midstaffs Public Inquiry, 2010n)).

The role of sponsor transferred to Mr. Sumara and, as the Improvement frame did in similar fashion, the Leadership frame underwent a dramatic set of changes over the course of events (as highlighted in the Analysing the Evolution of the Frames and Storytellers: A Summary section). Through this analysis I suggested that during events two to five, the frame, and Mr. Sumara, seek to build new dimensions that aim to engage a wider audience. By the fourth event Mr. Sumara was acknowledged as the leader that has made a significant difference in MSFT (BBC News, 2010j). The most notable data item that highlights the relationship Mr. Sumara attempts to create with the local and national communities is set out below:

“Now that Dr. Foster said we are in the top 10, I can go home now, could I, because they have said we are okay? Well, life is not like that, is it? It is my responsibility to make sure that the hospital is safe; it is my responsibility and the Board’s to make sure that the care is good. Just because somebody
outside is saying it is okay, that is not – I would be giving away my duties (Francis, 2010a, p. 179).

This move was significant as Mr. Sumara and the presentation of the Leadership frame took an approach that (in part) rejects the formal structures and assurance processes that exist within the NHS. This choice of words is in stark contrast to the criticism of Mr. Yeates (Sun, The, 2010b) and Mr Morton (Midstaffs Public Inquiry, 2010i). However, even with such assertive challenges, the response from the local community and national community is largely limited to the responses from Ms. Bailey, Cure the NHS and Monitor.

In the publication of the independent inquiry (during event four), and the focus of the Public Inquiry during event six, the focus shifted to communicating with the leaders of other NHS organisations. This presented a challenge to those organisations to respond to the lessons learnt (for example “Francis warns other trusts that the Stafford board – whose Chair, executive and non-executive members are responsible for all its activities – were oblivious to most of the failings (Vize, 2010)). There was, however, no questioning of the capability of leadership across other NHS hospitals.

Of interest is that with the acceptance that Mr. Yeates took over a failing hospital (Boseley, 2010b), and with Mr. Sumara’s introduction of schemes such as “zero harm” (Midstaffs Public Inquiry, 2010q), there is no discussion, questioning or challenge found within the data as to how or why the hospital was failing initially (and if other hospitals could also be failing). Also, questions regarding why schemes such as zero harm were necessary or not already in place across the healthcare system. It implies that without it hospitals are allowing harm to be performed, systemically, culturally and physically.

**Distress frame**

The Distress frame, sponsored by Ms. Bailey, kept a consistent approach over the course of the six events. The frame emphasised the specific examples of care, and failings of care, to patients and relatives. The volume of emotional accounts of experiences at the hospital was captured and documented through volume two of the inquiry (Francis, 2010b), these messages are replayed and repeated through the media and identified in the data items (see (Triggle, 2010a); (Leigh Day, 2010b); (Boseley, 2010b)).
I would suggest that the Distress frame predominantly addressed two audiences: the first was the local community, and I suggest that the creation of volume two (Francis, 2010b) is a formal record and account of the experiences of patients and relatives who live in the local community. It creates a lasting record, acknowledging their experiences. The whole report, including volume two, was presented to the Government as a record of the overall findings. I’d therefore suggest, and will consider in more detail below, that this is a memorial to the local community and patients who died at the hospital. The data items in the Distress frame make the events tangible and provides numerous “sound bites” that ground the stories in the experience of the patients and relatives (for example “He asked for a bedpan...The nurse said he would have to soil his pyjamas” (p. 6); There was incompetence, negligence, indifference and dangerous practice (p. 15); Calls for help were regularly ignored and he was often left in his own excrement for hours. (p. 23)). The second audience was the Government. Ms. Bailey attempts to highlight the systemic failings across the NHS and address Government directly:

"The fundamental error in all NHS and government thinking, and the reason why all these failures are happening (and are endemic now in the NHS) is that errors and appalling standards of care are inevitable and should be accepted as part of everyday life in the NHS; on the wards, in the A&E department, and in the operating theatre and, therefore, can be left to be discovered after patients have suffered and died (Midstaffs Public Inquiry, 2010q).

The key response from Government to the events at MSFT was the commissioning of a series of reports already discussed in chapter 3 (see (Alberti G. A., 2009); (Colin-Thomé, 2009).

**Blame frame**

The Blame frame emerged during the sixth event and I suggest that it was sponsored by Ms. Bailey. The frame supports the Justice Frame, which (as highlighted) by the sixth event takes a more formal and structured approach to the call for change. The presentation of the data items within the Blame frame provided an opportunity for a more emotive challenge and support to the Justice Frames’ need to recruit support for on-going change across the NHS. Where the initial approach of the Justice frame, from event one, was the drive to secure an
audience and support for a Public Inquiry, the Blame frame provided a new attempt to engender the same engagement and action against specific individuals and organisations, for example: “the first thing within the NHS is to get rid of a lot of the managers, because I think they have imposed managerial skills on the NHS instead of the culture of caring” (Midstaffs Public Inquiry, 2010i).

At this stage of the timeline, the Blame frame attempts to re-ignite the need for change; for further argument – given, as highlighted already, the absence and lack of discussion outside of the main storytellers identified here. The Blame frame emphasises two key issues, the first is the complex arrangement around which NHS organisations are there to provide assurance about the care and service provided by hospitals. This focused on the responsibilities and roles of Monitor and the Healthcare Commission (for example: “Monitor’s understanding was that the Department of Health, which provided Monitor’s budget, encouraged a clear distinction between Monitor’s scrutiny of the financial data and viability of proposed FTs and the HCC’s role of quality scrutiny” (Midstaffs Public Inquiry, 2010d)). Secondly it highlights the tense relationship that Cure the NHS has with the local community when challenging these structures (for example, “some of the staff representatives pointed the finger at Cure the NHS and portrayed themselves as victims” (Midstaffs Public Inquiry, 2010q)).

**Defence frame**

The Defence frame also emerged during the sixth event and I suggest that it was sponsored by Mr. Francis. The frame supported the Learning Frame. The Public Inquiry was structured to provide an opportunity to publicly challenge how the NHS and MSFT operated. The frame, and Mr Francis’ role as Chair, is therefore crucial to providing a stage through which these arguments can be made and managed, without undermining confidence in the NHS system. To continue this point, the Inquiry was commissioned by Government, which retained the statutory, political and elected responsibility to ensure that the NHS continues to deliver safe and effective care. It therefore must also be seen to be acting in response to the crisis. The primary action is the Inquiry. Government also has a duty to protect and ensure the NHS continues to function therefore, through the Terms of Reference and authority granted to Mr. Francis as Chair, it required the Inquiry to protect the existing structures. For example in the Terms of Reference for the inquiry the Secretary of State asks
the Inquiry to identify how lessons can be learned for the future, but assumes the same regulatory structure, form and function of the NHS continues:

“To identify the lessons to be drawn from that examination as to how in the future the NHS and the bodies which regulate it can ensure that failing and potentially failing hospitals or their services are identified as soon as is practicable” (Midstaffs Public Inquiry, 2010f).

The Defence frame also emphasised the complex arrangements in and around NHS organisations, and sought to provide an opportunity for a shared responsibility/accountability. The defence did not challenge or seek to unpick this complexity, but merely acknowledge the value and need to learn from experience. This was best illustrated in Dr. Moyes reflection on Monitor’s role in approving MSFT to become a Foundation Trust:

“Dr. Moyes told the inquiry that, with the benefit of hindsight, they shouldn’t have granted the Mid Staffordshire Trust Foundation Status, and that the Department of Health shouldn’t have put it forward for consideration in the first place (BBC News, 2010h).

Summary

In this section I have considered the issue of audience throughout the course of events. Although I have identified the individuals and the groups to which the stories were ostensibly addressed, I have found only a very limited engagement with and responses to the frames from these individuals and groups.

In particular, out of the local community or a wider national community presented, only one individual, Ms. Bailey (a storyteller herself) and one group, Cure the NHS, actively engaged with the storytellers and storytelling. Out of the individual medical and management professionals and their professional associations, only a few members of the MSFT staff responded, whilst groups such as Royal Colleges of Physicians and Royal College of Nursing issued no response. Out of the individuals employed by government organisations and the Government itself, the Secretary of State for Health was vocal through the events (there were three holders of the position of Secretary of State for Health, and all three engaged
with events at MSFT) and Dr. Moyes (a storyteller himself) responded through the inquiries and press releases issued whilst he was Executive Chairman of Monitor (the Government appointed regulator of Healthcare). Monitor and Dr. Moyes continue to emphasise the actions that were taken, although there was no evidence of a two way dialogue. Dr. Moyes is referred to (Francis, 2010a, p. 329) as being focused on ensuring profitability as a key focus of any action taken.

From event four, the dialogue, rather than engaging the storytellers and the local and wider community, is largely centred on Ms. Bailey (representing the local community); Mr. Sumara (representing MSFT); and Mr. Francis (representing an independent role as lead investigator into events appointed by Government). The dialogue and story development rotated around these three individuals; for example, Ms. Bailey is critical of the inquiry (Boseley, 2010a), Mr. Sumara is critical of the NHS system (Francis, 2010a, p. 347), whilst Mr. Francis is critical of management, the leadership and NHS structures (Express and Star, 2010d). All three appear to present themselves as representing the local and wider community.

The relationship between Mr. Francis, Mr. Sumara and Ms. Bailey became even more interconnected through Mr. Francis’ engagement of both storytellers in the public inquiry. For example, Mr. Sumara’s summarising of the problems with MSFT was replayed and used by Mr. Francis (Midstaffs Public Inquiry, 2010d). Mr. Francis acknowledged that Ms. Bailey was a significant and positive influence (Lissaman, 2010). The storytellers and the frames structured from the data items identified and highlighted the seven different messages that were being presented to the audiences, but there is little or no response to these outside of the interactions between the storytellers themselves. One exception to this is seen during this event at the opening day of the inquiry when there is a rare example and sense of a public audience at the point when the start to the Public Inquiry is delayed by the public (Lissaman, 2010).

Given the significance of the issue (widely reported as “over 400 unnecessary deaths” (Gould, 2009)) and the strength of the storytellers’ messages delivered (e.g., “It was like a Third World country hospital” (Basford, 2009)), it is somewhat surprising that the response and the audience engagement was so limited.
Research question 2: Changing roles of storytellers

Figure 5 Chapter 2 (Literature Review) identified the theoretical framework applied to consider the second research question - How do the roles of the storyteller and audience become defined and re-defined over time?

Frame analysis of the data identified that the role of the key storytellers changed significantly during the course of the study. From the analysis above, how each had a role as storyteller and a role in the audience was highlighted. The definition of the storyteller and the audience was blurred and could be identified through frame analysis. In appendix 3 (tables a3.1 to a3.7), I identified the audiences that corresponded to each of the frames identified. To illustrate this Ms. Bailey engaged five key audiences as a storyteller; the local community, national community, MSFT, politicians and Government. Similarly Ms. Bailey was also an audience member as a part of the local and national community.

Ms. Bailey, initially defined as the daughter of a patient, and member of the local community, evolved into the leader of Cure the NHS which represented the local community and her own views and needs. Ms. Bailey was also a part of the intended audience – listening to and receiving comments and instructions from Mr. Morton, Monitor, Mr. Francis, and Government. Ms. Bailey moved beyond the audience through her role, as Cure the NHS provided a platform and authority to engage directly in person, via telephone and writing with the Secretary of State for Health – at which point Ms. Bailey becomes the storyteller. Furthermore, Ms. Bailey’s accounts are picked up by other storytellers, such as Government and MSFT (via Mr. Sumara) and replayed through those individuals and organisations. This provides evidence of a blurring of the roles between the storyteller and the audience. This study highlighted the ebb and flow of the roles of storytellers, which evidentially became mutually dependent, even where the position or views were opposing. Frame analysis overcame the paradigmatic constraints and helped to identify a managerialist approach to storytelling with clear transformative messages that, when simultaneous, are used speculatively. Table 19 below illustrates, using the Leadership and Improvement frames, how storytelling blurs the roles of the storyteller and the audience over time.
Through an application of frame analysis and the theoretical framework Table 19 highlighted the prioritisation of the speculative appreciations of storytelling is illustrated. It identified Ms. Bailey as both storyteller (see data items 4, 8, 16 in table 19) and audience (see data items 5, 9, 12 in table 19). The approach to storytelling also highlights the speculative, poetic and simplified messaging across storytellers and audiences. For example, Mr. Sumara, as key storyteller (identified in Chapter 3) used multiple approaches in the delivery of a story of leadership (see data items, such as speculative appreciations 3, 14, poetic tales 7 and simplified messages 10 in table 19).

Summary

The theoretical framework placed frame analysis at the centre of the methodology; the purpose of the framework was to foreground storytelling over the story. The structuring of the data items, frames and testing the frames with the sponsors, storytellers and audiences allowed for a richer appreciation of their changing nature of the roles. The analysis of the frames highlighted the “the struggle for meaning” (Vliegenthart & Zoonan, 2011, p. 105), and the shared use of storytelling approaches was illustrated over the timeline to the point that the final event became difficult to distinguish between Ms. Bailey, Mr. Sumara and Mr. Francis. Finally the focus on storytelling and the roles of the storyteller and audience avoided the affect of stultification. Stultification can lead to the relationship becoming defined, separated and with the audience dependent on the storyteller to explain what the audience has learnt (see Ranciere (2007)).

Through this study a mutual dependency is developed between the storyteller and actors; it was not informed by the dominance (or ignorance (Ranciere, 2007)) of the other, rather the relationship between the storyteller and the audience was one whereby the roles became blurred to the point a distinction between them is difficult to discern. What binds them is their speculative relationship to the telling of the story cognisant of the need to answer the “did it really” and “so what” questions Gabriel (2008). When these questions fail it “threatens to undermine the narrative contract of experience”.


<table>
<thead>
<tr>
<th>Improvement Frame</th>
<th>1 Everybody comes in with ideas (Francis, 2010a, p. 169)</th>
<th>5 The action plan would be “a line in the sand” to allow the hospital to move forward. (Express and Star, 2009r)</th>
<th>9 Our top priorities must be the safety and experience of every single patient who comes through our doors, and the effectiveness of the care we offer” (BBC News, 2009e)</th>
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<td></td>
<td>2 Mrs A told the Inquiry that during this time there was a backlash from parts of the community, with people writing to the paper praising the care provided by the hospital. (Francis, 2010b, p. 284)</td>
<td>6 There would be a serious vacuum in the most senior executive position at the hospital. (Monitor, 2009a)</td>
<td>10 &quot;The most important thing is to get the patient care bits right and people need to be clear about what that looks like when it is good,&quot; (BBC News, 2009i)</td>
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<td></td>
<td>3 I think we have another year’s worth of work to make this hospital one of the best in the country. (BBC News, 2010d)</td>
<td>7 staff being very bruised and battered (Francis, 2010a, p. 169)</td>
<td>11 There can no longer be any excuse for denying the enormity of what has occurred. (Francis, 2010a, p. 3)</td>
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<td></td>
<td>4 The group plan to ask Mr Lansley to give more support to hospital boss Antony Sumara in his efforts to turn the hospital around. (Express and Star, 2010i)</td>
<td>8 It would have been easy to give up when they were being resisted but they persisted and they were right to persist.” (Express and Star, 2010j)</td>
<td>12 the public need to believe that there has been genuine and lasting change in their hospital. (Monitor, 2010)</td>
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<tr>
<td>Leadership frame</td>
<td>13 rebuild public confidence (Monitor, 2009b)</td>
<td>16 Antony Sumara, had &quot;vision&quot; and &quot;strength&quot;. (BBC News, 2009f)</td>
<td>20 The Trust is in significant breach of two conditions of its authorisation and that discretionary intervention was appropriate. (Monitor, 2009a)</td>
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<td></td>
<td>14 &quot;There is a feeling that it will be better, that it’s getting better and actually it’s not going to be in the position it was a few months ago.&quot;I am very confident this will be a very, very good hospital.&quot; (BBC News, 2009i)</td>
<td>17 There would be a serious vacuum in the most senior executive position at the hospital. (Monitor, 2009a)</td>
<td>21 Strategic-free zone … in the sense that they didn’t have a clear sense of where the organisation was going (Francis, 2010a, p. 328)</td>
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<td>15 Now that Dr Foster said we are in the top 10, I can go home now, could I, because they have said we are okay? Well, life is not like that, is it? It is my responsibility to make sure that the hospital is safe; (Francis, 2010a, p. 179)</td>
<td>18 Sense of denial in the organisation, characterised by “It’s not our fault, it is somebody else’s (Francis, 2010a, p. 18)</td>
<td>22 Mr Sumara commented on the Board’s lack of insight and its focus on the wrong priorities. (Francis, 2010a, p. 348)</td>
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<td></td>
<td>19 There was a chasm between the trust leadership and the staff (Vize, 2010)</td>
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CHAPTER 8. CONSEQUENCES OF THE STORYTELLING

In the previous chapters I considered: How does storytelling unfold and escalate from one event into multiple stories? and How do the roles of the storyteller and audience become defined and re-defined over time? Finally, in this chapter, I will consider the third research question: Within this process of unfolding stories, what are the intended and unintended consequences of storytelling?

For each of the three key events identified in chapter five above I reviewed the data items, signature matrices and elaboration frames. I also considered all the data items coded to each of the key storytellers. To analyse the intended and unintended consequences of storytelling, I used the frames and specifically the elaboration functions of the frames to identify the motivation and intended consequences for each of the frames. I then considered if the intended consequences were achieved, leading the research to consider what unintended consequences were observed.

INTENDED CONSEQUENCES

In Appendix 4 I have provided an example from the Learning frame of the motivations identified through an identification of the elaboration functions and motivations for each of the six events. Across the timeline, the Learning frame identifies a body of data items that are connected to the learning of lessons at the hospital. This basic theme is evident across the timeline of the events. However, the nature and form of how the lessons could or should be learnt was contested. Of interest is that over the time line, the number of reviews undertaken and published had been highlighted previously, yet the call for further review continues. The consensus across the frames and storytellers suggested that the pain and suffering was unacceptable, that the need to ensure the public, patients and staff are protected from harm was consistent and agreed upon:

Learning frame: “We demand to know what really happened and why. It must never happen again” (Express and Star, 2009b);

Justice frame: “Why did Health Secretary Alan Johnson and his predecessors fail to prevent these deaths? (Express and Star, 2009b) ;
Improvement frame: “Our top priorities must be the safety and experience of every single patient who comes through our doors, and the effectiveness of the care we offer” (BBC News, 2009e).

Leadership frame: “That person [the leader, Mr. Sumara] must also continue to rebuild trust in the hospital, and critically to enhance patient, staff and community confidence (Monitor, 2009a).

Distress: “Denials of dignity” and "unnecessary suffering" (Leigh Day, 2010b)

Blame: “Untimely and ill-judged, it has upset bereaved relatives a great deal and undermined straight away their picture of him as a new broom. This was all the stuff we got from Yeates and Brisby. I understand Eric's urge to rebuild the reputation but he won’t do it this way, just the opposite” (Midstaffs Public Inquiry, 2010q).

Defence: “It is like you’re shutting the stable door after the horse has bolted (Midstaffs Public Inquiry, 2010l).

The intended consequence of each of the frames was to ensure that the events at the hospital did not happen again. The role of stories in the investigation was crucial (as demonstrated through volume two of the independent inquiry (Francis, 2010b)) and the Patient’s Association also used patient stories to illustrate the need for change within the NHS (Patients Association, 2009).

Using this approach for each frame I found that the intended outcomes that underpinned the development of the frames were: for the Justice frame - a public inquiry that was necessary in order to hold people to account. The Justice frame emphasised the need for action as a result of the decisions taken that led to poor care at the hospital (Leigh Day and Co, 2009a). For the Learning frame, lessons needed to be learned to ensure this did not happen again (Moyes, 2009). The data items that supported the Improvement frame emphasised the need for demonstrable improvement at MSFT and in addition to this, there was an identified need to restore confidence in the hospital (Monitor, 2009a) and allow relatives and patients to talk and share publicly their experience (Francis, 2010b). While this is supported through effective leadership at the hospital, the data items associated with the
Distress frame focused on and emphasised the intention to stop the suffering. The data items identified within the Blame frame were responses to the emerging accounts, with the intention to blame those responsible. Finally the Defence frame presented data items with the intention of defending the structure and systems of the NHS.

At the end of the timeline (November 2010), the public inquiry had been launched, improvements had been illustrated from Mr. Sumara’s time, and a new permanent CEO was in place. Therefore, prima facie, the intended consequences had been realised. What was not clear was if the fundamental challenges at MSFT and the wider NHS system had been addressed, and although the public inquiry had been launched, there was no clear evidence of accountability or systemic changes as to how care would be organised, managed and delivered.

By December 2011 the public inquiry had concluded it was not published until January 2013 (Francis, 2013). The Government response in March 2013 highlighted the need for “radical new measures” (Triggle, 2013). In June 2013, 300 cases were reviewed by the Police (BBC News, 2013). In January 2014, the plan to dissolve MSFT was approved which would see the main hospital services run by UHNS (BBC News, 2014). If the intended consequences were to improve the way healthcare is provided, the Keogh review (2013) of fourteen trusts identifying failing care may suggest that changes have not been delivered. Whilst the dissolving of MSFT was a significant step, the provision of care will continue in the same structure as previously, but with the governance provided by other existing NHS organisations. Furthermore, the plans to dissolve MSFT were likely to see services reduced at the Stafford Hospital site – however, was this an intended consequence?

Therefore, from the analysis I am concerned that if the intended consequences of storytelling were to realise change and improvements, as well as to hold individuals (and latterly, the local and national organisations) to account, there has been some degree of achievement of these goals. Nonetheless, the intended consequences have not been realised entirely. Furthermore, the formal changes and response to MSFT were realised in January 2014, almost 10 years after the period of concern; the research asked – what were the unintended consequences that might have contributed to this?
UNINTENDED CONSEQUENCES OF THE STORYTELLING

My analysis of the acts of storytelling in the MSFT case, undertaken through the lens of frames (their emergence, interaction and evolution), led me to identify two consequences of this storytelling. Rather than promoting an active engagement with the issue and generating an impetus for change, the evolution of the frames in the MSFT case appears to have led ultimately to the “memorialisation” of the accounts and experiences, and the “sacralisation” of the NHS structures. In the following section I examine these consequences in detail. In short, the unintended consequence was the protection of the existing NHS structures.

Memorialisation of the stories

I drew the concept of memorialisation from the literature on disaster memorials sponsored by governments. The literature was discussed in Chapter 2 (Literature Review). The focus here is the understanding of memorialisation as a unique form of government communication. Nicholls (2006, p. 1) suggests from her research that “governments use memorials to send specific, complex and subtle messages to the communities they govern”. The need to act is a response to a “community’s expressed or perceived need to seek to ‘do the right thing’” (2006, p. 1). In this case, the disaster was the avoidable deaths of over 400 patients at MSFT, in response to which the local community, as primarily represented by Ms. Bailey, challenged the local/national NHS system and Government to respond.

The literature review highlighted the structure, types and forms of memorials that have been developed; it also highlighted two contrasting positions regarding the consequences and impact of memorials. Memorials provide an opportunity for rehabilitation, which works in contrast to memorials as a vehicle to control or silence the response to a disaster.

From this literature and of specific relevance to this study, disaster memorials are interpreted as one of the ways in which a government may deal with the “psychological, social and political issues associated with ... the immediate post-impact and longer term rehabilitative stages of disaster” (Eyre, 1999, p. 23). For MSFT there was no natural disaster, and the data items do not reveal that any consideration was given explicitly as to need for/or the type of memorial, and no formal response or memorial was created or dedicated to those who died at the hospital.

212
Although no explicit data items were identified considering the creation of a memorial, the complexity in how to respond to the crisis at MSFT by Government (be that action, or no response) was significant. I suggest there were two forms of memorials observed from the frame analysis of events over the course of the timeline. The first example which was referred to as a memorial, was the spontaneous, informal and public reaction, pertaining to the collection of photographs and accounts of patient stories presented on a wall of the Breaks Café (this café was owned by Ms. Bailey). The second example was the production and publication of patient stories in Volume 2 of the Independent Inquiry (Francis, 2010b); this was not identified or presented as a memorial, but I will demonstrate that this also has the characteristics of a memorial.

With the public response and reportage of the original report compartmentalised into events published by the Healthcare Commission (Healthcare Commission, 2009), which was a comprehensive damming of the service, there was significant political capital that could be gained from successfully managing an NHS story by politicians. This political opportunity was highlighted in Sir Nigel Crisp’s (a previous NHS CEO) book; he highlights how, during the early 2000’s the NHS had become so intertwined with politics “there was little shared national pleasure in a new service or hospital opening but only an opportunity to make political capital” (Crisp, 2011, p. 155), that the need to publicly respond and acknowledge the crisis was critical.

To identify the types and forms of memorialisation I found two specific examples. The first was the establishment of Ms. Bailey’s café as the meeting point for Cure the NHS (Gould, 2009); at the venue, a wall of images was created and the shared through the media. This formalised a local presence, a local memorial and memory of events. The second was the publication of volume two in the independent inquiry into events. This pulled together and presented the accounts and stories of patients and carers that provided evidence to Mr. Francis (Francis, 2010b, p. 1). I will consider each of these examples in turn. In addition to these two examples, one further notable observation was the acknowledgement by Mr. Francis at the opening of the Public Inquiry:

“I would like to pay particular tribute to Julie Bailey, without whose tenacity many of the issues which have been exposed would not have seen the light of day. I would like to offer her and her family my particular sympathy today
at the opening of this inquiry, which by sad coincidence is the third anniversary of the death of her mother, whose case it was which propelled her into starting her campaign” (Midstaffs Public Inquiry, 2010c).

This public acknowledgement provided, at such a key point in the event timeline, a reminder of the reason why the investigations and inquiries – albeit those focusing on systems and bureaucracies of the NHS rather than clinical care – are due to failings that led to the death of patients. That view is embodied in Ms. Bailey’s mother and the anniversary acknowledged by Mr. Francis formally as the Chairman of the inquiry. There were no data items to suggest that MSFT undertook any acts to create or support memorials.

The first example of memorialisation, the establishment of Ms. Bailey’s café as a meeting point for Cure the NHS, provided a space and place for those impacted by events at the hospital – either as a relative or a patient. The café was significant within the data items, and referred to in connection with the early period of the timeline and the recruitment of members to Cure the NHS:

“Customers began to talk, about wards that were filthy and understaffed, about too many patients dying and complaints being fobbed off. Grieving relatives - including cafe owner Julie Bailey, whose mother died in the hospital - shared horror stories and pinned pictures of loved ones to a wall. Gradually, it became a memorial and a rallying point, and Cure the NHS was formed. What had become clear was that official channels for their concerns were either ineffectual or hopelessly complex. (Gould, 2009).

Bailey had to close the café last week because there were queues of people coming in who were worried about the care of relatives who died in January and February.

The café became a base from which activities were co-ordinated:

For the first meeting we went down to the café which she ran. We discussed what happened to mum ... it just really snowballed from there. We started meeting on a regular basis. I had no heard of the HCC before meeting Julie (Midstaffs Public Inquiry, 2010q, p. 27).
PALS at Stafford eventually became nothing more or less than a referral service to Breaks Cafe, where Julie Bailey would provide her support and assistance (Midstaffs Public Inquiry, 2010e, p. 101).

Importantly it was referred to as a place where individuals from the local community were able to, away from MSFT, share their stories and experiences. This extended to the creation of the memorial wall (see figure 13 below). There was no evidence of a theistic component to the café, it became a secular site for key events in the campaign process, and was the public place chosen for a number of high profile meetings including with Mr. Francis (Midstaffs Public Inquiry, 2010k); Clare Raynor (Express and Star, 2010g), and David Cameron (Express and Star, 2009e). The café became a place of support and rehabilitation, as well as place where action plans and strategies to challenge the system were developed.

The second example of memorialisation was the creation of Volume 2 of the Independent Inquiry in MSFT undertaken by Mr. Francis (Francis, 2010b). Figure 14 below sets out images of the document.

If the creation of a café and the memorial wall can be considered Cure the NHS’ response to the events at MSFT, which enabled remembrance, action and rituals (meetings) to discuss what happened, from the study’s perspective Volume 2 was Mr Francis’ (on behalf of Government) approach to the creation of a permanent reminder. Similarly highlighting (Suddards, 1987) the importance of selecting the most appropriate permanent reminder is a crucial step (although not without problems) to be taken. The reason for creating the separate volume and distinct from the detailed findings and recommendations was set out by Mr. Francis:

“The evidence that has been provided has proved invaluable to my Inquiry and has played a significant part in shaping the outcome of my final report. I am extremely grateful to everyone who has contacted me, and to those who gave their time to attend an oral hearing; I appreciate that for many this has involved reliving painful memories. The stories they have told me deserve to be read by anyone seeking to understand the impact of poor care on those who seek help in hospital and on their families. I have therefore included them in this separate volume” (Francis, 2010b, p. 1).
In volume two Mr. Francis highlighted that the comments reflected the experiences shared through the investigation by families, but the inquiry “had not sought to confirm the facts or information provided” (Francis, 2010b, p. 2). It is important to recognise, at this stage that the inquiry was undertaken in private – and was not planned to be made public. Therefore volume 2 was a formal way the inquiry could share the accounts, in turn making public the stories told. In essence, I suggest the inquiry gave Governmental legitimacy and authority to these accounts, and therefore, this memorial. Mr. Francis talked to, and on behalf of those giving evidence, and took the step to challenge other NHS organisations to consider the material provided.

“The tragedy was that they were ignored,” Francis said. "I suggest that the board of any trust could benefit from reflecting on their own work in the light of what is described in my report" (Boseley, 2010c).

The content of volume two provided significant material that was then shared through the media. Volume two presented perfect “sound bites” to be transmitted (See (Boseley, 2010b); (Boseley, 2010a); (Express and Star, 2010e); (Leigh Day Solicitors, 2010c); (Express and Star, 2010d)). It provides a lasting record of the stories (in some cases) of those who died. As discussed previously, it also allowed for the separation of the emotive, subjective stories from the findings and recommendations within volume one (Francis, 2010a). Government commissioned the inquiry, and the Secretary of State approved the proposed final documents before presenting them to Parliament and the public. This acceptance and approval is significant; in accepting the inquiry and the permanent and documented accounts, Government is accepting a level of responsibility through this step. However, the act of memorialisation is an action to conclude and address the consequences of that responsibility. Nicholls (2006, p. 4) highlighted that “By taking responsibility for the creation of a memorial, governments may tacitly recognise (if not acknowledge), to a greater or lesser extent, their ‘implicatedness’ in, and even responsibility for, the ills that may befall their communities.”
Figure 13. Ms Bailey’s café and memorial wall. (Gould, 2009)
Figure 14. Snapshots taken from the independent inquiry volume two. (Francis, 2010b)

Admitted to Stafford Hospital in March 2005 for open surgery for a cholecystectomy the patient was expecting a short stay. The surgery went well but her recovery was poor as she was not eating or drinking. Her family were concerned that she was dehydrated as she was not being given regular fluids and there was no fluid chart even though she was on IV. Her nutrition was also poor and caused her weight to plummet.

She was then discharged to a nursing home with C. difficile and diarrhoea. Her condition deteriorated further and she was re-admitted to Stafford hospital where she received very poor care. No one communicated with her or the family and she was left on a bedpan for hours without a bowl of water to wash her hands. The family often found trocdes of faeces under her fingernails and on her hands and she was not given a bath or shower whilst at the hospital.

The patient died shortly afterwards.

Source: Independent case notes review

A diabetic patient has visited Stafford Hospital as an outpatient on a regular basis. She has always found the staff on duty to be ‘polite, helpful and very friendly’. She had also spent a couple of nights at the hospital and found the support and aftercare to be excellent.

Source: Direct contact

Following a fall the patient was admitted to Stafford Hospital. When the patient requested a bedpan he was told by the nurse to soil himself as she was too busy to help. On another occasion the patient injured himself by climbing over the bedrails to try to get to the toilet. The patient’s son found the hospital understaffed and the care provided poor.

A few years later another family member was taken to A & E following a head injury and received excellent care. The patient was seen quickly and the doctors were both attentive and caring.

Source: Direct contact

The patient was moved to Ward 10, which was also dirty and understaffed. A tube was inserted into the patient’s stomach for feeding, which shocked the family as their mother had always been able to eat normally with assistance. She was then transferred to a nursing home where on arrival it was revealed that she had contracted MRSA, from the feeding tube.

On one occasion her daughter found her mother exposed and she had to replace her nightdress to preserve her dignity. The staff rarely washed their hands or wore a gown or gloves when dealing with patients.

The patient died 12 months later. Complaints were made to the Healthcare Commission and Parliamentary Committees.

Source: Independent case notes review/Cure the NHS

A week after a routine operation at Stafford Hospital to remove gallstones, an internal abscess ruptured and the patient was rushed back to hospital. In A&E she was provided with antibiotics and again discharged. At her follow up appointment the consultant prescribed more antibiotics and advised the patient to use antiseptic to clean the wound. Requests for a scan were refused and she was told the wound “would clear up”. Seven months later the wound was still weeping and the patient was re-admitted. It was then discovered that one of her stitches was infected which had prevented it from dissolving.

Source: Direct contact
These two acts of memorialisation were considered steps taken by the community (Cure the NHS) and the inquiry (Mr. Francis/Government) to raise the profile, record, and provide support to and remember the events at MSFT. However, as Bowring (2005, p. 8) highlighted, I question the level to which both of these significant memorialisations actually created wider engagement and understanding of the events at MSFT. The examples of memorialisation within the events at MSFT during the evolution of the frames illuminated the process of dissociation of an audience from a storyteller that is characteristic of memorialisation.

The events at MSFT were the cause of significant pain and distress for the patients and relatives in the Stafford community. When proposed changes occur (especially the downgrading of a hospital services) to a Hospital (including Stafford) across the UK, these changes are vehemently challenged by the communities. Therefore to define the local community by its relationship to the local hospital is plausible. However as Marsh & Buckle (2001, p. 5) point out: “community as a term is misleading and unhelpful in terms of emergency management, and that individuals in communities defined by location may have little else of importance in common”. Therefore an assumption that the whole community should or must be moved and engaged in the crisis is not accurate. I would go further to suggest that with such clear vocal and visible reaction through Cure the NHS, the “need “ to respond or react was not necessary; in fact, the publication of volume two was an attempt to conclude the stories as a permanent record.

Sullivan (2003) helps to clarify and widen the definition of community, “to not be bounded by geography, but for the purposes of analysing the effects of emergencies on communities in terms of their recovery, will be bounded by the impact of the emergency” (Sullivan, 2003:19). Such clarification, suggests that the local community and wider communities (relevant to the crisis at MSFT) were narrower than first suggested, and therefore were defined by and limited to those with a shared appreciation of the impact of MSFT. The memorials provided a focal point for those impacted, and the ability for others in the community not impacted by the crisis to acknowledge the lessons (such as the leaders of NHS organisations whom Mr. Francis urges to read the findings) evident. There was no requirement to be vocal.
The impact of this refers to the development and impact of the frames on the audience. Through the timeline the formal responses had centred on the development and sharing of reviews into events at MSFT (see (Healthcare Commission, 2009); (Alberti G. A., 2009); (Thome, 2009); (KPMG, 2010); (Francis, 2010a) (Francis, 2010b)). The various reviews, including that of the independent inquiry, present their findings with an easy to digest executive summary, via presenting the facts and their judgement of events at the hospital. At the same time as the series of investigations were being undertaken, a theme of resistance to holding a public inquiry was held by government which deferred the commencement of the public inquiry to eighteen months after the first inquiry.

When the public inquiry was initiated, the scope and expectation was limited and narrow (Midstaffs Public Inquiry, 2010f). It sought not to cover ground already evaluated in previous investigations; this steers the discussion away specifically from the emotive and distressing events that have now been memorialised in volume two (Francis, 2010b). This story work, in essence, had been completed and there was nothing more to say. The overall impact of simplifying the message through the various investigations led to a form of neutering of the accounts, with which the frames and frame analysis could identify and the frames would potentially lose the ability to influence.

**Sacralisation of the NHS**

The emergence of the key storytellers, Ms. Bailey, Mr. Sumara and Mr. Francis, and the frames constructed from the data items over the timeline have underlined a convergence in the stories told. Through the loss of engagement with the audience illustrated through the unintended consequence of memorialisation, matters of fundamental change were not discussed or even considered. This lead me to the second finding, which was the extent to which the NHS in its broadest sense, as well as MSFT in its local context, had become a “sacred cow”; this implies that the organisation and structures have an imbed scared character, which holds them beyond or above criticism. This is achieved through a process of sacralisation.

Sacralisation is the process by which organisations and institutions are motivated to construct a sense of the inviolable (Harrison, Ashforth, & Corley, 2009, p. 225). A review of the literature in this area was presented in Chapter 2 (Literature Review). Successful
Sacralisation fosters normative control through “unique structural relationships among the individuals” (Harrison, Ashforth, & Corley, 2009, p. 225). From the outset and establishment of the NHS the ideals, values, and beliefs espoused were based upon three core principles set out at the launch of the NHS in 1948, which has established a structural relationship that is deeply connected to British politics and the wider population. This includes: (1) that it meet the needs of everyone; (2) that it be free at the point of delivery; and (3) that it be based on clinical need, not an ability to pay.

These core principles have not changed, although the technologies, people and organisations have. The sacralisation process involves the desire to encourage participation and secure commitment from key stakeholders other than through material or relational inducements (Harrison, Ashforth, & Corley, 2009, p. 244). The development of Foundation Trusts within the NHS structure reinforces both the core principles and the structural relationship with communities:

“NHS foundation trusts were created to devolve decision-making from central government to local organisations and communities. They provide and develop healthcare according to core NHS principles - free care, based on need and non-ability to pay” (Monitor, 2013).

Therefore, if the NHS is considered sacred, I suggest that the events preceding the Healthcare Commission’s report were acts of sacrilege. Frame analysis helped to identify how attempts were made to “recover from such violations” (Harrison, Ashforth, & Corley, 2009, p. 225).

To clarify the difference between wrongdoing and sacrilege, wrongdoings are errors and mistakes that can happen, while complaints processes are in place to acknowledge and respond to. Sacrilege is more or less unthinkable, the individual disbelief and organisational denial are likely to be more pronounced under sacrilege (Harrison, Ashforth, & Corley, 2009, p. 244). Harrison, Ashforth and Corley (2009) suggest there are four stages of response to a sacrilegious event that impacts a sacred organisation – discovery and disbelief; breach of covenant; labeling and punishment; and repentance.
The discovery of the events at the Hospital was highlighted prior to the publication of the Healthcare Commission’s report (Healthcare Commission, 2009). Ms. Bailey and others were already raising their concerns about care at the hospital (see: “I would like to pay particular tribute to Julie Bailey, without whose tenacity many of the issues which have been exposed would not have seen the light of day” (BBC News, 2010g)). In Event one, the publication of the healthcare commission report raised the profile and publicly “discovered” the events. Where a sacralised relationship existed, the reflex response is one of disbelief and attempting to reaffirm the original basis of what was sacred (Harrison, Ashforth, & Corley, 2009, p. 238).

In the case of MSFT, the sacred is the delivery of safe care or more specifically the public trust and confidence that safe care is delivered. In the period preceding the Healthcare Commission’s report, the organisation largely denied that there was an issue, and that the data presented (that suggested the level of deaths was higher than normal) was not accurate as a result of information collecting errors rather than the standard of care (see (Healthcare Commission, 2009, p. 3)). The reinforcing and evidence of this denial is best highlighted through the steps Ms. Bailey followed to raise her complaints, as they “were stymied by local bureaucracy and obfuscation” (Gould, 2009).

During event one, Mr. Morton assumed the role of Chief Executive of MSFT and set out in the Learning frame his response to the report. This, as highlighted previously, was delivered with little dialogue. However, later, and through the frames it became clear that the confidence and Trust in Mr. Morton did not exist (see: trust had pulled the wool over his eyes (Midstaffs Public Inquiry, 2010j)); and “I met Mr. Morton at one of the overview and scrutiny meetings and he was just so dismissive of what was still going on at the hospital. He didn’t seem to have a grasp really of what was going on at the hospital at all. (Midstaffs Public Inquiry, 2010i)). In the second stage of a response to sacrilege, Harrison, Ashforth and Corley (2009, p. 239) suggest that individuals may become skeptical of organisational pronouncements. Although at this stage the response from staff was limited, Harrison, Ashforth and Corley (2009, p. 240) suggest, and I make the argument of relevance to NHS Staff, that “given potentially high barriers to exiting and strong initial identification with the organisation, many employees may strive mightily to rationalise away the accusations and cling to their preconceptions of the organisation”. Where many staff have trained and have
careers that are largely constrained to the NHS, and moreover the NHS in their local area, the ability to leave the job would have a significant personal impact. Similarly the structured relationship between the local community and the local NHS is equally significant. The ability to visit another hospital (especially in an emergency) is limited.

The publication of the independent inquiry findings (Francis, 2010a) (Francis, 2010b) was a key step in setting out the problems, confirming said problems and ascribing solutions to the hospital. The significance of volume two of the inquiry is documented above, through the process of memorialisation. I would therefore suggest that volume one has the significance of labeling the problems – this is led by Mr. Francis and represented through the Learning Frame; Ms. Bailey referred to both volumes, and through the Justice Frame called for punishment as a result of this acceptance of the problem. In doing so this labeling allows for the failing at MSFT to be isolated, and the ability to tacitly reaffirm the sacred values. In this case, MSFT is labeled and considered the failure, allowing the wider institution of the NHS to be protected.

The final stage in Harrison, Ashforth and Corley’s (2009) response to sacrilege, is repentance. I suggest that the final event (six – the opening of the public inquiry) is an act of confession. In considering the nature and consequences of a public confession, the literature highlighted the difference between a public confession for a wrongdoing, and that of a sacrilegious act. They suggest that a public confession for a wrong doing can benefit from accounting for the outcome as a result of wider external factors (potentially) out of the individual’s control; as Harrison, Ashforth and Corley suggest, it pays to “pass the buck” (2009, p. 241). Comparatively, they suggested that for acts that challenge the sacred core of the organisation, they do not often “relieve the actor of moral responsibility for his or her actions.” In short, there may be no acceptable excuses or justifications for something as “heinous as sacrilege” (2009, p. 241). The Justice frame throughout the course of events has been a call for a public confession, for example:

“I was shocked to hear about this family’s experiences. I offer our unreserved apologies for the deficiencies in treatment and the subsequent breach of trust policy when Mrs. Barrett’s belongings were returned” (Express and Star, 2010k).
“The failure at Mid Staffordshire NHS Foundation Trust was real, serial and had a devastating impact on the way patients were cared for” (Francis, 2010a, p. 183).

“How can any patient have trust in the managers and systems that have allowed this disaster to run and run? It is not enough for the chairman and chief executive to take the fall for this” (Guardian, 2009b).

“The only way Mr. Yeates will be held to account for his decisions is if he is called to give evidence under oath” (Express and Star, 2009i).

“We are campaigning for the public inquiry. It’s about justice” (Express and Star, 2009g).

“His decision not to hold a public inquiry into the Trust was unlawful under Article 2 and 3 of the Human Rights Act” (Leigh Day & Co, 2009b).

Harrison, Ashforth and Corley’s (2009) suggest that there is a need to accept the label of sinner before it can be shed (p. 241). The impact of admitting that events were unacceptable and the necessity to apologise were identified though a significant body of data items that underpinned the Leadership and Improvement frames under the direction of Mr. Sumara (see for example: “as an NHS professional, I would want to apologise for that” (Francis, 2010a, p. 183) and his acknowledgment by Ms. Bailey as having "vision" and "strength" (BBC News, 2009f)).

To return to Goffman (1971), he highlights the split of the actor between the “bad self” and the “good self” that renounces it (1971, p. 113). Perhaps of greater significance is the stage of repentance that allows for the development of a concreteness and shape, labeled and separated from other aspects (1971, p. 113). This is evidenced in the creation of both volumes one and two of the independent inquiry and the process of memorialisation identified above.

The second stage of repentance is through corrective actions; in this instance Mr. Francis and Mr. Sumara, as highlighted through the Learning and Leadership frames, come together. The focus on patients and zero harm that are created by Mr. Sumara, and repeated and reinforced by Mr. Sumara, are steps to reclaim the “moral character”
(Weiner, Graham, Peter, & Zmuidinas, 1991, p. 281) of the NHS and MSFT.

“Excellence was not guaranteed by their star rating – what mattered was the way patients were treated” (Boseley, 2010b).

“It is vitally important that the NHS listens to what people have to say so that the mistakes of the past are not repeated” (Mid Staffordshire NHS Foundation Trust, 2010).

"The only approach is getting all treatment and care right the first time with zero harm to patients — zero" (Midstaffs Public Inquiry, 2010q).

I suggest that the Public Inquiry is a process through which the Government and NHS seek to be freed or “pardoned” from sin (Harrison, Ashforth, & Corley, 2009, p. 243). The independent inquiry held in private was deemed insufficient to be considered appropriate and sincere (Leigh Day, 2010a); the public inquiry is the final step in the formal process, with the focus on the structure and systems surrounding the NHS (Midstaffs Public Inquiry, 2010f) also supporting the continuing objectification of the original problem. This was fully captured in the independent inquiry (Francis, 2010a) (Francis, 2010b).

Research question 3: Intended and unintended consequences of storytelling

The intended consequences of storytelling were articulated by the structuring of frames and an appreciation and definition of the roles of the storyteller and the audience. The Justice frame emphasised the need for action, and that the lessons to be learnt from the events at the hospital must prevent the problems from occurring again. It also identified the need to restore confidence in the hospital, alongside the need to allow the relatives and patients to share their experiences publicly. Frame analysis helped to clarify the intentions of the storytellers and sponsors through the development of signature matrices and the examination of the frame functions. The signature matrix provided an opportunity to understand the definition, differentiation and similarities between the storyteller and the audience.

I found that the unintended consequence of the approach taken to storytelling was the protection of the NHS structures; this was at the expense of the intended consequence of delivering change. Frame analysis allowed me to identify how, through my presentation of
the frames, the storyteller built their story over time. This allowed me to highlight how each of the key storytellers sought to critique the events from their perspective – Justice (Ms. Bailey, “Complaints being fobbed off” (Gould, 2009)), Improvement (Mr. Sumara, “the failure at Mid Staffordshire NHS Foundation Trust was real, serial and had a devastating impact on the way patients were cared for” (Francis, 2010a, p. 183)), Learning (Mr. Francis, “It is vitally important that the NHS listens to what people have to say so that the mistakes of the past are not repeated” (Mid Staffordshire NHS Foundation Trust, 2010)).

Frame analysis also identified how the storytellers and their critique of events were similar and would overlap; this was highlighted in Chapter 7 (Analysing the role of the storyteller and audience), where I highlighted how the relationships between Mr. Francis, Mr. Sumara and Ms. Bailey had become interconnected through Mr. Francis’ engagement of both storytellers in the public inquiry. However, of particular interest was a consideration of the frame effects (that is not (necessarily) to describe the story, but rather the consequence of storytelling), with all three storytellers being bound together by their relationship (albeit each very different) to the structure of the NHS. For example, Ms. Bailey through her aim to “cure” the NHS (not destroy it) (Cure the NHS, 2013); Mr. Francis and his inquiries are bound and defined by Government, to whom he is ultimately accountable (Midstaffs Public Inquiry, 2010f), or Mr. Sumara who with a significant and successful career in the NHS, is focused on improving the care provided (Monitor, 2009b).

From the analysis of the frames I found that the protection of the NHS structures was delivered through the story work of memorialisation and sacralisation. Referring to the theoretical framework (see Chapter 2, figure 7), frame analysis sits at the point between the events, accounts of events and the frames. As identified in the answer to research question 2 above (see Chapter 7), the roles of the storyteller and the audience were blurred; therefore a traditional pedagogical perspective of the relationship could not illustrate the complex associations and the consequential effects of undertaking story work.

To explore this point further, a managerialist and critical management studies approach to analysing the storytelling may have accounted for failure in systems and the need to reconnect with the “consumer”, creating a “wave of lust” (Peters (2003) in (Collins D. , 2008, p. 218), or highlighting the silencing of public voices, staff and the domination of the system and structures. Examples of such a narrative can be seen within the data items from which
the frames were constructed. For example, the simplified messages such as: “We would like to apologise sincerely once again for harm and distress caused to patients, their families and loved ones” (Mid-Staffordshire NHS Foundation Trust, 2010); or recognition of the complexity – "The story of Stafford Hospital is more complicated than one bloke sitting in an office asleep on the job [he said]. I wish he could [give evidence] (Midstaffs Public Inquiry, 2010e).

Of importance is that each of the approaches (managerialist and critical management observations of the data items) would be presented in relation to the intended outcomes, and the relative performance against this intention. The focus of this study was not on the validity and effectiveness of the story. Through the theoretical framework and an application of frame analysis, the study focused on the process of storytelling and its development over time. I found memorialisation and sacralisation to be, not a consequence of the story, but an unintended consequences of storytelling. Table 20 below illustrates the unintended consequence of sacralisation and memorialisation on story work through the frames. From these examples of memorialisation, the data items used within the frames presented a lasting need for remembering what happened, and the significance of the consequences. For sacralisation it highlighted the fundamental failures at the hospital.

Summary

In Chapter 2 (Literature Review) I identified the theoretical framework used to consider the third research question that was - within this process of unfolding stories, what are the intended and unintended consequences of storytelling?

Frame analysis identified the speculative appreciations as the story developed over time; the theoretical framework underlined the act of storytelling over the story itself in order to avoid the effect of stultification. However what the study observed was that through an appreciation of the story work stultification was a product not of the research method, but rather, the blurring of roles between the storyteller and audience that led to a mutual dependency between the roles. Stultification was a phenomenon observed through memorialisation and sacralisation as a function of storytelling. In the case of MSFT, this story work came from the inquiries, particularly the independent inquiry (Francis, 2010a) (Francis, 2010b) and more public inquiries (Francis, 2013).
Table 20: Illustrating the unintended consequence of sacralisation and memorialisation on story work through the frames

<table>
<thead>
<tr>
<th></th>
<th>Memorialisation</th>
<th>Sacralisation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Justice</strong></td>
<td>“denials of dignity” and “unnecessary suffering” (Leigh Day, 2010b)</td>
<td>“How can any patient have trust in the managers and systems that have allowed this disaster to run and run? It is not enough for the chairman and chief executive to take the fall for this.” (Guardian, 2009b)</td>
</tr>
<tr>
<td><strong>Learning</strong></td>
<td>“I really need to pay tribute here to the effort they put into that change, but I think the culture has proved very, very intractable.” (Midstaffs Public Inquiry, 2010r)</td>
<td>“It is vitally important that the NHS listens to what people have to say so that the mistakes of the past are not repeated.” (Mid Staffordshire NHS Foundation Trust, 2010)</td>
</tr>
<tr>
<td><strong>Improvement</strong></td>
<td>“the failure at Mid Staffordshire NHS Foundation Trust was real, serial and had a devastating impact on the way patients were cared for.” (Francis, 2010a, p. 183)</td>
<td>“We clearly have some issues that we need to address and what we are doing here is to be as open as we possibly can about the actions we are trying to take.” (Express and Star, 2009r)</td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
<td>“I am very confident this will be a very, very good hospital.” (BBC News, 2009i)</td>
<td>“the Trust is in significant breach of two conditions of its authorisation and that discretionary intervention was necessary.” (Monitor, 2009a)</td>
</tr>
<tr>
<td><strong>Distress</strong></td>
<td>“Mrs N told the Inquiry that the morphine had negative effects on her mother-in-law and said the diagnosis was like a black cloud over the family.” (Francis, 2010b, p. 298)</td>
<td>“You say that Antony Sumara and his team have adopted &quot;zero harm&quot; and &quot;right first time&quot; as the core of everything they do.” (Midstaffs Public Inquiry, 2010q)</td>
</tr>
<tr>
<td><strong>Defence</strong></td>
<td>“Mr Yeates apologised for the anxiety that this caused, and that the staffing issues had been an issue for the trust. &quot;Mr Yeates confirmed that it was agreed that further investment would be provided and a total of £1.15 million was allocated to the recruitment of nurses.” (Midstaffs Public Inquiry, 2010s)</td>
<td>“he was sorry they'd pulled the wool over his eyes.” (Midstaffs Public Inquiry, 2010)</td>
</tr>
<tr>
<td><strong>Blame</strong></td>
<td>“it was the immediate indication that they were not really addressing what we knew as a group from contacts from group -- bereaved relatives, grieving relatives, was still the case on the wards.” (Midstaffs Public Inquiry, 2010q)</td>
<td>“He didn't seem to have a grasp really of what was going on at the hospital at all.” (Midstaffs Public Inquiry, 2010i)</td>
</tr>
</tbody>
</table>
The frame analysis of stories told over the timeline of the study helped to understand the structures used in the act of storytelling and how the storytellers move between the frames. In this study frame analysis uncovers the absence of voices, audience and engagement as a function of the story work. The absence highlights the function of memorialisation and sacralisation as a method to protect, and/or avoid confrontation with the NHS as an institution. I suggest that the relationship between Ms. Bailey, Mr. Francis and Mr. Sumara sought to avoid “estrangement, the unknowable, acquiescence to transitoriness and a multiplicity of possible interpretations” (Bull, 2005, p. 48), or as Nicholls (Nicholls, 2006, p. 2) suggests – the anti-memorial. The anti-memorial would lead to a breakdown of trust in a healthcare system, which would have significant ramifications for the provision, and funding of care.
CHAPTER 9. DISCUSSION AND CONCLUSIONS

This chapter explores the significance of this study. Firstly, I revisit the purpose of the study and consider the theoretical catalyst that informed the development of the study. I then summarise the key findings and their theoretical implications. Finally, I identify the limitations of the study and outline the opportunities for future research.

REVISITING THE PURPOSE OF THE STUDY

When I started the PhD programme in 2007, I was intrigued by a sense of disconnect between the emerging public narrative, which portrayed the NHS organisations as mutual organisations owned by the members of the local community, and the reality, as I perceived it through my experience of working as a manager in various NHS Trusts and my interactions with patients and staff. The point in time, at which I committed to a specific direction for my research, coincided with the publication of the first report into the events at MSFT (Healthcare Commission, 2009). My responses to these events in my various identities as a carer, an NHS manager and an academic were in conflict. This conflict provided encouragement that the topic would be personally engaging (and sustaining of interest). What I was unable to predict at the time was that five years later the events at MSFT would still feature as a high profile issue (see, for instance, Wheatcroft’s (2013) reflection of the state of the NHS used in Chapter 1 and the recent report of the Care Quality Commission (2014), which identified a number of “failing” hospitals, whose problems were similar to those uncovered at the Mid-Staffordshire Trust).

Initially, I was interested to examine how the story unfolded and how different groups and individuals became involved. Eventually, what came to interest me most was how little had actually changed, despite considerable attention devoted to the Mid-Staffordshire case and the similar cases. During the same period, I worked with McKinsey and Company (a large international Management Consultancy organisation) who supported 200 leaders in the NHS to develop and use storytelling as a vehicle to engage and support transformational change. Listening to and sharing stories of experience in the NHS is considered and promoted as a key element of delivering services within the NHS. The former NHS Chief Executive Sir David Nicholson described it thus:

“It may sound clichéd – listening to service users or patients is a common mantra among public service reformers – but in the NHS it is literally, he
continues, a matter of life or death: since when things go wrong in the service, it is often because this basic principle has not been followed”

(quoted in Brecknell (2013: p. 2)

Despite – or possibly because of – this emerging attention to storytelling, I perceived from the outset, and still continue to perceive, a certain disconnect in the accounts of lived experience. A story allows for a presentation of an event and is a proxy for having experienced it. The role of the storyteller and the audience to the story become stultified, disconnected by and from the story.

To explore the processes of storytelling, I identified the following three research questions:

(1) How does storytelling unfold and escalate from one event into multiple stories?
(2) How do the roles of the storyteller and audience become defined and re-defined over time?
(3) Within this process of unfolding stories, what are the intended and unintended consequences of storytelling?

This study acknowledged the paradigmatic issues in the construction of stories and storytelling. It used frame analysis not to redefine stories, but to identify the consequences of storytelling across organisational and community boundaries in the UK’s NHS.

In the next sections I explore the significance of this study in more detail. I discuss, in particular, the theoretical catalyst for the study, the theoretical implications of the study’s findings, and the opportunities for future research.

THEORETICAL CATALYST

With change as a matter of life and death and the literature of storytelling vast and complex, a review of the literature – taking a simple separation of the literature into managerialist and critical management approach – identified an opportunity to build consensus within the material.

An opportunity existed to consider how stories move and change across both internal and external boundaries – as one story, rather than two counter posed positions. Similarly, rather than focus on the singular elite story teller and mass audience, over a multiplicity of
voices and interpretations an opportunity existed to understand how the roles of the storyteller and audience are created and defined, and how this changes over time.

The theoretical opportunity from storytelling literature was to identify the managerialist turns of single univocal presentations, whilst simultaneously understanding the acts of interpretation – through the development and analysis of a story, the storyteller and the audience. From the literature review I identified three components from both managerialist and critical management literature that I wanted to explore in further detail, which I have set out in figure 2 Chapter 2. The three component were (1) Ante narrative (which exist before plotting), (2) Poetic delivery (which builds on the plot), and (3) Simplified message (which seeks to silence the complexity). All three are in conflict with one another, but equally are mutually dependent. Speculation is the theme that pulls them together.

An opportunity existed with all three approaches to understand the relationship each had to the storyteller and the audience. The grounding of the three approaches – and a move away from defining story and narrative, to one focused on the relationships - provided a theoretical frame work that recognised the complexity and multivocality of story telling but avoided making an argument “for the non-existence or irrelevance of facts or celebrating the infinity of interpretations and symbolic constructions.” (Gabriel, 2008, p. 162).

I used a frame analysis method to explore storytelling. I found the principles of frame analysis had been taken and developed across a wide field of interest, however whilst a basic structure of analysis could be articulated through Gamson and Lasch’s (1983) signature matrix and Benford and Snow’s (2000) development of frame analysis and social movement, the literature did not identify a single unified approach to developing or applying frame analysis. That said, from the literature review, the value of frame analysis as a tool to understand storytelling and sense making activity was clear. Of particular importance was the value of frame analysis to traverse the complexity in the definition of storytelling, through a structured understanding of the sequencing and presentation of the story.

Frame analysis allowed for stories to exist in their fragmented forms – this fragmentation and a distinction between narrative and story allows as Boje (2001, p. 3) suggested for “a retrospective explanation of storytelling’s speculative appreciations”. For poetic delivery
frame analysis focused on the “reality construction” or “meaning generation” (Benford & Snow, 2000, p. 625), and the process through which the frames (and plots) are set out. Finally, frame analysis offered an opportunity to categorize and connect pieces of information and by doing so reduce complexity into single coherent stories yet carrying ideological and political implications (Gamson, 1992).

Frame analysis provided a structure to support the uncovering of the components and presentation of accounts, enabling an understanding of where and how connections were made (or not). Through the presentation of connections and weaving of these accounts together, frame analysis offered an opportunity not only to re-present accounts, but present opportunities to develop theory. Where frame analysis was applied over the course of an event it provided an opportunity to observe how the accounts and connections changed over time – it presented an opportunity to consider not just movement organisations, but organising of movement. The opportunity, or promise of such an approach to frame analysis was to develop theory through the identification or new connections, explanations and account for story work, which hitherto remained hidden.

The challenge for the study was to consider if a better understanding of story or frame building impacts on the effects. In order to understand this I analysed the data set (set out in Chapter 2) and from the case study (set out in Chapter 4), and considered the following three questions posed at the outset: (1) how does storytelling unfold and escalate from one event into multiple stories? (2) How do the roles of the storyteller and audience become defined and re-defined over time? (3) Within this process of unfolding stories, what are there intended and unintended consequences of storytelling?

**IMPLICATIONS FOR THEORY**

In Chapter 2 I set out the theoretical framework of the study. This framework is graphically depicted in Figure 15 below, and emphasises the dynamic relationship between the audience and storyteller, and the frames and accounts of the events at MSFT. In the analysis I found that the story evolved from one account to several accounts. The emergence and evolution of these accounts was documented by examining the seven frames established and described using frame analysis. Similarly I observed movement and blurring between the storyteller and audience over the course of the timeline. Therefore, from this study the opportunity to develop theory from this complex set of relationships was significant.
Figure 15 Movement within the theoretical framework
In the next section I provide the specific outcomes for the three research questions and theory development.

**Research question 1**

In Chapter 6 I set out the analysis of the data that responded to the first research question: How does storytelling unfold and escalate from one event into multiple stories? I was able to show that from the initial event and story, the publication of the Healthcare Commission’s review of MSFT (2009), the stories evolved and this was presented through the frames developed over the timeline of the study. The story evolved from the report into care at the hospital, into stories that made claims to seek justice in response to the findings relating to the care provided at MSFT, running concurrently with a set of stories that sought to demonstrate the learning from the events, which developed separately into more specific improvements that could or had been made.

Through the data a group of stories developed and highlighted the role and significance of leadership in the NHS. Finally, distress, blame and defence were three further areas of storytelling evolution. Frame analysis was able to analyse, track and present the evolution of the stories (see Chapter 6 figures 11 and 12) over time.

Chapter 2 (Literature Review) considered the value and contribution of the storytelling literature, and identified an opportunity to question the lines of debate between the two paradigmatically different storytelling approaches presented through managerialist and critical management studies. In Figure 16 below, I highlight that the traditional approaches to storytelling literature foreground the story as a function of the research. This leads to an analysis of the effectiveness of the story. Accepting that managerialist and critical management studies literature have different epistemological and ontological relationships with the text, organisation and individuals, the managerialist approach will analyse the transformative value of the story and seek to identify how the effectiveness of the story can be improved. A critical management studies approach would identify and consider the relationship and effectiveness of the story as a structure of control, power and complexity; such an approach seeks to identify the complexity of the messages delivered through the story.
Figure 16 below also illustrates how this study’s theoretical framework removed the story from the direct/immediate focus of the research, and in doing so emphasises the relationship directly between the storyteller and the audience. In Chapter 2 figure 2 I presented the contribution from the traditional storytelling literatures relating to the role and speculative appreciations, and in Chapter 6 (Table 18) I was able to provide examples of the speculative appreciations from the three components of ante-narrative, poetic tales, and simplified messages. Finally, the movement the seven frames took was illustrated in figures 11 and 12 (Chapter 6). Identifying speculation within storytelling and the presentation of the findings through frame analysis provided me with the ability to explore the relationships between the storyteller and the audience. I found that (1) although by event six, four frames (Justice, Defence, Blame and Distress) were focusing on specific aspects of the frame to amplify, they also sought to connect to other frames, rather than maintaining a singular focus and definition. (2) Some frames (Justice, Distress and Learning) sought to develop new connections and audiences, whilst others (Leadership and Improvement frames) were appealing to existing audiences. (3) The relationship between the frames changed over the course of the events, with frames such as learning and leadership becoming aligned during the early part of the timeline, only to become markedly different by the final event. Frame analysis provided a structure to analyse how storytelling unfolded and escalated from one event into multiple stories.
Figure 16 Illustrating the novelty in the theoretical approach of the study

Analysis focuses on the complex changing relationship between the storyteller, audience and the interaction with the stories. The changes illustrated through frames.
Research question 2

In Chapter 7 I set out the analysis of the data that responded to the second research question: How do the roles of the storyteller and audience become defined and re-defined over time?

The review of traditional storytelling literatures found that the prioritisation of story created a distinction between the storyteller and the audience. This led to stultification between the two roles – whereby the audience became dependent on the storyteller to understand what it knows. The study used frame analysis as a tool to challenge and avoid this stultified relationship. Frame analysis, as a research method was considered in Chapter 2 and the application of frame analysis for this study was set out in Chapter 3. This study used the method to build and analyse frames, but did not see frames as *out there* to be found. To do so would impose a relationship between the storyteller and audience. Frame analysis was a tool to create frames by the researcher, as dynamic and ambiguous. The frame was temporarily fixed and bound by the research in order to understand how the data and idea elements are deployed. The frame did not produce the effect, but was used to account for, and was able to explain why the effect of the story happened. In short – the focus was to understand the story work of storytelling.

In Appendix 3 I identified the audiences and illustrated, using the data items, the relationship to the frames. This allowed me, in Chapter 6 to consider the relationship between the storyteller, the audience, and, through the application of frame analysis, understand the relationship between the frames and accounts of events. In Chapter 5 (preliminary analysis) I identified and presented the sponsor for each frame (see table 14). The role of the sponsor provided me with a critical test for the frame, and to consider what was holding the data items and fragments of text together.

An application of frame analysis and the theoretical framework, Chapter 7 (see table 19) highlighted the prioritisation of the speculative appreciations of story telling. The focus on storytelling and the roles of the storyteller and audience avoided the affect of stultification observed in applications of traditional storytelling literatures. Through this study a mutual dependency was identified and developed between the storyteller and actors, but the relationship was not informed by the dominance (or ignorance (Ranciere, 2007)) of the
other, rather the relationship between the storyteller and the audience was one whereby the roles became blurred to the point a distinction between them was difficult to discern. What binds the individual together was their speculative relationship to the telling of the story cognisant of the need to answer the “did it really” and “so what” questions (see Gabriel (2008)). I was able to identify how the roles of the storyteller and audience became defined and re-defined over time. I considered the “struggle for meaning” (Vliegenthart & Zoonan, 2011, p. 105) and a shared use of storytelling approaches over the timeline by Ms Bailey, Mr Sumara and Mr Francis as they became inextricable intertwined with a need to maintain a shared account – from their individual relationships – of MSFT.

Research question 3

In Chapter 8 I set out the analysis of the data that responded to the third research question: Within this process of unfolding stories, what are the intended and unintended consequences of storytelling? The intended consequences of storytelling were identified from the structuring of frames and an appreciation and definition of the roles of the storyteller and the audience. In Appendix 4 I identified examples of the intended consequences from the Learning frame. I found that the intended consequence of storytelling was to deliver change at MSFT in order to ensure the events identified by the Healthcare Commission report (2009) would not happen again. I also found that whilst a range of inquiries and improvement plans had been discussed, what was not clear was if the fundamental challenges at MSFT and the wider NHS system had been addressed. Although the public inquiry had been launched, there was no clear evidence of accountability or systemic changes to how care was organised, managed and delivered. With this in mind the analysis moved to consider the unintended consequences of storytelling and found that the approach to storytelling was paradoxically focused on the protection of the NHS structures, rather than delivering fundamental change.

Frame analysis allowed me to identify, through my presentation of the frames, how the storytellers built their stories over time. I was able to highlight how each of the key storytellers sought to critique the events from their perspective. Frame analysis also identified how the storytellers and their critique of events were similar and would overlap; this was highlighted in Chapter 7. I found the relationships between Mr Francis, Mr Sumara and Ms Bailey had become interconnected through Mr Francis’ engagement of both
storytellers in the public inquiry and were bound together by their relationship (albeit each very different) to the structure of the NHS. Frame analysis also uncovered the absence of voices, audience and engagement as a function of the story work. From this analysis of the frames I found the protection of the NHS structure was delivered through the story work of memorialisation and sacralisation as a method to protect, and/or avoid confrontation with the NHS as an institution.

Referring to the theoretical framework (see Chapter 2, figure 7), frame analysis sits at the point between the events, accounts of events and the frames, and as identified in the answer to research question 2 above (see Chapter 7) the roles of the storyteller and the audience were blurred; therefore a traditional pedagogical perspective of the relationship could not illustrate the complex relationships and the consequential effects of doing story work. Frame analysis provided an opportunity to consider that complex relationship and I found memorialisation and sacralisation, not a consequence of the story, but as an unintended consequence of storytelling. In Chapter 8 (Table 20) I illustrated the unintended consequence of memorialisation and sacralisation on story work through the frames. From these examples of memorialisation the data items used within the frames presented a lasting need for remembering what happened, and the significance of the consequences. For sacralisation it highlighted the fundamental failure at the hospital. However, memorialisation and sacralisation had become a shared function of storytelling between the storytellers and primarily through the inquiries into events at MSFT (Francis, 2010a) (Francis, 2010b) (Francis, 2013). The impact of this paradoxical prioritisation of a protection of the NHS structures over and above the realisation of fundamental change had the affect of stultification, whereby the need and ability to create the memorial was a vehicle through which to allow for an acknowledgement of the crisis publicly (to allow the audience to know what it has learnt), and through sacralisation to promote the special nature of the NHS. I was therefore able to identify both the intended and unintended consequences of storytelling, the consequence of which was to prevent a dialogue about fundamental change that could undermine the current/future provision of the NHS.

DIRECTIONS FOR FUTURE RESEARCH

I found, through the development of the theoretical frame work, and evidenced through frame analysis, stultification was identified as a function of storytelling, which served to
create a disconnect from the story through the act of storytelling. A managerialist account of events would focus on the transformative opportunities, and a critical management approach would emphasise the potential multiple meanings. I have found that whilst empirical and methodological paradigms place constraints, those involved in building and supporting stories move in response to the emerging story. This movement is achieved through the use of the poetic and the simplified message of transformation whilst engaging or speculating with the multiple interpretations. What this study finds within this case and in the context of the NHS, was the overwhelming function of storytelling is not one of transformation and sensemaking, but of stultification.

Within the context of this case, where failings can be a matter of life and death, storytelling stultification can have significant individual, local community and national consequences. Engaging in analysis of storytelling and the audience – be that within the organisation, between organisations, the community or nationally – the act of storytelling binds the parties together (intentionally and unintentionally). This is a surprising, if not a depressing finding. It suggests that ultimately even when a community responds and calls for change, or government/organisations seek to transform, they are bound in a process of speculative clarity: one that seeks to provide the perfect sound bite. It is a paradox of what I would describe as the “shallow depth” of the message – what I mean is perhaps illustrated through the analogy of a kaleidoscope. A kaleidoscope operates on the principle of multiple reflections, where several mirrors are placed at an angle to one another. The effect is to create multiple patterns through reflection symmetry. In formal terms, a mathematical object is symmetric with respect to a given operation, if, when applied to the object, this operation preserves some property of the object. The set of operations that preserve a given property of the object form a group. Two objects are symmetric to each other with respect to a given group of operations if one is obtained from the other by some of the operations (and vice versa). Within the context of stories and storytelling, the current literature seeks to provide a reflection of the accounts – be that a single (managerial) or multiple (critical management studies).

The practical implications from this study are to understand the acts that construct the symmetry between the audience and storyteller, and those stories that lead to the preservation of the property of the other.
PRACTICAL IMPLICATIONS

Within organisation theory’s approach to storytelling, this research clarified the lines of debate, to support the on going development of storytelling as a valuable tool to understand the intimate accounts within organisations. The practical implications of this include an improved understanding of the relationship between the storyteller and audience, which support further investigation into how and why transformation in complex organisational and community settings succeeds or fails.

For the researcher, this improved understanding and evidence of the effects of storytelling provides a grounded approach to analyse the storyteller and audience. The approach provides a challenge to the researcher to focus on the speculative; performance and strategies employed by storytellers and the audience. Such an approach holds both the storyteller and audience in suspension – in reflected symmetry. For the practitioner such an approach helps to consider the structure that may support or hinder change, more importantly it asks the practitioner to consider the risks, and to consider the intended and unintended consequences of their actions. Practically, this approach provides a grounded opportunity to traverse the tension between stories as fact and stories as experience.

The study also provided a practical structure and a methodological approach to capture and analyse storytelling over time. This study has identified a significant data set (over 1200 documents and 2900 data items), and analysed the data through frame analysis. The study demonstrated that frame analysis provided an effective tool to analyse significant volumes of data and presented it in coherent structures that supported a critical investigation of the data. The frame analysis structure provided the practitioner or the critical management scholar a framework to suspend temporarily fragments of text for scrutiny and consideration. It demonstrated the importance of a need to ask the questions (1) what holds the data items together (and why)? (2) is the account believable – and why is it so? (3) and so what, who cares that the story is believable? The structure and questions provide the practitioner and the academic the ability to capture momentarily and understand storytelling from their own particular perspective.

Memorialisation and sacralisation literature focuses on the approaches and effects of these
two subject areas. This study identified and developed the notion of memorialisation and sacralisation within the NHS as an unintended consequence of stories. The novelty of this study, and the practical opportunity, is to acknowledge the complex and emotive structures of (for example) the NHS and identify when memorialisation and sacralisation frame building strategies are being deployed. When the practitioner discovers memorialisation and sacralisation strategies within storytelling, they should be keen to understand the broader consequences and risks identified through this study (namely the risk of stultification). Furthermore this study highlights that the scepticism we reserve for the transformative systems of management should be reserved, if not prioritised further, when considering the significance and consequences of embarking on public inquiries.

We started with the complex and broad fields of critical management studies and managerialist literature, a live case with consequences that hitherto would have been neglected. The theory development focuses on storytelling, not to develop another definition, or paradigm, but rather the development of a practical methodological approach.

**LIMITATIONS OF THE STUDY**

There are four key questions relating to limitations that need to be highlighted prior to developing areas of future research. The first question relates to the specific case, the case of a hospital experiencing major failings in UK. I would suggest that such an event is unique. However, since the publication of the report into MSFT, a further fourteen hospitals have been investigated and found to have significant failings, five of which were placed in special measures (Keogh, 2013). At the conclusion and submission of this study, hospitals were still being identified as having significant failings (Care Quality Commission, 2014). Responses to, for example, the failings at Tameside Hospital (Keogh, 2013) do include similarities compared with MSFT, such as the creation of an action group, (Tameside Hospital Action Group (Carr, 2013)). It is therefore important to acknowledge that this study is limited to and by the local context and events at MSFT, the causes and sources of issues, and the nature of response (e.g. Cure the NHS) are specific to this event, however, this type of event within the NHS is not unique.

The second question relates to the opportunity the case presented in relation to access to data. With a public organisation, the availability of information is greater than privately
owned organisations; this is further supported by the opportunity to use Freedom of Information legislation to access information in publicly funded organisations. The nature and sensitivity of the crisis also drives greater information shared in the public domain. If the method used in the study is applied in a different sector the access to the broad information may be limited. Finally it is worth noting that the data gathering for this study was limited to written material, and did not include any first hand interviews or observations with staff, patients, relatives or the local community. The “intimate accounts” considered are limited to the representation and my interpretation of the material.

Taking account of the first two limitations, it does present a challenge for replicability of the application of frame analysis. I suggest that, as identified above, there are scenarios in other hospitals that may value from a similar structured review. But what this study cannot conclude is if such an approach would have validity in other public sector organisations (e.g. the analysis of Police (for example the contribution of the Police to the events at the centre of the Public Inquiry into the disaster at Hillsborough football stadium) or an Education crisis), or even private sector organisations (e.g. the failure and review by Lord Myners into the Cooperative Group of organisations (see (The Co-operative Group, 2014)).

The final question is the limitation of generalisability of the findings. Can the findings from the study of MSFT and the related crisis, be generalisable? The method and findings focus on the relationship between the storyteller and audience, and not the specific context per se. There are risks inherent in any generalisation approach to qualitative findings, I believe the findings are significant and offer areas for further research to test the potential for replicability and generalisability.

**QUESTIONS FOR FUTURE RESEARCH**

There are four questions I suggest deserve further research attention as a result of this study.

How can an understanding of stultification between storyteller and audiences inform individuals and groups to realise effective change? The finding from this study was that the understood complexity of delivering change itself within the organisation also extends to formal structures (such as public inquiries) that are initiated to drive change. Further
research into the notion of reflected symmetry and stultification would seek to consider in what instances does this occur and why? Further research across previous healthcare inquiries and investigations would provide a significant data source. With the continuing profile of failings in service provision, and the risks faced by patients, it would provide a valuable cause for further research.

What is the significance of the increasing number of and interest in public inquiries, and can the examples of stultification be found in other previous and current inquiries? Adam Burgess asks if “we are in the age of the inquiry?” (Burgess, 2009). He argues that Public Inquiries “involve giving up direct political control in response to major events” and those public inquiries “remains an instrument of last resort.” (Burgess, 2009, p. 13). However, the findings of this study do not afford such a notion of giving up control. Clothier also highlights “a tiresome cliché has been invented, namely a ‘full public inquiry’, as if there was some sort of half baked inquiry which might suffice on occasion...” (Prins, 2004). The presumption, and the protected status of the “full” public inquiry should arouse suspicion. At the time of writing, the full public inquiry into the events at Hillsborough football ground, where on 15th April 1989 ninety-six people died, commenced. This followed police investigations (1989 – 1990), Lord Taylor’s report (1990), criminal investigations (1990), civil liability cases (1989 – 1990), coroners inquest (1990 – 1991), complaints process (1991 – 1992), Lord Justice Stuart-Smith review (1997), and an independent panel (2012); Therefore the expectation of the process, outcomes and consequences of this full public inquiry will be high, and of interest to this area of research. With current investigations into Jimmy Saville and Cyril Smith, further and future calls for public inquiries will be made. The opportunity to understand the events and actions leading up to a public inquiry (and the instances where no public inquiry is initiated) are significant, with a broad range of potential areas for research. Can (or will) a public inquiry ever prevent patients from drinking water from flower vases?

To what extent can sacralisation and memorialisation be found together, or individually as a product of community engagement? I would suggest there is value in further research in memorialisation and sacralisation. The examples such as the Hillsborough disaster provide several instances of the significance of memorials post crisis. But of specific interest and
further research is how either, or both of these phenomena impact on the role and relationship between the storyteller, audience and event. The findings from this research suggest that memorialisation and sacralisation provided a mechanism through which conflicting parties could agree, and upon which, and around which, action took place. The consequence was that improvement and transformation where it mattered – stopping patients drinking water from flower vases – was missed. Understanding why, what, where, who, and how memorialisation and sacralisation occurs will assist researchers to conceptualise and consider forms of organisation across organisational and community boundaries. It would also allow practitioners to understand and develop an appreciation of their relationships with the organisation they work within, and the consequences of failure to change (where change is needed) on the organisation, staff and local community.

Finally, with financial pressure on UK publicly funded organisations likely to continue, a narrative of innovation and transformation prevails, and the NHS is no exception. The findings from this study highlight the intransigence of such complex organisations to respond and transform. I would ask if the call for radical innovation is simply another narrative turn that generates stories and accounts of transformation but remains detached, dislocated from the communities and users of services? I would want to pursue research, based on the findings of this study in to what forms of direct action are successful in other fields, for example the arts, crisis management, terrorism? As a practitioner in the NHS I will use frame analysis and an understanding of storytelling as a tool to engage complex groups to support and develop activism, and challenge where possible the acts of reflected symmetry and stultification. For me it is the promotion of the impertinent dialectic:

“There can therefore be moments of community – not those festive moments that are sometimes described, but dialogic moments, moments when the rule laid down by Gergory of Nazianzus is contravened, when an impertinent dialectic is created by those who have no rights in the matter, but who nevertheless assert such rights in the junction between the violence of a new beginning and the invocation of something already said, something already inscribed.” (Ranciere, 2007, p. 91)
CONCLUSION

Is it possible that some degree of embarrassment about the egregious failings of this health service that we love too much explains why the full, almost indescribable horror of that scandal seems not to have fully sunk in?

(Wheatcroft, 2013)

This study acknowledged the paradigmatic issues in the construction of stories and storytelling. It used frame analysis, not to redefine stories, but identify the consequences of storytelling across organisational and community boundaries in the UK NHS. As highlighted above this approach answered the research question posed, and contributed to the literatures identified, through the development of a methodological approach to capture and analyse storytelling over time. Within an organisational theory’s approach to storytelling, the study demonstrated the significance of speculation within storytelling which contributes to an on-going development of storytelling as a valuable tool to understand the intimate accounts within organisations. Finally the study identified and developed the notion of memorialisation and sacralisation within the NHS as an unintended consequence of stories – even when there is a shared and urgent, or life threatening, need to change.

What is left to do is significant and I suggest this study provided a structured challenge to the confidences we have in NHS and systems we seek to put in place to assure ourselves as practitioners, users and academics. Wheatcroft’s observation of the egregious failings, those flagrant failings that we have held in perfect symmetry, need a new level of activism. Within the NHS, non-commodified labour in a neo-liberal ideology is currently just one emerging frame, as organisations seek to address the financial deficits by using voluntary organisations to deliver care. More frame analysis research is needed if we are to support academics and practitioners to find their way through the complexities of delivering services in publicly funded organisations.
### APPENDIX 1. THE FIRST SIGNATURE MATRIX FOR EACH FRAME

#### Table a1.1. The signature matrix for the Justice frame

<table>
<thead>
<tr>
<th>Category</th>
<th>Justice Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metaphors</td>
<td>It was like a Third World country hospital. It was an absolute disgrace. This is an outrage that this has been happening at Stafford Hospital (Basford, 2009)</td>
</tr>
<tr>
<td>Exemplars</td>
<td>Investigating individual claims of negligent, abuse and/or degrading treatment that has occurred and that are still continuing in the Hospital at the present time. (Leigh Day &amp; Co Solicitors, 2009a)</td>
</tr>
<tr>
<td>Catch phrase</td>
<td>Drinking water from flower vases (Boseley, 2010b)</td>
</tr>
<tr>
<td>Depictions</td>
<td>What we saw will haunt us forever. (Symons, 2009)</td>
</tr>
<tr>
<td>Visual Images</td>
<td>(Symons, 2009) (Image - Ms Bailey and her mother)</td>
</tr>
<tr>
<td>Roots</td>
<td>Bailey says her attempts to improve hospital care were stymied by local bureaucracy and obfuscation. (Gould, 2009)</td>
</tr>
<tr>
<td>Consequences</td>
<td>Leigh Day &amp; Co Solicitors have been instructed by Julie Bailey and Christine Dalziel of Cure the NHS regarding the Healthcare Commission’s investigation into Mid Staffordshire NHS Foundation Trust to call for, and to challenge any refusal to hold a public inquiry, and to consider issues about the past and on-going patient care within the Trust. (Leigh Day and Co, 2009a)</td>
</tr>
<tr>
<td>Appeals to principle</td>
<td>How can any patient have trust in the managers and systems that have allowed this disaster to run and run? It is not enough for the chairman and chief executive to take the fall for this. (Guardian, 2009b)</td>
</tr>
</tbody>
</table>
### Table a1.2. The signature matrix for the Learning frame

<table>
<thead>
<tr>
<th>Category</th>
<th>Learning Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metaphors</td>
<td>There has been a &quot;vacuum&quot; in oversight and patient involvement in the NHS (Gould, 2009)</td>
</tr>
<tr>
<td>Exemplars</td>
<td>Mr Morton said lessons had since been learned and that staffing levels had been increased. (BBC News, 2009c)</td>
</tr>
<tr>
<td>Catch phrase</td>
<td>Building on the considerable improvements (BBC News, 2009b)</td>
</tr>
<tr>
<td>Depictions</td>
<td>Mr Johnson has apologised for the fiasco and described the failings at Stafford Hospital as “inexcusable” (Express and Star, 2009a)</td>
</tr>
<tr>
<td>Visual Images</td>
<td>![Image](Symons, 2009)</td>
</tr>
</tbody>
</table>
| Roots          | Mrs Bailey said that an inquiry needed to address a number of questions – including exactly how many deaths have there been and why did Health Secretary Alan Johnson and his predecessors fail to prevent these deaths? (Express and Star, 2009b)  

we all know that the Healthcare Commission’s report leaves many questions unanswered. It looked at what happened but not the reasons why. For all of us and for all NHS patients now and in the future we need to learn all of the lessons from Stafford Hospital.” (Express and Star, 2009b)  

Consequences | Eric Morton, has now pledged that meetings would be arranged for all concerned patients and relatives about the "quality of care they have received". (BBC News, 2009c)  

Health Secretary Alan Johnson pledged that the roles of all senior managers would be investigated but would not condone “knee-jerk” sackings. (Express and Star, 2009c) |
| Appeals to principle | Mrs Bailey said: “We demand the full statutory public inquiry for the sake of the loved ones we lost and for all patients in the NHS who have been let down by poor care. We demand to know what really happened and why. It must never happen again.” (Express and Star, 2009b) |
Table a1.3. The signature matrix for the Improvement frame

<table>
<thead>
<tr>
<th>Category</th>
<th>Improvement/Rescue Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metaphors</td>
<td>The action plan would be “a line in the sand” to allow the hospital to move forward. (Express and Star, 2009r)</td>
</tr>
<tr>
<td>Exemplars</td>
<td>None</td>
</tr>
<tr>
<td>Catch phrase</td>
<td>Leading hospital of the future (Express and Star, 2009r)</td>
</tr>
<tr>
<td>Depictions</td>
<td>None</td>
</tr>
<tr>
<td>Visual Images</td>
<td>None illustrative of the frame</td>
</tr>
<tr>
<td>Roots</td>
<td>Its about time that NHS is left along now so they can get on with job off look after people my dad as been in stafford hospital and cannock he as had very good care in both all staffs worked well. its about time ms julie bailey now can see. That NO INQUIRY WILL GO AHEAD and go back to her café (Express and Star, 2009j)</td>
</tr>
<tr>
<td>Consequences</td>
<td>None</td>
</tr>
<tr>
<td>Appeals to principle</td>
<td>None</td>
</tr>
</tbody>
</table>
### Table a1.4. The signature matrix for the Leadership frame

<table>
<thead>
<tr>
<th>Category</th>
<th>Leadership Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metaphors</td>
<td>None identified</td>
</tr>
<tr>
<td>Exemplars</td>
<td>Monitor has worked closely with the Trust and other partners to identify the right candidate for this position. Antony Sumara is currently Chief Executive of NHS Interim Management and Support, and Director of Turnaround, NHS London. He has over 25 years experience of senior level NHS management in acute hospitals, primary care trusts and strategic health authorities, and was previously Chief Executive of University Hospitals of North Staffordshire NHS Trust. (Monitor, 2009b)</td>
</tr>
<tr>
<td></td>
<td>“Antony Sumara has a proven track record of delivering sustainable improvements within NHS organisations, while Sir Stephen has the frontline clinical experience to ensure that quality of care remains at the top of the Trust’s agenda. Together they make a formidable team. (Monitor, 2009b)</td>
</tr>
<tr>
<td>Catch phrase</td>
<td>rebuild public confidence (Monitor, 2009b)</td>
</tr>
<tr>
<td>Depictions</td>
<td>that person must also continue to rebuild trust in the hospital, and critically to enhance patient, staff and community confidence. (Monitor, 2009a)</td>
</tr>
<tr>
<td>Visual Images</td>
<td>None identified</td>
</tr>
<tr>
<td>Roots</td>
<td>absent the recruitment to date by the Trust of a Chief Executive, in light of the imminent departure of Mr Morton, and the practicality of the Trust completing a further and comprehensive appointment process for that role within an acceptable timescale, there would be a serious vacuum in the most senior executive position at the hospital. (Monitor, 2009a)</td>
</tr>
<tr>
<td></td>
<td>Without a Chief Executive in post to provide the necessary strategic and operational leadership and decision-making, there is a significant risk to the Trust’s ability to deliver its plans to achieve a full recovery of the Trust. As such, the Trust would also not be compliant with its general duty under condition 2 of the authorisation to exercise its functions effectively and efficiently. (Monitor, 2009a)</td>
</tr>
<tr>
<td>Consequences</td>
<td>Accordingly, the Trust is in breach of condition 5(1) of its authorisation. This requires the Trust to have appropriate arrangements to provide comprehensive governance (in accordance with the relevant legislation) to maintain the organisational capacity necessary to provide mandatory healthcare goods and services for its patients (Monitor, 2009a)</td>
</tr>
</tbody>
</table>
Appeals to principle to ensure the Trust has full time leadership in place to take it through the next phase of its recovery (Monitor, 2009b)

Antony Sumara, had "vision" and "strength". (BBC News, 2009f)

"The most important thing is to get the patient care bits right and people need to be clear about what that looks like when it is good," he said. (BBC News, 2009i)

"There is a feeling that it will be better, that it's getting better and actually it's not going to be in the position it was a few months ago. "I am very confident this will be a very, very good hospital." (BBC News, 2009i)
### Table a1.5. The signature matrix for the Distress frame

<table>
<thead>
<tr>
<th>Category</th>
<th>Distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metaphors</td>
<td>None identified</td>
</tr>
<tr>
<td>Exemplars</td>
<td>Mrs N told the Inquiry that the morphine had negative effects on her mother-in-law and said the diagnosis was like a black cloud over the family. (Francis, 2010b, p. 298) patients left &quot;sobbing and humiliated&quot; Julie Bailey, whose mother died at the hospital and the founder of the victims' campaign group Cure the NHS, said the handling of the scandal had been &quot;disgraceful and unacceptable&quot; - and reiterated her call for a public inquiry. (Triggle, Hospital left patients 'sobbing and humiliated', 2010a) &quot;denials of dignity&quot; and &quot;unnecessary suffering&quot; (Leigh Day, 2010b)</td>
</tr>
<tr>
<td>Catch phrase</td>
<td>nothing to do with patient care (Francis, 2010a, p. 182) patients drank water from vases (Boseley, 2010b)</td>
</tr>
<tr>
<td>Depictions</td>
<td>we could not possibly keep the same standards as Asda. Well for goodness sake, it is a hospital. (Francis, 2010a, p. 107) Her daughter believes that her mother “was not treated properly because she was elderly” and “the hospital were selecting people to concentrate their resources on”. (Francis, 2010b, p. 276) her daughter found her sitting alone in the lavatory covered in faeces with a soiled sanitary pad beside her. Her daughter rang the buzzer but no one came. Her daughter slowly managed to clean her mother herself, but only 45 minutes later did a nurse respond to the buzzer. She also suffered a number of cuts and grazes, which could not be explained by nursing staff. (Francis, 2010b, p. 254) Frances and her team have taken shocking witness statements from families whose relatives died in squalid and distressing conditions at Staffordshire Hospital. (Speaker – Leigh Day) (Leigh Day, 2010b)</td>
</tr>
<tr>
<td>Visual Images</td>
<td>None identified</td>
</tr>
<tr>
<td>Roots</td>
<td>None identified</td>
</tr>
<tr>
<td>Consequences</td>
<td>Those present at the oral hearings were &quot;deeply affected by what they heard (Francis, 2010a, p. 10)</td>
</tr>
<tr>
<td>Appeals to principle</td>
<td>As an NHS professional, I would want to apologise for that. (Francis, 2010a, p. 183)</td>
</tr>
</tbody>
</table>
Table a1.6. The signature matrix for the Blame frame

<table>
<thead>
<tr>
<th>Category</th>
<th>Blame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metaphors</td>
<td>And I think that is the first point that it hit me, like a baseball bat, at that point I thought, &quot;They really don't care&quot;. (Midstaffs Public Inquiry, 2010j) it is like you're shutting the stable door after the horse has bolted (Midstaffs Public Inquiry, 2010l)</td>
</tr>
<tr>
<td>Exemplars</td>
<td>Only a year ago before authorising Foundation Trust status Monitor would have scrutinised the Mid Staffordshire governance arrangements, including the experience and capability of the executive and non-executive teams. If that process was robust, why does governance need to be improved now? Does the Mid Staffordshire board itself not have the capability of improving the governance arrangements? If not, then it should not be in place. (Midstaffs Public Inquiry, 2010q) it was very difficult to speak to the back of his head whilst he ran off. (Midstaffs Public Inquiry, 2010j) Whereas when we were just talking to Mr Yeates at the hospital, you know, you weren't so sure of that. You thought, they're just fobbing you off. You know, I think a lot of people felt that. (Midstaffs Public Inquiry, 2010m)</td>
</tr>
<tr>
<td>Catch phrase</td>
<td>just a PR operation (Midstaffs Public Inquiry, 2010q) &quot;I appreciate that Martin Yeates is a scapegoat but he is answerable. He cut down the number of nurses in order to get foundation trust status. That is where the danger came in.&quot; (Midstaffs Public Inquiry, 2010c) trust had pulled the wool over his eyes (Midstaffs Public Inquiry, 2010j)</td>
</tr>
</tbody>
</table>
| Depictions   | What would you say about the tone of Dr Moyes' replies to you? A. Well, I think by -- by this last one, I think they're cooling a little because they started off very positively, and I think he's getting a little bit frustrated that I'm keeping on at him. (Midstaffs Public Inquiry, 2010q) Mr Sumara discussed with him whether a particular ward could be turned into a specialist dementia ward: "A few months later [he says] I asked him about this again. He told me it was up and running ..." And invited him to go and visit but he was dissuaded from the visit by Julie Bailey, who felt that it might damage the campaign that Cure the NHS was still fighting and he cancelled the meeting. (Midstaffs Public Inquiry, 2010k) I was told that Martin Yeates was a man of the people. He'd started working class, he'd started at the bottom, he'd worked his way up. When I met that person in Lichfield he says "Martin Yeates will bend over backwards. He will meet with you and your family and he will be absolutely disgusted with what's gone on". We had none of that. Martin Yeates hid in a corner (Midstaffs Public Inquiry, 2010l) there's an appalling culture of bullying there that had persisted for some time. (Midstaffs Public Inquiry, 2010q) "Yet again, we find patients being let down appallingly, lack of
monitoring, lack of help with feeding, lack of dignity. How many times do the public need to keep hearing about this, before the government is embarrassed enough to do something about it? (Midstaffs Public Inquiry, 2010g)

### Visual Images
None identified

### Roots
I didn't see David Kidney at this point independent of the trust. I saw him as part of the problem, because he wasn't even acknowledging that there was a problem (Midstaffs Public Inquiry, 2010i)

Dr Helen Moss who responded, when they were challenged about mortality ratios, I think I'm correct in quoting her as saying "There are no problems with mortality ratios". That was almost certainly not the case (Midstaffs Public Inquiry, 2010q)

they were making press statements that were simply to play down everything that had happened, and to say "Well, look, it's all behind us now. It's in the past. Things are fine". (Midstaffs Public Inquiry, 2010q)

an admission that the trust failed to keep patients in its care safe and failed to treat them with dignity. They describe a series of failures, both from within the trust and by the regulator (Midstaffs Public Inquiry, 2010d)

Julie Bailey had written to the Healthcare Commission with 66 points of care that she felt were deficient. And what I think we’d realised by this stage, to our real horror, I suppose, that the NHS does not seem to have -- I think I am right in saying this -- does not seem to have a standard set of quality measures for bedside care which would have met those 66 points. (Midstaffs Public Inquiry, 2010q)

attention should have been given and support given to Stafford Hospital, because, as we now know -- and this is one of the critical issues, really, what was known about the standard of care at this time in the SHA, and that they should have been supported to get the care right, rather than push for foundation trust status (Midstaffs Public Inquiry, 2010q)

It seemed to me that though the frontline staff at PALS were very helpful, nothing happened when they tried to transfer the complaint up through the chain. PALS did not seem to have the power to do anything about it. (Midstaffs Public Inquiry, 2010n)

### Consequences
Cure are critical of the fact that only nine of those questions touched upon clinical matters. Monitor is further criticised for failing to take action as soon as it received the HCC's damning draft report at the end of 2008. (Midstaffs Public Inquiry, 2010c)

### Appeals to principle
Are you a man or a mouse?" I'm sorry, I shouldn't say that, but that's how I felt, because he would not acknowledge us at the time, and he wouldn't speak to us as individuals either -- sorry, as a group, which is what we wanted. (Midstaffs Public Inquiry, 2010j)
<table>
<thead>
<tr>
<th>Category</th>
<th>Defence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metaphors</td>
<td>he was sorry they'd pulled the wool over his eyes. (Midstaffs Public Inquiry, 2010j)</td>
</tr>
<tr>
<td>Exemplars</td>
<td>They did not encourage correspondence with patient groups, because they saw that far more as being the role of the Healthcare Commission. (Midstaffs Public Inquiry, 2010d) Do you really mean that nothing had changed since Mr Sumara, Manjit Obhrai and the rest had come into management positions? Yeah, unfortunately -- unfortunately, I think that may be the case. I really need to pay tribute here to the effort they put into that change, but I think the culture has proved very, very intractable. (Midstaffs Public Inquiry, 2010r)</td>
</tr>
<tr>
<td>Catch phrase</td>
<td>None identified</td>
</tr>
<tr>
<td>Depictions</td>
<td>&quot;The story of Stafford Hospital is more complicated than one bloke sitting in an office asleep on the job [he said]. I wish he could [give evidence]. (Midstaffs Public Inquiry, 2010e) Mr Yeates confirmed that this was totally unacceptable and patients should have their dignity respected whilst they were in the care of Stafford and Cannock Chase hospitals. Mr Yeates apologised for the anxiety that this caused, and that the staffing issues had been an issue for the trust. &quot;Mr Yeates confirmed that it was agreed that further investment would be provided and a total of £1.15 million was allocated to the recruitment of nurses. &quot;Finally, Mr Yeates' letter considered the incompleteness of the medical records provided. He restated in his letter the offer for the family to meet with the clinical team to discuss concerns regarding the missing records. (Midstaffs Public Inquiry, 2010s)</td>
</tr>
<tr>
<td>Visual Images</td>
<td>None identified</td>
</tr>
<tr>
<td>Roots</td>
<td>describes Monitor's relationship with the government as &quot;not particularly easy&quot;, and he says that many in the Department of Health were &quot;hostile&quot; to the concept of foundation trusts. (Midstaffs Public Inquiry, 2010d)</td>
</tr>
<tr>
<td>Consequences</td>
<td>Monitor should not second-guess or duplicate the work of the HCC, by employing clinical experts when the HCC already had them. (Midstaffs Public Inquiry, 2010d)</td>
</tr>
<tr>
<td>Appeals to principle</td>
<td>None identified</td>
</tr>
</tbody>
</table>
## APPENDIX 2 – THE FIRST ELABORATION MATRIX FOR EACH FRAME

### Table a2.1. The elaborative functions of the Justice frame

<table>
<thead>
<tr>
<th>Category</th>
<th>Justice Frame</th>
</tr>
</thead>
</table>
| **Diagnostic function**<br>“What is the problem?” | Katherine Murphy, of the Patients’ Association, said: “Money and greed have taken priority over patients’ lives.” (Symons, 2009)  
Clinical staff, struggling to cope, told management that action needed to be taken but they were ignored. It descended to the level where the majority didn't want to be treated by their own trust. Even the royal colleges were brushed off. Complaints being fobbed off. (Gould, 2009)  
Bailey says her attempts to improve hospital care were stymied by local bureaucracy and obfuscation. (Gould, 2009) |
| **Prognostic function**<br>“Who is responsible?<br>What outcomes can be predicted with or without intervention | What had become clear was that official channels for their concerns were either ineffectual or hopelessly complex. (Gould, 2009) |
| **Motivational function**<br>“What action should be taken?” | Gradually, it became a memorial and a rallying point, and Cure the NHS was formed. (Gould, 2009)  
It is not enough for the chairman and chief executive to take the fall for this. (Guardian, 2009a) |
<table>
<thead>
<tr>
<th>Category</th>
<th>Learning Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic function</td>
<td>Mrs Bailey said that an inquiry needed to address a number of questions – including exactly how many deaths have there been and why did Health Secretary Alan Johnson and his predecessors fail to prevent these deaths? (Express and Star, 2009b)</td>
</tr>
<tr>
<td>“What is the problem?”</td>
<td></td>
</tr>
<tr>
<td>Prognostic function</td>
<td>“We demand a full statutory inquiry in order to compel witnesses to appear and to answer questions on oath. Because the Healthcare Commission has done so much preliminary investigation the timescale can be shorter than normally and it will, anyway, be an excellent investment in the future healthcare of everyone. “The number of deaths involved is very large and they continue.” (Express and Star, 2009b)</td>
</tr>
<tr>
<td>“Who is responsible? What outcomes can be predicted with or without intervention”</td>
<td></td>
</tr>
<tr>
<td>Motivational function</td>
<td>Eric Morton, has now pledged that meetings would be arranged for all concerned patients and relatives about the &quot;quality of care they have received&quot;. (BBC News, 2009c)</td>
</tr>
<tr>
<td>“What action should be taken?”</td>
<td>The Tory leader promised a Conservative government would make huge changes to the NHS during his visit to Stafford late yesterday by slashing targets and focusing on patient feedback. He spent more than an hour listening to members of Cure the NHS in campaign group founder Julie Bailey’s cafe on Newport Road, before saying an investigation “absolutely independent” from the hospital, the Government and “the whole system” was needed. (Express and Star, 2009e)</td>
</tr>
<tr>
<td></td>
<td>The trust now has the strong leadership it needs to respond to the report's recommendations, but we'll be monitoring what happens next very closely - and we won't hesitate to step in again if the trust doesn't continue to build on the progress already made. (Guardian, 2009a)</td>
</tr>
<tr>
<td>Category</td>
<td>Improvement</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Diagnostic function</td>
<td>Our top priorities must be the safety and experience of every single patient who comes through our doors, and the effectiveness of the care we offer” (BBC News, 2009e)</td>
</tr>
<tr>
<td>“What is the problem?”</td>
<td></td>
</tr>
<tr>
<td>Prognostic function</td>
<td>“It’s clear that for a period of time the hospital lost its way. “They didn’t put patient safety and the care they receive at the top of the agenda. “We clearly have some issues that we need to address and what we are doing here is to be as open as we possibly can about the actions we are trying to take.” Mr Morton said the cost of the improvements could run into “seven figures” and he expected it could be done without any Government help. (Express and Star, 2009r)</td>
</tr>
<tr>
<td>“Who is responsible? What outcomes can be predicted with or without intervention”</td>
<td></td>
</tr>
<tr>
<td>Motivational function</td>
<td>Mr Morton said the majority of the actions would be completed within the next eight months and he said he hoped the action plan would be “a line in the sand” to allow the hospital to move forward. (Express and Star, 2009r)</td>
</tr>
<tr>
<td>“What action should be taken?”</td>
<td></td>
</tr>
</tbody>
</table>
Table a2.4. The elaborative functions of the Leadership frame

<table>
<thead>
<tr>
<th>Category</th>
<th>Leadership Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic function “What is the problem?”</td>
<td>the Trust is in significant breach of two conditions of its authorisation and that discretionary intervention was appropriate. (Monitor, 2009a)</td>
</tr>
<tr>
<td>Prognostic function “Who is responsible? What outcomes can be predicted with or without intervention</td>
<td>My directors noted that, absent the recruitment to date by the Trust of a Chief Executive, in light of the imminent departure of Mr Morton, and the practicality of the Trust completing a further and comprehensive appointment process for that role within an acceptable timescale, there would be a serious vacuum in the most senior executive position at the hospital. (Monitor, 2009a) Antony Sumara has been outlining his priorities since taking on the role on 1 August at Mid Staffordshire NHS Trust which looks after Stafford Hospital. (BBC News, 2009i) the new chief executive, Antony Sumara, had &quot;vision&quot; and &quot;strength&quot;. (BBC News, 2009f)</td>
</tr>
<tr>
<td>Motivational function “What action should be taken?”</td>
<td>“Antony Sumara has a proven track record of delivering sustainable improvements within NHS organisations, while Sir Stephen has the frontline clinical experience to ensure that quality of care remains at the top of the Trust’s agenda. Together they make a formidable team, able to take on the challenges ahead and to continue to rebuild public confidence in the Trust. (Monitor, 2009b) &quot;The most important thing is to get the patient care bits right and people need to be clear about what that looks like when it is good,&quot; he said. &quot;There is a feeling that it will be better, that it’s getting better and actually it’s not going to be in the position it was a few months ago. &quot;I am very confident this will be a very, very good hospital.&quot; (BBC News, 2009i)</td>
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Table a2.5. The elaborative functions of the Distress frame

<table>
<thead>
<tr>
<th>Category</th>
<th>Distress</th>
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<tbody>
<tr>
<td>Diagnostic function</td>
<td>“What is the problem?”</td>
</tr>
<tr>
<td>“This is all money that could have been spent on staff at a time patients were dying because of a lack of beds and other basic needs. “They have kept on putting out spin and the country has had to listen to it, but meanwhile more patients have suffered.” (Express and Star, 2010c)</td>
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<td>Her daughter believes that her mother “was not treated properly because she was elderly” and “the hospital were selecting people to concentrate their resources on”. (Francis, 2010b, p. 276)</td>
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<tr>
<td>Frances and her team have taken shocking witness statements from families whose relatives died in squalid and distressing conditions at Staffordshire Hospital. (Leigh Day, 2010b)</td>
<td></td>
</tr>
<tr>
<td>Prognostic function</td>
<td>“Who is responsible? What outcomes can be predicted with or without intervention</td>
</tr>
<tr>
<td>Mrs N told the Inquiry that the morphine had negative effects on her mother-in-law and said the diagnosis was like a black cloud over the family. (Francis, 2010b, p. 298)</td>
<td></td>
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<tr>
<td>That was the most harrowing experience I think I have ever been through and all of us were there. MR BELL: Yes. MR HINDLEY: I will be quite open and honest about it, I had no idea about the magnitude of the problem before that meeting, but by hell did I when I left that meeting. It was harrowing. But to project that and say that the whole of the organisation was failing, I think is a gross overstatement. (Francis, 2010a, p. 183)</td>
<td></td>
</tr>
<tr>
<td>Motivational function</td>
<td>“What action should be taken?”</td>
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<tr>
<td>None identified</td>
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### Table a2.6. The elaborative functions of the Blame frame

<table>
<thead>
<tr>
<th>Category</th>
<th>Blame</th>
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<tbody>
<tr>
<td><strong>Diagnostic function</strong></td>
<td><strong>What is the problem?</strong></td>
</tr>
<tr>
<td></td>
<td>do you think he understood the depth of the problems as you saw them?</td>
</tr>
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<td></td>
<td>Answer: I suspect he probably didn’t. I don’t think he -- as I understand it -- I mean, this is where we come for matters for the inquiry to look very precisely at the brief, the role of Monitor and Dr Moyes leading that organisation, and what the Secretary of State required of them and him. And I rather think that they had -- this is my impression -- far too little clinical expertise of their own to be able to make the judgments, and particularly to make the plans. And I assume that he would have had to rely rather heavily on other parties, presumably David Nicholson for that. So I feel he perhaps felt he was a little bit exposed by my continuing to go back to him and kind of nag him about front-line nursing care. an admission that the trust failed to keep patients in its care safe and failed to treat them with dignity. They describe a series of failures, both from within the trust and by the regulator (Midstaffs Public Inquiry, 2010d) that you perceived the trust’s position was as to the existence of serious problems at the hospital at that time? A. They were in denial, completely and utterly in denial, and also the -- the -- where it says &quot;nurses were brilliant&quot; that’s the Royal College of Nursing regional officer is saying pretty much the same thing that the nursing staff is adequate and that skill mix is adequate, and there's also a local doctor who is chair of -- secretary South-west Stafford GP Group. He has full confidence in the trust and would recommend Stafford and Cannock Chase hospitals -- is that &quot;to residents&quot;? (Midstaffs Public Inquiry, 2010i) the first thing within the NHS is to get rid of a lot of the managers, because I think they have imposed managerial skills on the NHS instead of the culture of caring (Midstaffs Public Inquiry, 2010i)</td>
</tr>
<tr>
<td><strong>Prognostic function</strong></td>
<td><strong>Who is responsible? What outcomes can be predicted with or without intervention</strong></td>
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<td></td>
<td>Monitor’s understanding was that the Department of Health, which provided Monitor’s budget, encouraged a clear distinction between Monitor’s scrutiny of the financial data and viability of proposed FTs and the HCC’s role of quality scrutiny.&quot; (Midstaffs Public Inquiry, 2010d) I met Eric Morton at one of the overview and scrutiny meetings and he was just so dismissive of what was still going on at the hospital. He didn’t seem to have a grasp really of what was going on at the hospital at all. (Midstaffs Public Inquiry, 2010i) it was the immediate indication that they were not really addressing what we knew as a group from contacts from group -- bereaved relatives, grieving relatives, was still the case on the</td>
</tr>
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</table>
wards. We knew enough to tell that it was PR and spin. People were not being taken off line to protect patients, and again, I would perhaps contrast this to the way Antony Sumara acted when he arrived at University Hospital of North Staffordshire, the changes began immediately. (Midstaffs Public Inquiry, 2010q) some of the staff representatives pointed the finger at Cure the NHS and portrayed themselves as victims It seemed enormously loyal, as I say here, to Yeates and Brisby and didn't seem to realise that they'd failed, and the hospital had been producing the most appalling care. (Midstaffs Public Inquiry, 2010q)

<table>
<thead>
<tr>
<th>Motivational function</th>
<th>None identified</th>
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<tbody>
<tr>
<td>“What action should be taken?”</td>
<td>None identified</td>
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</table>
Table a2.7. The elaborative functions of the Defence frame

<table>
<thead>
<tr>
<th>Category</th>
<th>Defence</th>
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<tr>
<td>Diagnostic function</td>
<td>Dr Moyes told the inquiry that, with the benefit of hindsight, they shouldn't have granted the Mid Staffordshire Trust Foundation Status, and that the Department of Health shouldn't have put it forward for consideration. (BBC News, 2010h) Martin Yeates, set up a series of meetings with GP practices to reassure them, following complaints of poor care at the hospital. He provided the GP surgeries with action plans and as one GP says: &quot;Unfortunately we were reassured by the meeting.&quot; (Midstaffs Public Inquiry, 2010d) Mr Yeates stressed the need to ensure that the trust remains cost-effective and competent and is on a sound financial base in order to continue to deliver services to patients. In order to reduce the financial gap, and having already considered options surrounding non-pay budgets, a reduction in the workforce was considered to be the only option in the short-term.&quot; &quot;It was proposed that around 150 posts be removed from the workforce as soon as possible, with the focus being within managerial and support.&quot; We better go over the page, please: &quot;Services, in order to minimise the impact on front line clinical services a number of posts would be identified from current vacancies.&quot; (Midstaffs Public Inquiry, 2010t)</td>
</tr>
<tr>
<td>Prognostic function</td>
<td>Monitor’s understanding was that the Department of Health, which provided Monitor’s budget, encouraged a clear distinction between Monitor’s scrutiny of the financial data and viability of proposed FTs and the HCC’s role of quality scrutiny.&quot; (Midstaffs Public Inquiry, 2010d)</td>
</tr>
<tr>
<td>Motivational function</td>
<td>None identified</td>
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**APPENDIX 3 – INTENDED AUDIENCE FOR EACH FRAMES**

Table a3.1 Justice frame and the intended audiences

<table>
<thead>
<tr>
<th>Intended audience</th>
<th>Examples</th>
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<tbody>
<tr>
<td>Local community</td>
<td>What we saw will haunt us forever. (Symons, 2009) Eric Morton, has now pledged that meetings would be arranged for all concerned patients and relatives about the &quot;quality of care they have received&quot;. (BBC News, 2009c) “increasing public outcry” (Francis, 2010a, p. 30) [Mr Francis] would like to pay particular tribute to Julie Bailey, without whose tenacity many of the issues which have been exposed would not have seen the light of day. I would like to offer her and her family my particular sympathy today at the opening of this inquiry, which by sad coincidence is the third anniversary of the death of her mother, whose case it was which propelled her into starting her campaign (Midstaffs Public Inquiry, 2010c)</td>
</tr>
<tr>
<td>National community</td>
<td>Drinking from flower vases, (Symons, 2009) How can any patient have trust in the managers and systems that have allowed this disaster to run and run? It is not enough for the Chairman and Chief Executive to take the fall for this. (Guardian, 2009b) He spent more than an hour listening to members of Cure the NHS in campaign group founder Julie Bailey’s cafe on Newport Road, before saying an investigation “absolutely independent” from the hospital, the Government and “the whole system” was needed. (Express and Star, 2009e) &quot;It is time that the public were told the truth about the very large number of excess deaths of patients in NHS care and the very large number of avoidable but deadly errors that occur in NHS hospitals every day.&quot; (Triggle, 2010a) If we do form a government, we have made a commitment to (campaigner) Julie Bailey and Cure the NHS campaign. &quot;I put this to them when I met them and I have confirmed that we would establish a full public inquiry as soon possible after we are elected.&quot; (BBC News, 2010a) It's there daily, a horrible feeling that will never, ever go away. &quot;It's the knowledge that people have died needlessly. (Lissaman, 2010) &quot;This will get to the truth. We really believe this will be a full examination of what went wrong, not just at the hospital but with the regulatory bodies. &quot;We believe that if they had done something about it when we first reported concerns, it would have saved many, many lives within this community,&quot; she said. (BBC News, 2010g)</td>
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<tr>
<td>MSFT</td>
<td>Investigating individual claims of negligent, abuse and/or degrading</td>
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treatment that has occurred and that are still continuing in the Hospital at the present time. (Leigh Day & Co Solicitors, 2009a)

staff members found to be "a perpetrator of harm or poor care" would "not be working at my hospital anymore". (BBC News, 2010b)

An “overwhelming sense of denial... characterised by ‘it is not our fault, it is somebody else’s’”

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<tr>
<th>Other NHS organisations</th>
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| Bailey says her attempts to improve hospital care were stymied by local bureaucracy and obfuscation. (Gould, 2009)

The experience of Cure is that the ombudsman did not provide redress for patients or their families. Julie Bailey had her first contact with the Ombudsman in April 2009, when she was not happy with the Healthcare Commission’s response to her complaint. She found the Ombudsman aggressive and said that they had decided not to pursue her case because the hospital had since put systems in place which meant everything was now fine. The ombudsman said that Julie had received an apology and should move on. This attitude is worrying, given that the ombudsman is now understood to be the second and final point of contact for health complainants. (Midstaffs Public Inquiry, 2010e) |

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<tr>
<th>Politicians/ political parties</th>
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| Mrs Bailey said that an inquiry needed to address a number of questions – including exactly how many deaths have there been and why did Health Secretary Alan Johnson and his predecessors fail to prevent these deaths? (Express and Star, 2009b)

"The committee members were very civilised but there was no real scrutiny. The questioning was so bland and two committee members even dropped off to sleep during the meeting. (Midstaffs Public Inquiry, 2010q)

Rebecca, my daughter, stood up and outlined what had happened to mum. The councillors had no idea what was going on. "Philip Jones drew breath when he saw the photos of my mother, as did the lady with him. But these were the same people who sat on the scrutiny committee and were used to just nodding their heads ... As a group we decided to lobby support from Andy Burnham but he didn't want to do anything because he had given them Foundation Trust status. He said he would come to Stafford. He in fact promised on radio that he would come to meet Cure the NHS, but he cancelled in December 2009. (Midstaffs Public Inquiry, 2010q) |

<table>
<thead>
<tr>
<th>Government</th>
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<tr>
<td>If we do form a government, we have made a commitment to (campaigner) Julie Bailey and Cure the NHS campaign. &quot;I put this to them when I met met them and I have confirmed that we would establish a full public inquiry as soon possible after we are elected.&quot; (BBC News, 2010a)</td>
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<tr>
<td>Intended audience</td>
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| **Local community** | Mr Johnson has apologised for the fiasco and described the failings at Stafford Hospital as “inexcusable” (Express and Star, 2009a)  
We all know that the Healthcare Commission’s report leaves many questions unanswered. “It looked at what happened but not the reasons why. “For all of us and for all NHS patients now and in the future we need to learn all of the lessons from Stafford Hospital. (Express and Star, 2009b)  
Eric Morton, has now pledged that meetings would be arranged for all concerned patients and relatives about the "quality of care they have received". (BBC News, 2009c) |
| **National community** | Mr Morton said lessons had since been learned and that staffing levels had been increased. (BBC News, 2009c)  
Building on the considerable improvements (BBC News, 2009b)  
What had become clear was that official channels for their concerns were either ineffectual or hopelessly complex. (Gould, 2009)  
“Robert Francis, who conducted the inquiry, said he "focused on systems, not their outcomes". (Boseley, 2010a)  
There is no statutory obligation to be honest with patients when things go wrong. (Guardian, 2010b)  
"At a time of change in the NHS, it is essential that the lessons to be learned from the Stafford disaster are incorporated into its governance," said Francis. Francis has had to postpone his plan to give Lansley his final report by the end of next March because there is so much evidence: around 150 potential witnesses and an estimated 1 million pages of written material. (Campbell, 2010b) |
| **MSFT** | Health Secretary Alan Johnson pledged that the roles of all senior managers would be investigated but would not condone “knee-jerk” sackings. (Express and Star, 2009c)  
“It’s not our fault, it is somebody else’s”, it is the PCT or the department or the Healthcare Commission or whoever else was around that you could blame for how awful it is. Then the second overwhelming impression that everywhere else is probably the same but they just have never been caught (Francis, 2010a)  
"inwardly focused and complacent, resistant to change and accepting of poor standards" (Boseley, 2010a) |
<p>| <strong>Other NHS organisations</strong> | Patients, former and present, those close to them and members of the community served by the Trust must be constantly engaged and consulted in relation to issues about service delivery to establish their needs and views. Francis warns other trusts that the Stafford board – whose chair, executive and non-executive members are responsible for all its activities – were oblivious to most of the failings. (Vize, 2010) |
| <strong>Politicians</strong> | “We demand to know what really happened and why. It must never happen again.” (Express and Star, 2009b) |
| <strong>Government</strong> | None identified from the data items |</p>
<table>
<thead>
<tr>
<th>Intended audience</th>
<th>Examples</th>
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<tr>
<td><strong>Local community</strong></td>
<td>Mrs A told the Inquiry that during this time there was a backlash from parts of the community, with people writing to the paper praising the care provided by the hospital. He also paid tribute to the relatives and Campaigners from groups such as Cure the NHS, which was set up to highlight problems at Stafford Hospital. (BBC News, 2010g) We’ll get this hospital absolutely right in the longer term. &quot;I’m confident now we do feel like a normal hospital and patients coming here will be both safe and cared for.&quot; (BBC News, 2010e)</td>
</tr>
<tr>
<td><strong>National community</strong></td>
<td>that is what the hospital is for, to treat patients. That is all there is to it. the hospital is now in the top band as one of the top 14 hospitals with a patient safety score of 93.84 against the top performer (100) and the lowest of 0.00</td>
</tr>
<tr>
<td><strong>MSFT</strong></td>
<td>a sense of the staff being very bruised and battered by the experience of the Healthcare Commission report and the unprecedented scrutiny that they had been subjected to as part of that, and suffering low morale and actually being quite angry about the way that they had been treated. Antony Samara threatens to close wards at the hospital if they fail to make the grade. (BBC News, 2010g)</td>
</tr>
<tr>
<td><strong>Other NHS organisations</strong></td>
<td>This is already well recognised nationally in, for example, the Darzi report and locally by the Board’s adoption of the Antony Sumara’s five principles Therefore, no change should be authorised or implemented without: – timely, and recorded, consultation with professional staff who are to deliver or whose service will be affected by the proposed change (Francis, 2010a, p. 402) I am not aware of any external body, a regulator, that has that sort of capability, and certainly the Foundation Trust process wouldn’t give you any assurance about the quality of patient care and safety. In fact I think Monitor are only now just trying to build up that expertise. my investigation has unearthed a considerable amount of material that will be useful in helping not only Mid Staffordshire NHS Foundation Trust, but also the wider NHS, learn from the appalling experiences suffered by such a large number of people</td>
</tr>
<tr>
<td><strong>Politicians/ political parties</strong></td>
<td>None identified from the data items</td>
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<td><strong>Government</strong></td>
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<td>Intended audience</td>
<td>Examples</td>
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<tr>
<td><strong>Local community</strong></td>
<td>The trust now has the strong leadership it needs to respond to the report’s recommendations, but we’ll be monitoring what happens next very closely – and we won’t hesitate to step in again if the trust doesn’t continue to build on the progress already made. (Guardian, 2009a) As you know, I and my colleagues in Monitor have complete confidence in David Stone and Eric Morton. In the first instance it is up to them to decide whether they need to bring additional support into the hospital or whether there are changes they want to make in the board or the senior team. (Midstaffs Public Inquiry, 2010q) I don’t think Eric Moreton understood how to communicate with the community. (Midstaffs Public Inquiry, 2010q)</td>
</tr>
<tr>
<td><strong>National community</strong></td>
<td>now that Dr Foster said we are in the top 10, I can go home now, could I, because they have said we are okay? Well, life is not like that, is it? It is my responsibility to make sure that the hospital is safe; it is my responsibility and the Board’s to make sure that the care is good. Just because somebody outside is saying it is okay, that is not – I would be giving away my duties (Francis, 2010a, p. 179) But at the end of the day he [Mr Yeates] was missing stuff. He was either missing it – and you ask why a Chief Executive is missing serious failings like this. (Francis, 2010a, p. 345) Mr Yeates said he was “appointed to a failing organisation lacking in any governance arrangements and suffering from poor leadership”. (Boseley, 2010b)</td>
</tr>
<tr>
<td><strong>MSFT</strong></td>
<td>None identified from the data items</td>
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<tr>
<td><strong>Other NHS organisations</strong></td>
<td>my investigation has unearthed a considerable amount of material that will be useful in helping not only Mid Staffordshire NHS Foundation Trust, but also the wider NHS, learn from the appalling experiences suffered by such a large number of people Francis warns other trusts that the Stafford board – whose chair, executive and non-executive members are responsible for all its activities – were oblivious to most of the failings. (Vize, 2010)</td>
</tr>
<tr>
<td><strong>Politicians/ political parties</strong></td>
<td>None identified from the data items</td>
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<tr>
<td><strong>Government</strong></td>
<td>None identified from the data items</td>
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<tr>
<td>Intended audience</td>
<td>Examples</td>
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</table>
| Local community          | Frances and her team have taken shocking witness statements from families whose relatives died in squalid and distressing conditions at Staffordshire Hospital. (Speaker – Leigh Day) (Leigh Day, 2010b)  
I offer our sincerest apologies to the families concerned, for the distress caused by the poor care their relatives received. We have made a lot of progress over the last year in improving the care and will continue to focus our efforts on building on these improvements.” (Express and Star, 2010l) |
| National community       | patients left "sobbing and humiliated" Julie Bailey, whose mother died at the hospital and the founder of the victims' campaign group Cure the NHS, said the handling of the scandal had been "disgraceful and unacceptable" - and reiterated her call for a public inquiry. (Triggle, 2010a)  
"denials of dignity" and "unnecessary suffering" (Leigh Day, 2010b) patients were "routinely neglected", endured "unimaginable" distress and suffering, and were left "sobbing and humiliated" by staff. (Campbell, 2010b) |
| MSFT                     | None identified from the data items                                                                                                                                                                     |
| Other NHS organisations  | None identified from the data items                                                                                                                                                                    |
| Politicians/ political parties | None identified from the data items                                                                                                                                                                   |
| Government               | "The fundamental error in all NHS and government thinking and the reason why all these failures are happening (and are endemic now in the NHS) is that errors and appalling standards of care are inevitable and should be accepted as part of everyday life in the NHS, on the wards, in the A&E department, and in the operating theatre and, therefore, can be left to be discovered after patients have suffered and died. (Midstaffs Public Inquiry, 2010q) |
Table a3.6. Blame frame and the intended audiences

<table>
<thead>
<tr>
<th>Intended audience</th>
<th>Examples</th>
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<tbody>
<tr>
<td>Local community</td>
<td>some of the staff representatives pointed the finger at Cure the NHS and portrayed themselves as victiMs It seemed enormously loyal, as I say here, to Yeates and Brisby and didn't seem to realise that they'd failed, and the hospital had been producing the most appalling care (Midstaffs Public Inquiry, 2010q)</td>
</tr>
<tr>
<td>National community</td>
<td>None identified from the data items</td>
</tr>
<tr>
<td>MSFT</td>
<td>None identified from the data items</td>
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<tr>
<td>Other NHS organisations</td>
<td>the first thing within the NHS is to get rid of a lot of the managers, because I think they have imposed managerial skills on the NHS instead of the culture of caring Monitor's understanding was that the Department of Health, which provided Monitor's budget, encouraged a clear distinction between Monitor's scrutiny of the financial data and viability of proposed FTs and the HCC's role of quality scrutiny. &quot; (Midstaffs Public Inquiry, 2010d)</td>
</tr>
<tr>
<td>Politicians/ political parties</td>
<td>I didn't see David Kidney at this point independent of the trust. I saw him as part of the problem, because he wasn't even acknowledging that there was a problem (Midstaffs Public Inquiry, 2010i)</td>
</tr>
<tr>
<td>Government</td>
<td>&quot;Yet again, we find patients being let down appallinglly, lack of monitoring, lack of help with feeding, lack of dignity. How many times do the public need to keep hearing about this, before the government is embarrassed enough to do something about it? (Midstaffs Public Inquiry, 2010g)</td>
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Table a3.7. Defence frame and the intended audiences

<table>
<thead>
<tr>
<th>Intended audience</th>
<th>Examples</th>
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<tbody>
<tr>
<td>Local community</td>
<td>None identified from the data items</td>
</tr>
<tr>
<td>National community</td>
<td>The story of Stafford Hospital is more complicated than one bloke sitting in an office asleep on the job [he said]. I wish he could [give evidence]. (Speaker – Mr Yeates) (Midstuffs Public Inquiry, 2010e)</td>
</tr>
<tr>
<td>MSFT</td>
<td>None identified from the data items</td>
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<tr>
<td>Other NHS organisations</td>
<td>None identified from the data items</td>
</tr>
<tr>
<td>Politicians/political parties</td>
<td>None identified from the data items</td>
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</tbody>
</table>
| Government                | Describes Monitor's relationship with the government as "not particularly easy", and he says that many in the Department of Health were "hostile" to the concept of Foundation Trusts. (Midstuffs Public Inquiry, 2010d)  
Dr Moyes told the inquiry that, with the benefit of hindsight, they shouldn't have granted the Mid Staffordshire Trust Foundation Status, and that the Department of Health shouldn't have put it forward for consideration. (BBC News, 2010h) |
### APPENDIX 4 – INTENDED CONSEQUENCES: AN EXAMPLE OF FRAME MOTIVATION OVER THE SIX EVENTS

<table>
<thead>
<tr>
<th>LEARNING</th>
<th>Event 1</th>
<th>Event 2</th>
<th>Event 3</th>
<th>Event 4</th>
<th>Event 5</th>
<th>Event 6</th>
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<tr>
<td><strong>Motivation:</strong> “What action should be taken?”</td>
<td>Eric Morton, has now pledged that meetings would be arranged for all concerned patients and relatives about the &quot;quality of care they have received&quot;. The Tory leader promised a Conservative government would make huge changes to the NHS during his visit to Stafford ...saying an investigation “absolutely independent” from the hospital, the Government and “the whole system” was needed. The trust now has the strong leadership it needs to respond to the report’s recommendations, but we’ll be monitoring what happens next very closely – and we won’t hesitate to step in again if the trust doesn’t continue to build on the progress already made.</td>
<td>Mrs Bailey said: “I lost my mother and thought something had to be done’....’It’s been the hardest 15 months and I’ve only just begun to realise just how hard things were. “The Healthcare Commission report is the worst report in the history of the NHS and we are still here now fighting to get patients treated properly. It is an absolute disgrace that we are still having to fight everyone.”</td>
<td>The new inquiry will be chaired by Robert Francis QC, who will hear evidence from patients and families and identify lessons for the future, the government said. A spokesman for the Department of Health said: “On Tuesday, we announced a further, independent, inquiry chaired by Robert Francis QC to hear evidence from patients and families – building on the reports to date and the Independent Clinical Reviews under way – and identify lessons for the future.</td>
<td>A number of people have recalled the Bristol heart babies inquiry. In our view the critical difference is that that inquiry was initiated when, under the previous Conservative Government, there was no independent watchdog or regulator for the NHS. The whole point of establishing the Commission for Health Improvement in 2000 and the subsequent regulators since was to provide the public with the confidence that any concerns that they might have about NHS care in their areas would be properly and independently investigated. I have not heard any criticism of the Healthcare Commission’s investigation or any suggestions that it did not get to the bottom of what went wrong at Stafford hospital.</td>
<td>We welcome the Public Inquiry and wish to see a transparent and honest representation of the events that led up to the Healthcare Commission’s Report. Questions that remain unanswered will be addressed and that the whole NHS can learn from our experience. Mr Lansley said he did not want Mr Francis to go over the ground already covered, but focus instead on how the culture in the NHS allowed this to happen.</td>
<td>None identified</td>
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273


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