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Two years on: **The utility of critical action learning in the leadership development of Doctors.**

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Introduction

Previously we have explored how critical action learning (CAL) as part of a leadership development programme may help senior doctors and groups deliver business change in uncertain conditions in the National Health Service (NHS). We achieved this through portraying the research participants views of what constitutes CAL and what it might accomplish six months post development programme using the methodologies of narrative inquiry, (McCray et al, 2016) and case study (Warwick et al, 2017). We sought to develop our understanding and practical (phronetic) wisdom (Flyvberg, 2001) as researcher/ facilitators guided by a collaborative autoethnography; a fusion of collaborative ethnography and autoethnography (Walker & Taylor, 2014).

Here we present our findings from an additional set of nine interviews with the original NHS research participants two years on, the aim being to advance further understanding (Flyvbjerg, 2001) of what CAL may offer over time. Within the complex NHS environment, any form of evaluation is not only a patchwork of insights, but a patchwork of approaches, some of which make awkward companions (Watkins et al., 2011). We share both our research findings and our reflections on their usefulness as a form of evaluation within the NHS context. We document our own experience as researchers as we move further away from a natural sciences position of evaluation and act as collaborative researchers participating in a larger social science project (Flyvbjerg et al., 2012, 122–36). An emerging contribution is that a form of CAL or action learning (AL) is being sustained and applied in organisational practice by senior doctors as they facilitate change. We discuss our perceptions on the nature of these findings and what they bring to the evaluation of leadership programmes in the NHS, sharing our research reflections and further intentions and actions post study.

Evaluation in the context of NHS Leadership Development

The NHS is complex, wherein complexity can be defined as “consisting of adding different kinds of parts to a system and then adding constraints to those parts” (Tainter and Taylor, 2014, p168). Within this complex environment the design and evaluation of leadership programmes and effectiveness measures of leaders/leadership in action has become harder (Watkins et al., 2011). Finney and Jenkins define evaluation as ‘assessing the value, worth or merit of an intervention, programme or project’ (Finney and Jefkins, 2009).The participants and the type of selection process affects evaluation; voluntary, compulsory, elite selection and the innate leadership knowledge or experience they already possess. The approach of many research practitioners when evaluating is to focus on both qualitative and quantitative

factors (Finney and Jefkins, 2009), (Francis et al., 2012). For whilst there is clearly a desire and rationale for evaluation of leadership development there is a myriad of problems in establishing credible approaches. Short (2009) characterises these as the vacuum in evaluation that echo the concerns of others 'evaluating evaluation' whilst the political agenda of commissioners and of leadership development is an influence on what is required from evaluation and how far this includes stakeholders' input.

When looking at the evidence base for evaluating leadership development West and others (West et al., 2015) echo Mabey's (Mabey, 2013) point that one should consider multiple approaches. However, they are far less embracing when it comes to what counts as knowledge; they rely on positivist criticisms to raise issues of validity, reliability, sample sizes and underpinning theory (West et al., 2015, p15). In this epistemologically focused approach they note that many of the traditional leadership techniques are problematic. For example: 360° appraisal instruments vary considerably and offer only marginal effect; development centres are more beneficial, but there is little evidence as to what works and to what effect; action learning is effective, but they are critical of the number of unaccounted variables when addressing any effect; and, it is a similar story of developmental projects, pointing out that whilst they can be helpful dropping people in at the deep end often does more harm. The paper concludes: 'This review suggests that approaches to developing leaders, leadership and leadership strategy can and should be based on robust theory with strong empirical support and evidence of what works in healthcare' (West et al., 2015,p, p25), underlining that the route to understanding comes with a positivist approach. In contrast Jarvis and others (Jarvis et al., 2013) use the complexity work of Stacey and colleagues (Stacey et al., 2000) noting that we should focus on micro processes between people as offering insights into broader perspectives. In doing so they suggest a range of qualitative techniques from ethnography, interviews focusing on critical incidents, and learning in both post hoc and in real time.

Clearly metrics imply precision whilst complexity requires more openness that suits a more time consuming constructivist evaluation (Edmonstone, 2013).Kirkpatrick (Kirkpatrick, 1978) developed a four stage framework for training evaluation; level one focused on the experience of the participant and their initial reaction; whilst level four considered organisational impact. Whilst these lower levels were straightforward to evaluate and provide some numerical finding, level four with issues of unique organisational context and multiple events and stakeholders was more problematic (Bates, 2004), particularly for those drawn to a scientific epistemology.

Paper Aims

We will begin to answer:

1. The extent to which the CALS activity trajectory of critical interrogation and exploration of others has been continued and whether two years post the development programme any new understandings of self and leadership in the NHS have emerged for the Doctors in the study?

2. What this form of small scale exploration of learning can contribute to the debate on leader development programme effectiveness?

3. How working towards a mutual understanding of what change has occurred has influenced our position as researchers on the contribution and meaning placed on evaluative measures on leadership programmes?

The setting and the development programme

A National Health Service Foundation Trust sought to provide a more locally based clinical leadership programme for doctors that have medical director and consultant roles. West et al (2015) write that "Organisational leadership development, tailored to the organisation's needs and combining learning activities with practice activities, has been recommended for the NHS over the last decade" It was hoped that this group of people would be the first to begin to:

- Initiate a change in the organisational culture,
- Impact positively on performance,
- Establish new networks for collaboration
- Improve the quality and resilience of care delivery.

The model of delivery commissioned was a critical action learning (CAL) module within a bespoke one year leadership programme leading to an accredited Post-Graduate Certificate in Strategic Management and Leadership. The programme was solely for Doctor leaders whom as Curtis, de Vries & Sheerin, (2011) write require high levels of support compared with leaders in other organisations. Some participants did continue to a year 2 Post Graduate Diploma, but we are seeking to explore only the year one experience in this paper. Action learning (AL) is an experiential learning method in which participants learn by doing and then reflecting on what they have done. Participants work on real tasks in small teams (learning sets). Revans (1980) describes learning as having two components. One part consists of programmed instruction, where a teacher or instructor provides information to the learner. The other component consists of the understanding that arises when learners use questioning to help each other explore the situations they face; this second component can be referred to as AL. A key element of AL is that a prescribed theoretical model of leadership is not provided in the programme curriculum instead participants develop and build their own models based on their learning, interactions in the set and from feedback on their actions in the workplace. Vince (2008),amongst others, advocate the practice of CAL, because it involves less prescriptive approaches than AL and ones that are more critical in that attention is paid to power relations and attendant issues of politics and emotion.

CAL was the model adopted for the programme which was held one day a month and comprised of three events: (1) a reflective commentary and discussion led by the Trust's chief executive; (2) critical action learning sets of five to six people (3); and lecturer-led input to support a work-based project that formed a key area for CAL discussion on progress. Findings from study one responses, affirmed the work of other researchers (Ram and Trehan, 2010: p 414), that CAL promotes reflexivity and that this is enabled by the safe space of the set, wherein participants can be challenging and supportive; thereby recognising striking moments, a shift in their perspective and the nature of unsettlement in creatively tackling

problems. Further a new contribution of resilience showed how the sets provided a way of building individual and group relationships to reduce risk and make the best of limited resources.

Methodology

The development programme was concerned with complex issues involved in delivering change. As we come to review its impact two years on, we were initially challenged by the use of the term evaluation and how it could be interpreted. Practitioners focus on the outcomes of actual development activity evaluation in terms of what is immediately 'seeable'(Finney and Jefkins, 2009; Francis et al., 2012). It is therefore context dependent over a limited period of time. Here as we were reviewing experience a considerable time after the activity, we decided to reframe the notion of evaluation and to preference the word learning which features in the literature more widely (Francis et al., 2012; Holbeche, 2012) and specifically explore what learning over time had occurred as a result of the organisational development process of CAL.

Proposing a more nuanced approach to reviewing leader and follower power, influence, and agency (Collinson and Tourish, 2015) can be hard when a traditional position remains privileged. Further whilst supportive of Mabey et al's (2008) point that within the complex and shifting context of the NHS a solely functionalist mind-set towards evaluation is problematic and that we should complement our insights from critical, dialogic and interpretive perspectives, we are also aware that in the context of an actual project what is immediately 'seeable', as opposed to the entire span of the intervention from cause to effect may be more important and connected to keeping funding, assuring commissioners and enabling further business. We find the position of Jarvis et al (2013, p 29) helpful when they write that viewing evaluation as both research and development can enable a process of collaboration and knowledge sharing and harvesting of wisdom, which can in turn inform thoughtful leadership development investment.

The length of time between the development programme and evaluation is a commonly identified as an issue for evaluators. When is the right time in relation to short term and long term impacts? Will all that was said previously by participants about the growth in leader resilience and reflexivity have become outdated? In terms of the context of the study – the NHS, there is danger if temporal issues are ignored. Bate et al (2014, 7) write in reference to quality improvement programmes. that a "longitudinal, historical view (of a programme) is essential if one is to understand why it has ended up as it has, where it is heading and what it may be able to achieve in future". With these factors in mind, as developers, facilitators and researchers of CAL in an organisational development context, we have chosen to proceed and to continue to apply more qualitative formats that embrace interpretivist research paradigms (MacNeill and Jillian, 2014). We draw on collaborative autoethnography to guide our research decisions and processes and use narrative inquiry in gathering participants views of what they have prioritised and interpreted and made sense of in relation to their CAL experience, to inform all stages of our research building stories from the intention, language (Riessman, 2008: p11) and the 'how's and whys' of incidents experienced by people as they come together.

Sample

The study participants are nine members from an eleven-member senior medical doctor cohort enrolled in a postgraduate leadership programme. The experience the cohorts are exploring is the Postgraduate Certificate part of the programme (year 1). Some participants went on to undertake a second year at Diploma level. Study participants are identified as (P1) - (P9) in the findings section. The cohort is seen as important group of change agents in the NHS trust capable of leading business change required for integration. Their medical disciplines range from urology to gynaecology. Prior to this research, the participants have also undertaken a formal external NHS evaluation immediately after the development programme commissioned by the NHS trust, and an exploration of their learning from CAL undertaken by ourselves (Warwick et al, 2017a, 2017b).

The Interviews

The interview was chosen as the empirical data collection tool. As our approach is auto-ethnographic we were guided by Brinkmann and Kvale's (2015) advice that we should approach the interview as an ethnographic situation and defamiliarise ourselves with it. We were aware of Alvesson's (2003) caution regarding the "authority" placed on the interview as a valid source of knowledge and found his eight metaphors for interviewing techniques (2003, p15) useful as a reflective tool. We return to both writers in our discussion of findings The interview schedule was semi-structured, beginning with questions about Doctors' role and scope, progressing to learning from CAL . The questions included : *What skills and techniques do you feel you have gained from the learning approach? Can you give me examples, of how and when you've drawn on those skills and techniques?*

For pragmatic reasons the interviews were conducted by telephone by the fourth author T and were planned for a 45 minute session. Prior to undertaking the research full university ethical approval was gained and consent from the NHS trust and participants. Doctors were at work, in their cars and at home during interviews.

Data analysis

The interview recordings were transcribed by a fourth researcher prior to data analysis. The preliminary stage of analysis was undertaken separately by the remaining three researchers. We then met to discuss the interviews and agree our final analysis. Alvesson (2003, p 14) writes that "Reflexivity operates with a framework that stimulates an interplay between producing interpretations and challenging them". For us this involved intense discussion about what the interview process and findings offered. The data was then placed under three overarching themes with sub themes. For the purposes of this paper, brief reference can only be made to these themes and findings here, with a more developed look at one theme, CAL and Change. The three overarching themes were:

1. The experience of CAL. What was significant and unique about CAL despite other development experiences described such as visits to other hospitals in the USA and formal training.

2. Delivering CAL. This theme offered insight into the make-up of CAL groups and organisational timing was also flagged in the data.

3. CAL and Change. The theme of delivery of change where leadership behaviour has incorporated CAL techniques and learning.

Findings

CAL and Change

Whilst participants were asked about the continued use of CAL as part of their leadership behaviour and development in the workplace one participant (P2) gave an unequivocal no:

"*I'd like to say yes to that but if I'm honest no, it's just a, it's just so busy that the time to do that is very limited*" (P2).

One participant (P6) said yes:

"*Yeah I have actually, we funded some money through XXX, um for um, some of the doctors I'm consulting for carrying out a masterclass which included an action learning set"*.

Seven out of nine participants initially responded they were not using the pure form of the CAL model directly. One participant explained:

' I think we have genuine action learning sets type stuff although we don't call them action learning sets, they're more informal" (P4).

Whilst another notes: *"you wouldn't recognise it as an action learning set, but actually have some of their foundations based in those principles* (P3)'.

Participant 1 explains: *"Having said that* (referring to a not directly response) *I think that the culture that we engendered within that action learning set has been continued on by those that were in it. But it is kind of rooted in the workplace rather than we left it outside, which I think is a positive thing."(P1)*

However all of these seven participants offered an example of their indirect application of the CAL experience in practice as being influential in the leading and delivery of change. We include here one detailed response which accounts for the use of CAL in meetings about system integration (P7),

P7 "yeah I suppose I have in fact I've got the perfect example of em yesterday I suppose were there, of, um, it's action learning through a different mechanism, but we, one of the areas

which we're responsible for now is the XXX service, XXXology, XXX surgery and um we have a, an issue within the XXX surgery where we have different people with very different ideas who are very, very strongly opinionated. (P7)

I – OK

P7– *Erm so, um it's a very, I mean this is a bit of a, sort of a left, left field of action learning but I brought everybody together yesterday to talk about their particular issues and their particular problems in front of their peers in which there are four, five consultants.(P7)*

I – OK

P7– *Who are involved in the service. So it's a, it's a bit of a form of action learning actually. So basically bring them together so they can talk about their issues and problems and then um with others hearing how they were feeling, others were able to offer advice and support as to how the, they could overcome their problems. And interestingly the dynamics within the group were quite supportive of each other, from writing quite venomous emails to each other about doing things, to getting into a room and facing each other and talking about their problems, emm there was quite a bit of mutual support. I'll be able to tell you more in a few weeks' time if it really has come to work in fruition. And I know it's not quite what you're meaning in the true thing of action learning but it was each individual people, bringing their problems to the table for others to solve, which was very much how I saw the action learning* (P7).

Discussion

One of the paper aims was: "Whether two years post the development programme any new understandings of self and leadership development in the NHS have emerged for the Doctors in the study, and the extent to which the CALS activity trajectory of critical interrogation and exploration of others has been continued". The analysis of data would suggest that Doctors are continuing to develop new understandings of their leadership, some of which may be related to CAL development, but other development is attributed such as placements, visits, and training. When asked to offer examples of unique attributes to leadership development by CAL all participants noted a tolerance of understanding of others and more than half noted the political knowledge gained during the process which has been sustained. When we explore whether the critical interrogation and exploration of others that occurs through the CAL set process is being applied and facilitated, we note our interpretation of the examples of change in the data from 8 of the 9 participants as being an effect of CAL. We consider that leaders have used tacit knowledge or practice wisdom gained from their own CAL learning to shape its use in subsequent organisational practice. Oakeshott (1967, p 167) writes that "tacit knowledge is the component of knowledge which does not appear in the form of rules and which, therefore, cannot be resolved into information or itemized in the manner characteristic of information" Knowing is not just about knowing how something is done but how to do it, and along with this comes "the interpretation of the knowledge that is made"(Duguid, 2005,

p111)– both by the individual leader and other audiences in this case the research team. We have concluded that a set of actions framed within the contextual question on the use of a CAL development tool are as a result of the application of CAL or AL in the leading of organisational change, resulting in some changes in practice.

This takes us to our second paper aim which is: "What this form of small scale exploration of learning can contribute to the debate on leader development programme effectiveness? Evaluation of leadership development is of interest to many organisations, but given the scale and the political nature of the NHS the question of impact is more pressing; not only is there impact, but the nature of it is also of interest. Reay and colleagues (Reay et al., 2009) carried out a review to determine whether methodologies associated with evidence based medicine can be applied to management development. Although they reported a large number of papers had been published most were based on opinion and anecdote. West et al (2015, p 13) write that the " preponderance of weak study designs in health care leadership research has been noted key problems being small sample sizes; lack of underpinning theory; survey instruments with inadequate reliability and validity; failure to measure important control variables; cross sectional designs; reliance on self-report." Further they indicate that "The patchy nature of the evidence suggests important moderating factors that affect whether and how leadership development interventions lead to improvements in health care team or organisational performance. Including the design of programmes, knowledge and skills of facilitators, motivation of trainees, supports in the workplace and processes to facilitate the transfer of training" Indeed, their study of healthcare leadership development made the following point on action learning: "There is some evidence that this works best when a whole team works together.

Very few published studies have evaluated outcomes, however Prideaux and Ford (1988) reported positive outcomes, but these were based only on retrospective self-reported benefits (West et al, 2015, p 15). Our contribution here, and in previous papers (Warwick et al., 2016, 2017), has been to hear the participants own stories about the personal learning they have experienced through leadership development using CAL and how they perceive this has affected their organisation. As qualitative researchers we have attempted to respond to the challenges of methodological rigour in relation to our study design and the interpretation of data collected. That said the study is temporal and as Hampshire et al note (2015, p 228) who is to know in advance how relationships might develop (and here we mean ourselves as researchers with participants and their organisation) over time and how they may come to influence the impacts of the research outcomes.

Finally and to conclude the paper, our third aim was to report on how working towards a mutual understanding of what change has occurred, has influenced our position as researchers on the contribution and meaning placed on evaluative measures on leadership programmes? We return to Brinkmann and Kvale's (2015, p 15) advice that we (the researchers) should approach the interview as an ethnographic object of study and are aware of the criticism of many forms of leadership development evaluation and Alvesson's (2003) caution regarding the "authority" placed on the interview as a valid source of knowledge – pertinent in the evaluation trajectory. In the context of this study we note that "whilst " 'objectivity' might

be the aim of more structured forms of ‘data collection’” (Hampshire et al 2014, p 226) we are drawn to explore more fully Hampshire et als’ argument “ that treating the interview as an ethnographic object means acknowledging and foregrounding the social relations and context in which narration occurs, not just the narrative content (Gubrium & Holstein, 2008)” As we move away from a natural sciences position on evaluation to explore participants’ learning in a form of collaborative endeavour this is important and for further reflection. In writing this exploratory paper and as we continue with it, we have benefitted from the positivist natural sciences position and scrutiny that has dominated leadership evaluation methods. In this case because it has aided our reflections on our interview data, interpretation and any claims made of it. It has as Alvesson (2003, p 25) writes made us look self critically at favoured assumptions and consider more critically what the research participants are telling us. For example what form of self representation is being conveyed by the participants? How has this affected our methods of analysis as we explore the data and our interpretations of it in more depth? As we proceed we intend to pursue further the question of what learning about leadership development is being captured, the form it has taken over time and what this offers the broader literature on evaluation.

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