**Temporal patterns of action learning and the implications for Doctors in Leadership Roles**

**Abstract**

The purpose of this paper is to analyse the ongoing effects of a United Kingdom situated Doctor Leadership Development Programme (LDP) which used action learning (AL) as the vehicle of practice. The aims of the research are firstly to gain insights into the meanings given to the LDP experience two years on by a cohort of doctors with senior leadership roles. Secondly, to establish what the development tool applied, that of Action learning (AL), offered these senior doctors and their practice as they attempted to facilitate change. An interpretive design is applied and the research is context specific, capturing a local experience of leadership (e Cunha et al, 2017, Authors, 2018) over time. Participants were invited to take part in semi-structured interviews which were used as the data collection method. Study findings show that at a critical point for the organisation, the AL model of facilitation built a bridge between individual and collaborative action which has been sustained over time. In doing so new social support processes were created which enhanced the individual doctor’s leadership style to move towards that of a collective leadership model.

**Introduction**

The purpose of this paper is to explore the ongoing long term effects of a United Kingdom situated Doctor Leadership Development Programme (LDP) in the National Health Service (NHS) which used action learning (AL) as the vehicle of practice. In an earlier study (2018) the authors explored the outcomes reported by the doctors who were participants on the LDP six months after they had completed their programme. These outcomes included deeply held trust of their AL peers, enhanced reflexivity and resilience in care delivery . Here the same cohort is revisited to focus on their experiences and any lasting effects two years later. The LDP commissioned by Human Resource Managers (HRMs) had aimed to initiate a change in the organisational culture, impact positively on performance, establish new networks for collaboration and improve quality whilst sustaining care delivery. AL is an experiential learning method in which participants learn in a group called a set (Leonard & Lang, 2010) A key element is that a prescribed theoretical model of leadership is not provided in the programme curriculum (Anderson &Coleman, 2015) instead participants bring their own leadership issues and learn through interactions in the set and from feedback on their actions in the workplace. AL has long been associated with the UK’s NHS, (Revans, 2011, Pedler & Attwood, 2011) and applied by management academics (Kozubska & Mackenzie, 2012) and developers to further support the resolution of workplace problems. It has featured in other organisationalresearch including Pedler (2011), Lynch & Verner, ( 2013); Phillips & Byrne,( 2013); Coghlan & Brannick, (2014 ), and Volz-Peacock, et al (2016). However, critics argue that the approach faces the same problems as other LDPs in that there are challenges in evaluating their impact (Mehrabani, & Mohamad,2016).

**Study Aims**

The aims of the study are to :

1) Increase understanding of what AL as part of an LDP has provided for doctor leaders in an organisation over time.

2) Present participant insights on the LDP experience two years on.

3) Explore the benefits the AL offered these senior doctors as they have continued to facilitate change.

4) Offer insights on the long-term effects of AL as part of an LDP that may be helpful to HRM workforce development commissioners and employers.

**The Study Context**

The doctors in the study are working in a United Kingdom (UK) healthcare organisation in the National Health Service (NHS), delivering care against a backdrop of diminishing fiscal resources, public concerns over patient safety and the quality of care (Francis, 2013), digital technology and the challenging demographic of an aging population with complex care needs (Oliver, Foot & Humphries, 2014, Hassan, 2018). They are also at the centre of a UK care landscape that is becoming more complex and volatile which affects both frontline and senior managers (Murray et al, 2017, Ghate et al,2013, Welbourn et al, 2012 ) and demands new ways of working to meet the needs of service users (Department of Health and Social Care, 2019). To achieve this, these doctors are required to be more engaged in leadership and management (The Kings Fund, 2012, 2018 ) and medical doctors holding strategic clinical leadership roles are charged with making the end delivery of changing care models effective. Dickinson, Ham, Snelling & Spurgeon, (2013) noted that between 10 and 20% of medical consultants are involved in leadership and that clinical directors are allocated 20% of their time to leadership with medical directors spending more than half their time leading. The doctors in this study are working in the gap between managerial and clinical communities (Marnoch, Mckee & Dinnie 2000), and face the differences between clinical priorities and financial controls, and individual versus systematised perceptions of clinical work (Degeling, Maxwell, Kennedy, & Coyle, 2003; The Kings Fund, 2012; Rose, 2015). To further add to these challenges, there are a number of occupational risk factors doctors face, such as experiencing higher levels of stress and burnout (Maslach, 1976), when compared to the general population (Shanafelt et al. 2012). This is created by an occupational culture of long working hours, and a high workload combined with balancing work and home life, and a pattern of low help seeking behaviours when in difficulty (Ireland et al 2017; McCray et al. 2008; Markwell & Wainer 2009; Elliot et al. 2010). If all of these policy, technological, organisational and personal factors are considered together, there are implications for how, where and when doctors can be supported to lead.

Nationally a common solution to address the leadership challenges doctors face has been the provision of medical leadership development programmes (LDPs). However, UK LDPs are often criticised (West et al, 2015) as LDPs in the NHS are publicly financed programmes, curricula and outcomes are likely to be judged by measures such as value for money and changes in performance. Despite their perceived importance, LDP are a “far less well explored and researched” topic in healthcare (West *et al*., 2015, p 21). West *et al* (ibid) suggest that a relatively narrower theoretical focus may have indirectly encouraged leadership development facilitators to pay too much attention to developing individual leaders, as opposed to focusing on the activity of developing a more collective leadership of social capital including networks, collaborations, and partnerships. These can support the implementation of change, improve resilience and maintain good care practice. West *et al*. defined this collective leadership as a “constantly swirling mix of changes in leadership and followership, dependent on the task at hand or the unfolding situational challenges” (2015: 21).

Frequently, an LDP’s success may be judged on a last day of programme evaluation, where what is immediately ‘seeable’, as opposed to the entire span of the intervention from cause to effect, may be more important and reassuring to HRM and commissioners concerned with the value of further programmes. In relation to generic LDPs, Watkins et al (2011) described the challenge of the knowledge transfer problem with all the difficulties of translating activity learnt on an LDP to individual behaviour and organisational change back in the workplace. Further Berber and Lekovic(2018) advise caution in the planning and focus of HRM support that use team or group type activity as it may have limited return on investment for organisations seeking to develop innovative practice and change. Yet, in terms of the NHS and quality improvement programmes, a key argument has been 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” (Bate et al, 2014: 7). Additionally Day et al (2000) write of the need for more longitudinal studies of LDPs exploring the interpersonal and intrapersonal effects over time. By identifying and analysing the longer term results of AL, this study offers a new perspective on the effects and value of AL for leaders in the healthcare setting. Significantly ties and the deep peer trust established on the LDP have been maintained and the social capital created has enabled these communities to continue to flourish. The sustaining of such connections has been important for leading through a hospital integration, where ongoing change to make things happen was needed.

These findings provide a further example of an action learning evaluation model and contribute to the literature which as Scott (2017 ) argues remains limited.

**The Development Programme**

The model of delivery commissioned was a bespoke one year accredited leadership programme which started several months after the merger of two smaller hospital organisations. The hospitals were located within a forty mile radius but prior to the merger offered similar medical services within the same NHS hospital trust but requiring separate administration, diagnostics and leadership. The consultant leaders were, prior to the merger, working in separate teams yet providing the same medical specialisms. The intention of the merger was to provide a more coherent patient journey and care pathway with some cost savings by avoiding the duplication of the administration of services.

The LDP was solely for doctor leaders who, as Curtis, de Vries and Sheerin, (2011) argued, require high levels of support compared with leaders in other organisations.The LDP aims were to: Consolidate a merger of two hospitals, initiate a change in the organisational culture via a more collective leadership model, impact positively on performance, establish new networks for collaboration and improve the quality and maintenance of care. The issue of timing of the leadership development programme was important as the merger allowed the changing power relations to become a point of conversation and reflection (Cunliffe, 2004) within the action learning sets (Trehan, 2011) .

Having described the LDP aims and its constituents the theoretical drivers that underpin the LDP and inform the paper are now presented.

**Theory informing the paper**

**Leadership Networks and Social Support**

In the UK, the Centre for Creative Leadership reports (2014) have strongly advocated a shift in the NHS from a traditional top down (Jensen, Jain & Kjeldsen, 2016) leadership model to one of collective leadership, in order to begin to change the organisational culture. West et al (2014:14) described collective leadership as where:

“……cultures, responsibility and accountability function at both individual and collective levels. They breed regular reflective practice focused on failure, exploratory learning and making continuous improvement an organisational habit”.

The NHS organisation sought to build a network of people who shared and could deliver on a collective goal, that of an integrated, safe, acute healthcare system. On one level, such goals could be achieved through the doctors’ access to existing networks. However, these networks do not support the leadership vested within the doctors appointed in executive roles who, to achieve the strategic organisational goals, may require interactional links with a specific set of individuals or groups. The development of social networks are important in this regard, that is to say a set of socially linked or interconnected discrete individuals or groups, as well as the structure, number and character of the relationships that link members of the network (Hawkins and Maurer, 2012:355). Heiligers, de Jong, Groenewegen, Hingstman, Völker & Spreeuwenberg (2008) wrote that in their clinical role, all doctors are dependent on others in three forms of network. These are communication networks about all aspects of their work within an organisation, consulting networks which offer access to professional information and trust networks where confidential information about practice is divulged. Groups formed as part of LDP participation offer membership of a different social network (Zacharakis & Flora, 2005) for doctor leaders, where social support is present and related to leadership development. This form of social support gives individuals who come together as part of the LDP group reciprocal emotional support, (Hawkins & Maurer, 2012:354) knowledge and encouragement, guidance and advice (Findler, 2000), together with concrete action, all of which should mitigate stress levels (ibid :355). Further, when knowledge is discussed here, it is of a different form from the professional transactional information shared clinically by the doctor leaders. The idea of networks and social support integrating and coming together to provide access to resources (here practical knowledge and wisdom support, feedback on managing transformation and the merger of some care pathways) for the Doctor LDP participants offer important steps towards social capital (Day, 2000; Van de Valk, 2008). Social capital has been defined in many disciplines and a full analysis is beyond the scope of this paper. Social capital has been seen to contribute positively Putnam (1995) in democracy and political participation. Perceived negatively from Bourdieu (1986) as an element in maintaining inequality and Lin (2012) suggests it offers an individualist approach, demonstrating the value in connections and relations. Here, as in the network literature, doctors’ ownership of social capital may be different when they are in a leadership role. For, as professional clinicians with advanced status, they hold high levels of social capital and may be viewed by some as maintainers of the status quo as they, albeit unconsciously, may gate-keep access to resources and contribute to inequality in the organisation. In contrast, in their leadership role, this may not be the case, as social support and networks in this domain were previously absent.

Van de Valk (2008) provided a synopsis of common themes in the social capital and leadership development literature, noting bonding ties as being common within individuals and groups and bridging ties, those with communities and external organisations (Van de Valk, 2008: 51). In addition, researchers suggest that LDP networks offer access to building links with external resources in a larger community network (Kilpatrick & Falke, 2003; Diem and Nikola, 2005). Such connections may be important for leading through the hospital integration, where sustainable and ongoing change is needed. The paper continues to consider the original human resource development vehicle of action learning and its potential usefulness over time.

**Action Learning and sustainability**

Revans ( 1980) “scientific method” of action learning continues to be pertinent to LDP change projects like the one reported here in this paper. In action learning participants explain a problem they are dealing with and from the conversation they identify some actions they can try. Experimenting, auditing theoretical remedies and planning future action are features of the progress of the AL over the course of the programme. The NHS with its political context and the power dynamics of the organisational setting (Vince, 2004), meant that the original conventions of Revans seemed appropriate for the LDP described. Action Learning is a management technique based on “doing the thing” and not on abstract theories, and “that action learning is about real people tackling real problems in real times” (Revans, 1980, p5). A learning strategy for supporting individual and organisational change and defined by Weinstein (1995) as “*a process underpinning a belief in individual potential: a way of learning from our actions, and from what happens to us, and around us, by taking the time to question, understand and reflect, to gain insights, and consider how to act in future”.* The leadership programme in this study was designed to engage participants in identifying and undertaking demanding integration projects often in an environment of considerable resistance. The programme sought to embrace participants’ thinking, feelings and reflection on their current practice position and experiences and the collaborative exploration of alternative and integrative approaches to organisational transformation.

There are two strands of action learning theory which are important for this research in relation to sustainability and performance. First there has been an ongoing debate within the literature about what action learning is and how much action learning can claim to achieve (Scott,2017) . As AL is increasing in application there is a debate within the literature about the dilution of the original aims and intent of Revans, and different philosophies and strands have emerged. Pedler et al (Pedler, Burgoyne, & Brook 2005, 58–9) write that for Revans, AL incorporated the following components :

Profound personal development resulting from reflection upon action;

Working with problems (no right answers) not puzzles (susceptible to expert knowledge);

Problems being sponsored and aimed at organizational as well as personal development;

Action learners working in sets of peers (‘comrades in adversity’) to support and challenge each other and the search for fresh questions and ‘Q’ (questioning insight) takes primacy over access to expert knowledge or ‘P’).

Whilst other researchers such as Marquardt (2004), present a different model with the main difference being that of the inclusion of an action learning coach. Importantly for Revans , the facilitator should step away as soon as possible and should not assume the role of an expert as this will dampen the potential for new ideas to emerge (Revans, 2011) .

Through Revans himself, action learning has a long association with the UK’s NHS. It has been argued (Brook, 2010) that its longevity in this context is testament to its fluidity and adaptability, not least because it does not adhere to any particular syllabus. However, it is its application that has attracted some doubts as to its efficacy in practice claims of its supporters. It is important to note the common criticism that Revans’ principles are not generally adhered to and that what is termed an “action learning programme” is often merely the processes involved in any work-based project (Brook, 2010; Cunningham, 1999). An AL development model is designed to focus on the interconnected individual, teams and organisational requirement. Yet some argue that emphasis tends to focus on individual personal development, whilst its impact at organisational level is minimal (Cho and Egan, 2009, Brook, Pedler & Burgoyne, 2012) and when public money is at stake such investment on individuals can be viewed as an unaffordable luxury (Rigg, 2008). This may be due to a reluctance to question some of the collective organisational norms and power relationships. The application of critical action learning advocates a less inward-looking strategy for action learning facilitation (Vince, 2004) where motion, power and politics are addressed and connections with other sets are made. Nonetheless, there are challenges and potential costs for individuals working collectively to deal with often contradictory real world organisational problems. In healthcare, where technical rational approaches are favoured, an acknowledgement of uncertainty around group and organisational action can be very unsettling for leaders. Therefore a tendency to avoid action beyond one’s own practice may be understood (Vince, 2008). A second important strand is that there are challenges in transferring and sustaining any collective form of practice in the organisation over time. Pedler wrote of the context sensitive role of AL (Pedler, 2011) and when organisational contexts are considered, they are unlikely to stay the same for very long. Further, Vince (2008) wrote of an imagined stability of the organisation. Raelin (2006) warns of making an assumption that action learning will create a collaborative synergy of individual ,team and organisational leadership activity to sustain change. For Raelin (2006) assessing the effect of AL may be dependent on three key strands. Firstly the individual’s capacity to explore their defences and action when it comes to beliefs about leading and collaborating with others. Secondly in how much individuals learn from their previous experience and use their institutional memory to look at and solve problems in new contexts. Finally, at organisational level how collaborative leadership is played out. He notes that more individuals would be “connected to each other in the team and that no one actor would be permanently central as a key decision maker” (Raelin, 2006 p 164) if collaboration was being practiced. Hence as the authors look to explore the sustainability of AL, and any success or failure of transferability of action into the organisation, the unpredictable nature of the organisation and the potential for influence of collective action is at the forefront of the author’s thinking.

**Research Design**

The design is interpretive in that the research is context specific and the research captures a local experience of leadership (e Cunha et al, 2017) over time. The use of a narrative inquiry methodology (Reissman, 2008) enabled us to focus on the significance that the doctors ascribe to their experiences and thereby provide, 'insight that (befits) the complexity of human lives’ (Josselson, 2006, p4). Participants were invited to take part in semi-structured interviews which were used as the data collection method. Our interview method draws on constructionism where the dialogue (data) created is a product of both the participant and the researcher (MacNeill and Jillian, 2014). We pay attention to the dynamics, processes, changes, and continuities that the AL experience created for the participants and the influencing factors.

**The Sample**

Participants are nine members (P1—9) from an eleven-member senior medical doctor cohort enrolled in a postgraduate leadership programme; the other two members of the cohort were unavailable to participate in the study due to work commitments. The study sample method was purposive in that participants were selected as being most able to discuss the research topic. They were interviewed at two points at 6 months (research cycle one, reported previously XXXXXX (2018) and at two years (research cycle two) after the programme and the subject of this paper. The cohort are an important group of change agents in the NHS trust, becoming part of the executive team who are leading the business change required for hospital merger and integration. Their medical disciplines are wide ranging. Prior to the programme, two participants out of the nine in the sample had attended a previous formal (but not accredited) leadership development programme. The remaining participants had attended short seminars, sessions and presentations. Seven members of the sample described their leadership training as largely ‘on the job’ and had not chosen to be leaders.

**Ethics**

Formal research convention has been followed in gaining approvals and consent to proceed, from the university, organisation and individuals of the study.

**The Interviews**

The interview was chosen as the empirical data collection tool. In qualitative research the interview aims to understand the world from the participants’ view and to unpick the meaning they give to their experience (Kvale, 1996: 1). A constructionist approach guided the process (Lincoln & Guba, 1985: 207). Within this approach both the participant and interviewer are connected as they shape the narrative. For pragmatic reasons the interviews were conducted by telephone and doctors were at work, in their cars (hands free) and at home during interviews.

The interview schedule was planned to explore the overall experience of being on the programme and any continued effects. We firstly determined the purpose of the interviews based on the study aims, which resulted in four key areas of exploration in the interview schedule . These were : (1) To capture participant leadership experience and role development post the programme. (2) Gather participant recollections of the usefulness of action learning as a model of leadership development (3) Seek current perspectives on the AL approach and its legacy. (4) Collect examples of any ongoing self or peer reported behaviour change in the workplace as a result of the AL approach. The questions were derived from these four areas and included: *Two years on how and where would you say that action learning has affected your leadership responses?*  *What skills and techniques do you feel you gained from the learning approach? Can you give me examples, of how and when you have drawn on those skills and techniques? Broadly questions focused on 1) how their practice had changed over a period of time; and, 2) how this was affecting their practice in the here and now.*

**Data Analysis**

The analysis of data was guided by the aims of the study which were firstly, to increase understanding of what AL as part of an LDP has provided doctor leaders in merging organisations over time and secondly, to explore what benefits AL offered these senior doctors and their practice within the NHS trust as they have continued to facilitate change. Our analysis followed that of a previous study undertaken (xxxxxxxx, 2016) and used thematic analytical procedures (Braun & Clarke, 2014). We have taken an inductive approach to the data analysis . This involved each of the three authors reading the full interview transcripts separately and noting any salient moments (Katz & Shotter, 2004) words and phrases (Shotter, 2006; Shotter & Tsoukas, 2014) prioritised by the participant within the flow of conversation. Resulting in the creation of a set of common descriptions and participant stories from the data which were coded and organised into themes. Themes being defined as data which says something of importance to the research question (Braun & Clarke, 2014). A thematic map was created and then checked once more against the research question. The following themes were then taken forward for final analysis. Theme 1 Collective leadership: ties and connections. Theme 2 Working together in the present. Theme 3 Direct attribution to AL. ( Meaning Participants ‘reference to Action Learning as the key source of a leadership behaviour). Theme 4 Application of skills in practice. The following section presents these findings and a selection of extracts from the participant narratives.

**Findings**

In this section extracts from participants’ reflections on the key themes are presented since the LDP.

**Collective Leadership: Ties and Connections**

For participants, new tieshad been forged with other doctors on the programme, all of whom they described as having known previously but in very different ways. For example, participants stated they had interacted with other medical specialism leads on specific patient cohort care outcomes. However these relationships had not involved the strategic development and planning of care pathways across two hospitals. Such delicate discussions had needed mutual support and responses to problems in common and came from the increased trust and openness which the programme constituents had facilitated. P1 describes how:

*“the networking opportunity and the chance of just sitting down with colleagues across disciplines doing similar roles, with a similar set of problems which we don’t talk about so much at work at the hospital and, and having that opportunity to realise that everyone really does have the same problems and it was a safe forum to discuss different things”* (P1).

The LDP participants recollected how they had grown their self-awareness and built relationships with fellow participants to lead and deliver a change agenda. During the programme’s duration participants had shared their experiences and heard others in a way that had not previously been possible in their organisation. P3 notes:

“*Just through the power of having senior leaders away together on that course learning together out of the working environment was a powerful thing”.* (P3)

As P 2 comments: “*It brought a number of us together who were in similar sorts of positions of leadership and influence who were known previously but not in a close way”.* That said, this was not immediately comfortable. As P5 shares:

*“I have to confess, I went into it quite negative, and the reason I went into it negative is because I am actually quite a stiff upper lip Brit. And wearing your heart on your sleeve and telling everybody else how you feel that particular day is not what I do! And I was surprised with how comfortable and safe I felt doing it (The LDP) with that group of colleagues (*P5*).*

These previously unexperienced ways of knowing each other resulted in a present built on different relationships and ways of working together - notably the enhanced listening and understanding of other colleagues.

The social support, trust and shared memory this had created was recognised and fostered by participants in the LDP in their present day working together. Participants told us that meetings are now intra-organisational, and all but one participant noting different collective leadership styles being adapted. The paper continues now to explore these findings .

**2) Working Together in the Present**

Two years on, the social support that the LDP fostered has enabled the participants to practise a more collective form of leadership, creating new networks in the organisation beyond that of the doctor’s traditional single clinical discipline boundaries.

Participant 5 describes how this now occurs in conversations about hospital merger:

*“I think there has just been a change in style of how we do our meetings and I think certainly when you are trying to go through meetings and trying to understand the need for change, how the practicalities of making it happen, you often forget to listen to someone else’s point of view. So, I think the technique of learning, of teaching you to listen and reminding you it worked for somebody was very good”* (P5).

Participants reflect on how the programme and the skills gained have shaped their current and future approaches to collaboration, offering individuals support in their leadership role. This was illustrated by P4 who observes the change as it is now being enacted in the organisation:

*“I think the other thing that we do now which is completely different is that we hold a support forum which operates under the same sort of conditions (as the LDP) i.e. confidentiality, safety, respect for the others and so on”* (P4).

There continue to be new opportunities to build these forms of support and interaction with access to new resources and modes of resourcefulness present. P6 notes how this works:

*“Yeah, we meet occasionally to talk about our developments and to be honest with you it’s mainly an evening, you know social event where we talk about the problems that we’re having. Be it going on for supper or coffee or whatever it takes the conversation onto the next level.”* (P6)

Resulting in new energy, as P5 explains here:

*“I think the enthusiasm for and the approach to discussing problems or new directions or new managerial issues or whatever may be has grown “*(P5).

The reported deeper relationships are enabling the LDP participants to feel more comfortable when conflict is shared and addressed. For example when discussing closer working across the once very separate boundaries of hospitals and community services. Here viewed as an enabling force for people in the wider organisation to work better together, as P7 reminds us:

“*In the hospital all the major interpersonal conflicts … were occurring because we had different fractions who were trying to pull in different ways. So it was very much to try and get that on the straight and narrow, So yes, the thing that we talked about trying to get the whole service community based about trying to establish better relationships within the community team that is still being pushed forwards. And I’ll go as far to say I think the relationships within the team are phenomenally better****”*** (P7)***.***

Whilst with some surprise, P8 tells of a recent difficult meeting in the organisation that ended very productively:

***“****Yeah I mean to a degree I don’t know I was expecting carnage. You know lots of shouting and screaming, and I didn’t get that, and I was quite surprised … the way the meeting actually went. So yes, I suppose you could argue that from being a little bit sceptical to there being a result in that respect. I was quite surprised that we actually got a meeting with. A very sort of amicable result at the end. So yeah I suppose it has changed*” (P8).

Further, P6 expresses the way in which the nursing disciplines specifically were now supported:

*“the nursing cohort with the hospital systems integration for instance where there was a great deal of stress, a great deal of uncertainty, we use a lot of skills we developed on the course which sort of helped to support that”* (P6)

Participants refer to their ongoing use of AL with colleagues including divisional directors, community services, multi-disciplinary teams and nurses creating a more inclusive approach to working with others:

“*You can trace some of the elements of [the AL] back to daily meetings between groups of individuals within our organisation, which focus on service improvement, safety and the working environment and are intended very much to be non-hierarchical, challenging in as much as you can challenge but you must be able to do it respectfully and in a safe environment, where everybody has the right to be heard, everybody has the right to make a suggestion, everybody has the right to receive comment and so on”* (P1).

The AL strand of the LDP continues to help the doctors explore, experience and reflect on the dynamics of leadership through interactions with different groups and stakeholders in a way that means they can address challenges in their roles. A different use of leadership emerged from the doctor leaders, moving from a use of power and professional clinical reputation to exclude others (Putnam, 1995), to one where the doctors have been able to leverage and open their networks up to collaborate with other disciplines and colleagues beyond the programme cohort- a shift to less control and more influence. In turn this has helped the LDP participants to gain access and share other resources to lead change, moving them towards a less individual-centric form of leadership to a more collective model that has had impact across the organisation. The LDP facilitated doctor leaders to practise a series of interventions and access different models of social relations in response to their localised contexts and the need to come together. Interestingly though in conversation, the Doctors did not immediately claim to be still doing AL as the theme of direct attribution explains.

**(4) Direct Attribution to Action Learning**

Leggat, Gardner & Balding (2011), in their study of Australian health care managers, wrote that it is reasonable to assume that the positive effects of action learning will diminish over time. They had yet to explore their hunch with the participants. Here, when participants were asked about the continued use of AL in the workplace, they initially all responded they were not using the AL model directly . Initially affirming Leggat Gardmer & Baldings’ (2011) position . However in further unpicking of participants narrative, a different story emerged. Participant 7 explained:

*“I think we have genuine action learning sets type stuff although we don’t call them action learning sets, they’re more informal”* (P7)*.*

Whilst participant 3 suggests that*:*

*“You wouldn’t recognise us as an action learning set, but actually [we] have some of their foundations based in those principles”* (P3)*.*

A more unequivocal ‘no’ was also heard by two participants:

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

However P1 notes:

*“Having said that (referring to a No 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). Whilst participant 1 sets the AL legacy out:

*Yeah, we’ve certainly done some informal stuff where we’ve developed forum of people, so for example four chiefs of service would be a good one where we will go out and we will away from the workplace and have a discussion. It may not be as formal as the action learning sets in as much as we don’t do check INS and check outs and so on errm. But I think it is, it is certainly a support forum which operates under the same sort of conditions i.e. confidentiality, safety, and respect for the others and so on* (P1).

Therefore we concluded that variants of AL were still in use by the members of the executive in the organisation. As we asked participants if they had sustained any of the skills of AL, our conclusions were further verified , because participants offered practical examples of the application of the AL experience in leading and delivering change. These were illustrated in the theme application of skills in practice and highlighted through one participant narrative who discussed how they were accessing their AL attributes.

**(5) Application of Skills in Practice**

Participant 7 summarises:

*“Yeah, I suppose I have in fact got the perfect example - I suppose its action learning through a different mechanism, we have an issue within the XXX surgery where we have different people at different hospitals with very different ideas who are very, very strongly opinionated. So basically we bring them together so they can talk about their issues and problems and then with others hearing how they were feeling, others were able to offer advice and support as to how they could overcome their problems. And I know it’s not quite what you’re meaning in the true thing of action learning but it was each individual person bringing their problems to the table for others to solve, which was very much how I see the action learning”* (P7).

Returning to the overall set of data extracts, an enduring role for AL is endorsed. Note how the group of leaders depict sustained application of continuing trust, listening, the acceptance of vulnerability and collective leadership in occasional meetings and informal interactions amongst members which still operate and be effective. Whilst the legacy of AL may not be a feature of every meeting and engagement it may still be an important anchor to draw on for present day workplace support, which moves beyond that of individual leader concerns to that of organisational performance and which are considered next in the discussion. For participants the development programme itself was offered at a specific time in the organisations’ chronology as there was a major integration of hospitals. We would conclude that the AL was a tool which has continued to be helpful as the Doctors continue working to embed change.

**Discussion**

**Action Learning and Leadership**

This research study has shown how within its NHS organisational setting the individual skills and relational ties made through an AL experience have been maintained over time. Doctors have described the sustainability of their leadership practice , and connections between the skills gained in the AL and doctor’s collaborative leadership style are noted. However the Doctors suggest that formal action learning is not practised. Nevertheless if we go back to both Revans (1980 ) and Raelin (2006), there are key aspects of their definitions of AL practice in place. If we return to Revans’ definition of action learning, the attributes of working with problems (no right answers) not puzzles (susceptible to expert knowledge), as the doctors describe their approach to engagement, are present. For the Doctors make reference to a culture where anyone can share a problem in a working group established to help individuals examine options for action. As Kumar and Khiljee (2016) observe doctors are often very averse to change, and as a result quality improvement can fail. Interestingly the organisation care standards have improved further overtime despite the challenges the English healthcare system faces. Further the stated characteristics of collective leadership where every voice is heard have been sustained. Subsequently meeting the criteria of Revans ,where problems being sponsored and aimed at organizational as well as personal development are addressed.

The participants recollect how the support and behaviours offered from the ALS group has been maintained and shared with other organisational members, developing new networks and communities and resulting in a positive individual and group memory of previous coping with change . Revans held the belief that action learners working in sets of peers (‘comrades in adversity’) to support and challenge each other, and the search for fresh questions and ‘Q’ (questioning insight) should take primacy over access to expert knowledge or ‘P’) is alive and well in the organisation. The participant narratives display an awareness of the individualistic tendencies that doctors recognise from their professional training to solve problems through rational diagnosis and lead through the authority of their specialism. However reference is made in the narrative to creating and taking opportunities for problem solving in groups or through interdisciplinary discussions across the organisation to support closer working post hospital merger. As research into what interventions can build collective leadership in healthcare remains limited (De Brún, & McAuliffe, 2019) these study findings offer some additional insights into what they may contribute. Additionally our conversations with the Doctors demonstrate the profound personal development resulting from reflection upon action which Revans viewed as a key element of AL.

Raelin, (2006) suggests that assessing the effect of AL may be dependent on three key strands. The study has found that the first strand that of individuals’ capacity to explore their defences and action when it comes to beliefs about leading and collaborating with others, remains post the ALS experience. It is evident that for the leaders in our sample, there remains a sense of revelation that sharing and exploring a difficult problem can support individual progress and change old habits. Raelin’s second strand of how much individuals learn from their previous experience and use them to look at and solve problems in new contexts is also present and described when the Doctors shared a recent experience related to surgery at the two different hospitals. Finally Raelin’s third strand of impact which is whether at organisational level collaborative leadership is played out. Here the Doctors have shared current experiences of collaboration where they have adapted elements of AL to build relationships across disciplines and boundaries, and they describe how collaboration has made a contribution to organisational integration during change.

Therefore we would argue that whilst formal AL set meetings are not present, key strands of AL consistent with Revans and Raelin’s definition of AL have been adopted and sustained.

There are several studies which correlate positively AL and Leadership Development (Blackler & Kennedy, 2004; Winterburn & Hicks, 2012) but far less that document its sustainability over time. The findings have implications for other organisations in the process of designing LDPs and seeking a high return on investment and raises questions not only about LDP design but also about evaluation methods and timing and their purpose. Finally as the paper reports on a second set of interviews undertaken with the same cohort of participants two years later, it also makes a contribution to the post programme evaluation methods literature.

**Limitations**

In the interpretation of findings, a return to an earlier point made in the paper, concerning the challenge of the knowledge transfer problem (Watkins et al, 2011:213) is made. Difficulties that lie in making claims for the translating of activity from the development programme to individual behaviour and organisational change over time are pertinent. As Van De Valk (2008) warned there are many threats to such assertions (ibid:59) including the impact of other activity in the organisation. One limitation here is a direct cause and effect for the LDP, and organisational transformation cannot be made. What has been done however is to explore the possible contribution the LDP and AL can make over time. When these are aligned with the new social relationships that are being developed within the organisation through and beyond the LDP the emergent and non-linear (Patton, 2011) relationships between the doctor leaders, groups and systems in the change process are identified. These have had unexpected outcomes and are often overlooked. To affirm or make stronger these relationships a further study of social network theory and relational theory and the application of causal mapping may be productive.

**Conclusion**

The aims of the research are firstly to gain insights into the meanings given to the LDP experience two years on by a cohort of doctors with senior leadership roles. Secondly, to establish what the development tool applied, that of Action learning (AL), offered these senior doctors and their practice as they attempted to facilitate change. The study has shown that at a critical point of merger for the organisation, the AL model of facilitation of the LDP has built a bridge between individual and collaborative action over time. In doing so new social support processes have been created which have enhanced and sustained the individual doctor’s leadership style to move towards that of a collective model. The healthcare organisation in its willingness to do something differently within an LDP in response to the recognised complexities of the NHS, has made a small event have a significant impact (Patton, 2011:1).

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