‘DEVELOPING DIALOGIC LEARNING IN CHILDREN’S HEALTH AND SOCIAL CARE TEAMS THROUGH THE USE OF PERSON CENTERED THINKING’

AN ACTION RESEARCH STUDY

by

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ABSTRACT

This action research study reports on the development of a process for dialogic learning underpinned by Person Centred Thinking and the use of Person Centred Planning Tools (PCPTs). This learning occurred in three separate but associated teams delivering family support services to children and their families. The aim of this study was to explore and attain an understanding of how the use of these tools and processes would affect the process of organisational learning in the three settings. It is believed to be the first time PCPTs have been used in this context.

Facilitated action learning supported the use of Person Centred Thinking to attend to and decipher the challenges of the daily working practices and collaborative relationships of the three teams. This appreciative and inclusive methodology supported the development of a ‘common language’, which, where successful, helped to embed a system of whole service dialogic learning. This model of change management distinguishes the process used in this study from other interventions.

Where successful, leadership was central to successful implementation of dialogic learning in the teams and their ambition to become learning organisations. The importance of the individual actions taken by the leaders and their use of power was influential to the outcome of the study.

The synergy created by the synthesis of Person Centred Thinking and dialogue in the teams with good leadership, suggests that the dialogic learning emanating from it has perceptible and noteworthy connections for, and to, organisational learning.

The original contribution to knowledge from this study is the development of a theoretical understanding of how person centred practices when embedded into teams can transform and positively augment ways of working. Specifically it posits how dialogic learning practices provide the culture and context to facilitate individual and team growth and understanding through organisational learning.

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ACKNOWLEDGEMENTS

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I begin by thanking my parents who have both passed away. Their kindness, love, political insight, values, principles and support were ever present. Although Mum died when I was a teenager, she remains as central to my life as she ever was. Dad always reminded me how proud mum would have been as I achieved my professional and academic qualifications as a mature student. This thesis is underpinned by the values they instilled in me, I am proud to be their son.

I have a debt of gratitude to my friend Paul whose companionship means everything to me. My career pathway is guided by our friendship. Without Paul I would be a far poorer person in so many ways. Thank you Paul for keeping me sane, making me laugh and keeping things real. I aim to continue to learn from you in order to make a difference, for and with, people who use the services I provide and those who are on the front line delivering the service itself.

My thanks for my family have no bounds. My children Oscar and Milena have grown up with me repeatedly moaning at them through tiredness or not being able to play because “I am working.” They will soon have their Daddy back ready to play, while the use of my computer, which holds an ever present place on our dining room table will soon be reassigned for school homework.

My wife Sarah has spent half of our married life sat alone in an empty lounge during the evening, while I have sat in another room dealing with an ‘empty head’. Sarah’s love, support and encouragement have been consistent. I look forward to us sharing time together without the company of Habermas, Handy or Senge et al.

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CHAPTER ONE: BACKGROUND TO THE STUDY

1. A personal drive to make a difference: where the study began

I am able to trace the values, principles and philosophy which underpin this study back to 13th September 1977. This is the date I first met Paul, who aged three years was attending the 'Toy Library' (a place where people from disadvantaged backgrounds were able to take their children to play and subsequently borrow toys they liked) where I had a placement from school as a part of my 'Community Studies' lesson. When I arrived Paul was alone playing: a noisy, chirpy little fellow with an infectious laugh. I wondered why no other person was playing or even engaged with him. I then heard people talking about him and his mother, who lived with a mental health problem. This was my first experience of a person being labelled and openly discriminated against.

The toy library was organised and run by volunteers who openly spoke in a derogatory manner about Paul's family, and were clearly wary of Paul because he was loud and already had a vocabulary that consisted mostly of rude words. It was fortunate for Paul and me, that as a twelve year old I immediately took a liking to him. Paul had a severe learning disability and some physical disabilities, but there was nothing I could see that was 'wrong' with him. I only saw a child who engaged with me and made me laugh. This meeting was not only the beginnings of a friendship that is as strong today as ever before, but it also laid the foundations for my career.

From the day we met, I befriended Paul. I would call at his house and take him out at weekends and during school holidays. At sixteen, I enrolled on a course that prepared me for working in residential care. Through this vocational course, I worked with Paul during his visits for respite care in a local children's home, where I also volunteered, and at the school that he attended. What a start to my career, getting to work with people and spend time with my 'best mate'. At eighteen, I took up my first full time post as a 'House Parent' in a residential establishment. Here I worked with Paul and many other children for five years. As I gained in experience I began to increasingly question why other people I met, and worked with did not always respect and value disabled people as being equals, people who I understood were just like anybody else, simply requiring support to enable them to live as full a life as possible.

My journey with Paul has taken us from friendship to foster family, from adult placement to home share. He has been my best friend and best man, yet he is still oppressed and discriminated against, living alone in a house supported by carers provided by the local authority.

My disappointment with the care Paul has received has led to numerous complaints, letters of support and a lot of frustration. Truth be told though I was just one person fighting a system designed to defend itself. In 2001, while seeking new ways of supporting Paul, I came across new United Kingdom (UK) Government Guidance for supporting adults living with a learning disability . This guidance promoted the use of Person Centred Planning (PCP) to support

people with learning disabilities to describe how they wished to be supported to live their lives. I asked myself “is this the panacea I have been seeking?” Wasting no time, I contacted the Valuing People Support Team , those responsible for ensuring the new guidance was acted upon in practice, and arranged to meet with a representative to discuss how I could support Paul to develop his own plan. Several months later Paul had his PCP. He was the first person in the local authority where he lived to have one.

In theory Paul’s PCP was perfect. Paul had been at the centre of its development, it was thorough and truly reflected who Paul was, how he wished to live his life and the support he required to be successful in doing so. Unfortunately, ten years later Paul is still waiting for his plan to be recognised and implemented. Although I revisit it with Paul and his staff team on a regular basis, and some of the detail is acknowledged, this is more attuned to my relationship with Paul’s carers than it is a reflection of the ‘power of his plan’. It appears to me that Paul has been the victim of a tension between the status of his PCP and the legal, commissioning based, care planning process followed by his social worker. In my experience, this process for people dependent on care services appears to have dominance over their PCP, at times riding roughshod over the stated wishes and feelings of the service users.

Although disappointed at the outcome for Paul, I remained impressed by the inclusiveness and the appreciative nature, process and tools of PCP. I believed that there was potential to use PCP in children’s services to make a difference. The manner in which children’s

services were set up, and their requirement to meet the stated wishes and feelings of children (Children Act 1989) supported my belief.

1.1 Policy and Contextual Framework

The Children Act (1989) brought a renewed emphasis on the value of family support services, and this approach was later reinforced by government policy on refocusing services (Biehal 2006;Parton 2006). The aim was to shift the focus of attention away from the investigation of abuse, which resulted in a small number of children who were considered to be 'at risk of significant harm' receiving a service, in favour of providing support to a wider range of families where children had been assessed as being 'in need' (Department of Health 2005).

Parton (2006) discussed the 'refocusing' of children's services in the 1990s, for which he argued there were two major catalysts: the publication of the Audit Commission Report '*Seen But Not Heard: Coordinating Community Child Health and Social Services for Children in Need' (Audit Commission 1994)*, and the launch by the Department of Health of '*Child Protection: Messages from Research' (Department of Health 1995)*. He went on to overview the introduction of a plethora of mainly Treasury- led policies introduced under the New Labour Government that underpinned UK social policy in relation to children and their families. These covered areas of general support for all parents with children, specific and targeted support for poor families with children, and a range of initiatives specifically targeted at disadvantaged children who were at risk of

being socially excluded. These policies advocated a universal approach to service delivery, with an aim to eradicate child poverty and improve outcomes for all children. During a speech known as ‘the Beveridge Lecture’, Tony Blair, the then Prime Minister of the UK, announced “Our historic aim will be for ours to be the first generation to end child poverty and it will take a generation. It is a twenty year mission but I believe it can be done” (Blair 1999).

The resulting aim then of national statutory and non-statutory interventions with young children and their parents or carers was to target known risk factors in an attempt to prevent or ameliorate negative outcomes for the children and their families. Most interventions were targeted at particular groups of children or their parents and not all children or all families. These groups ‘in need’ were normally identified by known risk factors, including material factors such as poverty or poor neighbourhoods; family factors such as poor parenting, family violence or poor maternal mental health; or child factors such as developmental delay or behavioural problems (Smith 2006).

In April 2000 the government in England and Wales also issued national guidance on assessing children in need and their families (Department of Health 2000). The purpose was to promote interdepartmental and multi disciplinary working, and “To ensure that referral and assessment processes discriminate effectively between different types and levels of need and produce a timely service response” (Department of Health 2000: 20). The Assessment

Framework was developed to take account of the complex inter-relationship of factors in the inner and outer world of the child and family which can have an impact on a child and to provide a conceptual map for practitioners to use in the process of gathering and analysing information about what is happening (Rose 2001). The framework is, therefore, a way of understanding a child within the context of the family and the wider community in which he or she is living. The framework consists of three systems or domains:

- the child's developmental needs;
- the parents' or caregivers' capacities to respond appropriately to those needs; and
- family history, wider family and environmental factors (Rose, Gray, & McAuley 2006).

Cleaver, Walker, & Meadows (2004) found that staff working with children in need and their families, were generally very positive about the framework. However, practitioners were reported as experiencing difficulties when it came to analysis, judgement and decision making about how and when to intervene. Practitioners (and their managers) appeared to be displaying a lack of confidence about what services may make a difference for the people they were working with. Such feedback has strengthened the commitment of policy makers to address issues of intervention and to explore how to assist practitioners in their day to day decision making.

Although the *Framework for the Assessment of Children in Need and their Families* (Department of Health, Department for Education and Employment, & Home Office 2000) introduced and reinforced a holistic and multi disciplinary approach to assessment, the outcome for children and their families at the end of this process remains service led, and service centred. Working with 'The Assessment Framework' in a person centred way aims to allow practitioners the opportunity to gain much more detailed, fuller information relating to the three domains, how each family member perceives the 'family's functioning' and how best they need to support each other, and be supported by others. The information gained may then be used to inform judgements and decision making about how and when to intervene.

Throughout this period, however, concerns relating to the effectiveness of our child welfare and protection services continued to be raised. July 2001 saw the publication of *'The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 -1995: Learning from Bristol,* commonly known as the Kennedy Report (Kennedy 2001). This highlighted issues of poor teamwork and communication within the National Health Service. The aim of Professor Kennedy's recommendations was to produce an NHS in which patients' needs are at the centre and in which systems are in place to ensure safe care and to maintain and improve the quality of care. Earlier, the Inquiry into the circumstances surrounding Victoria Climbie's death, led by Lord Laming, resulted in an influential report (Lord Laming 2003). The chilling and tragic manner in which Victoria died was described as "deeply disturbing."

Victoria was known by all of the main statutory and non-statutory children's services, and was admitted to two different hospitals because of suspected deliberate harm. The report concluded that she was failed by the system that was in place to protect her. The report of Lord Laming echoed many of the conclusions drawn by Kennedy (Kennedy 2001).

Every Child Matters, a Green Paper (Department for Education and Skills 2003) published for consultation, formed a part of the Government response to the Laming inquiry and led to the development of a framework to strengthen preventative services. Margaret Hodge, Minister for Children, Young People and Families, described the consultation as "the richest and most significant debate on children's services for over a decade" (Department of Health 2004b) and gave clear endorsement to the Government plans for radical and positive change in service delivery for children, young people, and their families. The Children Act (2004) provides the legal framework for the programme of reform .

Every Child Matters: *Change for Children (Department for Education and Skills 2004a)*, champions how partnership agencies and stakeholders can work together towards improving outcomes for children, young people, and families into a national framework. Children and young people were also to receive increasingly personalised care from health services in line with the standards of the Department of Health's *National Service Framework for Children, Young People and Maternity Services (Department of Health 2004b)*.

1.2 Sure Start Programme

One of the specific initiatives that had been introduced following the refocusing debate, targeted at disadvantaged children 'at risk' of being socially excluded, was the Sure Start Programme. When launched in July 1998 the National Sure Start Programme was given a remit to improve the life and early educational chances for families living within the most socially and economically deprived wards within Britain, but mostly based in England. By 2004 there were 524 Sure Start programmes delivering services with a 'bottom up approach' through local consultation and partnership working with families, community and voluntary groups, and statutory service providers.

One of the opportunities afforded to Sure Start Programmes was the ability to design service delivery specifically for the identified needs of the local community. At a Sure Start programme in East Lancashire (East Lancs Sure Start), local consultation undertaken by myself indicated that the skills of social workers, in particular providing support in the area of parenting, were highly valued by families, although their statutory duties, often perceived as being able to 'remove children at will', were not. This resulted in the recruitment of a social worker who was given the opportunity to support families within a non-statutory organisation.

Following a period of careful consideration of the processes and practices involved in PCP, the Management Board at East Lancs Sure Start (of whom 50% were parent/carer representatives) agreed that the values and principles that underpin PCP traditionally used within adult service provision were equally relevant to children and

their families served by Sure Start programmes. They agreed to pilot the use of PCP within their service delivery.

1.3 Person Centred Planning

The Department of Health describes Person Centred Planning as a way of assisting people to work out what they want, the support they require and helping them to get it. It is the cornerstone of the government's White Paper for people with learning disabilities `Valuing People' (Department of Health 2001). At East Lancs Sure Start, the concentration was on the use of PCP with the children and families who use services, while also developing plans written with the whole family (Sanderson, Acraman, & Short 2004). Skilful PCP with an individual always aims to consider the person within the context of their family. However, the Sure Start Programme took this a step further aiming to focus on 'what is important' to each family member, and to identify the support that the child and each individual family member required to be successful. Therefore, I used the Person Centred Planning Tools (PCPTs) in an attempt to be both child centred and family focussed.

Using this person centred approach we aimed to support families to find their own solutions when experiencing difficult periods in their life, providing an opportunity for them to have ownership of their support packages, while creating possibilities for the sustainability of their plans, or care packages. Where there was an identified need for statutory service intervention for families who received a service from the Sure Start Programme, it was important for them to continue to have ownership of their PCP, and that these plans were recognised

and respected by other professionals and used to inform and build upon the traditional needs-led assessments.

Smith (2006: 47) argues “there are two varieties of interventions for young children and their parents in the UK. The first are ‘home grown’ interventions, that are usually developed and used locally, and of relatively small scale”. Many of these interventions she states are developed locally and designed to meet local need. The second type of interventions is ‘imported’ intervention programmes usually developed in the USA. The person centred approach developed at East Lancs Sure Start sits between these, using tools developed in the USA and designing them around identified local need with a very different group of service users.

While discussing service delivery for older people Bowling et al. (2002) assert that the reason public services and support systems exist in the first place is because there are service users. People who use services aim to live independently in an environment in which they can thrive and live life to the full. The main factors that reflect independence from the perspective of people who use services are the ability to make choices and to exercise control over their own lives (Bignall & Butt 2000;Boaz, Hayden, & Bernard 1999;Bowling et al. 2002). These observations may also be attributed to service delivery for children and their families and indeed reflect the outcomes identified within *Every Child Matters* (Department for Education and Skills 2003). Dowling et al (2006) assert that PCP can facilitate the personalisation of service delivery.

1.4 Personalisation of Service Delivery

A major aim of social policy for children and their families at the outset of this study was the drive towards the 'personalisation of service delivery'. My interpretation of this was to drive change through the perspective of service users and therefore to personalise service delivery through participation. It was my hope that by using PCP (and the associated tools and process) to inform this I would enable individuals, families and groups to move from being passive recipients of services designed for them, to being at the centre of service redesign and delivery. My best hopes for success were supported through social policy as Dr Stephen Ladyman MP, the then Parliamentary Under Secretary of State for Community announced:

> "Our society is based on the belief that everyone has a contribution to make and has the right to control their own lives. This value drives our society and will also drive the way in which we provide social care. Services should be person centred, seamless, and proactive. They should support independence, not dependence and allow everyone to enjoy a good quality of life, including the ability to contribute fully to our communities." (Department of Health 2005: 12).

The values and principles that underpin the use of PCP within adult services, marry with expectations within health and social care services for children, young people and their families. They are equally relevant when considering the five outcomes for children and their families identified within the *Every Child Matters* documentation (Department for Education and Skills 2003;Department for Education and Skills 2004a;Department for Education and Skills 2004b) which are:

- To be healthy;
- Stay safe;
- Enjoy and achieve through learning;
- Make a positive contribution to society; and
- Achieve economic wellbeing

However, although the use of PCP appears to complement what is seen as good practice within children's services, an initial search of the literature indicates that this approach to service delivery is rooted within adult services. Therefore, this study considers Person Centred Planning within the context of services for children and their families for the first time.

The practice guidance, *Framework for the Assessment of Children in Need and their Families* (Department of Health, Department for Education and Employment, & Home Office 2000) leaves the practitioner at the point of making decisions about a plan of intervention (Rose, Gray, & McAuley 2006). As Saunders, Berliner, & Hanson (2003) explain:

> "A basic principle of all clinical practice is that assessment should precede the initiation of interventions. Based upon the results of the assessment, a treatment plan should be developed that is tailored to the problems and needs of individual family members as a whole. The likelihood of a successful outcome is enhanced substantially when effective interventions are matched correctly to specific problems through appropriate assessment" (Saunders, Berliner, & Hanson 2003: 14).

Using a person centred approach to service delivery enables practitioners to learn alongside a family 'what is working' and 'what is

not working' from the perspective of everybody involved with a family, about all relevant aspects of the family's functioning. By doing this, and supporting the family to develop and take ownership of their plan, support interventions are identified with, and for, the family, rather than attempting to fit families into services that are not always appropriate to their holistic needs.

To enable practitioners to work in a person centred way there are a number of practical tools called Person Centred Planning Tools (PCPTs). These tools offer a different way of gathering information about what is important to someone, what they want now and for their future, or what support they need. This is very different from typical assessments as it is a shared journey of learning (Mount 1990).

Professionals can use PCPTs to learn more about the children and families they support, but in a different way. The family support team at East Lancs Sure Start recognised that the development of a PCP may be informed by the accumulation of information gathered from the use of a number of the PCPTs. Delivering a person centred service, however, may also be achieved by using individual PCPTs to support children and their families to work out 'what is important to them' and 'what support they need to be successful'. The tools used regularly within East Lancs Sure Start to gather information were:

- *Like and Admire*: This tool is used upon first contact with a child/family and at regular intervals. It helps to counter the frequent focus on what is wrong with a child or member of their

family. It records what people like and admire about someone and aims to appreciate the qualities and strengths of individuals, families and team members.

- *What is important to a person/family, and what support they need:* This aims to identify what is required to support people in a manner that is right for them. This enables service users to feel supported appropriately, while identifying issues around health, safety and safeguarding in order to work honestly and transparently with families to reach mutually agreed outcomes.

    - *The doughnut sort*: used to enable professionals to identify their core responsibilities, where they are able to use their own creativity and judgement without fear of not responding appropriately. It clarifies the purpose and roles of different professionals and agencies, and identifies where people are delivering a service outside of their remit. This works well in the multi disciplinary children centre environment when reviewing their non-statutory work, identifying when there is a need to refer on to statutory organisations.

    - *Sorting what is working and what is not working**:*** Aims to help professionals and families to clarify what to build on, maintain or enhance in relation to service delivery, and to understand how any part of family life, or an organisation, is working (or not) from everybody's perspective. This has proven to be a

very effective tool when used in mediation between families, professionals and organisations.

- *4 + 1 questions:* This 'action learning' tool aims to enable practitioners and families to learn from their efforts and reflect on their interventions. The questions being: 1). What have we tried? 2). What have we learned from what we have tried? 3). What are we pleased about? 4). What are we concerned about? The +1 question therefore looks at the whole picture and identifies actions and expected outcomes: "Given what we know now, what are we going to do next?"

- *Communication charts:* This tool is used to gather information about what people are trying to say when they do not communicate in words, or where their behaviour communicates more clearly than words. This may prove valuable within settings where children have developed reputations for having 'challenging' or 'disruptive' behaviours. Mapping their behaviour on a communication chart aims to decipher what their behaviour is telling us about the environment around them or the people they are living with.

- *Good days and bad days:* This tool aims to understand what a good day looks like for someone and what a bad day is like. This information aims to work out with the person what change needs to happen for them or their family to have more good days.

1.5 Family Essential Lifestyle Planning

While using PCPTs to support a particular family, in autumn 2004, staff at East Lancs Sure Start recognised that they had, together with the family, gathered a significant amount of information about the family's views and needs, that may be put together to begin a 'PCP'. A decision was made to show the mother of the family 'Angie' a copy of an Essential Lifestyle Plan (ELP) and ask her if she would like to have her family information gathered and presented in this manner.

The result of this was to call two Child and Family Meetings, which lasted a total of four hours. The family were asked who they thought would benefit most from the information gathered. At the time, they were receiving support from the children's school, the local authority children and families' social work and family support team, and a Health Visitor. Letters were sent out on behalf of the family inviting these professionals to attend. All of the professionals invited attended the meeting, as did the four children in the family aged 5, 7, 9, and 14. These meetings used headings from PCPTs to gather information about each member of the family and the family as a unit from everybody's perspective. The 'team' then worked out 'what was working' for the family, and 'what was not working'. From this information an Action Plan was devised which used the followed headings:

- Actions we are going to take with family and friends. We have discussed the services that are available with the people who

work with us. This is the support we have agreed we need as a family, and individually.

- We have discussed how things are going with the people who work with our family. These next steps are priorities for us at the moment
- Next step (individually broken down to achievable tasks).
- Who can help and how, where and when will support be given?
- How will we know if it has made a difference?

Therefore, within four hours, they had achieved a detailed plan of work to support the family, of which the family had ownership and the information gathered was placed into the format of a Family Essential Lifestyle Plan (FELP) for the family to keep and add to when they thought it appropriate to do so. I believe that this was the first time, internationally, that PCPTs had been used to gather information in this way for more than one person (Sanderson, Acraman, & Short 2004).

The actions from this planning process echoed, in many aspects, the results of previous social work assessments and set out in detail how the family should best be supported from the perspective of the family and professionals alike. Where it differed significantly was in the process. This had involved the whole family in developing a plan that belonged to them, and therefore they had ownership of it and were determined to ensure they each respected what was important to each other, and to support each other to make a difference for themselves. Although this appears to be positive and empowering for

families of children who are identified as ‘in need’, the power held by statutory services remains an issue for families being supported by them. Power is an issue because it is not always equally apportioned. This means that some people have more power than others and, traditionally within services power has resided in the hands of service providers rather than users (Dowling et al. 2006). Therefore, implementation of plans developed with children and their families may be reliant on social workers, their interpretation of social policy and the lack of clarity of what is meant by personalisation of service provision.

1.6 Research Aims

This study builds on the early work of developing a person centred approach to working with children and their families within the East Lancashire Sure Start Programme. Using the same action learning approach I used the PCPTs to inform family support services in three different but related services.

At the outset of the study, my over-arching research aim was to explore and attain an understanding of how introducing the use of Person Centred Planning Tools and Essential/Family Lifestyle Planning to health and social care services for children and their families would influence their service delivery. However, through introducing this process into the teams I was working with, I quickly recognised that the performance and understanding of individual staff and the teams themselves were benefitting from the use of the tools. This led to me exploring and attaining an understanding of how the use of PCPTs had an impact on the process of organisational

learning in the three settings (two focusing on family support, one in a statutory setting, the other in a children's centre and project supporting children living with obesity and their families).

1. 7 Research Objectives

There were specific research objectives that needed to be met in order to achieve the above aim:

- To review the literature and research on the use of Person Centred Planning in service delivery as it exists.
- To gain an understanding of how the use of PCPTs, and development of Essential/Family Essential Lifestyle Plans, impacts on service provision in the identified health and social care service providers.
- To gain an understanding of how the use of Person Centred Planning Tools, and development of Essential/Family Essential Lifestyle Plans, affects the experience of service users of the identified health and social care services.

1.8 Research Methods

A major aim of health and social policy in the United Kingdom is to move towards the 'personalisation of service delivery'. Person Centred Planning (PCP) is one means of personalising service delivery (Sanderson, Acraman, & Short 2004). This study uses specific Person Centred Planning Tools (PCPTs) and a process I have developed from PCP to inform an appreciative method of dialogic learning that may if replicated support organisational learning within aspiring health and social care settings.

The study uses an interpretive, critical theoretic Action Research approach with the focus being on the practice of professionals and non-professionals from health and social care services. It additionally draws on Appreciative Inquiry (AI) with an aim to explore settings and issues in an affirmative way.

Four main themes were evident in data from each of the services:

- Engagement
- Process
- Context
- Culture

These themes provide a complex and interesting way of exploring what was happening within the teams. The mechanism at work in this study is what Liebling, Elliott & Arnold (2001: 162) describe as a “normative process”. The approach appeared to engage the research participants in a meaningful process that they understood. This developed into a whole team approach establishing a dialogue about how to achieve appreciative ways of working and outcomes through dialogic learning.

The literature on PCP is limited but that which does exist supports the notion that the specific tools and process used within this study may be effective in promoting an appreciative approach to organisational development (Dowling et al. 2006;Robertson et al. 2005;Sanderson, Acraman, & Short 2004).

My original contribution to knowledge is the development of a theoretical understanding of how embedding person centred and appreciative practices into teams can alter and positively enhance ways of working. Specifically I theorise how appreciative, dialogic learning practices provide the culture and context, which facilitates professional growth and understanding through organisational learning.

1.9 Research ethics and research governance

This study was approved by, the Research Applications Sub Committee at East Lancashire Primary Care Trust, The University of Central Lancashire Faculty of Health Ethics Committee and Cumbria and Lancashire B Local Research Ethics Committee (LREC).

Careful consideration of all consent and assent issues was made throughout the research. All participants received a comprehensive information letter and had the opportunity to discuss fully their potential involvement in the project with me personally. As the principle researcher, I placed no pressure on anyone, at any time to participate in the study.

1.10 Thesis Structure

This action research study took me and the teams involved on a journey of discovery using a fusion of approaches to social inquiry, dialogue and theories relating to communication, leadership and organisational learning. Undertaking a scoping review of the literature in each of the subject areas would potentially produce a scholarly publication on its own merits. I chose, therefore, to review these

subject areas specifically in relation to their relationship with the study. In chapter two, I provide a brief context for the philosophical values of Person Centred Planning (PCP) and look at how PCP is moving out from adult-focused health and social care settings to address service delivery focused on children and their families. I briefly indicate how the work that is central to this research study has built on earlier work I have been involved in. I then address two other areas, 'family support' and 'childhood obesity' both of which are fundamental to the study itself as these are the arenas in which this action research study was undertaken. In drawing my review to a close, I summarise the key gaps and deficits in the literature.

In chapter three, I introduce my study data and discuss the methodology I used to determine my findings. I used action research to inform and underpin a reflective process of solution focused, progressive problem solving. I facilitated this process, which was led by individuals working within a team of shared learners. These teams used the PCPTs to address team and individual issues and to solve the challenges their day to day practice of working alongside children and their families raised. This methodology provided the participants with an opportunity to work together and support each other to improve their strategies, practices, and knowledge of the environments within which they practice. As a facilitator, I supported the teams to examine 'what was important to them' individually and collectively, and how best they needed to be supported in order for them to be successful in achieving their desired outcomes and improving their work practices.

In chapter four I present my findings which centre around a thematic analysis of a deceptively complex process developed from the methodology of action research, introduction of PCPTs and the dialogic nature of this fusion of approaches.

In chapter five I offer a theory of leadership and organisational learning which I have christened Appreciative Dialogic Learning. This is developed from my findings, Habermas' work on communicative action and communicative rationality and Wenger's work on communities of practice (Habermas 1990;Wenger 1998;Wenger 2000). I first address how the person centred planning tools (PCPTs) were central to developing team dialogue through the vehicle of action learning. I then present a reflexive discussion of the influence of power, Appreciative Inquiry, and cognitive team learning on leadership and organisational learning theory. Finally, I introduce my model for Appreciative Dialogic Learning (see Figure 4: 191).

In chapter six, I conclude my study and offer my recommendations for future research and service delivery with health and social care settings. Here I describe how my work may influence the future development of a sustainable dialogic approach to leadership underpinned by appreciative learning and informed through the associated processes of PCP.

CHAPTER TWO: REVIEW OF THE LITERATURE

2. Philosophical values of PCP and the Person Centred Planning Process

It could be argued that the concept of PCP can be traced back to the work of Carl Rogers in the fields of psychotherapy and counselling (Rogers 1951;Rogers 1961). Rogers' person-centred approach, according to Embleton Tudor et al (2004), is informed by the values found in existentialism and phenomenology. While the approach they argue is neither exclusively nor completely phenomenological nor existential, it shares some of the assumptions and stances of both. Geriatrician, Brooker (2004) recognises these same values in PCP. PCP has emerged from a continuous search for better ways to include people with disabilities in society (Sanderson, Kennedy, & Richie 2002). The 'Principle of Normalisation' developed initially by Nirje and then by Wolfensberger (Nirje 1972;Wolfensberger 1972) was based on the belief that a person with disabilities should enjoy a quality of life and position in society equal to, and as valued as, that of a non-disabled person. Wolfensberger (1972) viewed the role of support services as assisting and enabling disabled people to achieve this. In order to measure how this could be achieved, and evaluate how well services were doing, he developed tools to help capture the identity of individuals as opposed to their characteristics (Wolfensberger & Thomas 1983;Wolfensberger & Glenn 1975).

In parallel the emerging principle of normalisation the disability rights movement in the United States of America (USA) and the United Kingdom (UK) were beginning to gather momentum and to develop

their own theoretical framework for understanding disability and the role of disabled people in society (Finkelstein et al. 1993)

The social model of disability (Oliver 1983) locates disability in the interaction between the individual and the social and physical world. The job of support services, therefore, is not to 'fix' the individual but to reduce the restrictions they face and to support them in leading their own life (Finkelstein, Oliver, Swain, & French 1993;Sanderson, Kennedy, & Richie 2002). Similarly, PCP places the emphasis on transforming the options available to (and for) individuals as opposed to fixing or changing the individual themselves (Sanderson 2000).

One of Wolfensberger's early collaborators, O'Brien (1987), recognised that there was little guidance for people working in the support services to enable them to understand what success would look like for people they were supporting if they did so appropriately. His key publication 'The Five Accomplishments' (O'Brien 1987) introduced a framework to enable people to understand what was required from them. O'Brien (1987) introduced five areas for practice widely agreed to be important in informing the quality of life that disabled people were experiencing. He believed that support services should be judged by the extent to which people were supported to live their lives through his five accomplishments:

- Sharing ordinary places
- Making choices
- Developing abilities
- Being treated with respect and having a valued social role

- Growing in relationships

These five accomplishments (O'Brien 1987) were viewed as a valuable guide for supporting disabled people to have a better quality of life. This work was further developed through ‘Personal Futures planning’ (Mount 1990).

The developing recognition for people with learning disabilities to be valued and respected as individuals in their own right was further emphasised by Smull & Burke-Harrison (1992). While supporting people in the USA to move out of long stay institutions back into their communities, Smull & Burke-Harrison (1992) recognised that the documentation kept on people reported solely on their conditions and risks they may pose. There was no documentation describing the personalities of these people, nor what was important to them about the support they received. Together, building on previous work (Mount 1990;Nirje 1972;O'Brien 1987;Wolfensberger 1972), they developed an approach to inform successful planning with people who reportedly had ‘severe reputations’. They named this approach ‘Essential Lifestyle Planning’ (Smull & Burke-Harrison 1992).

Using a number of person centred planning tools (PCPTs) ‘Essential Lifestyle Planning’ (ELP) supported people individually to indentify who they were, how they wished to live their lives and helped them to have their choices honoured by the services which supported them. These were people for whom traditional approaches to service design had repeatedly failed.

Smull & Burke-Harrison's (1992) work created much interest in the USA and several practitioners attempted to build on their work, which in turn led to the development of several methods of intervention designed to support disabled people to improve their lifestyle and support mechanisms. There are currently four specific methods commonly used to develop or inform a Person Centred Plan in the UK (Dowling, Manthorpe, Cowley, King, Raymond, Perez, & Weinstein 2006): the McGill Action Planning System (Vandercook, York, & Forest 1989); Essential Lifestyle Planning (Smull & Burke-Harrison 1992); Personal Futures Planning (Mount 1990); and Planning Alternative Tomorrows and Hope (Pearpoint, O'Brien, & Forest 2011).

The method used in this study is closely related to the work of Smull & Burke-Harrison (1992). The philosophy that underpins this approach supports the belief that at the centre of PCP are the fundamental values of inclusion, choice, and independence. O'Brien & Lovett (1992) suggest that the PCP process is challenging to service providers because traditionally, they have kept service users at a distance through a controlling relationship. Working in a person centred way requires true collaboration that works towards an equal non-coercive relationship.

PCP seeks to extend the range and depth of things over which people can exercise choice and control, both in the planning process itself and in the way services and support are organised as a result of planning (Sanderson 2000).

Traditionally the focus of professional intervention in the lives of disabled people has been focussed on the person's impairment (Oliver 1990). People, therefore, have been channelled into different services depending on the category of their impairment; for example, learning difficulty, sensory impairment or loss of mobility (Sanderson, Kennedy, & Richie 2002). This leads to a process of assessment which analyses and quantifies the impairment and its impact on the person's ability to undertake a range of tasks. Undertaking an assessment in this way results in a negative description of the person in terms of what they are not able to do it is deficit centred.

The resulting information gained from this process is then used by professionals involved with the person, on whom they are reliant, to set goals for the person to attempt to overcome their deficits (Sanderson, Kennedy, & Richie 2002). In a sense, it could be argued that there was a misguided tendency to focus on what people were unable to do, while attempting to teach them to become more independent. This contrived method of 'support' can often be observed within organisations which attempt to measure their employees' competency against a series of measures they are unable to achieve.

The most serious consequence of this for disabled people is that their participation in ordinary community life is judged as being dependent on their success in achieving their goals. This allows staff working with disabled people to only provide them with new opportunities when the staff feel they are 'ready' (O'Brien 1987). It is as though people have to earn the right to be a part of their own

community. People who expected services to help them manage their own lives instead become trapped in a world where others make judgements about their future (Sanderson, Kennedy, & Richie 2002). There is a similarity with a person who is judged by an organisation not to be competent to carry out their role appropriately and has to earn the right to remain employed as others make judgements about their future based on what they are not able to do, as opposed to building on what they are good at.

PCP starts with the person rather than the service and asks, “given your circumstances and the things you need support to achieve, how can we work with you to make it possible?” This challenges the traditional perception of ‘independence’, as it views independence in terms of choice and control as opposed to having the mental or physical capacity to carry out particular tasks. PCP, therefore, seeks to extend the range and depth of things over which people can exercise choice and control, both in the planning process itself and in the manner in which services and support are organised as a result of the planning (Dowling, Manthorpe, Cowley, King, Raymond, Perez, & Weinstein 2006). Asking staff “what is important to you in order for you to work to your maximum potential?” and “what support do you need from colleagues and the organisation in order to be successful?” provides similar opportunities for people to obtain the right level of support to do well in the work place.

PCP, therefore, questions the assumption that needing help and support is in itself undesirable. As French (1993: 48) states “giving and receiving help can greatly enrich human experience.” PCP

assumes that people with disabilities are ready to do whatever they want as long as they are adequately supported. The ‘readiness model’ is therefore replaced with the ‘support model’, which acknowledges that everyone needs support and some people need more support than others (Sanderson, Kennedy, & Richie 2002).

2.1 The relationship of PCP to services for children and their families

While working as the Programme Manager of an East Lancashire Sure Start programme, I introduced and developed the use of ELP (Smull & Burke-Harrison 1992) with children and their families who used the service. At the same time I developed plans with the whole family, moving this method of planning away from the previous focus on planning with individuals for the first time. These plans were named Family Essential Lifestyle Plans and they attempted to be child centred whilst being family focussed. Along with two colleagues, I reported on the use of FELPs within a learning disability nursing publication (Sanderson, Acraman, & Short 2004).

A major aim of UK social policy for children and their families during the early part of this century was the drive towards the ‘personalisation of service delivery’. This was made explicit through guidance publications such as Every Child Matters: Change for Children (Department for Education and Skills 2004a) and the Department of Health’s ‘National Service Framework for Children, Young People, and Maternity Services (Department of Health 2004b). However, identifying what was meant by this rather grand statement can be an arduous task. Houston (2003) suggests it is a

process that positions the child and their family at the centre of their own planning processes, humanises the professional services and restrains what he describes as ‘inflexible bureaucracy’.

The fundamental values that underpin a person centred approach to service delivery are the principles of independence, choice, inclusion, equality, and empowerment (Sanderson, Kennedy, & Richie 2002) which need to be embraced as the foundations of service provision. Although aimed at adult services this is equally relevant when considering the five outcomes for children and their families identified within the ‘Every Child Matters’ literature (Department for Education and Skills 2004a;Department for Education and Skills 2004b). Dowling et al (2006) assert that PCP can facilitate the personalisation of service delivery.

The practice guidance, ‘Framework for the Assessment of Children in Need and their Families’ (Department of Health, Department for Education and Employment, & Home Office 2000) was developed as an assessment tool. This information gathering process, however, places the practitioner at the point of making decisions about how to use the information to create a plan of intervention (Rose, Gray, & McAuley 2006). Using a person centred approach to service delivery compliments the assessment process and enables practitioners to learn alongside a family ‘what will’ and ‘what will not work’ for them in terms of intervention. By doing this, and supporting the family to develop and take ownership of their support plan, interventions are identified with (and for) the family, rather than attempting to fit families into services that do not always respond in an holistic way to

their needs (Sanderson, Acraman & Short 2004).

2.1.1 Gaps in the Literature relating to PCP

Although there is a literature on PCP, it is limited in a number of ways including the fact that PCP adopts a primarily individualised adult focus. This approach pays scant attention to the wider role of the family, which is the 'unit of dialogue' for services wishing to personalise service delivery for children. In previous work as a manager, I have developed PCPTs to be of use with children and their families (Sanderson, Acraman, & Short 2004). In this study, I take their use further into organisational service delivery.

Within the existing literature on organisational learning, there appears to be little evidence from work place based research to validate the association between the adoption of a learning culture and improvement of organisational performance. To my knowledge, this study brings together the processes of PCP and organisational learning for the first time. While there is a plethora of literature debating the theoretical impact of organisational learning as a process (Glynn, Milliken, & Lant 1992;Huber 1991;Love et al. 2004), for underpinning leadership (Kim 1993;Popper & Lipshitz 2000) and as a system for underpinning change (Brown & Duguid 1991;Fiol & Lyles 1985;Senge 1990), there is little published on its implementation within health and social care settings (Hart & Bond 1995) and even less on its practical application , or how it is put into practice (Winter & Munn-Giddings 2001).

I believe this study may prove useful to those who wish to implement

change within health and social care organisations as I introduce to the literature a practical model for implementing organisational learning, which is replicable and may prove sustainable.

2.2 The need for family support services

The introduction of The Children Act (1989) in England and Wales placed a renewed emphasis on the value of family support services. The resulting aim of national statutory and non-statutory interventions for families has been to try to prevent or ameliorate negative outcomes. Most interventions have been aimed at particular groups of children or their parents in a targeted manner rather than using a universal approach to reach all children or all families. These targeted groups of families who are identified as being 'in need' are normally identified by known risk factors, including material factors such as poverty or poor neighbourhoods; family factors such as poor parenting, family violence or poor maternal mental health; or child factors such as developmental delay or behavioural problems (Smith 2006). Family support services for this targeted group of families are at the centre of this action research study.

2.3 Childhood Obesity

Childhood obesity and overweight has been increasing for a decade and has now become a global epidemic (World Health Organisation 1997). If effective preventative measures are not introduced it is predicted that there will be huge implications for international population health (Butland et al. 2007). Jotangia et al (2005) assert that should the proportion of obese children in the UK continue to

rise, a whole generation of children may have a shorter average life expectancy than their parents.

Childhood obesity is associated with a number of co-morbidities which are evident in many areas of paediatric medicine (Flynn et al. 2006). While this is worrying in itself, Wabitsch (2000) predicts that the true extent of adverse health outcomes for children is underestimated. The reason for this he suggests is that a child's mental health is equally important as their physical health and there is potential for this not to be recognised when working with childhood obesity. Because childhood obesity is such an overt condition, these children are susceptible to pressures from their peers and adults. It is common for obese children to be bullied because of their body shape which may lead to low levels of self esteem and self worth, social alienation and lack of self confidence (National Institute for Health and Clinical Excellence 2006).

The UK government through its White Paper on improving public health in England 'Choosing Health' (Department of Health 2004a) placed reducing childhood obesity and health inequalities at the centre of health policy. Guo & Chumlea (1999) suggest that the management of overweight and obesity in children should be a priority for preventative services. Against this background concern about childhood obesity, existing ways to 'solve' obesity had proved inadequate. The need to develop a supportive intervention had been identified, which led on to the Primary Care Trust considering the use of PCP to underpin an Obesity Support Project. PCP appeared to offer a new way of working with obese children and their families.

This new project became central to this action research study.

2.4 Organisational learning

For almost five generations authors have attempted to define, develop and differentiate organisational learning and its components (Chandler 1962;Duncan 1974;Jelinek 1979;Miles & Snow 1978;Miller & Friesen 1980;Senge 1990;Senge 2006;Shrivastava 1981). While there appears to be widespread acceptance of the concept of organisational learning and its importance to strategic performance, It seems that there is no widely accepted single theory or model of organisational learning. Interestingly, each author appears to have approached the subject from a different perspective, which has led to further discrepancy.

A key component of organisational learning is that it can only be achieved by using the cognitive whole of the organisation (Marquardt & Reynolds 1994;Simon 1976). As individuals in an organisation develop an understanding of their individual roles, and team purpose, their shared perceptions and successful restructuring of organisational challenges are reflected in the structural elements and outcomes of the organisation itself. Learning in this context, therefore, consists of the development of individual and team insights on the one hand and structural and other action outcomes on the other. The first involves a change in the understanding of team knowledge (which is not clearly observable), while the second involves a change more easily noticeable in terms of an organisational outcome (Fiol & Lyles 1985;McNiff & Whitehead

2000). Perhaps most importantly, however, the two often do not occur simultaneously, as team learning has to take place before outcomes are achieved and, once embedded, learning becomes a part of the organisational culture. This makes the challenge of distinguishing between them more important. Although written three decades ago Hedberg's (1981) explanation remains contemporary:

> "Although organizational learning occurs through individuals, it would be a mistake to conclude that organizational learning is nothing but the cumulative result of their members' learning. Organizations do not have brains, but they have cognitive systems and memories. As individuals develop their personalities, personal habits, and beliefs over time, organizations develop world views and ideologies. Members come and go, and leadership changes, but organizations' memories preserve certain behaviors, mental maps, norms, and values over time" (Hedberg 1981: 6).

Defining learning appears to have been a further challenge for theorists who have referred to learning in a variety of different ways. It has been referred to as; new insights or knowledge (Argyris & Schon 1978;Hedberg 1981); or new structures (Chandler 1962); or new systems (Jelinek 1979;Senge 1990); or simple actions (Cyert & March 1963;Miller & Friesen 1980); or a combination of all of these (Bartunek 1984;McNiff & Whitehead 2000;Senge 1990). These phenomena are referred to as learning (Cyert & March 1963;Jelinek 1979;Revans 1982); adaptation (Meyer 1982);change (Dutton & Duncan 1983;Mintzberg & Waters 1982); or unlearning (McGill & Slocum 1993;Nystrom & Starbuck 1984).The common thread that links all of these theories is a supposition that learning will act as a catalyst for the improvement of future performance.

2.5 Individual learning informs shared learning outcomes

The literature places a strong emphasis on the role of individual learners. Shrivastava (1984) viewed the organisational learning system as being dependent on individual learning as opposed to the practice of knowledge sharing across an organisation. In contrast the focus of others consider individuals as 'agents' for organisational learning to take place (Argyris & Schon 1978), through what appears to be the early manifestations of communities of practice:

> "Organisational learning occurs when individuals within an organisation experience a problematic situation and inquire into it on the organisation's behalf. They experience a surprising mismatch between expected and actual results of action and respond to that mismatch through a process of thought and further action that leads them to modify their images of organisation or activities so as to bring outcomes and expectations into line, thereby changing organisational theory-in-use" (Argyris & Schon 1996: 16).

A learning organisation, therefore, evolves as a result of the cognitive whole of its members (Marquardt & Reynolds 1994;Senge 1990). This ability for teams within in an organisation to learn faster than those in other organisations according to De Geus (1998: 71) constitutes "the only sustainable competitive advantage at the disposal of a learning organisation".

Organisational learning should be a place for individuals to consciously interact through a process of education and shared experience (Kolb 1984). Therefore, a learning organisation should focus primarily on valuing, managing and enhancing the individual development of its employees (Scarbrough, Swan, & Preston 1998). However, shared learning cannot take place if the employees in an

organisation are prevented from learning (Kim 1993;Romme & Dillen 1997). Therefore, Hyland & Matlay (1997) claim that a learning organisation can be defined or measured in terms of the sum total of accumulated individual and shared learning.

Further , Matlay (2000) notes that the relationship between individual and shared learning is an important characteristic that distinguishes learning organisations from one another. However, if a distinction between the organisation and the individual is not made explicit, a model of organisational learning will either obscure the actual learning process by ignoring the role of the individual or become a simplistic extension of individual learning by glossing over organisational complexities (Kim 1993).

2.6 Organisational Learning: process or system?

There is a stream of organisational learning research focussed on organisations themselves as opposed to the individuals within them, which refers to an organisation as a 'learning system' (Revans 1982). In a learning system learning is the process whereby organisations understand and manage their experiences (Glynn, Milliken, & Lant 1992). Different perspectives are stressed within the learning process: leadership (Popper & Lipshitz 2000;Revans 1982); personal mastery, mental models, shared vision, team learning and systems thinking (Senge 1990).

The system view of organisational learning is taken from the perspective of information processing (Cyert & March 1963). Organisations are referred to as information processing systems,

acquiring, interpreting, distributing, and storing information within the organisation, and therefore four components of the organisational learning process are proposed: knowledge acquisition, information distribution, information interpretation and organisational memory (Huber 1991).

The literature discusses two alternatives within the system view: organisations that operate as a closed system and those that operate within an open system. In a closed system, organisational learning is restricted within an organisation itself which Wang & Ahmed (2002) is a reflex of the classical approach to organisational management (Burnes 2001). Organisations operating an open system take into account situational factors and include inter-organisational learning as an important part of the whole organisational learning system (Wang & Ahmed 2002).

In an open system, knowledge is acquired widely within, and external, to the organisation. The open system viewpoint reflects the contingency approach to organisational management (Becerra-Fernandez & Sabherwal 2001) and some practices from what Wang & Ahmed (2002) refer to as the new organisational paradigms. In a learning organisation, the highest stage incorporates three aspects of learning: adapting to their environment; learning from their people; and, contributing to the learning of the wider community or context of which they are a part (Pedler, Burgoyne, & Boydell 1991). However, there is lack of emphasis on flexibility, interaction, innovativeness and creativity within the system view, and these factors become

increasingly important for an organisation to survive and succeed (Wang & Ahmed 2002).

2.7 Environmental Alignment

In order for any organisation to remain competitive and innovative they need to be aligned with their environment (Lawrence & Dyer 1983;Senge 1990) . The importance of alignment to organisational performance and sustainability is reiterated throughout the literature (Chandler 1962;Katz & Kahn 1966;Senge 1990). Alignment implies that the organisation must have the potential to learn, unlearn, or relearn based on its past behaviours (Chakravarthy 1982;Chandler 1962;Cyert & March 1963;Miles & Snow 1978;Miller & Friesen 1980;Senge 1990;Winter 1989)

2.8 A Perspective on Culture

There is a strong emphasis on the cultural perspective of the learning organisation. Culture serves as a sense-making mechanism that guides and shapes the values, behaviours and attitudes of employees (O'Reilly & Chatman 1996), and it is through values that behaviour flows and is guided (Simon 1976). An organisation's culture manifests itself in the overriding ideologies and established patterns of behaviour (Martin 1982;Schein 1983). Therefore, organisational culture consists of the shared beliefs, the ideologies, and the norms that influence organisational action taking (Beyer 1981;Mitroff, I & Kilman 1976;Pfeffer 1981). Kets de Vries and Miller (1984) suggest that the culture of an organisation can be used to predict the actions taken, which helps to determine organisational strategy and direction for change.

Traditional hierarchical cultures, such as those often found in health and social care settings, are reported to be anti-learning and anti-training and undermine the ability of organisations to match and survive increasing competition in the global marketplace (Jones 1996). The behaviour of people who have leadership responsibilities influences the pattern of behavioural and cognitive development undertaken within an organisation (Wang & Ahmed 2002). In turn, this enables change and/or learning to occur which involves a restructuring of the broad norms and belief systems they hold (Argyris & Schon 1978;Jelinek 1979;Shrivastava & Schneider 1984). Where the belief systems are not aligned with the process of organisational change, their behaviour prevents change and/or learning to occur with equal effectiveness.

An organisation's strategic posture, therefore, partially determines its learning capacity (Fiol & Lyles 1985). Leadership within an organisation determines the goals, objectives and the breadth of actions available to staff who enact the strategy (Brymen 1996;Handy 1993). Therefore the strategy influences team learning by providing a boundary to decision making and a context for the perception and interpretation of the environment in which they work (Chandler 1962;Cyert & March 1963;Daft & Weick 1984).

2.8.1 Changing the culture of the organisation to be receptive to change

It could be argued that the majority of people I have worked with, managed and led while working in health and social care organisations, if asked, would not wish to change their location, style,

or mode of working. Change is often seen as something that is done to people (Handy 2000) and therefore staff find it difficult to embrace and engage with change, even when it is planned. Indeed, they may actively resist it (Garside 1998). The culture of the organisation, its norms, values, behaviours, and policies as perceived by staff, must change if change is to occur (McNiff & Whitehead 2000). The culture must support the direction of change by rewarding behaviours which support the change, and, in some cases, penalise those that do not (Garside 1998). If an organisation is to be supported to move to a learning model, where innovation and even risk are rewarded and where problems are approached in an integrated way, then a culture of learning, supported by clear systems of communication and training, needs to be developed (Wenger 2000;Winsor 2001).

Berwick (1989) believes that as healthcare organisations pursue quality improvement, problems of quality can at times be caused by poor intentions; the cause of the problem being people and the implication being that people must be made to care. Identification of the “bad doctor” or “bad professional” and exposing them is an attractive concept to centralists who have a preference for regulation and the use of fear as an incentive to improve quality (Garside 1998: S13). This approach may change the culture of the organisation, but not to one where people or groups will take risks, have opportunities to learn, use data to improve processes and win the hearts and minds of staff for the change effort. (Garside 1998;McNiff & Whitehead 2000;Schein 1983)

In order to change a culture positively, leaders must constantly show both the desired direction of change, and that they mean what they say through organisational policies and actions (which reinforce what they are communicating). The behaviour of leaders, in other words, must match their rhetoric (Bass 2005; Garside 1998; McNiff & Whitehead 2000). It is important that leaders recognise that knowledge is not reserved for people in managerial or professional positions. The culture has to be right to enable the full contribution of all staff members. Organisations need to change to a collaborative team culture (Jones 1996) and focus on the process and involvement of people within the organisation (Mintzberg 1994). Every member of the organisation must be able to contribute positively within a learning environment (Kline 1999).

The linkage between culture and organisational performance has been tentatively defined by researchers (Denison 1990;Gordon & DiTomaso 1992). Culture enables an organisation to best utilise the cognitive whole of the people who work for it to establish and achieve desired goals and learning from action based on knowledge and wisdom (Bierly, Kessler, & Christensen 2000). This type of learning is associated with the 'third order learning' or triple-loop learning by Bateson (1972), Berman (1981) and McWhinney (1992).

The process of appreciative, dialogic learning supports teams to develop a "structure and framework" from which to operate. The structure of an organisation is often viewed as an outcome of learning. However, structure plays a crucial role in determining these processes (Garside 1998;Wang & Ahmed 2002). Health and social

care settings are hierarchical by nature, but different decision making structures may be beneficial, dependant on the degree of flexibility that is required. This is supported by Galbraith (1973) who suggests that a centralised, mechanistic structure tends to reinforce past behaviours, whereas an organic, more decentralised structure tends to allow shifts of beliefs and actions (McNiff & Whitehead 2000). The decentralised structure reduces the cognitive workload, thereby facilitating the integration of new patterns and associations to take place (Galbraith 1973). Hierarchical, functional organisations may be efficient but they are less likely to adapt within changing environments (Fiol & Lyles 1985;Starbuck, Greve, & Hedberg 1978). Further Meyer (1982: 533) suggests that "formalized and complex structures retard learning but that learning is enhanced by structures that diffuse decision influence". Therefore, organisations can be designed to encourage learning and reflective action taking, but this generally means moving away from mechanistic structures (Morgan & Ramirez 1983).

2.9 Designing an Organisational Environment for Learning

To support learning to take place within an organisation the environment, both internal and external should not be so overly complex or dynamic that the organisation is unable to handle it (Lawrence & Dyer 1983). This is not a simple task to achieve as too much stability within an organisation may stifle the opportunity for learning to take place, whereas too much change and turbulence make it difficult for learners to feel comfortable in their environment (March & Olsen 1975). Learning therefore “requires both change and stability. . .between learners and their environments" (Hedberg

1981: 5). Change, learning, and adaptation have all been used to refer to the process by which organisations adjust to their environment (Fiol & Lyles 1985;Wang & Ahmed 2002).

> "In organisational environments, the learning context such as structure, process, and culture has significant impact on the organisational learning process. It is commonly believed that internal factors such as a flat teamwork structure, bottom-up feedback system, cross-functional team, flexible working process, and employee overall involvement, and external factors such as networking and alliances contribute to the organisational learning process" (Wang & Ahmed 2002: 8).

Learning necessitates experimentation, unlearning of past methods, and encouraging multiple viewpoints and debate (Nystrom & Starbuck 1984). The guidance of this process is an essential element of leadership (Andrews 1980) to ensure that learning is occurring and to assure the organisation's long term survival.

CHAPTER THREE: METHODS AND METHODOLOGY

For decades there has been a reported division in the social and behavioural sciences that has separated the qualitative and quantitative research traditions (Tashakkori & Teddie 2003;Teddie & Tashakkori 2003). Recently mixed methods approaches such as those used in this study have emerged which have potential to bridge these traditions (Haverkamp, Morrow, & Ponterotto 2005). The strengths and weaknesses associated with quantitative and qualitative research approaches are widely discussed in the literature (Castro et al. 2010;Creswell 2009;Creswell, Plano Clark, & Garrett 2008;Gelo, Braakman, & Benetka 2008;Moghaddam, Walker, & Harre 2003;Tashakkori & Teddie 2003).

This chapter is devoted to the methods and approaches to Action Research (AR) I used to gather data, their relationship with reflection, reflexivity and the methods used to interpret my data. My ontological and epistemological assumptions are presented in this chapter and I highlight how they influenced the methods that I chose to gather the data. I discuss recruitment to the study and explore the use of semi-structured interviews, action learning sets, reflective practitioner logs, and my personal history. Ethics and rigour are also addressed in this chapter.

3.1 Approaches to Action Research

An understanding of how ontological perspectives influence personal and social practices is essential to understanding different approaches to AR. Some action researchers maintain an almost exclusive self-interest as external researchers who watch what other

people are doing. These researchers establish firm boundaries that come to act as demarcations between themselves and others. They stand outside the situation and observe other people doing AR asking: 'What are those people doing? How can their practice be described? How can it be explained? (McNiff & Whitehead 2006).

Often, however, the researcher becomes involved in the situation, and can become an insider researcher (Asselin 2003). Sometimes the researcher becomes so involved that they become a participant and begin to ask 'What are we doing? How can our action be described and explained?' (Whitehead 2000). This approach helps to dissolve the boundaries, as participants come together to work collaboratively in a common endeavour to improve their own circumstances. This approach is useful in terms of implementing a change in practice or within a team / organisation. However, it can create problems for reporting a research study as questions arise about who is telling the research story, whose voice is heard, and who speaks on behalf of whom? McNiff & Whitehead (2006) and Dwyer & Buckle (2009) raise the issue that in much interpretive research the researcher's voice is heard as opposed to the participants' voice. The caution raised here in terms of reporting is that participants may be viewed as sources of data rather than as 'actors' this leading to questions of how power relationships are used and why (McNiff & Whitehead 2006).

3.1.1 My chosen method of Action Research

The 'living theory' approach (Whitehead 1989;Whitehead 2000;Whitehead & McNiff 2006) I chose to use in this study is

described by McNiff & Whitehead (2006) as ‘self study’ and Dwyer & Buckle (2009) as the ‘space between’, the hyphen of insider-outsider research. This placed me at the centre of my enquiry where I asked ‘What am I doing? How do I describe and explain my actions to you?’ The individual ‘I’ exists alongside other ‘I’s’, each asking ‘How do I hold myself accountable to myself and to you?’ (McNiff & Whitehead 2006: 11). Using the research participants as fellow researchers helped to dissolve boundaries as they came to recognise themselves, sharing meaning through a common understanding about what they were doing and why. Capra (2003) describes the boundaries as permeable membranes where meanings and commitments flow between lives, and people perceive themselves not as separate entities, though still unique individuals, but as sharing the same life space as others (Whitehead 2005).

Engaging with living theory approaches means placing the ‘living I’ at the centre of our enquiries and recognising ourselves potentially as living contradictions. We may believe we are working in a morally committed manner and then find from our self evaluation that we are denying much of what we believe in (Whitehead 1989).

Self-study is now widely recognised as a powerful influence for personal and social renewal (Dwyer & Buckle 2009;McNiff 2002;McNiff & Whitehead 2006). Using this approach to AR researchers need to accept responsibility for accounting for their own practice, and in work contexts, accounting for their own professionalism. In order to demonstrate that the work has had a positive impact on others, this approach offers descriptions and

explanations of the work undertaken through professional narratives (McNiff & Whitehead 2006). Data from practice is gathered and tested and evidence produced to show that claims are well founded. This results in people or teams who have been involved stating that they have benefitted (or not as the case may be) and those with whom they are working testifying that they in turn have benefitted. Through this process, it is possible to trace lines of influence from the researcher to others with whom they have had no personal contact but whose lives they can claim they have touched (McNiff 2002).

Schön (1995) implies AR, is a form of practical theorising in action to be appropriate to all professional contexts. I relate his work to this study as he asserts:

> "If community outreach is to be seen as a form of scholarship, then it is the practice of reaching out and providing service to a community that must be seen as raising important issues whose investigation may lead to generalisations of prospective relevance and actionability" (Schön, 1995: 31).

McNiff in McNiff & Whitehead (2000: 3) builds on this and states:

> "if management is to be seen as a form of scholarship, then the practice of managing must be seen as enabling others to understand their relationships and practices as contexts of professional learning where identities may be created through discourses in which freedom of mind is valued and people are regarded as on equal footing. If organisational study is to be seen as a form of scholarship, then it is the practice of asking questions about human purpose and the development of sustainable social orders through personal and collective enquiry".

McNiff, in McNiff & Whitehead (2000) relates her experience of developing these views within organisational contexts as becoming

embroiled in battles for ideas, job security and professional recognition. My work supports this and I empathise with McNiff. The methods I used in this study at times felt as though they were unintentionally creating battlefields of change through dialogic learning. It is inevitable, therefore, that my role in this process must have been influenced by my own values of social justice, honesty, transparency and professional integrity.

As I reflect on my friendship with Paul (see pages 1-4) and my professional career to date, I believe it inevitable that this approach to AR was my chosen methodology. AR is equally concerned with the process of inquiry as with its 'findings'. It may be argued that any research process creates relationships, and AR is concerned that its long term impact on relationships should be positive as well as enlightening. Perhaps more importantly, AR emphasises the value of insights derived from practical involvement in a situation from the 'inside', as opposed to the contribution of supposedly 'objective' methods applied by outsiders (Deery 2011;Winter & Munn-Giddings 2001). Rather than consider this issue from a dichotomous perspective, locating myself at the hyphen (the space between insider-outsider) allowed me to occupy the position of both insider and outsider rather than insider or outsider (Dwyer & Buckle 2009)

This kind of AR embraces the concept of recoverability (Checkland & Holwell 1998;McNiff & Whitehead 2006), while acknowledging that the central purpose to the participants is the development of staff, the service they provide and the organisation (Elden & Chisholm 1993;McNiff & Whitehead 2000;Stringer 1996;Whitehead 1994).

3.1.2 Origins of Action Research and early approaches to Action Research: a presentation and a critique

In the following section I will present an overview of the origins of AR. I will then clearly present what I perceive to be the two main schools of thought. I perceive the first broad school to cover those approaches most related to Lewin (1946) whose work focuses on many recognisable attributes of AR although it is less focused on AL. I then present the other main school of thought which is the educational approach to AR where I perceive the focus to be on AL (McNiff 2002;McNiff, Lomax, & Whitehead 1996;McNiff & Whitehead 2006;Reason & Bradbury 2001;Whitehead 2000). I also acknowledge that these divisions are necessarily messy and there is some level of overlap between these schools. As Reason & Bradbury (2001: 2) assert that “it is not possible to provide one coherent history of action research” as its origins are unclear in the literature, a similar proposition was made in Masters (1995) work.

The concept of AR is most commonly attributed to Kurt Lewin’s pioneering work with factory workers and immigrants in the United States of America (USA) during the 1940s (Adelman 1993;Deery 2011;Hart & Bond 1995;Hart 1995;Holter & Schwartz-Barcott 1993;Kemmis & McTaggert 1988;McIntosh 2010;Zuber-Skerritt 2001). McKernan (1991:8) observes that AR as a method of inquiry has evolved over the last century and careful study of the literature shows, "clearly and convincingly that action research is a root derivative of the ‘scientific method’ reaching back to the Science in Education movement of the late nineteenth century". McKernan (1991) also refers to evidence of the use of AR by a number of social

reformists prior to Lewin and cites a physician named Moreno using group participation in 1913 in a community development initiative with prostitutes in Vienna.

Early conceptions of AR (Alderfer 1993;Coch & French 1948;Lewin 1946) emphasise the need for field experimentation and hypothesis testing in the research design. It is argued therefore, that this approach has some similarities to ethnographic and other forms of research that derive their theoretical insights from naturally occurring data (McIntosh 2010). These data are gathered in the form of expressed experiences, perceptions, action-centred dilemmas, actual actions of participants, and events in the life of the practitioners rather than solely through interviews (Marshall & Rossman 1989;McIntosh 2010;Tetlock 2000). Although interviews are used here to measure a baseline for the research, the remainder of the data were gathered using the systemic method of action learning to inform the AR process (McNiff & Whitehead 2000;Mwaluko & Ryan 2000;Pedler 2012;Wenger 2000).

Huxham & Vangem (2003) criticise this type of AR and suggest it is not a solution for research in organisations and further that it would be inappropriate for many research agendas. As this is my method of choice however, I argue that using action learning techniques to inform AR methodology creates opportunities for theory development that other methods do not. In particular, health and social care settings can provide rich data about what people do and say, and what theories are used and are usable when faced with a genuine need to take action (Winter & Munn-Giddings 2001). They therefore

have the potential to provide the kind of new and unexpected insights that Marshall & Rossman (1989) have argued lead to important theoretical developments. For this reason, there is a need for the development of emergent theory (Eisenhardt 1989;McNiff & Whitehead 2000), which is grounded not only in the data but also in action (Glaser & Strauss 2003;McIntosh 2010). Each intervention provides an opportunity to learn through praxis by revisiting theory in order to design the intervention and develop it further as a result (Diesing 1972;McIntosh 2010).

Despite uncertain origins, Lewin's (1946) work in which he outlines the principles of democracy, participation, reflection and change, before presenting a theory of AR as "proceeding in a spiral of steps, each of which is composed of planning, action and the evaluation of the result of action" (Kemmis & McTaggert 1990: 8) has remained central to most descriptions of AR over the intervening years (Deery 2011;Koshy, Koshy, & Waterman 2011;McNiff 2002;Parkin 2009;Waterman et al. 2001). Lewin argued that in order to "understand and change certain social practices, social scientists have to include practitioners from the real social world in all phases of inquiry" (McKernan 1991:10). Lewin's construction of theory therefore made AR a method of acceptable inquiry (Koshy, Koshy, & Waterman 2011)

Post Lewin, the term action research, along with similar terms, such as action science (Argyris, Putman, & Smith 1985), action inquiry (Torbert 1976), and action learning (Mwaluko & Ryan 2000;Revans 1982) have been used to describe many processes involving

interventions in organisations that have the dual purpose of bringing about service development and of advancing knowledge. AR provides a research process that brings theory and practice together (McKellar, Pincombe, & Henderson 2010). It enables researchers and practitioners to identify and address problems faced in practice through dialogue, avoiding unnecessary hierarchy and compulsive control (Reason 1994), so as to collaboratively develop solutions that can be evaluated, providing evidence to support practice (Deery 2011;Kemmis & McTaggert 2000;Lewin 1946;Raelin 2006;Waterman, Tillen, Dickson, & de Koning 2001). It provides a person centred approach (McKellar, Pincombe, & Henderson 2010) that addresses the needs of the vulnerable through research that is democratic (Deery & Hughes 2004;Hart & Bond 1995;Meyer 2000).

Through collaboration AR guards the researcher from becoming self serving (McKellar, Pincombe, & Henderson 2010). As AR is context-specific, that is, focusing on a local or discrete situation, location or group (Morrison & Lilford 2001;Waterman, Tillen, Dickson, & de Koning 2001) there is diversity in the amount and nature of collaborative processes involved. Further, AR provides a means for intuitive knowledge to be validated and avoids a ‘cookbook’ approach to evidence based practice by systematically evaluating actions in practice (Closs & Cheater 1999). It also emphasises the value of critical reflection and encourages personal reflection and self evaluation (McIntosh 2010;Winter & Munn-Giddings 2001).

Using this methodology allows the researcher to gain a generic theoretical understanding of the aspects of leadership or

organisational change being researched which, when replicated, could inform other contexts (McNiff & Whitehead 2000). Huxham & Vangem (2003) warn that one danger for a researcher undertaking an intervention in an organisation in the role of consultant or facilitator is for the researcher to use the intervention solely as a means to a research end. The theoretical output of the research therefore relies on the conceptualisation of the researcher's experience. However, the source of the theory relies on the principle that the intervention is of genuine importance to the practitioners involved (McKellar, Pincombe & Henderson 2010). This was demonstrably the case in two of the three teams studied in this research.

AR appears to be used most widely within education and health services (McIntosh 2010) and there are a variety of definitions (see for example, (Bassey 1998: 93;Bell 2005: 8;Frost 2002: 25;Hopkins 2008: 47;Winter & Munn-Giddings 2001: 8). I find Coleman's (2007) definition particularly relevant to this study as it exemplifies the reason this was my methodology of choice, as I set out intentionally to support teams make a difference through praxis and dialogue:

> "Action research is intended to combine a strong and rigorous research activity with a respect for participants' knowledge and understanding. It therefore brings together theory and practical knowledge, to test each other with the purpose of developing practice." (Coleman 2007:484).

3.1.3 Action Research with a concern for learning and praxis

My understanding and application of AR is influenced by the work of a number of authors and theorists. Here, I identify a number of my key influences. McNiff (1996;2000;2002;2006) and Whitehead (1989;1994;2000;2005;2006) describe how AR contributes to the creation of a good social order, a form of living in which people are free to make choices about creating their own identities and to recognise the need to negotiate those identities with others. I share with them a view of AR, not as a set of concrete steps but as a process of learning from experience, a dialectical interplay between practice, reflection and learning (McNiff 2002).

The model of AR I used to inform my study (see Figure 1: 65) is closely related to the seminal work of Kemmis & McTaggert (1982) and that of McKernan (1991). Kemmis' self-reflective spiral of planning, acting, observing, reflecting and re-planning underpins an understanding of how to improve an educational situation. McKernan (1991) built on Kemmis' work producing a diagram of sequential spirals suggesting a 'time process' model, asserting the importance of not allowing a 'problem' to become fixed in time, but to build in the necessary flexibility to allow the focus to shift and innovative episodes to occur.

Writing from a critical theoretical and externalist perspective, Zuber-Skerritt (1992;1992a;1996;2001) links AR with professional learning, organisational change, management development, Action Learning (AL) and praxis. Schön (1983;1995) has informed my understanding of the theory and practice of learning, reflection and change. Schön

called for a new scholarship which demonstrated a new epistemology and a new way of knowing so as to meet the everyday needs of people working in real-life situations. His argument was constructed around a belief that conventional research methods which test knowledge against a standardised criterion of hard scientific analysis and technique are “rigorously controlled experimentation, statistical analysis of observed correlation of variables, or disinterested speculation” (Schön 1995: 29). McNiff (2000) presents a correlation between Schön’s assertions and traditional organisation studies and practices, which are at times, messy, uncontrolled and unpredictable (Deery & Kirkham 2000;Schön 1995), “seriously separated from the sanitised world of abstract theorising and, far removed from the worlds of real life practice” (McNiff, 2000: 3).

The manner in which AR is undertaken varies, particularly when the emphasis is on service change compared with the advancement of more general knowledge. The range of AR referred to in this chapter is particularly concerned with learning, praxis and the development of theory. I argue that AR through AL is well positioned to develop theory relevant to practice. Theory development through AR should be considered as an organic process, which inevitably will develop incrementally with each intervention adding new slants or insights to the pre-existing theory. This in turn made AR a particularly relevant approach to organisational learning methodology as used in this study.

I used AL methods to inform AR through a spiral of holistic and flexible cycles: the collection, analysis and interpretation of data interwoven with planning and introduction of action strategies which

were evaluated through the same process to inform service development (Deery 2011;McIntosh 2010;McKellar, Pincombe, & Henderson 2010). While all action researchers ask questions about influencing processes of change, different approaches to this methodology have emerged within the AL community (McNiff & Whitehead 2006).

Through this dynamic and empowering research process, I sought to influence praxis by uniting theory, research and practice. I asked for a commitment to critical reflection, collaboration and change (Deery 2011;McIntosh 2010;McKellar, Pincombe, & Henderson 2010). Specifically, it provided a dialogic forum to address the diverse issues faced by children and their families by involving stakeholders and improving practice through knowledge development and positive change. The appreciative, dialogic learning approach to AR used in this study provides both practitioners and researchers with a framework to actively participate in collaboration and to improve praxis.

3.1.4 Bringing Learning and Research Together

Action Learning (AL) underpins this AR study. Although both AL and AR are recognised as separate methodologies with their own literature, the terms ‘Action Learning’ and ‘Action Research’ are often used interchangeably. Indeed, AR is based on the same philosophical assumptions and includes AL in its construction. Zuber-Skerritt (2001) recognised this and predicted AR and AL methodology would

> “play an important role in Research and

> Development programs in small and corporate businesses, communities and in the public sector. They have proven to be appropriate methodologies and processes for (re) creating change, innovation, leadership and personal, professional and organisational learning." (Zuber-Skerritt 2001:1)

The main difference between AL and AR argues Zuber-Skerritt (2001) is the same as that between learning and research generally. AR is more systematic and rigorous in its methodology and methods so that it can be scrutinised and it is always made public.
As the origin of AR is most commonly attributed to Kurt Lewin, the original architect of AL is acknowledged as Reginald (Reg) Revans.

Since Revans first introduced action learning in the coal mines of Wales and England in the 1940s, there have been multiple variations of the concept (Marquardt 2004). However, all forms of AL share the elements of real people resolving and taking action on real problems in real time and learning through questioning and reflection while doing so. As with AR one of the attractions of AL is the potential to simultaneously and imaginatively solve difficult challenges and sustainably develop people and organisations at minimal cost. Revans never operationalised AL into a standard approach (Marsick & O'Neil 1999), but over the years a number of individuals have developed approaches and models that capture the essence and critical elements that make AL successful (Dilworth 1998;Dotlich & Noel 1998;Marquardt & Reynolds 1994;Marquardt 2004;Marquardt & Waddill 2004;Mumford 1991;Pedler 2012).

The process of AL used in this study is most closely associated to

that developed by Marquardt (1999; 2004) with the exception of the number of participants, which in this case exceeds Marquardt's (1999) recommendation. This approach appears to capture the essential components of the process originally proposed by Revans (1982) which has been effectively implemented worldwide and in global organisations (Boshyk 2009;Coghlan 2002;Marquardt 2003;Marquardt 2004;Marquardt & Waddill 2004). Marquardt's approach to AL centres around six components: (1) a problem or challenge of importance to the group; (2) a group of 4-8 members, ideally from diverse backgrounds and/or parts of the organisation; (3) a process that emphasises questions and reflection; (4) the power to take action on strategies developed; (5) a commitment to learning at the individual, team and organisational levels; and (6) an action learning coach who focuses on and ensures that time and energy are devoted to capturing the learning and improving the skill level of the group (Marquardt 1999;Marquardt 2004).

One of the 'seven practices of successful organisations' (Pfeffer 1998) is effective training and development. Using AL as a tool for developing organisational leadership has contributed to improved organisational performance (Mabey & Thomson 2000;Pedler 2012), and is a part of a number of 'context specific' teaching/learning methods that have grown in relation to other educational and development approaches (Mabey & Thomson 2000). The use of AL also appears to be developing alongside the use of coaching and mentoring (Boshyk 2009;Pedler 2012). Further, Raelin (1999;2006) proposes action research, participatory research, action science, developmental action inquiry, cooperative enquiry and action learning

being amongst ‘the burgeoning action strategies that are now being practiced by organisation and management development practitioners around the globe’ (Raelin 1999: 115).

Revan’s (1998) proposes that AL should be facilitated by ‘insiders’; colleagues who support each other to tackle ‘intractable organisational problems’. I came to understand that my knowledge of the process and context of the research environment, my decision to use the Person Centred Planning Tools to inform AL and my previous life experience meant that I was inextricably a part of the participant and research elements of the study. Participants in AR programmes expect to be treated not as objects or even subjects but as co-researchers engaged in ‘empowering participation’ and in ‘co-generative dialogue’ between ‘insiders and outsiders’ (Elden & Levin 1991).

The value of AL being led solely by ‘insiders’ has been variously criticised; for throwing the baby (of teaching) out with the bathwater (McLaughlin & Thorpe 1993); for being too rational and for neglecting the role of emotions and politics in learning (Vince & Martin 1993) and for needing a component of ‘critical theory’ if action learning ‘is not to be selectively adopted to maintain the status quo’ (Wilmott 1994: 127). It is perhaps worthy of note that these criticisms are made in the context of the authors having aspirations for AL as a promising means for the development of a more critical management education (Burgoyne & Reynolds 1997;Pedler 2012;Pedler, Burgoyne, & Brook 2005;Rigg & Trehan 2004).

An indication of how these two research methodologies complement each other may be identified by a similarity in definitions presented. This is highlighted with great effect by Marsick & O'Neill (1999) who define three subcategories of AL: scientific, experiential and critical reflection, and Zuber-Skerritt (2001) three types of AR: technical, practical and critical or emancipatory. Like critical AL, emancipatory AR aims at the participants' empowerment and self-confidence in their ability to create theory grounded in praxis by solving complex problems collaboratively as a team, with everyone in the team being a 'personal scientist' contributing in different ways but on an equal footing with everyone else. There is no hierarchy but there is open and 'symmetrical communication' (Zuber-Skerritt 2001).

3.2 Choosing an appropriate cycle for the application of Action Research

In order to achieve the delicate balance between being systematic and being flexible, most researchers have tended to adopt some version of Lewin's (1946) formulation of the process. This process is illustrated diagrammatically by a number of authors (Coghlan & Brannick 2005;Deery 2011;Kemmis & McTaggert 1988;MacNaughton & Hughes 2009;McKellar, Pincombe, & Henderson 2010;Mertler 2009). As Drummand & Themessl-Huber (2007) suggest the "variations of the action research cycle presented in the literature include circles of action, spirals, varying combinations of circles and cycles and flow diagrams" (Drummond & Themessl-Huber 2007: 432).

The defining characteristic of AR is its cyclical, iterative nature.

Drawing on the work of Kemmis & McTaggert (1988), McKernan (1991) and McNiff (2006) I based my research framework on an iterative spiral of learning in action. This spiral incorporated planning, action, learning, reviewing, reflecting and re planning, as shown in Figure 1 (see page 65).

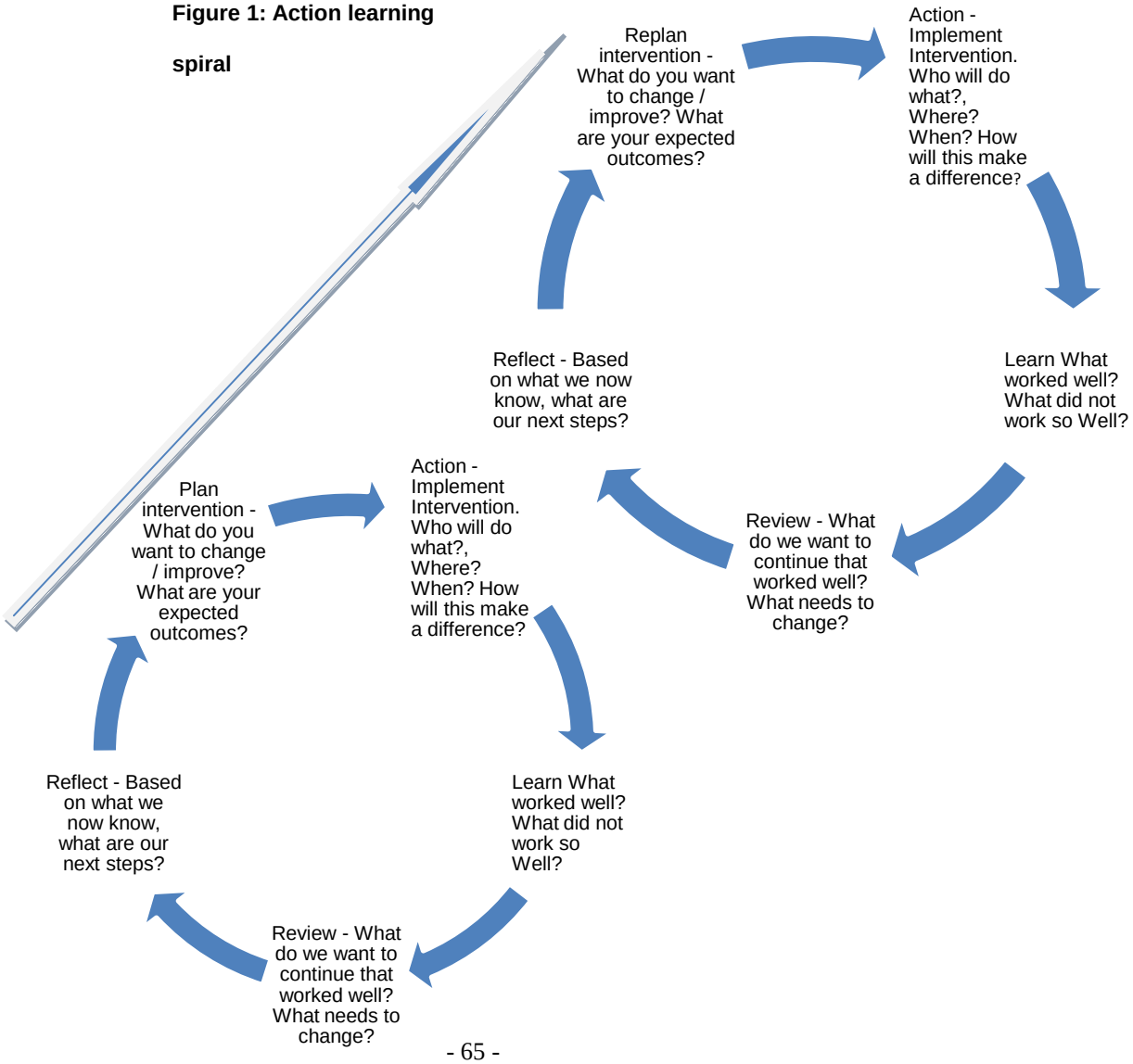
There are perceived weaknesses in using an AR cycle. McNiff (1988) was concerned that it may be seen as an oversimplification of a complex process. She notes that if the notion of a cycle suggests the overall focus has to remain fixed and reduce the potential for discovery this would be at odds with what is intended. Instead, researchers and participants' concerns may need to shift and become increasingly complex as actions, observations and reflections on the subject deepen.

Secondly the emphasis on the importance of the need for the cycle to be repeated suggests that even the basic process requires a long period of time to complete (Winter & Munn-Giddings 2001) which may be perceived as difficult to sustain in many work settings where staff may be short of time even for reflection (Deery 2011;Kline 1999;Palmer, Burns, & Bulman 1994). This could mean that the long term commitment of management to an inquiry process may be doubtful (Fuller & Petch 1995;McNiff & Whitehead 2000) and there may be a high rate of turnover among participants (Meyer 1993).

3.2.1 *Application of the methods in the study: the action learning spiral, Person Centred Planning tools and reflective practitioner logs*

I used a spiral to ensure the process of AL / AR included continual 'planning and replanning' before new action was taken and the Person Centred Planning tools to develop practitioner reflective logs (Koch & Harrington 1998) to support action learning through dialogue and reflection. The introduction of these tools in the chosen methods, supported dialogue and interventions aimed at maintaining workplace interactions (between colleagues, between managers and staff, between professional workers and service users) which may have become restricted during periods of pressure on the team (Winter & Munn-Giddings 2001)

Figure 1: Action learning spiral



Using practitioner reflective logs within the AR spiral I intended to generate practical theory out of the actions and interventions of staff who wanted to improve their understanding of their practice in order to improve their service delivery.

All action enquiries begin by asking questions such as ‘how do I improve my work? (Whitehead 1989;Whitehead 2000) with the initial intention of understanding the work more thoroughly by studying it and raising awareness, and then by imagining ways it can be improved (McIntosh 2010). The research process of this study, involved gathering data using the chosen methods. These data generated evidence to show that claims to improved practice were genuine. Subjecting the evidence to the critical scrutiny of the participants for validation that their practice had improved occurred by way of action learning sets and the recording of interventions through the reflective practitioner learning logs (Koch & Harrington 1998).

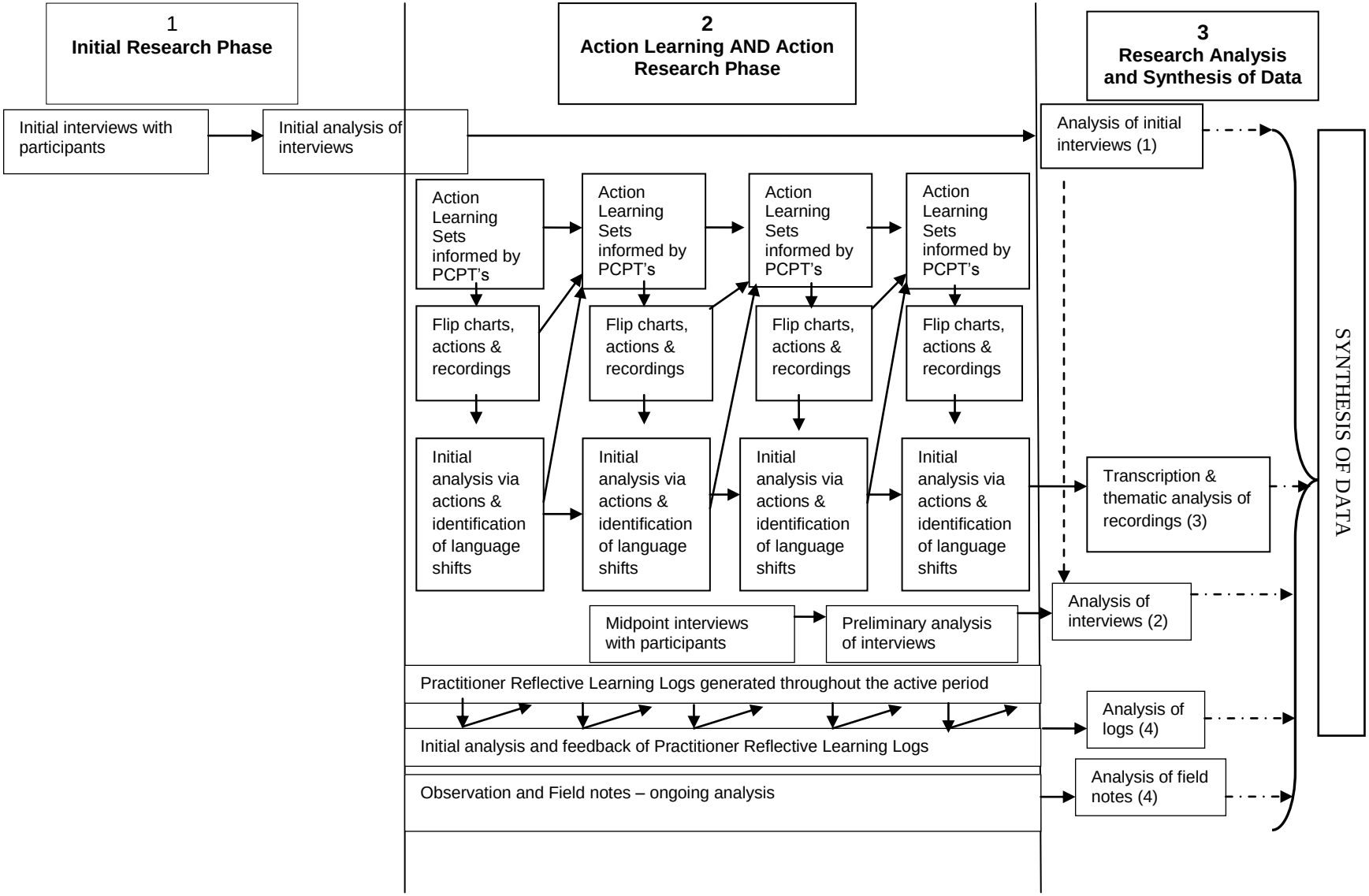
Using these methods supported collective validation, as participants became a community of reflective practitioners, each investigating their work and recognising how individually they affected the work of the team. Work in organisational contexts never exists as something separate from a practitioner: it is always in relation (McNiff & Whitehead 2000). When a practitioner investigates their work, it means they are investing in how they work and relate to others. When a team does this, it enables them to collectively and cognitively share their power so as to inform organisational change (Koch & Harrington 1998). Figure 2 (see page 68) explains how each method

informed the service development and research elements of the study.

Implementing organisational change through the cognitive whole of the team in this way supports the notion that organisations should not be viewed as abstract entities. Rather they should be seen as contexts in which people learn together by sharing their values, beliefs and principles within a non-hierarchical environment, coming together on an equal footing with the intention of achieving common goals and shared outcomes. Acting out these living processes through AL offers a variety of experiences: some good and some not (McNiff & Whitehead 2000).

The practitioner reflective logs (see Appendix 6: 319) captured these experiences and presented powerful opportunities for learning and the foundations for a ‘learning organisation’. A learning organisation (Raelin 2006;Senge 1990;Senge 2006) is a place in which people can learn from their experience of being with others by reflecting on it and taking action to improve it where necessary.

Figure 2: Process of data analysis (Acraman, Carter and Duxbury, 2011)



3.3 Reflection, reflexivity and their application in this study

Here I explore how I have used reflection and reflexivity to inform this study. As a researcher and learner in health and social care settings I have often been asked, or expected to reflect upon my experience of learning and researching and report what I have found. Through the method of reflection used in this study, there was an expectation that it would inform and develop the knowledge base of the participants individually, and collectively, in their teams, in order that they may become more effective and informed practitioners.

Reflection places an emphasis on learning by asking questions and seeking solutions that may lead to a development of team understanding. McIntosh (2010) argues, and I concur, that it is through this type of expectation that models of reflection have come to be significant in the learning lives of practitioners. However, it is important to be mindful that reflection becomes real and works for practitioners and researchers when it is understood, not when it is required as an outcome. I believe that when reflection is understood the results are tangible: changes in the learning process can be seen and felt. Practice is more thoughtful with a deeper and fuller understanding, and practitioners engage in a meaningful way. When a team reflect together, learning becomes an adventure rather than an event they endure and it is the team who benefits dialogically together.

Finley (2002) posed the question “Are we ready to embrace the challenge?” She asserts ‘coming out’ through reflexive analysis is ultimately a political act. Done well it has the potential to enliven,

teach, and spur participants toward a more radical consciousness. Voicing the unspoken can empower both researcher and participant. As more researchers grasp the nettle, research in the future can move in new, creative directions (Finlay 2002: 544). I used reflective practice to examine what I and others believed happened throughout my involvement in the study. The purpose of using reflexivity was to increase learning at the individual, team and organisational levels, and to understand the impact of this for practice and research purposes.

3.3.1 *Reflection, Schön and professional practice*

It is thirty years since Schön (1983) began to analyse the way in which professionals think in action. Principally, he saw a model of preparation for professional life as one which supplied knowledge relevant to the practice of a particular discipline, but which failed to provide the capacity to work through the complexity associated with professional activity. It was Schön (1983; 1995) who introduced the terms 'thinking in action' (i.e. while doing something) and 'thinking on action' (i.e. after it has been done) which have come to have significance in recent professional education. Schön's (1983;1995) argument being that while professionals are able to deal with the specifics of their discipline, they are ill equipped to manage the human interactional relationships between that discipline and its impact on social life.

As a result of Schön's work, the concept of critical reflection in adult learning began to permeate professional education through the work of authors such as Zuber-Skerritt (2001) and Mezirow (1990), who

focussed particularly on ‘transformative learning’. As with Schön’s philosophy of how professionals think, (Schön 1983) presuppositions based on technical professional knowledge assume that things will just happen as planned because the knowledge suggests it (McIntosh 2010). This of course is not the case. It then becomes important as Mezirow (1990) indicates, to enter into an act of transformation whereby what we believe we know becomes reformulated as understanding the meaning of an experience which has emerged not as a technical rational puzzle to be solved in the ‘high ground’ of professional knowledge but in the ‘swampy lowlands’ of human interaction (Schön 1983). This has led to a variety of models and principles collectively known as ‘reflective practice’, which are practised within professional education and practice (McIntosh 2010). It was my intention to use the AL sets and practitioner reflective logs as methods in this study to develop praxis through a ‘reflective conversation’ (Ghaye & Ghaye 1998).

3.3.2 *Reflection, reflective conversations and dialogue*

Ghaye & Ghaye (1998) outline the reflective conversation as one which considers and questions the values that the practitioner is committed to; the values that give shape, form and purpose to professional practice. The reflective conversation is often one of questions and responses which may be internal or external: asking the right question is fundamental to creating a dialogue. Questions such as those posed by the practitioner reflective logs along with what Revans (1982) termed questions of epistemology (e.g. how do we come to know?), education (e.g. what/how did I learn?), ontology (e.g. who am I? And who would I like to be?) and ethics (what is

right, fair and sustainable?) (Zuber-Skerritt 2001: 17) were drawn upon. It is important when using questions like these to look forward for the 'next steps', the future possibilities for individual, team and organisational development, as well as looking back exploring and justifying previous practice and experience.

The role I played in the context of this study facilitating AL is described by (Johns 2004;Senge 2006) as that of 'dialogical other'. I did this by creating a balance, helping the teams to explore 'what was not working' to support informed change to their structure and support mechanisms. I also helped them explore 'what was working' in order to identify and articulate the strengths that required reinforcing to support change.

Reflective conversations therefore are dialogic in nature and developmental in praxis, as opposed to discussion or debate where one person hopes to be victorious over another by overpowering their point of view (Johns 2004;Senge 2006). The result being that all participants in collaborative dialogue are empowered to create knowledge on the basis of their action and experience in a non hierarchical environment. This form of dialogic learning supports participants to listen to the views, shared vision and perspectives of fellow participants and opens them up to scrutiny, through which wider possibilities of understanding can unfold (Johns 2004;McIntosh 2010;Senge 2006).

Understanding this I was particularly concerned to avoid hierarchical 'power relationships' developing during AL sessions as these would

have been potentially detrimental to the study and learning emanating from it. This was important as I was aware that most forms of organisational conversation, particularly around tough, complex, or challenging issues, lapse into debate, a conversation where one participant wins and another loses (Johns 2004;Senge 2006). This is a particular challenge to AL in health and social care settings which culturally have operated with a certain element of debate. McIntosh (2010) questions how effectively reflective conversations may be facilitated in these public organisations where "arguably, reflection is seen as a 'good thing' to be encouraged by these bodies, but only if it is evident that one person is learning from another who has greater authority and knowledge" (McIntosh 2010: 48).

The introduction of dialogic learning, underpinned by the PCPT's through non-hierarchical AL sets supported the introduction of an organisational system, which engaged the participants in a reflective conversation.

3.3.3 Reflexivity, research and research based selves

Finlay & Gough (2003: ix) discuss the etymology of the word 'reflexive', which means 'to bend back on oneself'. In research terms there is consideration of the kinds of dynamics that can exist intersubjectively between the researched and the researcher, focussing particularly on matters of critical reflection around the researcher's social background, assumptions made, and behavioural impact on the research. As if to exemplify what Finlay & Gough (2003) mean, Reinhartz (1997) posed the question 'Who am I in the

research field?' asserting that as qualitative researchers, we bring a number of selves into our research. Reinhartz (1997) constructs a picture of the impact of self in any research study and I recognise that this study has Clive Acraman running through it. My research based selves (Reinhartz 1997), being a researcher, being a good listener and being a person who has given feedback. My 'brought selves' (Reinhartz 1997) including my friendship with Paul, my sense of social justice, my parenting, my experience of living in a politically active, socialist family and my contribution to the development of person centred planning (Sanderson, Acraman, & Short 2004). My situationallly created selves (Reinhartz 1997) such as my career pathway, my being a manager in the health and social care industry and my being a carer.

According to (Reinhartz 1997) the impact of 'self' is present in any research process and findings. This does not mean that the study will have any less significance whoever conducts it, but the value of my reflexivity supported me to 'sift out' the 'personal' from the 'literal'. This was not by any means a simple process and I thank my supervisors for their vigilance, questioning and support with the 'sifting process'. As Reinhartz (1997:18) suggests:

> "reflexivity is not about narcissistic display, nor is it a reaction to positivist thinking; rather, it is a balance between the objectivity of unreflexive positivism and subjective navel-gazing which enables the documentation of the self as a key field work tool".

To some extent, all research is interactive, and it is through these interactions that a 'symbolic interactionist sensibility' emerges that is, how the researcher sees what has been studied through their own

lens, and how a reflective 'seeing of the self' is conveyed through the medium of that which has been studied McIntosh (2010: 51).

I recognise that the subject of this research study comes out of my personal experience and an intense interest in the process of Person Centred Planning: an introspective self-dialogue. While the inter-subjective element is translated as a critical gaze towards my emotional investment in my research relationships, a self reflective consciousness allows for psychodynamic analysis of unconscious structure relations between participants in the research process (Finlay & Gough 2003). I believe reflexivity as mutual collaboration promotes cycles of mutual reflection and experience through AR approaches. Further, as a social critique exploring the power imbalance between myself as the researcher and the participants through tensions which may arise as a result of different social positions, such as social class, race and gender (McIntosh 2010). Finlay, in Finlay & Gough (2003) cites Wasserfall (1997) in stating:

> "the use of reflexivity during fieldwork can mute the distance and alienation built into conventional notions of 'objectivity' or objectifying those who are studied. The research process becomes more mutual, as a strategy to deconstruct the author's authority" (Wasserfall 1997: 152).

Out of this, a number of opportunities and challenges emerged which I needed to take into account during the study. In one way reflexivity may be considered as a 'confessional account' of methodology (Finlay & Gough 2003: 16) or an examination of personal unconscious responses to what is engaged in and found, and the manner in which it impacts upon the self. In another way, it may be viewed as a critique of where the research is socially located and

constituted through deconstructing established forms of meaning.

Sartre (1996) warns that practitioners can immerse themselves in forms of reflection and yet remain a bystander to them, observing the process of reflection itself. Weaving together the discrete yet interlinked constructs and practices of AR, reflection and reflexivity was a central aspect to this study.

3.4 Reflecting insider and outsider perceptions

Bartunek & Louis (1996) describe how, epistemologically, inquiry from the outside is more akin to a logical positivist approach, which seeks one absolute truth, whereas, enquiry from the inside more commonly echoes an interpretative approach which acknowledges multiple realities.

Insider research refers to researchers who conduct research with teams and organisations of which they are also members (Dwyer & Buckle 2009;Kanuha 2000). As an insider, the researcher shares an identity, language, and experiential base with the study participants (Asselin 2003). Whether the researcher is an insider, sharing the characteristics, role, or experience under study with the participants, or an outsider, the personhood of the researcher, including her or his membership status in relation to those participating in the research, is an essential and ever-present aspect of the investigation (Dwyer & Buckle 2009).

Considering my career pathway and involvement in the development of PCP (Sanderson, Acraman, & Short 2004) I was not a detached,

objective researcher, I was situated as an involved insider (Reed & Procter 1995). I was also personally and professionally invested in the change I hoped would occur (McNiff 2002).

My position as an insider gave me a certain amount of legitimacy (Adler & Adler 1987) with the participants, and allowed me to quickly develop a level of trust and openness with them that may not have otherwise been present. It provided me with a starting point; a commonality that afforded access into the teams that might otherwise have been closed to 'outsiders' (Dwyer & Buckle 2009). As a consequence the participants may have been more willing to share their experiences because of an assumption of understanding and an assumption of shared distinctiveness. It was, perhaps, as if they felt "you are one of us and it is us versus them (those on the outside who don't understand)" Dwyer & Buckle (2009: 56). Although this shared status was beneficial because it afforded access and a common ground from which to begin the research, I also had to be aware of the potential my status had to impede the research process as it progressed.

Due to this shared distinctiveness, it was possible that the participants would make assumptions of similarity and therefore fail to explain their individual experiences fully (Dwyer & Buckle 2009). It was also possible that my perceptions may have been clouded by my personal experience and as a member of the group. I needed to be mindful to separate my own perceptions from those of the participants. I was very conscious of my place within the research environment and the potential to be perceived as having used this

insider status to influence the outcome of the study. I had to be careful that the methods I used were shaped by the participants and not by the core aspects of my own experience. Therefore, although I was hopeful that the tools and AR process would be implemented successfully within the teams, I held no preconceived ideas about what this might look like.

I managed my insider status differently in each of the projects. The staff in the Obesity Support Team were aware of my position as a manager within their NHS organisation and expected me to lead them. This was exacerbated by the senior manager's apparent expectation that I could manage this project in a dual role as a researcher. I had to assert my role as an outsider in a determined effort not to contaminate the data or my analysis of it. This was a stressful process to manage and my employers did not offer me clinical supervision. Instead, I had to find my own support networks through my peers, family and study supervisors.

The Children's Centre Family Support Team failed to engage with the study at any meaningful level, while the Local Authority Family Support Team who had clear leadership roles established throughout their project used me more in a consultative position. I was always aware of my status and believe that it was the shared understanding of my role in each of the teams that meant that much of the dialectic data was shared with me (Talbot 1999).

Being an insider was not without its potential problems as I needed to be aware of struggles I might have with role conflict such as "loyalty

tugs" and "behavioral claims" (Brannick & Coghlan 2007: 70). As Asselin (2003) asserts, my dual role, had potential to result in role confusion when responding to the participants or analysing the data from a perspective other than that of researcher. She observed that role confusion can occur in any research study but noted that there is a higher risk when the researcher is familiar with the research setting or participants through a role other than that of outsider.

There are costs and benefits that need to be considered in the insider versus outsider debate. Being an insider might raise issues of undue influence of the researcher's perspective. However, being an outsider does not create immunity to the persuasion of personal perspective. Furthermore, although there might be caveats to being a member of the team or organisation studied (Dwyer & Buckle 2009), access to the team may be difficult if the researcher were an outsider. The positive and negative elements of each therefore need to be carefully weighed up.

Being an insider in this research did not mean that I would necessarily unduly negatively influence the process. The framework in which I worked and the detailed reflection on the subjective research process overseen by my research supervisors enabled us, as a team, to maintain a close awareness of my potential personal biases and perspectives and to reduce the potential concerns associated with my insider status.

3.5 Aim(s) of the study

At the outset of this research study, the overarching aim was to explore and attain an understanding of how introducing the use of Person Centred Thinking Tools, Essential Lifestyle Planning, and Family Essential Lifestyle Planning to health and social care services for children and their families would impact on the process of personalised service delivery.

The aim of the study however, changed, as I reached my transfer from an MPhil study to PhD. At this stage of my research, I had begun to work alongside the teams in the study, and it had quickly been identified through our initial shared analysis of data gathered through the AR and AL processes that the teams were using the research process to inform their practice in a different way than I had first intended. I recognised this as an outcome of the AR process as the teams dialogically used the process to identify what was important to them and how they wished to be supported in order to be successful. The teams had used the process and associated tools to inform and address individual and workplace relationships within their multi disciplinary teams as well as their relationships with service users.

The aim of the study therefore shifted as a direct result of the early analysis. Post transfer to PhD my aim was:

- to explore and attain an understanding of how the use of the Person Centred Planning Tools had impacted on the process of organisational learning in the three separate but associated health and social care settings.

3.6 Access to the Sites and Participants

In my role as Programme Manager of a Local Sure Start Programme, I had successfully introduced the use of Person Centred Planning – an approach previously used in adult learning disability services - into service delivery for children and their families (Sanderson, Acraman, & Short 2004). This work had sparked interest from partners and stakeholders which led to a number of requests for me to work across different multi-disciplinary settings. Through the Management Board of the local sure start programme the main partners, the Primary Care Trust, Local Authority Child and Family Services and Early Years Team, agreed to select one service from each provider to participate in this study. Prior to the study, a private foster care agency also expressed an interest in the study and this was included in the application for ethical approval

Access to the teams was gained through senior managers from each of the organisations who also agreed to both oversee their service's involvement in the research, and also to take part strategically by joining in the action learning process.

I met with the teams involved in the study twice before the study began. This presented an opportunity to explore the methods to be used and for question and answer sessions.

3.6.1 The Participants

Local Authority Family Support Team

This team was strategically led by a Senior Manager from the Child and Family Directorate. Day to day operational decision making was

devolved to the Team Leader of the team. There were also two Senior Family Support Workers and a team of eight Family Support Workers.

The Obesity Support Team

This Team was led strategically by a Senior Manager from the Primary Care Trust. Operationally there was a Paediatrician (employed by the acute trust, two Dieticians', two School Nurses, two Healthy Lifestyle Coordinators (employed by the local council), a Food Worker (employed by a local sure start programme) and a Clinical Psychologist (employed by a local sure start programme)

Children's Centre Family Support Team

This team was led strategically by a Senior Manager from the Early Years Service, who devolved day to day leadership to the Children's Centre Manager, who in turn devolved her involvement and decision making to the Team Leader for Family Support Services. There was an Early Years Teacher, and four Family Support Workers.

3.7 Ethical Approval

Initially this study aimed at gaining an understanding of how introducing Person Centred Planning to Child and Family Services might influence the involvement of children and their families in care planning and decision making. This would have involved interviewing children and their families involved in statutory services and Looked After Children (Children Act 1989; 2004).

The process of ethical approval therefore was challenging and robust. The study received ethical approval from the NHS Ethics Committee of East Lancashire Teaching PCT. It was then presented on two occasions to the NHS Research Ethics Committee, Cumbria and Lancashire B, Lancashire and South Cumbria Agency (LREC), who scrutinised my proposal and methods (see Appendix 1: 295). My study was presented to the ethics committee of the University of Central Lancashire as part of my transfer process.

3.8 Methods of data collection and analysis

3.8.1 Interviews

Semi structured interviews were held with staff members prior to the implementation of the research study in order to establish baseline information relating to each teams' understanding of family support and how the study might best inform their practice. Further interviews were held at the midpoint of the research and the initial analyses used to inform the AL process. These interviews were further analysed at the completion of the study to inform a robust understanding of the data gathered through triangulation.

All of the interviews were taped and transcribed. The initial data gathered were grouped and organised using thematic analysis. All interviews were undertaken within the participant's place of work.

3.8.2 Action learning sets

Each team and each individual in each team (see Appendix 2: 301) agreed to take place in action learning sets. The Obesity Support Team asked for these to be arranged at six weekly intervals. The

Local Authority Family Support Team and the Children's Centre Family Support Team requested four weekly meetings. Each meeting was scheduled to last two hours. All participants were invited to the action learning sets that were scheduled for twelve months in advance. Each action learning set was time tabled for two hours. The action learning sets were tape recorded and transcribed. Data were also recorded on flip chart paper.

3.8.3 Practitioner Reflective Logs

The participants were asked, wherever possible, to write supplementary notes immediately after their interventions with families or colleagues in line with Flick's (2002) and Koch & Harrington's (1998) suggestion. This was seen to be important because action researchers and engaged participants are often left with a sense that something that seemed important at the time has not been captured (Winter & Munn-Giddings 2001). In practice, this sense of omission was frequently magnified, perhaps because the research process was undertaken between other aspects of my job, and I was not 'on site' for much of the time. Therefore, I was reliant on contemporary notes being taken. However, it was clear from some of the reflective logs (Koch & Harrington 1998) that there had been a delay between the date when the event occurred and the date it was written up. Inevitably, this meant that this delay created 'distancing' (Huxham & Vangen 2003).

All practitioners in each team were asked to keep a reflective written record of their involvement in the study (see Appendix 6: 319). Ninety eight separate reflective practitioner logs were received from the

Local Authority Family Support Team, fifty five from the Obesity Support Team and eleven from the Children's Centre Family Support Team.

These methods produced contemporaneous data which could be fed back to the research participants thus allowing the AR process to inform service development. Further analysis and synthesis of data was undertaken at the conclusion of the study which informed the research element of the study.

The process of AR meant that the collection and analysis of data was ongoing throughout the study. This allowed the reflections from practice and the testing of different ideas to continually contribute to the development of service delivery in the projects. As themes emerged from the data it was possible to cross reference the various data sets to ensure they were supported and were an authentic and credible interpretation of the data.

3.8.4 Data Analysis

The process of AR involved an iterative method of data collection and analysis, the complex process undertaken is illustrated in figure 1 on page 65. Data were gathered throughout the study and analysed using a transformative design, theoretically driven to initiate social change guided by the constant comparative method of action learning in which verbatim quotations, written reflections and observations were catalogued and developed iteratively to reflect the data (Curry, Nembhard, & Bradley 2009). This allowed the reflections from practice and the testing of different ideas to continually

contribute to the development of service delivery and to generate theory or insights describing a phenomenon, grounded in the views expressed by the study participants in the projects. As themes emerged from data it was possible to cross reference the various data sets to ensure they were supported and were an authentic and credible interpretation of the data (Creswell 2003;Patton 2002).

The process of thematic analysis used in this study reflects the work of Castro et al (2010: 347) on creating a methodology for integrative mixed methods studies. Themes and patterns within the data were identified in an inductive or "bottom up" way (Frith & Gleeson 2004): a process of coding the data without trying to fit it into a pre-existing coding frame or the researcher's analytic preconceptions (Braun & Clarke 2006). In this sense, this form of thematic analysis was data driven. However, I acknowledge that the data were subject to my own epistemology and therefore were not coded in an epistemological vacuum.

The process of analysis began upon completion of the initial interviews and was then taken into the action learning process. It was at this point that I began to notice and look for patterns of meaning and issues of potential interest in the data. This process became more complex and detailed as the teams used the data to inform decision making and service change throughout the study. At the end of the study all of the data were subject to a more detailed analysis. At this point I felt overwhelmed by the amount of data I had to immerse myself in and would use many 'work avoidance' techniques such as doing housework or cleaning the car, activities I usually

never do.

Prior to coding the data for research purposes I thoroughly immersed myself in it, reading all of the transcripts from interviews and action learning sets, my research diary and the reflective practitioner logs. Only then did I begin to do a detailed analysis. Following my initial reading, I repeatedly read the data in an active way, searching for meanings and patterns within it. This involved constantly moving back and forward across the entire data set, the coded extracts of data I was analysing, and the analysis of the data I was producing (Braun & Clarke 2006). As I read I wrote down ideas and potential coding to share and check with my research supervisors. As my research journey continued I began to identify themes within the data that would help me to describe the story that each theme told (Braun & Wilkinson 2003).

The type of mixed methods design used in this study has some of the elements of exploratory sequential design because there was a clear expectation that data would come in a particular order and be analysed as it was generated within each of the projects (Creswell et al. 2006;Creswell et al. 2007). In this study there were exploratory interviews, action learning sets and the use of reflective practitioner logs which occurred in a planned process but at different times as the research developed organically, that shaped the direction of the entire study (Creswell 2009). These data sets were brought together through thematic analysis. The qualitative component in this type of design was clearly not an appendage it was central to the study and given priority, which is not unusual within a mixed methods study

(Creswell, Plano Clark, & Garrett 2008;Morgan 1998).

Some experts (Gubrium 2007;Malterud 2001) argue that it is sufficient for an individual researcher, who is inextricably enmeshed in the data collection and analysis, to work alone. In these cases, it is important to be aware of the researcher's potential biases.

Other experts suggest that the quality and breadth of analysis are enhanced by ongoing and close involvement of multiple analysts from differing disciplines (Denzin & Lincoln 2000;Mays & Pope 1995;Pope, Ziebland, & Mays 2000). While I gathered my data contemporaneously and used the participants as researchers, I was grateful of the support and help provided by my supervisory team to help me make academic and theoretical sense of the data.

Using my study supervisors and the research participants as a 'multidisciplinary analytical team' I was able to generate unique insights from differing perspectives, engage in critical discussion of unclear or subjective data, and ensure consideration of multiple interpretations of the data (Curry, Nembhard, & Bradley 2009).

In contrast to a traditional approach where researchers collect and analyse data without the participation of people in the organisation, the AR process encouraged continuing dialogic learning and heterogeneous interpretations which some authors assert can result in more robust theorising (Bartunek & Louis 1996;Dwyer & Buckle 2009).

As an outsider, I searched for knowledge that might be generalised to other situations, while, as an insider, I was aware of my influence in supporting the generation of knowledge for practical use. In a sense, my two roles complemented each other and fostered a better understanding of the manner in which the teams made sense of their world. Furthermore, my role as part of an insider/outsider team, supported by my 'outsider' study supervisors, linked robust evaluation of data to the organisation's own learning (McIntosh 2010;McNiff & Whitehead 2000;Roth & Kleiner 1995).

In this study the teams clearly understood that their practice was being researched. They participated in initial interviews, action learning sets (during which copious notes were taken) provided feedback via a flip chart and submitted reflective practitioner logs which in turn informed their dialogic learning.

The manner in which research data was collated is supported by Huxham & Vangem (2003) who stress there are obvious advantages to action research if visible data collection can be managed without the practitioners involved feeling inhibited, threatened, or alienated. This allowed effective planning of the type of data to be collected in advance with the participants; this in turn enhanced the chances of it being collected successfully (Huxham & Vangen 2003).

In addition, as the participants understood what they were responsible for providing, it allowed for a great deal of detail to be recorded from each individual's perspective (Flick 2002;Koch & Harrington 1998). This meant that the interpretation of the data could

be repeatedly checked during the analysis process making it possible to subject it to independent interpretation from the participants and their managers. For example, the use of practitioner reflective logs (Koch & Harrington 1998), as both a detailed and a relatively unstructured method of recording data, proved particularly valuable in allowing review of the data many times for different interpretations.

The logs were used to inform supervision sessions, team meetings and child and family review meetings during this study (in addition to the research). This method of data collection may also provide an opportunity to review the data at future dates in the context of a different research agenda.

Data collected in this way are therefore somewhat affected in the sense that some data which could have been collected were missed. Nonetheless, data collected were full in the sense that they reported on theoretical and practical issues, and rich, in the sense that they frequently addressed complex practice demands and dilemmas as the participants faced them. This being the case, an organic process took place which enabled the participants and the researcher to act upon the data and make immediate enhancements to practice and theory.

The dilemmas involved with interpreting data collected through AR are reported to be similar to those posed by other forms of organisation research methods (Bryman 2001;Gill & Johnson 2001;McGrath, Martin, & Kulka 1982). The major dilemma suggested was the perceived intrusiveness of the researcher and the effect that

this might have on participants' behaviour (as previously discussed in the insider researcher section).

In the context of AR, the perceived dilemmas have additional significance because the researcher may be viewed as interventionist. As soon as practitioners begin to view the researcher more as an outsider (there to gather research data) rather than as an insider (there to support them in their work), the particular possibilities to gather rich insights which are the distinctive feature of action research disappear (Whetten 1989). The more the outsider role becomes intrusive upon the action, the less real the action is likely to be and the more difficult it becomes to interpret the outcomes (Huxham & Vangen 2003). The issue of how much the need to collect research data should be allowed to interfere with the action dimension of the intervention is therefore as significant as more familiar debates about the validity of the research data itself (Checkland & Holwell 1998;Susman & Evered 1978). The ethical issues (Christians 2000;De Laine 2000;Miles & Huberman 1994) are different or perhaps heightened when working with participants on a matter of genuine concern to them, compared to those that arise when research is restricted to the interests of the researcher (Asselin 2003;Dwyer & Buckle 2009;Miles & Huberman 1994).

3.9 The Role of the researcher: a personal reflection

Facilitating successful participation in this study was supported by my role as an 'insider' (Asselin 2003;Bartunek & Louis 1996;Brannick & Coghlan 2007). This supports the essence of AR which as McNiff (1988: 4) asserts is, "research WITH, rather than research ON" the

participants.

As I explain in Chapter one, my passion and drive for my work has its roots in a desire to make a difference to the lives of people who at any time have a need to use a health or social care service. I dislike social injustice and controlling powerful organisations. I prefer to work in partnership with others on a basis of shared power.

Even though I had made every effort to create a collaborative and power sharing base for the study I was perhaps naïve in believing that I could do so with absolute success given the positions of power I held. These roles, and my understanding of them, developed in complexity as I gained a deeper understanding of how the actions, observations and reflections recorded in the data impacted on individuals and their teams. While I had accumulated vast amounts of data I was aware that gaining a deeper theoretical understanding of them (and developing new and useful insights into their meaning) would almost certainly come from critical reflection on carefully selected responses or incidents rather than attempting to interpret the data as a whole. I understood that undertaking critical reflection is easier said than done. At time I felt 'lost in a sea of data'. I was therefore very grateful for the support, guidance and shared perspective (Denzin & Lincoln 2000;Mays & Pope 1995;McIntosh 2010;Pope, Ziebland, & Mays 2000) of my research supervisors to ensure that my interpretation of data was undertaken carefully and systematically allowing alternative perspectives to emerge and be explored.

The reflective practitioner logs (Koch & Harrington 1998) were shared across the organisation ensuring that all the participants were aware of how their own and the practice of their colleagues was developing and successful and where support was required to support service change. These reflections were used to inform the action learning meetings. This ensured that the participants became involved in a sustained and elaborate process of engagement together that informed their day to day decision making. Having this process in place ensured the AR 'spiral' was quickly established. Staff across the teams planned to critically reflect on their own practice, record and share their reflections and to meet regularly in order to compare, evaluate and design further plans and next steps based on their shared learning. The next steps were a part of the design process that ensured the participants remained focussed and outcome driven. This tool asks:

- Who is responsible for implementing the action or achieving the desired goal?
- How? Where? When will the action / intervention be undertaken?
- What are the expected outcomes from the action / intervention?
- How will you / your team / your organisation / the service user know you have made a difference?

It was my analysis of the data created and shared jointly with the participants through their reflective practice and action learning processes described above, that led us to understand how each of these themes had been present throughout in the outcomes of their work and from the process itself.

In this way, the action research process enabled me to develop a theoretical understanding of how embedding appreciative practices into teams can alter and positively enhance ways of working. This theory (see Chapter 5: Discussion) was generated not only by establishing links between variables or by supporting a hypothesis but also and importantly by portraying a specific sequence of events presenting such complexity of detail and 'depth' that its usefulness and application for different situations can be understood by others (Winter & Munn-Giddings 2001).

As an insider researcher, I observed and reflected upon the process of AR as it supported the participants to continually alternate between undertaking an inquiry into a perceived 'problem' in their service and taking 'action' to solve it. This process created an environment to support innovative thinking, which influenced practice through a developmental spiral of practical decision making.

CHAPTER 4: FINDINGS

There were four consistent themes present in each of the teams throughout the findings. I identified these themes as:

- Engagement
- Process
- Context
- Culture

These themes and my understanding of them developed in complexity as I gained a deeper appreciation of how the actions, observations and reflections from action learning impacted on individual staff, and on the teams themselves. There were other elements present which tied these themes together, these elements of learning, power and dialogue acted as vehicles which determined the direction taken by the individual teams by the manner in which they were used and executed. This was accentuated further by the style of leadership present in the separate teams. As I report on the four themes I will explain how these elements influenced the key themes.

4.1. Theme1: Engagement

The normative process this study followed led, in two of the teams, to a transfer of skills and knowledge through increased levels of dialogue and shared learning. Where this took place there was an intense burst of open communication that I identify as engagement. Engagement in this context was complex and it took place on a number of levels and in a variety of ways. These findings explain how

engagement occurred in the three separate teams, where it occurred and the effect it had on the teams at different levels.

Engagement in this study occurred in a number of contexts and on a variety of levels. Leadership of the teams and the effect this had on the teams' ability to effectively implement processes of dialogue and shared learning was central in relation to the levels of communication achieved by the teams. Where the levels of communication were at their highest, the teams' level of engagement increased. The teams' developing dialogue engendered confidence and increased self esteem in team members. The appreciative and outcome focused nature of action research supported the teams learning. Where the teams engaged at a meaningful level, conversations staff had together changed from being 'problem based' to being solution focused. Staff developed stronger partnerships and relationships with fellow professionals and service users, and shared responsibilities with these same groups, manifesting in a type of principle-centred and collaborative praxis.

The levels of engagement the teams achieved were demonstratively determined by the levels of commitment and support offered by the decision makers attached to the separate teams. Where the leaders used their hierarchical power positively, the teams used dialogue effectively to influence the development of their service through processes of team learning. This created an environment in which the team were able to think innovatively, which allowed non-routinised learning to take place. This provided teams with the opportunity to implement changes to their service swiftly and safely in

a supportive environment. Conversely, where hierarchical use of power effected the teams' engagement negatively some routinised learning occurred without being overtly linked to the vehicles of dialogue and shared learning.

While it should be acknowledged that there will always be some level of communication, and engagement (implicit or explicit) existing in any team delivering health and social care services, four distinct areas could be identified where a substantial level of engagement occurred:

1. Engagement with the leaders (senior managers and individual leaders) in the teams.
2. Engagement with the teams and individuals in the teams.
3. The team's engagement with service users.
4. The team's engagement with their partner organisations.

4.1.1 Engagement with the leaders (senior managers and individual leaders) in the teams.

From the outset of this study, the team leaders of the three projects engaged with me in my role as a facilitator on different levels and each appeared to have very different agendas. All of the team leaders, and their senior managers were at first enthusiastic, welcoming and initially appeared to engage readily both with me personally and with the research project. However, I found that this initial promise of engagement was not reflected in praxis in two of the three teams. What became apparent was that where the support and collaboration of the senior managers was lacking, organisational learning was less successful.

4.1.2 Engaging with the Senior Managers

I had been acutely aware during the planning and preparation period for this research study that each team was led and structured within hierarchical frameworks. Understanding the potential power differences within the teams involved in the study and their senior managers I carefully negotiated and obtained support for the study and their involvement in the process. Each of the organisations involved identified senior managers who would support the study in their team and attend steering groups. It was crucial to the study that they were able to understand and agree with the basic assumptions explicit within action research and action learning. This involved their commitment to a process that would critically analyse the practice and performance of their teams, and for them to be open to potential suggested changes arising from their team's involvement in the study. Implementation of any such change was to be agreed at the steering group meetings. It became clear that the senior managers commitment to, and understanding of, the processes involved in the study would be instrumental to the levels of success. The success of the relationship between researcher, team leader and the decision makers was heavily reliant on honest, open and accurate reporting by the team leaders. The attitude towards the study demonstrated by senior managers was also instrumental in the overall outcome of the study as shown in these findings. In the following sub sections, engagement within each of the teams will be explored further.

4.1.3 Engagement with Individual Senior Managers: Local Authority Family Support Team

The senior manager of the Local Authority Family Support Team was very supportive of the team leader and demonstrated a keen interest in the study. He attended the majority of steering group meetings, requested regular feedback from the team leader on the effect of the study on the team, individuals in the team and service outcomes for the children and their families. This close interest and monitoring of the study's progress placed him in a strong position to support decision making based on recommendations made by the team leader in relation to service development. He established his role from the outset of the study "while I am hopeful this study will prove useful I will necessarily liaise with (name of team leader) on a regular basis to monitor progress." He emphasized his position to all during an early steering group meeting:

> "The values and principles that underpin this approach to service delivery are wholly relevant and appear to be translating well to family support. (Name of team leader) reports that the tools reflect what is seen in good practice, and provide a framework and structure to operate in that previously didn't exist. I am encouraged by the shift of power that this approach potentially provides if used appropriately, putting families back in control of their own packages of support. I am cautious though about family meetings. These meetings appear to be a good way forward, but facilitators will need to be very skilled in keeping meetings focussed. What is missing in this part of (name of county) is a common currency, and language around Family Support, which I am hopeful this study may provide... I will support (name of the team leader) in her decision making based on the evidence she provides" (Senior manager, Local Authority Family Support Team during a steering group meeting).

This manager's close involvement and interest in the study supported the team leader's decision making throughout the study. This led to informed, evidence based changes in service delivery being achieved quickly. Such was his confidence in the process, and the quality of the team leader's decision making, he devolved much of this power to her by the conclusion of the study. At the penultimate steering group meeting (nine months into the study) he asked for the team leader and staff team to hold a celebration event for his peers across the county "it is important that we celebrate what you have achieved and attempt to replicate this across the county." He qualified this further stating:

> "...the change in the confidence and competence of the team reported by (team leaders name) has been very encouraging. We have not seen a reduction in the families using our services I had hoped for but I accept this may come as this approach becomes embedded in the team. The common language the team use is something I would like to see reflected across our region. I would like the final steering group to be a celebration and information exchange event. (Name of team leader) could you arrange for the service leads, your colleagues from children's services and the social work teams to be invited please?" (Senior manager, Local Authority Family Support Team during a steering group meeting).

By making this statement he was actively voicing and reinforcing his belief that the method of action learning used in the study was worthy of being shared and tested in other areas of social care in the region. The appreciative and reaffirming nature of this manager's approach to the study enabled the team leader to implement her team's learning in such a way that regular improvements were made to the service in a holistic manner. The team used their learning to inform

all aspects of their service including the administration of the team, student placements, team meetings, formal and informal meetings, supervision and their service delivery.

4.1.4 Engagement with individual senior managers: Children's Centre

From the outset of the study the senior management representative of the Children's Centre was equally if not more enthusiastic about the research study than the senior manager for the Local Authority Family Support Team: "the possibility of rolling this approach out across all of our Children's Centres is very exciting". At the inaugural Steering Group meeting she stated:

> "...having sat on the management board of (name of Sure Start Programme) I am really excited about this project. It is a great opportunity for us to work in partnership with the local authority to provide standardisation and consistency across Family Support services in (Name of county)." (Senior manager, Children's Centre transcribed from a steering group meeting).

There was also a suggestion that the Early Years Directorate were considering how they could roll out this approach to family support, while exercising some caution about its transferability.

> "...in principle, Early Years are interested in looking at how we can roll it out across (name of County). We have evidence on how it's been used already and understand it has made a difference to teams in (name of area). We appreciate that it is still very early days, but at least it has given us an indication. I think we do need to bear in mind that there aren't just two children's centres, but there are eight children's centres, not just a couple, and acknowledge that, and we've managed that and also the recruitment and I know we're looking at a long term project anyway. But yeah, in principle we'd be really

> interested, but I think before we could do anything, see what impact and difference it's makes here". (Senior manager, Children's Centre transcribed from a steering group meeting).

In contrast to the Local Authority Family Support Team's senior manager however, this person's relationship with the team leader of the Children's Centre Family Support Team was not as a line manager. This meant that she was reliant on "second hand information sharing" and communication. This created a missing link in the cycle of communication which led to delays in decision making and a lack of understanding of the dynamics in the team. As reported below, the team leader's personality and personal influence on the service had a significant effect on the effectiveness of the study and its outcomes.

As with the senior manager of the Local Authority Family Support Team, this senior manager's attendance at Steering Group meetings was excellent, but the outcomes were very different. By the penultimate meeting there had been very little evidence provided by the team leader about progress that had been made during the study. There was evidence of routinized learning in the Children's Centre Nursery, the Early Years Teacher used her learning to create transition plans for children, but did this in isolation. Moreover, non-routinized team learning (for example team members learning together through shared dialogue) and action learning could not be evidenced. This resulted in the senior manager asking the Local Authority Family Support Team to develop a buddying system for the Children's Centre staff "...it may be useful to use the Family Support Team at (name of service) as buddies for your team (name of

Children's Centre Team Leader) as they work together regularly". This appeared to be an attempt to implement service development through shared learning within the Children's Centre. She did this formally during a steering group meeting:

> "It appears that (name of family support team) have developed systems and informed their practice to a much greater extent than (name of the Children's Centre) although you have shared information and support mechanisms. I don't understand how this has happened, however, I think it is worthwhile taking up (name of Local Authority Family Support Team, team leader) kind offer of her team mentoring Children's Centre staff. I acknowledge that there have been difficulties with staff changes in the centre, but not to the extent that this project couldn't be implemented. We (the Early Years Team) would like to learn more about what has happened here before taking things forward in terms of the other centres" (Senior manager, Children's Centre transcribed from a steering group meeting).

It is my understanding that the lack of clarity of the leadership and decision making processes in the Children's Centre meant that their Family Support Service was not enabled to engage in a meaningful way with the action learning process. The result of this was the Children's Centre failed to establish an environment where learning could take place.

4.1.5 Engagement with individual senior managers: Obesity Support Team

Although this was a multi-agency team it was established with very limited financial resources and its sustainability was wholly reliant on future NHS funding.

The manager from the NHS Primary Care Trust identified to support the project attended meetings infrequently and rarely communicated with those delivering the service. This was very frustrating for the team who were delivering an under-funded service without strategic direction. Even though a senior manager from the Borough Council was usually present at the steering group meetings, she had no decision making powers.

The apparent apathy and failure to engage at any level with the project from the PCT strategic lead meant there was little possibility of the learning taking place in the programme being shared across and informing other health services. It was frustrating for the team as when the PCT lead manager did attend meetings they were required to bring him up to date with the service before they could make progress. Rather than establishing a learning environment this led to a lack of informed decision making at this most important level of management. This led members of the team to question the levels of communication about their work with the strategic lead. “Why is it (name of strategic lead) that we always seem to be saying the same things about the project to you but nobody, not (name of Consultant paediatrician), not (name of Public Health Lead) seem to know about this very important project. It is these people that need to know because they are the budget holders and they need to know about (name of project)” (Lead Paediatrician transcribed from a steering group meeting).

The strategic lead’s poor communication skills, lack of empathy with the project and what the team were attempting to achieve continued

to frustrate the participants. Two months into the study, and during an action learning set, a member of the team, the dietetic lead for the PCT, questioned the organisation's commitment to the programme "(name of strategic lead) just doesn't get what we are trying to do and nobody else appears interested", and the effect this was having:

> "I don't actually think there's the strategic leadership from the PCT, we've been delivering (name of project) for nearly three months now and (name of senior manager) hasn't a clue what we are trying to achieve. He doesn't, um, he doesn't understand about preventative programmes, he would make a good drugs rep though (she laughs). Seriously, though, um, there needs to, to actually, you know, be some direction and ownership from the top." (PCT Dietetic Lead, transcribed from an action learning set)

This woman's transparent personal drive and passion to make a difference for the children and families she worked with was clear. She was an experienced practitioner, however, her belief in the system created to support her and the team to deliver was tainted through previous experience as she explained:

> "As a team we are doing things differently and that's great but we need sustainability, we need him (name of strategic lead) to create, look at the, um, the direction we need to go in and, and make, make the changes, it's, it's um, I don't think, I mean we're, we're pushing against the tide a bit I feel. We just need somebody to hear us and support the work we've started, I experienced this before and I um, I don't want us to let patients down either" (dietetic lead during a steering group meeting).

The programme developed by the team over the twelve-month period was reportedly successful[1]. The team, however, were vociferous throughout the study period that their work and service development were not being recognised by the responsible senior manager from the PCT. The teams' expressed fears that they were developing a programme that would not continue after the pilot period, primarily due to the lack of strategic leadership from the PCT and the levels of engagement they had achieved with the PCT's representative, were born out. This was exemplified in month eight when again the team raised the question of future funding and sustainability with the senior manager. At this time, the team were so isolated in their roles they were only able to meet together once a month for two hours, and to deliver the programme one evening a week. None of the team had any dedicated time to allow them to prepare or plan in between sessions. There was no funding made available to release them from their day to day work and there was a distinct lack of leadership or even administrative support from their senior managers located in the hierarchies of the Local Borough Council and National Health Service. However, there was a strong and transparent work ethic, belief and commitment from the team whose frustration was articulated by the dietetic lead for the project:

> "just to say that it feels at the moment like a rudderless ship the (name of obesity project) programme. (Name of the programme) has developed over the last 7 or 8 months into what I think is a programme that can lead the way, but what we haven't got and it doesn't look like we're going to get at the moment is the funding to be able to manage the service,

[1] The service design, structure and philosophy is recognised by the Department of Health. The Programme continues to appear on the UK Government's obesity specific website as an example of good practice for others to learn from and to develop their own programmes.

> which we desperately need and that we were promised, and the other thing that we haven't got really is the clarity of how the programme should look now, so the programme's evolved hasn't it over the months and where I think that we need to, what we need to know strategically (from the stakeholders) is where's the programme at and what do we want to do with it? If the PCT aren't going to sustain (name of the project) as part of the overall obesity strategy that I know hasn't been written yet, then we need to be honest with parents coming to the (name of obesity project) programme because people will be leavin the pilot very soon with no funding" (Dietetic lead; transcript from an action learning set)

Unfortunately, these answers were not available from the strategic lead. Although he had been involved with the obesity project for many months there was a distinct lack of clarity about his decision making or commitment to the programme as a whole, the staff and the service users. He appeared to enjoy the authority and power that his position provided him with as he asserted "...well this is something I will raise with (name of Associate Director) when I next see her, which will be next week now, she's off, but to say that there is potential risk there but we also need to say, look it might well stop, okay, if there's no money, there's no money, there's nothing any of us can do about that, but that's the end of that, there's nothing more anyone can do"

When this response was questioned with some disbelief by the paediatrician attached to the obesity programme "I don't understand what conversations you will be having with (name of Associate Director). There are a number of ways we can deliver (name of programme), or at least implement things, important lessons we have

learnt together about how we should be working with families. What are you asking for funding for?" She was supported with equal disbelief by the lead person from the local authority "Wouldn't it be more beneficial for (name of Associate Director) to meet with us as a team, so we can talk about what we have learnt. Surely she, you, the PCT must be aware that your traditional services are simply not working for these children. This project can inform change without cost across your services but it appears you don't want to hear that, what does this hard working team need to do to be heard?"

His response was to request further information (which if he had been more engaged he would have already known). "...it'd be a big help for me to know what the (name of the programme) team is, who is in it in terms of who delivers the programme whole time equivalents, how much does it cost and who comes to the clinics. Then I can take it to the very senior management team to discuss what we need to do?" He effectively used his 'position power' to prevent the team from entering into any form of dialogue with other decision makers. This effectively left the team wholly reliant on this person's perspective, and interpretation of the project in terms of its potential to inform future service delivery.

4.1.6 Conclusion to engagement with senior managers

Senior managers in the three separate organisations had clearly engaged with the study at different levels. Where the senior manager engaged meaningfully with the study, the Local Authority Family Support Team thrived within an environment that supported shared learning through developmental dialogue, decision making and

leadership. The levels of engagement the team leader of the Children's Centre had with the study, however, did not always mirror that of her senior managers where-as the Obesity Support Team did not have a single identifiable lead at team level.

4.1.7 Engagement with the Individual leaders: Local Authority Family Support Team

The Local Authority Family Support Team leader was very accommodating. She included all of her staff team in the process of planning and preparation that was required to be a part of the study. Further, she had a clear vision of the outcomes she and her team wanted to achieve from taking part. She appeared to be a leader who understood the importance of her service's need to respond to one of the major aims of current UK social policy, the drive towards 'quality' and the 'personalisation' of service delivery (Department of Health 2001). This manager was demonstrably passionate about her team making a difference for the families who used her service, "...at the moment we struggle to make a real difference for the families we are involved with, we have known many of them for years and this upsets me because and I would love to reverse this trend and never see them again. Don't get me wrong it's not that I don't like them, but if I don't see them it would mean what we are doing is working". She went on to explain during an interview how she would like to address this:

> "I would like my managers (Senior managers in Children's Services) to recognise that we are *over* stretched and are unable to offer preventative services to families, they should also acknowledge that we only scratch the

> surface of our child protection work and that families leave our service when they are still at risk and children remain 'in need'. I would like us to deliver services that are targeted, preventative, effective and sustainable". (Transcribed from an interview at the outset of the study)

While appearing to be outcome focused, she did not lose perspective about the need to be "person centred" in relation to her personal support for her team and, in turn, with equally importance, the support her team offered to their service users. "We have a *stressful* job and I have a number of staff who are currently struggling personally and professionally. I want to understand how to support them individually while supporting them to deliver a quality service".

This attitude to what could be called appreciative leadership was instrumental to the engagement of her front-line staff in the study, as articulately reported by a member of her team:

> "It is (leader's name) who has really kept us involved, every time we meet with her she asks "what tools have you used?", or "have you done a family meeting?", or "well, what is working about your work with the family?" She never stops and that gets us thinking that we need to keep at it. It is hard though thinking about new things when you are so busy. We do need pushing and it works, look we're all here and we're still doing it" (Family Support Worker, transcribed from an action learning set).

The team leader's engagement with the study and her understanding of the continuous, organic process of team learning enabled her to enter into a dialogue of change with her team. This raised the self esteem of individuals in the team and informed "improved practice"

as they shared their knowledge and learning with each other. She described the positive effect this was having on the team through an entry in her reflective practitioner log:

> "....I am really pleased with the increased self awareness within the staff team and this has encouraged them to reflect both on the practice that they offer today but also to reflect on the former practice. One of my concerns was the lack of formal training for new staff so we have introduced champions who are going to support new members of staff, students, and other professionals in delivering the tools." (taken from an entry in a practitioner reflective log).

The team's "shared dialogue" was used by the team leader in her team meetings and during supervision with staff. She clearly understood how to use the power she had as a manager appropriately, and when she had the opportunity to "learn from the collective knowledge of her team." These leadership qualities, and willingness to share the power her position afforded her, proved to be important when driving change forward in her team. This informed innovative thinking and non-routinised learning throughout the service embedding a shared dialogue.

4.1.8 Engagement with the individual leaders: Children's Centre

The team leader of the Children's Centre Family Support Services was line managed by the Children's Centre Manager. Her line manager in accordance with senior managers from the Early Years Team had expressed a desire for their services to be a part of the study. However, the team leader was not so enamoured although she was not overt about her lack of enthusiasm with her managers.

While expressing her service's commitment to the process at the first action-learning meeting she was unsure about the suitability of the planning process given the nature of the client group who received services from the Children's Centre. A reluctance to become engaged in the research project was evident at this very early stage as she stated, "We will be struggling to use it in our service because we offer non statutory, short term support to families who volunteer to come to us. We are limited by time because of the nature of group work and short term work; we won't have time to do all that planning."

The apparent lack of engagement from the team leader at this early stage, and for the reasons she gave, came as a surprise to me as a facilitator. The service provided preventative services within a diverse community to families who without this early intervention may later be referred to the local authority for formal assessment and interventions. An entry from my own reflective learning log explains my uncertainty about this individual's commitment to the study at a very early stage:

> "I tried to understand how (name of manager) intends to lead her team through the process of the research study. I have learnt that this study is not high on her agenda. I was pleased that she was willing to discuss this with me, but concerned that she appears to be unable to 'see the wood for the trees'. The Children's Centre future reduced budget and perceived threat of staff losses is her priority even-though budgets and future service delivery are still being planned across the local authority. I am uncertain how this will affect the implementation of the tools and processes in her team. I need to keep her managers on board but want to do this in a non-threatening way through the steering

> group." (Taken from a personal reflective statement).

It was very difficult for me to encourage this team leader to examine her own practice, because she did not appear ready to participate. While I was successfully developing a better understanding of the situation I was engaged in, I was concerned that this manager was not going to be able to engage in the process to the extent that she could lead her team through a collaborative process working towards change.

The team leader further reinforced what appeared to amount to covert non compliance with the study by attending less than half of the planned action learning sets. Further she asserted that her staff were unable to attend consistently because of the Centre's requirement for them to facilitate groups and learning sessions for families. This person used her position of power to negatively influence the course of the study within the Children's Centre.

4.1.9 Engagement with the individual leaders: Obesity Support Team

Leadership at an individual, team leader level was difficult to identify in this team. Initially the team looked to me for leadership because I was perceived as an 'expert' in the process they were developing for this new team. However, once we had defined and agreed our role relationships, the dietetic lead stepped forward initially as a leader. This being a multi-agency team though led to others in more senior roles, the Paediatrician, Clinical Psychologist and Borough Council Senior Manager (who was line manager for one of the Healthy

Lifestyle co-ordinators) also attempting to assert some control. Without the over sight of a Senior Manager this led to much confusion and a lack of strategic planning in the service. While there was no malice between the 'would be leaders' the outcome from the study was a service that was led by well intentioned, like minded professionals who wanted to make a difference, but did not have the authority to use their learning to inform service developments outside the specific context of this study.

What did occur however was non-routinised learning, under service specific conditions, which made a real difference to the lives of the children and families who used the service. All of the 'would be' team leaders engaged with the study. They maximised the power afforded to them by their positions to influence the study to their maximum potential. As a team, they developed a shared dialogue and implemented reflective learning practices. This learning, however, remained within the programme without (with the exception of the clinical psychologist) permeating into the services the 'team leaders' usually worked in. The lead paediatric dietician explained during an interview why it would be difficult for her to transfer these working practices into her substantive team:

> We (dietician and her manager) just do not speak the same language in terms, he just doesn't see the vision and he, he's very personable, very likeable but no, there's a, there's a definite lack of focus or understanding of what we need to be doing. I have to do some clinical work, very clinical work and, but obviously I'm getting new ideas from experience with the community, it opens up the mind. But I mean I've always had the interest in the, like the counselling skills and

> so I think that's made me work more in a client-centred way in itself. And so, um, all that and being a part of (name of obesity programme) sort of changed my practice really and that, possibly that is in conflict with (name of manager) because he is very focussed on number crunching and, rather than I feel the quality of the service. He won't let us work with families outside of what he knows, no, no way, all of our time is written down we get fifteen minutes for everything. We know we can't do anything in that time and we get a lot of DNA's (abbreviation for Did Not Attend) but working differently, which is needed we know it is needed, won't fit into his model. He'd have a fit if we started having conversations with patients or attempted to understand them like we do in (name of obesity programme). (Dietetic lead, transcribed from an interview)

Other practitioners from health-related services involved in the project echoed these sentiments. Using their positions of power to control staff, and wielding power over people, was reportedly common in the health service. The Paediatrician reported that her seniors would think she:

> "...was mad if I started talking about individuals at length, what my bosses want is clinical solutions that are easy to pass on with minimal work needed by them. Making relationships (she laughs) this is not on their radar."

The school nurse stated:

> "...I can just imagine my manager's face if I suggested I talk to all of a family rather than just the child. Imagine the time involved. I'd get hauled over the stones, the only real communication we have with parents is for follow up appointments. We have set clinical duties and if we don't tick all the boxes they (her managers) let us know about it."

The exception to this rule was the Clinical Psychologist who wondered what all the fuss was about "...this is foreign to me, as a

service it is our responsibility to understand a child's situation holistically and therefore we would never work with children in isolation."

These examples were not isolated and suggest there is little understanding within this health service provider services of what is required from them in order for them to deliver a personalised service. What is important to people individually about their health care, where and how this should be delivered is secondary to clinical activity primarily guided by quantity (how many people are seen) as opposed to learning about the needs of individuals through a meaningful dialogue.

4.1.10 Engagement with the teams and individuals in the teams

I questioned whether engagement had occurred to any great depth at all during my early interactions with two of the teams. I believe that to some extent they had all engaged with me as a person. I was made welcome and provided with refreshments. The conversations created by my semi-structured interview questions appeared to flow although there was clearly reticence in revealing all of their inner thoughts about their current and future service delivery. The teams all appeared to be quite cautious about what was said and about whom. Perhaps this reflected the hierarchical nature of these health and social care settings, or if it was my presence, representing the unknown. I was aware that I would need to reflect on my influence on the research and research participants throughout the study.

4.1.11 Engagement with the teams and individuals in the teams: Local Authority Family Support Team.

In many ways the approach appeared to engage the research participants in this team in a meaningful process that they understood. This developed into a whole team approach that focused on establishing a dialogue about how to achieve appreciative ways of working and outcomes. The team's engagement was supported by a framework and structure which enabled them to communicate and share their learning through different media on a daily basis. They used reflective practitioner logs to share what they had learnt via email and through a shared file on their secure server, and developed a common language of appreciative learning which informed their informal and formal meetings with their peers and line manager. At the conclusion of the research period the team wrote a statement to support a celebratory event in which described how their engagement in the research had informed their practice:

> "As a staff group, our team come from many different backgrounds in child care from nursery nursing to residential care to secure units. We had all picked up various similar methods of working with young people but no common practice. The training and subsequent support groups we received provided us with shared tools and a common language. They have allowed us to support and advise each other better as a group and offer more consistent inclusive support to the families we work with" (Statement made by Family Support Team).

The work of this team was underpinned by a leader who believed in creating an environment that thrived on shared power through dialogue and shared learning. The team moved through several

stages of learning before the process and dialogue became embedded in their practice.

4.1.12 Engagement with the teams and individuals in the teams: Children's Centre

There was no evidence provided from individual staff in the Children's Centre that their family support service or their collective practice had been influenced during the period of the study. However, one person had clearly seen the potential for developing their practice and described in her practitioner reflective log how she had used two of the tools with a family she was working with:

> "I used two of the tools Shields and Like and Admire. I learnt that it was hard to make it clear what we wanted at first, family has never done anything like this before. It's going to be a long process with only an hour a week for three people. It worked well with children in regard organisation. Like and Admire was a bit difficult to get words from them and the mother. I'm concerned at my own lack of experience, would like to see an expert in practice. It went ok but am concerned that the family wouldn't really see the point."

This practitioners reflective log was recorded in the early months of the project when this level of naive dialogue, where staff were undertaking interventions without understanding the process, or how to interpret the outcomes, was being reflected across the other services. Unfortunately, this service did not use their experiences to learn dialogically and their learning was left un-harnessed and lost within their working environment.

Another member of the Children's Centre team who had particularly enjoyed the training and action learning process took the opportunity

to share her frustration that she was unable to share her learning with colleagues at the Children's Centre: "I have found it less isolating to share with the larger group and easier to get my head around things than when I am thinking about the training at work." Her contribution suggested that there may have been an unspoken agenda within her team about the application of the training and importantly the associated process within the Children's Centre. In my research diary following this session I noted that there appeared to be some willingness and interest from members of the Children's Centre team to engage in the research project. However, this seemed to be undermined by their manager who appeared to be entrenched in an emotional resistance to change which perhaps reflected the political repositioning of local sure start programmes to Children's Centre status.

This team and individuals in it failed to engage with the study at any meaningful level. The lack of attendance from individual members of the team at the action learning sets meant that they were unable to realistically enter into the process.

There was an element of routinized learning from one member of the team, the Early Years Teacher, who used her individual learning to introduce '1 page person centred plans' as a method of transition planning in her nursery setting. Her learning though was isolated, with no evidence that this was shared within nor had an influence on other practice or settings in the Children's Centre. The result of this woman's autonomous praxis was that her learning remained routinized and the team's dialogue did not develop.

The lack of engagement from this team disappointed their colleagues from the Local Authority Family Support team who made several attempts to keep their partners on board. The team challenged the services leadership openly during action learning meetings with one of the Local Authority Family Support Team commenting:

> "...they do not use any of the tools in their meetings or with families I talk to their staff who really want to work like we are but they can't. Nobody talks about it at the centre you know like we do all the time, it's our language now isn't it. It is one thing working with us and another remembering the tools and what to do and say when we are not with them".

The overt and clear messages of support and guidance offered to the Children's Centre were echoed by the Local Authority Family Support Team's team leader, who at the penultimate Steering Group Meeting at which the Children's Centre was not represented reflected:

> "...it is such a shame that (name of Children's Centre team leader) has not engaged with the project. We have made such progress in every part of our service that we could make a real difference to families if we had a common language shared across our services. I have tried talking with her and she gives, she makes all the right noises but then doesn't follow anything up so nothing happens. We will keep trying and will be happy to act as mentors whenever they are ready."

4.1.13 Engagement with the team and individuals in the team: Obesity Team

This group of staff had been "waiting for something to happen, a catalyst to move us from talking about Childhood Obesity to creating an intervention" (Senior Dietician transcribed from the first action

learning set). The team recognised the “something” as me, their facilitator. They used my expertise in the process to help them design the service using their combined cognitive strength. The team naturally developed a dialogue that grew in complexity as the study progressed. Without an identified team leader, several of the team took this mantle at times. However, far from being counterproductive, they recognised each other’s talents and skills and worked to them. The team were enthusiastic and willing learners. They embraced their shared learning experience and participated eagerly with all the processes they put in place. The team shared their power relationships appropriately and created a service in partnership with each other and their service users.

However, without the engagement of their senior management lead from the PCT their chances of developing a sustainable service were minimal. This angered and frustrated the team towards the end of the study period. The Paediatrician asserted “we are very proud of what we have achieved, but do we now throw it all away just as we begin to make a difference?” While a healthy lifestyle co-ordinator expressed “...it is wrong that we are letting families down because our strategic lead has not been involved in the project.” As the team’s frustrations came to the fore the Clinical Psychologist eloquently expressed what she described as the “greatest loss” resulting from the senior managers “lack of engagement with any element of the service.” During the final action learning set for the project she stated

> “It seems unjust, unfair and immoral that you as a team, your collective skills, knowledge and the shared appreciative language you have developed is all going to be lost because of one man who didn’t understand

> what you have achieved. I think we have all been wonderful and deserve much more than to fizzle out without the opportunity to continue to share what we have learnt." (Clinical Psychologist, transcribed from an action learning set).

4.1.14 Engagement of the teams with service users: Local Authority Family Support Team

The action learning process demonstrably worked for this team. As their dialogue matured into a common language used across the team the conversations staff were having together changed from being predominantly problem- based to being solution focused. Staff began to develop stronger partnerships and relationships with their colleagues, fellow professionals and service users. The increased levels of dialogue and shared learning this team achieved may be described as 'person centred and collaborative praxis'. In this case the praxis within the team who had learnt through action research to 'care for themselves' using the process as a form of self evaluation led to the team's developing a mindset that embraced organisational learning theory.

The new confidence and self-belief that emanated from the team and individuals within it enabled them to use the same process of engagement they had learnt to use to care for themselves, with their service users. The result was that the team were able to understand the process and dialogue needed in order to truly engage with families who used their service. A Family Support Worker reflected through her 'reflective practitioner log' how she had used a 'new tool'. Not only had she learnt the use of the tool but also she used her own

skills and talent brought out by increased confidence to inform her practice.

> "I used the introducing us booklet with 2 males aged 6 and 9 years and a younger sister 5 years old. The older brother was difficult to engage with but he completed the book and did some drawings. The younger children drew pictures to express themselves. I planned routines using the booklet, extracted some useful information from the children in a non-threatening manner. And went on to talk about safe touching. All the Children responded to the work sheets and engaged with me even the older child who had always been hard to engage. I was able to adapt the information in the booklet whilst talking to the children. The way in which the booklet is designed allows it to be used with a variety of ages and ability. I was Very pleased I was able to work with 3 children together in a relaxed positive manner and they each received attention individually."

For the first six months there was a consistent flow of reflective practitioner logs from this team extolling the effectiveness of the tools. Staff repeatedly named tools, and credited them for better and more informed outcomes in their work. Later in the study however, when their practice was becoming non-routinised, innovative, and creative they began to understand that it was their improved dialogue, communication, shared knowledge and increased effectiveness that was making the difference. The tools were merely a vehicle for this developing structure for organisational learning. The manner in which this was implemented through praxis is articulately and passionately described by a family support worker:

> "The training gave me a greater belief that using this approach provides an opportunity to deconstruct the culture of reviews that previously marginalised and oppressed service users. There is a strong focus on eliciting the service users view. The approach

> challenges traditional approaches to recording by using the service users own words and explanations, especially when providing written feedback. That people are actively participating in the choices that affect their lives and which gives them greater control. This process appears to take longer than the more structured approach but it also reduces the traditional power differences" (Family Support Worker; transcript from an action learning set).

The growing belief and maturity in the dialogue and reflective practice of the team led to professionals from their partner agencies developing a deepening "confidence in their abilities, assessment and decision making skills". This was reflected by their senior management representative asserting that their "developing, innovative practice should be shared across Local Authority Children's Services in the region."

4.1.15 Engagement of the teams with service users: Children's Centre

The absence of any level of meaningful engagement from the team leader in this project meant that it was unlikely the team would be able to share their learning in a meaningful way. Had this been in place, the team's close geographical and praxis proximity to the Local Authority Team meant that the two teams may have effectively learnt from and with each other.

While my study was essentially interested in the design and delivery of family support services, it did have a positive effect within the Children's Centre Nursery. The teacher, who had attended the training out of interest, had seen at an early stage the value of developing plans for the children who were going through transition:

> "I have discussed the possibility of introducing 1 page personal plans for children in Nursery and Playgroup, to help with transition into other Early Years settings. I am optimistic that we should be able to introduce personal plans for children in the near future. From the training, I have learnt that shared documentation and procedures should help information sharing between different team members to improve meeting children's individual needs.

The teacher's determination to implement her 'routinised' learning was done so with enthusiasm. She did not share her learning with others in the Centre nor did she attend the majority of action learning sets. She did though implement her routinised learning successfully for the benefit of the children using the Nursery as she explains:

> "I use the 1 page (person centred) plan with children it is especially useful for children who are in transition, just starting nursery, or moving into full time school. I have plans for all of the children in nursery and it does help us with relationships with parents and knowing who the children are" (Children's Centre Teacher; transcript from an action learning set)

4.1.16 Engagement of the teams with service users: Obesity Support Team

The obesity support team was made up of individuals from three separate organisations who only worked together on this very specific programme. They were very committed and enthusiastic learners who, with the exception of the Clinical Psychologist, only used their new practices within the confines of the programme.

The first two to three months of this team's involvement in the study involved them building working relationships together. This enabled

them to understand the processes they were to use with the families at a more complex level. Only the senior dietician in the team had previously worked outside of a 'clinical setting' with families. The early experience of delivering a service in this new environment appeared to enlighten some members of the team to news ways of engaging service users:

> "I have usually been involved in medical assessments where the recipient has been told what is wrong with them and then told what they need to do. I now talk to the children and am consciously trying to always put the emphasis on them. I have learnt to try to talk to them about what they want instead of being prescriptive about what I think they need. The response from (child's name) as the first child I have worked with in this way has shown me that it is effective. I need to continually think differently to prevent me from lapsing back into prescribing. It is consciously hard to keep emphasising them but it is definitely the right approach. I constantly re think how I should be talking to (child's name) keeping him central to our discussion is different from before when we would talk about him to his parents. We never really spoke to the children themselves before, well not properly" (Healthy lifestyle co-ordinator; transcript form an action learning set).

This new method of engagement through dialogue was universally celebrated across the team. Although interviewing parents and children was not a part of the study, one family openly shared their experience for a celebration event held at month seven. Their comments clearly demonstrate how the Obesity Support Team had engaged with them.

> "The programme taught me what to eat and how much exercise I needed to do to keep my weight down. I have stopped snacking, eat lots more fruit and vegetables and spend less

> time watching TV and playing on my xbox. Before I started the programme I couldn't run for long, now I can run for three miles without stopping. I have joined a football team and attend all the training and matches. I also go to the gym twice a week. Now that I have lost weight I can buy clothes that I could not wear before, such as jeans" (16-year-old male service user)

This young man's mother reported:

> (Name of young person) lifestyle is so much healthier since attending the programme; he is sleeping better now that he is eating more fruit and vegetables. He even asks me to buy more vegetables as he enjoys them so much. The programme has given (Name of young person) more confidence and motivation, I don't think he ever thought he could feel so positive about keeping healthy. I feel the main reason why (name of service) has been successful, compared to what (Name of young person) had tried previously, is because throughout the programme (Name of young person) was able to select an option that appeals to him, rather than having things forced upon him. (Name of young person) and I would like to thank the staff for all the support they have given us (Parent participant in the childhood obesity programme)

4.1.17 Engagement of the teams with partner agencies: Local Authority Family Support Team

As dialogue and confidence grew in this team during the length of the study, so did the teams confidence in their ability to understand the complexity of contributing to family support services provided by their partner agencies. This led to the team making positive and dynamic changes to the way they worked in partnership. This "new way of working" complemented and supported their social work colleagues formal assessments of the holistic needs of the families, while

engaging the family and multi-agency representatives in developing a plan for intervention. As one of the family support workers explains:

> "Previously our work was determined by a social worker who had done an assessment on the family. They would tell us what we had to do with the family but we didn't get told what the outcome was that they expected. We sort of had set-work that we did on relationships, play, family dynamics that sort of thing. Our work would be for twelve weeks but we would then get to know the family and know that what we had been asked to do was way off target and we couldn't do anything about it until the six week review. So by the time the six week review comes round, we then only have six weeks to do some work which isn't enough to make a difference.
>
> Now we hold a Family Meeting with everybody involved, all the professionals and families, and children when we get the referral. This helps the social worker with their work because using the perspective of everybody about what needs to happen, they get to understand what we need to do and everybody gets to know what the outcomes should look like." (Family Support Worker, transcribed from an action learning set)

This positive engagement with their professional colleagues from health and social care services formally involved with families they were supporting, was acknowledged through the local Children and Families Social Work Team. The team requested formal training in the same approaches used by the Family Support Team in order that they may use the same tools and approaches. They were especially interested in the family meetings. As the two teams worked increasingly more collaboratively further examples of shared practice evolved. One worker was particularly please with her feedback from a social worker she supported on a child protection inquiry:

> "I received a letter this morning from the social work manager at (name of the local team). The judge hearing the case I was involved in asked her to pass on his thanks for my report and the work I had done with the family. Even though, my report was damning and contributed to the children being placed for adoption, the judged thanked me for sharing the families perspective and getting them to understand what my report said. He really liked the tools I had used, that's the person centred stuff we do here and said I should be commended" (Family Support Worker, transcribed from an action learning set)

This comment was welcomed and celebrated collectively by the team. In her typical appreciative style the team leader suggested that this was the result of the team "collectively sharing their learning together, developing their common language and improving their service through praxis."

4.1.18 Engagement of the teams with partner agencies: Children's Centre

The Children's Centre was engaged through its day to day activity with a plethora of statutory, non statutory and community based service providers. However, there is no direct evidence from this study to suggest whether these relationships were successful or otherwise. The Team Leader's lack of willingness to engage with the study prevented relationships developing with their closest service delivery partners in the Local Authority Family Support Team, which had much potential for improved partnership working. However, there were reported improved partnerships between the nursery teacher and primary schools during the transition of children between the education establishments. Although her learning had been routinised,

and not related to family support, the transition plans she developed using the PCPTs were enthusiastically welcomed by families and schools alike. The teacher reported to a celebration event at the conclusion of the study

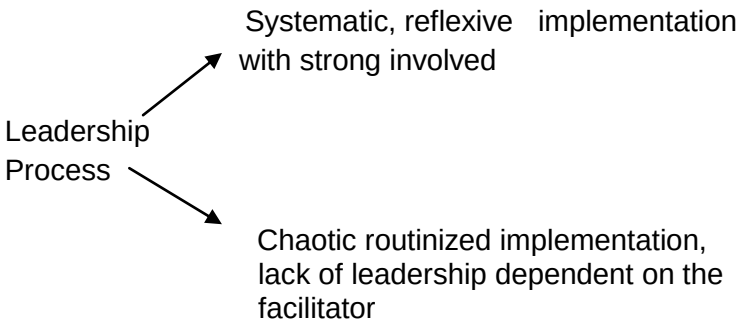
> "The one page plans we have written for all our children in transition from our nursery to school have been appreciated greatly by the teachers who are all asking me how I got the idea. Parents also really like them because they say lots of positive things about their children, but importantly I think they also provide information that parents do not always want to say about their children" (Children's Centre Nursery Teacher, Transcribed from a celebration event)

4.2 Theme 2: Process

To ensure parity across the research study from the outset, it was important to use the same process of action learning with all the teams: the action research cycle proposed by Winter & Munn-Giddings (2001). As with all action research studies, the direction the different teams took was determined through the cognitive reasoning of those who were taking part (McNiff & Whitehead 2006). The process of engagement with the study, and implementing the team learning in practice, was determined by the levels of engagement and commitment given to the study by the team leaders. Once these levels were determined, the team leaders demonstrably influenced the behaviour and compliance with the study by individual team members. These findings helped to make sense of the different elements that need to exist in a learning organisation: knowledge of the learning processes that took place (both at individual and

collective level); and how these were promoted (or opposed by the contextual factors) in the teams.

While the methodological process of the study was pre-determined, the outcomes, as is the case with all action research projects, were not. Based on an understanding that individuals are the organisation's primary learners it was clear that individual actions would be vital if the teams were to be successful in becoming learning organisations. Senge (2006) notes the importance of team leaders and their actions in the success of creating a learning organisation. Indeed, in this study, this was also the case. In these findings evidence is provided that the processes of action research and team learning were most influential in the teams where the leadership was at its strongest. Where this was not the case, the implementation was chaotic and routinized.



Data for each of the teams is presented separately in the next three sections.

4.2.1 Process in relation to the Local Authority Family Support Team

The Local Authority Family Support Team leader drove the process of action learning forward in the belief that a unified team would

make a real difference to their service delivery. Her leadership and commitment were at the fore even though she faced a level of apathy from some staff especially during the early part of the study. This was a busy team operating in a very challenging environment where change is traditionally difficult to implement because of the pace and complexity of the service. A family support worker whose views were captured during an action learning set, explains how the team were encouraged to stay focussed on the research study by the team leader

> *"*It is (leader's name) who has really kept us involved, every time we meet with her she asks "what tools have you used", or have you done "a family meeting", or "well, what is working about your work with the family" she never stops and that gets us thinking that we need to keep at it. It is hard though thinking about new things when you are so busy we do need pushing and it works, look we're all here and we're still doing it" (Family Support Worker, transcribed from an action learning set)..

Change did not occur instantly in this team although the process of change was transparent from the analysis. There was a gradual and rational development of their service delivery, informed by the process of action learning and their use of the person centred tools. This team initially reported that the tools were helping them to understand better how to work with people. The team reported that the information they gleaned as a result of using these tools provided them with richer, fuller information than they had previously managed to obtain from families. This information allowed them to share perspectives with families, which led to an empowerment of families through shared knowledge and more informed service interventions.

This shift in working occurred at an early stage of the study as described here by a family support worker:

> "I used what's working / not working with a parent (mother) who had a history of mis-interpreting information and guidance given to her previously by professionals and family support workers. Using working/not working helped her to understand what was being asked of her from everybody's perspective and for her to share her own perspective. This appears to have cleared things up for her and given more clarity about service interventions" (Family Support Worker; transcribed from an Action Learning Set held in month two).

The family support worker described this as a "good conclusion" which appeared naive, as he believed that as a direct consequence of using this tool on any one occasion the service user would now engage with his service's intervention. During the same meeting, another family support worker expressed that she was "unsure" about how to use the information she had received.

> *"*I've used Good day / Bad day with a lone parent who has been living in a violent relationship. I have gathered loads of information, but that's it, it's just more information I know it is a good outcome and should be useful because she has opened up and told me stuff we haven't heard before but besides writing it up in the service users file I don't really know what to do with it." (Family Support Worker, transcript from an action learning set)

Both of these workers were excited that they had managed to engage with their service users on a "different level." They had determined that the information was "different" and "useful" but

neither had used this “new knowledge” in a manner that would benefit the service users or inform their services expected outcomes. They saw their intervention as an isolated piece of work, as opposed to it being part of an integrated piece of the bigger multi-disciplinary picture. Once the action learning cycle had been established, the team expressed a desire to use the process and tools to help them consider how best to work together as a team, with their colleagues from health and education, as well as with their service users. The team agreed an action plan of *next steps* that identified what they were going to do, who was responsible for each point, and crucially how they would know that their actions and interventions had made a difference to their individual, group, and multi-disciplinary practices. This was the beginning of how their shared cognitive reasoning began to shape their organisational learning.

During the first three months of the study, many members of the family support team had used just one or two of the tools. These were usually the tools they felt they had most affinity with and felt at ease using in practice. As a family support worker recorded:

> “I used what is working, what is not working for a mother and daughter this was my initial visit to enable me to plan best for the family. I have used this tool often at initial home visits and it works for me!” (Family Support Worker; practitioner reflective log).

What this family support worker did not record was that while she was “practicing” the use of this tool in the early days of implementation she was doing little with the information she was

collecting. However, as the team shared their learning together they began to gain a much deeper, clearer understanding of how they were developing as individuals and together through their collective learning. This enabled them to begin to use the information they were gathering, to plan far more effectively with families than they had previously achieved. In this phase, the team were moving from their 'naive dialogue' stage towards a 'developing dialogue'. Using the same tool she had used in month three, the same person recorded in month five:

> "I tried using working / not working. I learnt that I could deliver the tool in a different approach, as usually I would just ask "what is working?" However, the young person said she would like to write it down herself. The tool is very flexible. I was pleased that I could easily identify the support the family required and that what was/ was not working for the mother was the same as what was /was not working for the daughter, also after completing the session I easily planned the work which they agreed with. It felt good that the family really appreciated that I was organised and that they were involved in planned their own sessions. I am not concerned about anything I feel confident in delivering this tool. I felt very happy and pleased that the session flowed well and I gathered rich information. (Family Support Worker, reflective log).

The team holistically acknowledged how much their practice was beginning to change through their shared learning experience. The system of action learning was beginning to permeate throughout the way the team implemented their caring praxis. A family support worker described how her practice had changed through shared experiences with the team:

> "... so we did that and we kind of, tell you what I really struggled with and remember it's a protected environment what we're saying within here but it was the outcomes and you struggled with outcomes didn't you, how do we know whether we've made a difference? So we both actually knew what we wanted from the action plan but to put a sentence in to say what the outcome was, I know you really struggled, I kind of really struggled until I came in the day after and I'd slept, well dreamt about it all night (laughter), I did! And you know that is when I knew how to express how we've made a difference. I didn't know what you had meant for weeks but didn't say anything I got it in the end talking with the team, I did, didn't I! But we got there in the end, so that's me."

As the team's dialogue developed they increasingly used the action learning process to "share their learning" as a team and to "action plan outcomes" for the team and service users. This supported Miner and Menzias's (1996) theoretical argument that in order to understand the different elements which supported their developing learning organisation the team needed to acquire knowledge of the learning process they were experiencing (both at individual and collective level) and how it was either promoted (or, opposed by the contextual factors). "All of the team contribute to the development of our team learning" this supports the theory that individuals in the team were the organisation's primary learners. It was clear that their individual actions were vital during the team's journey to become a learning organisation. This was particularly significant in the case of the Team Leader who "supports and encourages us to use reflective practice." Her attitude and actions were central to the success the team becoming a learning organisation.

As the team's dialogue matured, their communication as a team (and with their partner agencies) improved to levels that supported their team development, enhanced individual confidence and informed reflective practice. This extract from a family support worker's "learning log" explains how she used the tools and learning process to enable service users to "lead discussions" about the progress they had made with their family support plan. This approach "empowered" the service users to "feel fully involved" in their formal service review process.

> "The process enabled the parent to actively participate in the review giving a clear account in regards to their own perception of the planned piece of work...using the tool enabled the parent to lead the discussion in what works for them. This approach encouraged the parent in identifying the strengths and improvements they had made in respect of the family support work...using this person centred approach gives a greater understanding of the parents progress towards the agreed targets set by the fieldwork team from their own perspective. I am still learning it was not a natural process, I was consciously aware throughout the review that I was developing a new way of working, but that in way was exciting because the other professionals all enjoyed it and thought it went well" (taken from a Family Support Workers Reflective Practitioner Log)

The reason for this developing confidence and increased self-belief in the team was usually attributed to the 'framework' created by the person centred tools that underpinned the team's decision making. This was coupled with a common language or shared experience developed through the team's action learning. A senior member of the Local Authority Family Support Team who wanted to encourage

closer working relationships with the Children's Centre attempted to motivate the Children's Centre manager by describing her vision of how the two teams may develop a shared language of service delivery.

> "I've done two kinds of family meetings. One tends to be informal and the other one we sat down and used the flipcharts but families love it. I'm just backing what (name of colleague) is saying, the feedback from our team (name of Children's Centre Team Leader) is that it's kind of provided them with that framework which we didn't have and for new staff additionally given them the tools so they know what they are doing and they are not fumbling in the dark really trying to understand how to support families, where now it's very much clearer they know exactly what they are doing when they go out there and then they can come back and gain support from other members of staff, developing skills that are very similar. And another point that helps the team accordingly (name of Children's Centre Team Leader) is that when they are working with your staff we can understand better how we work together, again it's that common language between two different teams using these approaches"

As the Local Authority Family Support teams learning and dialogue matured, they began to use the process throughout their service. This led to a confidence in the team, which related to their practice and their 'common language' beginning to inform all aspects of their service delivery. The team leader shared, in a reflective practitioner log during month eight, how her learning was informing the manner in which she supervised a social work student who was on placement with the team. She shared how using the person centred tools had enabled her to be appreciative and reflective while working

individually to promote what she believed was best practice in her team.

> **"...**I have learnt that...taking a step by step approach and going through the process of supervision from the receiver's perspective has enabled me to make the necessary changes to meet the staff's needs.
>
> ...I am pleased that I have made an effort to develop an effective working relationship whilst carrying out my responsibilities to promote best practice. I have also critically reflected on my own practice during this supervision session...Using the person centred tools has provided a positive, natural tool to aid this discussion. Feedback from the student was encouraging. The student appreciated being asked how things were for her."

By months eleven and twelve the team were sharing their 'new' practices naturally within the work environment and had planned how they would 'induct' new team members, students, partners and colleagues into their service. They spoke about how their new practice was "embedded" into the fabric of their team. This term was prominent within the team's dialogue throughout the final quarter of the research period. At a final planning session the team recorded how they would ensure the process that became known as 'Planning with People' would continue to inform their practice following the research period. They recorded that they would continue to use the "planning with people" tools to underpin all of their interventions, individual and team dialogue with each other, service users, their partners and stakeholders.

“Embedding” the team’s learning and dialogue through their “common language” was designated as a “team responsibility.” The Team Leader reinforced this at the end of the research period as she prepared for an internal celebration event designed to share the teams learning and “new ways of working” with colleagues, peers and partners from the :Local Authorities Children’s Services. The Team Leader described how the study had been “central to the development of the service.” The study she believed had provided her staff team with a platform from which to deliver a service that met their organisational requirements while “personalising” their service delivery to reflect “what is important to families and how they wished to be supported” and not a service provided for a specific purpose that people had to “fit in to.”

At the outset of the study, three of the team members were under scrutiny because they were reportedly struggling to prove their competency in their roles. As the study progressed these team members “excelled,” became more “self confident” and “understood” their roles to an extent where their practice had “changed” and they were judged to be competent. The Team Leader asserted that the ‘Planning with People’ process “was an excellent tool that aids employees that are either new to the post or are under performing.” She described how the “consistency” of the approach and “embedding” the “common language” into the dialogue of the team had supported her team members to become “more effective.” The appreciativeness of the tools enabled the team to develop a framework for their service delivery which gave them “the confidence to develop their practice.” The increased “self awareness” of the staff

team encouraged “reflective” practice, and a “shared dialogue.” This shared dialogue was used in the absence of a formal training structure for their family support work, to support the development of a “team of champions” who ensured the practice remained “embedded in their team.”

4.2.2 Process in relation to the Children’s Centre Family Support Team

In sharp contrast to the Local Authority Family Support Team, the team leader of the Children’s Centre had not engaged with the study to any determinable extent. Because of this, the process of implementation of the team’s individual learning was severely limited in terms of their involvement in the study. The team leader did not regularly attend the action learning sets, and although the times and dates of the meetings were known and agreed prior to the commencement of the study neither did her team.

It is apparent that the team leader used her ‘power’ negatively, in terms of having control of her physical resources (the staff team) and through her position (Children’s Centre Lead for the study) within the organisation, not to engage in the process of the action research study. She appeared to utilise her power to ensure her staff team did not attend meetings by controlling their rotas “we can never attend because the meetings are always on our day off or when we are running groups.” She reported disingenuously to her senior managers in relation to the progress they were making with the study “the staff team really like the tools and are working with (name of the Local Authority Family Support Team) to develop our partnership

working". Using her power negatively in this manner allowed her to stop the study from progressing in the Children's Centre, one of the Children's Centre Family Support team expressed her team's frustration at not being involved in the process during an action learning set:

> "We are a bit behind, we want to learn about this and to do the planning with people stuff because the staff here (referring to Local Authority Family Support Team staff) use it all the time and we love it. We need to catch up though because the meetings are always on our days off or when we run groups so we can't attend really, the team here do work with us but it's hard to keep going when you don't really know about it. We do want to attend it's not as though we don't want to attend it just feels like we are missing out"

While the team were prevented as a whole from attending the action learning set meetings through the action of their team leader, their individual determination to use some of the tools and processes in their practice was undeterred. This was apparent from their reported actions, and led to some routinised implementation of the tools and process within the children's centre. This service's learning, perhaps ironically, informed practice within the Early Years team as opposed to the Family Support Team. The Early Years Teacher who attended only one action learning set, the penultimate meeting, throughout the duration of the study informed the meeting how "useful" she had found the process as she reported to the group:

> "I know it's not family support, but well it is of a sorts I suppose but we have used your approaches to inform some of our service and it is working really really well. Each child that attends our nursery now has a one page plan

> that describes who they are, what is important to them when they are with us, and how best we can support them. We use this information for transitions to reception classes in schools and it is very effective for the family and school to get to know each other very quickly. We use the tools in our initial meetings with families to start to draw up the plans and it has proven really useful in helping children settle and families to feel confident in leaving their children with us." (Early Years Teacher, transcribed from an action learning set).

The levels of dialogue identified as 'naive', 'developing', 'mature' and embedded, which led to this process becoming "embedded" in the practice of the Local Authority Family Support Team through their shared learning experience could not occur in this service. While some routinised learning occurred within the Early Years Service this took place at an individual level, most significantly with the Teacher. As the learning that did occur was not being shared or developed at a team level, it is highly unlikely that this process would be implemented sustainably.

4.2.3 Process in relation to the Childhood Obesity Project

This team had no identified leader in terms of decision-making or implementation of their learning from this research study on a day-to-day basis. While I made every effort not to be influential, in terms of my facilitation of this team's learning and development this proved difficult to achieve. This team (to support their desire and commitment to drive their project forward) manipulated my in-depth knowledge of the process. They used my position of 'expert power' (the power that is vested in someone because of their acknowledged expertise), to facilitate the development of the project through their action learning sets.

The team were very pragmatic in their approach. They used the first three months of the study to design and plan the structure of their new service. The process was then used to action plan their next steps on a month-by-month basis. The approach taken to their learning by the team led to the development of a successful and innovative programme. However, their learning, with the exception of the child psychologist, remained routinised. Individually, all of the team learnt dialogically. They learnt that the process associated with their “new ways” of working led to “noticeable changes” both in their “practice” and the behaviour of the children and families they were working with. The dieticians explained the affect the study had had on her “...this has sort of changed my practice really” in particular she was referring to the shared action planning model used to work with the family. She was used to offering families an initial consultation of half an hour followed by a six-month review of fifteen minutes “but they rarely came back.” These family meetings took one and a half hours, with follow up meeting every six to eight weeks of half an hour, she further explained:

> “...these meetings are working they are they are fantastic but they do take time, I mean that isn’t a big factor really though because we are engaging with very difficult families on a very different level. I mean we wouldn’t usually see them again in clinic, and here we are developing real plans that make a difference to the way we work, and to the families. I am just saying, thank goodness for (name of project)”.

Although she was positive about the impact the process was having in terms of her practice and results for the families referred to this specific service, she was less optimistic about implementing her

learning within the day-to-day practice of the dietetics team. Her pessimism was founded on her experience of attempting to use other innovative approaches to her work being, and the “lack of engagement” in these by her line manager (her line manager being the lead person assigned this project by the PCT):

> “...possibly that is why I am in conflict with (name of manager) because our manager is very focussed on number crunching and, rather than I feel the quality of the service. So introducing these family meetings has felt like a natural step to me that just introduces best practice into this project. I agree with (name of colleague) though, because, because I mean when she says our manager won’t allow us to work in this way he just won’t it’s not, he won’t believe it is efficient because we won’t see enough people. It comes down to quantity not quality.”

While the lead dietician was pessimistic about her ability to transfer her learning to her clinical environment, she shared her learning, knowledge, and skills openly with her colleagues in the childhood obesity specific project. As a group, the staff team began to understand that small differences made a “real difference”, that their “new ways of thinking, seeing, talking, valuing and sharing together” allowed them to affect the flow of the process through their involvement in the project. The Local Authority Healthy Lifestyle co-ordinator involved in the project provided a further example of how her “new inclusive attitude” towards her service users was “making a difference.”

> “The way I have worked previously has been very prescriptive and aimed at the child individually as though they were solely to blame for their obesity. I never thought about involving everybody, like we do in family meetings, to share their perspectives. Now I

> know that we can work with families educationally and support them in a way that works for them, rather than making them fit in to us, I don't want to go back to the old ways but it is very difficult because not everybody works like this, I mean they should but they don't do they and so it is easy to slip into my old practice, I really don't want to though because this is the right thing to do it works really well and the children have control of their plans too" (Healthy lifestyle co-ordinator; transcript from an action learning set)

The learning that took place in this team, through the action learning process, (accumulated through repeated actions) reflected the beginnings of non-routinized learning occurring with the participants. This process engendered a growing demand for new knowledge, interpretation of this through shared learning methods and the development of action plans that placed the service user at the centre of their intervention. While the team were rightly proud of what they achieved for families using this time limited "pilot" project[2]. Their "frustration" and "anger" that they would not be able to continue to work in this way was asserted on many occasions. These feelings which centred on the team's belief that losing this project would "let families down" and "lose a great opportunity to change how we work with families," were aimed at the PCT's leadership and monitoring of the project. It was not a personal assault on the leadership (or lack of it) provided by the PCT's representative, although he was conspicuous through his absence and his clear lack of leadership ability.

[2] The team's work was acknowledged as an example of best practice and placed on a Department of Health Website named the 'Obesity Learning Centre', see: http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Obesity/DH_101015

The absence of leadership ‘from the top’ in this project meant that any learning in terms of informing future strategy and service development for the PCT were at worst lost, and at best fragmented in the resulting chaos. At the end of the research period it was clear that the individual and collective actions of the participants, which were routinized engendered incremental learning which they may have been able to replicate within their usual service areas. However, the non-routinized thinking and actions, a critical source of innovative and creative learning, which occurred during the study through the team’s dialogic learning, were un-likely to be sustained without the associated process. The exception in this team that ‘proved the rule’ was the Child Psychologist, who introduced many aspects of the training immediately into her work:

> “A lot of my work is now underpinned by these tools and the processes of gathering information. The core values of the approach are actually really sound. I particularly like the ‘introducing me’ and ‘us’ books and the appreciativeness of the process. I have introduced my team to ‘like and admire’ and the 4 + 1 questions during a team supervision session. They have asked me to facilitate a team day on the training. So I feel we have something really special in this project.” (Clinical psychologist; transcribed from an action learning set)

This professional’s ability to work autonomously, underpinned by the instinctive nature of her professions embedded reflective practice appeared to promote the use of this appreciative process for intervention.

4.2.4 Conclusion to findings related to process

Based on an understanding that individuals are the primary learners in any organisation it was clear that individual actions would be vital if the teams were to be successful in becoming 'learning organisations'. The success or otherwise of the process of engagement in the study, and consequently the implementation of team learning through praxis, was determined by the levels of engagement and commitment made by the individual team leaders. The processes of action research and team learning were most influential in the team where leadership was at its strongest. Here, non-routinised actions proved a critical source of innovative and creative learning. As the team's understanding of the learning processes developed, it demonstrably influenced the levels of dialogic learning achieved by each of the teams.

Where learning was achieved most successfully in the Local Authority Family Support Team using the study's appreciative action learning process, the accumulative shared non-routinised learning engendered a growing demand for new knowledge, interpretation and action that enabled the participants to make sense of unfamiliar and non-repeated activities.

Where this was not the case, the implementation of the process was chaotic and routinized at best. The absence of strong leadership added to the chaotic nature of the learning in both of the other teams which effectively meant that achieving sustainable non-routinized learning through this process would not have been possible.

4.2.5 Local Authority Family Support Team

The evolution of an increasingly complex and appreciative dialogue within the Local Authority Family Support resulted from the team leaders commitment to the necessarily involved process of change. This involved the Team Leader sharing the power she had through her position in the service, with the team. In order to achieve this she acknowledged that the future of her service should be informed through the cognitive whole of her team, and not through an autonomous dictate from her. As the team learnt together, they experienced an evolving maturity to their dialogue of learning. This did not occur over night; the team had to work hard to change their dialogue from one based on “problem solving” to a solution focussed, person centred, and Appreciative Inquiry. As the team practised using the ‘person centred tools’ in a plethora of environments they created what they named their “common language.” This was more than the result of the team using an action learning cycle.

The team took their learning a step further using their knowledge and skills to underpin their “common language” and to drive their learning forwards. This was achieved by appreciatively ‘checking’ each others’ practice using reflective tools and by creating an environment in which learning was an essential element of the teams’ mentality. New staff and students were introduced to the team through profiles that explicitly explained the team’s purpose and how their individual and collective roles enabled the team to successfully meet their identified goals. Such was the subtlety of progress made in this team that change within it would have been imperceptible if the team had

not been a part of this research study. This evolutionary method of change appears to have provided the team with a foundation to achieve a level of sustainability with the continued development of their team through a dialogue of equals.

4.2.6 Children's Centre Family Support Team

The lack of engagement or involvement from a meaningful leadership perspective in this service meant that there was no possibility of the process used having an influence on the team's performance. Where an accumulation of maturing dialogue, with sessions designed to support this, was crucial to the Local Authority Family Support Team, there was no such dialogue in this team. Therefore, there was no mechanism in place to support the development of this teams learning. The Team Leader in this team used the power invested in her to actively avoid her team's involvement in this study. The team had an opportunity to accelerate change in their practice using their collective knowledge to learn together through an evolving dialogue. A consequence for the team of their leaders elected avoidance their practice remaining static. Where an opportunity within the team occurred for them to learn together from the routinized learning of the Early Years Teacher, it was not taken advantage of.

4.2.7 Childhood Obesity Project

The chaotic manner in which this team was led meant that sustainable implementation of the team's learning was unachievable. The team though were keen to learn together and used my facilitation of the process to support the development of their dialogue (using the power I held that was associated with my expert

knowledge of the process involved). With no person from within the team driving the process forward, it was a clear indication that a sustainable process, where ownership was held within the team, would not occur. The learning and sharing processes the team developed, however, were influential in the development of this group of multi-agency workers learning to practice together through a developing dialogue.

Routinized learning occurred across the team who came together to offer a specific service. Using their learning in this way worked for this service as these professionals only came together for very short periods. There was a lack of leadership from within the team and from the larger organisation responsible for overseeing the study. This left the responsibility of taking learning from the study and implementing it with their colleagues from the related services with the participants. This did not occur with the exception of the Clinical Psychologist who saw the process as a valuable addition to her teams' tool box'. There was however, a tension created within the dietetic service where the senior dietician who was involved in the study believed her service would benefit from a change in their practice by introducing this process. Her direct line manager was though the PCT's representative lead person for the obesity project who had failed to engage in any way with the process and did not understand the focus of preventative strategies.

4.3 Theme 3: Context in relation to the teams

4.3.1 Context in relation to the Local Authority Family Support Team

The Team Leader of the Local Authority Family Support Team was instrumental in supporting them to create the social context in which their learning occurred. One of the characteristics of a learning organisation is the ability to effectively disseminate learning from one part of the organisation to another within it. This team established a number of mechanisms which ensured their learning was shared systematically and supported their new methods of learning to become "embedded in their practice". The effectiveness of this was reported by a Family Support Worker during an Action Learning set at month four of the project *"...we talk differently now don't we, you know about families and stuff. I think we've really changed 'cos now we use the tools to help each other think, we use the logs (practitioner reflective logs) on our email and always, well I do anyway, always think about what is and isn't working"*. The mechanisms the team put into place included:

- Shared practitioner reflective logs
- Informal meetings and conversations held over the desk, in the staff room, on the telephone and any other place staff chanced to meet.
- During Team meetings and Action Learning sets.
- During formal supervision.

Using the same tools to inform their practice, individual supervision systems and team management mechanisms enabled them to develop what they termed as their "common language". The team

reported that it was these systems of communication, which were based on the appreciative and enquiring nature of the person centred tools and processes, that created a sustainable basis for continuity in their service. The team leader explained how this had occurred during an action learning set *"... what I am really pleased about is staff are beginning to critically reflect on their own practice and additionally, they receive positive feedback from myself about the work that they're undertaking. Using person centred tools for me has provided a positive natural tool to aid discussion, and feedback from the staff is encouraging."*

Linked to the importance of the social context of the organisations' learning is the manner in which the organisation is structured. In this study the team referred to a "structure" and a "framework" that was provided for them. The framework they refer to is that of the process and appreciative guidance provided by the person centred tools used in this study. The structure was the culture and mindset that the team have developed through their shared social and cognitive processes of cyclical and iterative learning, shared dialogue, and action planning.

A Family Support Worker recorded in a reflective practitioner log how her confidence and ability to effectively perform in her role had blossomed within the appreciative social context that the team were operating in "My confidence in working with families grows each time I use these person centred tools. Using these person centred tools provides me with a positive platform to start work with new children and families." This person discussed how the person centred tools

and process had supported their practice “they encourage free conversation and information sharing without being too intense during child protection work. The information I now gather is much richer and more informative that before.”

During the final quarter of the study, the team used their maturing and increasingly “embedded” dialogue to underpin the social context which was central to the “learning environment” in which they operated. The team individually and collectively spoke of an operational “structure and framework” that they had created by using the “process”, and “appreciative guidance” provided by the person centred tools used in this study. The structure was the “culture and mindset” that the team developed through their shared social and cognitive processes of cyclical and iterative learning, dialogue, and action planning. The framework being the PCPTs which allowed the team to gather information by openly communicating across the service sharing the lessons they learnt from practice and the action planning processes they had put in place. This supported their service delivery and mechanisms of asking for support from their colleagues using their “common language.” This consistency enabled the team to use their “shared dialogue” in a meaningful way, make sense of the information they gathered and use it to plan effectively, individually, as a team, and in partnership with service users.

This “appreciative” method of using a shared dialogue to support the service delivery worked well for the team. A Family Support Worker explained during an action learning set “...I also like it that I can talk to my colleagues using the same tools, it feels like we make mistakes

together and help each other to put things right, or explain how to use the tools differently".

By month nine of the study, "confidence" and "competence" within the team had been improved and was supported within the context of the team "...the tools make me feel more confident about my role in supporting families because they are positive rather than being punitive". The shift in the social context of the team's service delivery over the twelve months of the study was most accurately summed up by their team leader during the final action learning set "when I reflect on our team from where we started I think what is different now? The thing is we are a team now, we understand how to share our practice and we bring people into the team, and I mean people who we work with as well as support. We have a common language that we share and our students and colleagues are learning that with us. I guess we are like mentors and we all learn from each other".

4.3.2 Context in relation to the Children's Centre Team

The Team Leader of the Children's Centre Family Support Team had failed to engage with the study at any meaningful level and this was reflected through the social context in which her service operated. Although there was a determination from individuals in the team to learn and to develop their understanding of their roles "I really enjoyed the training, it has made me think about why families need our service" and also to change aspects of the way they worked as individuals "I love the one page plans they will be great to use in the nursery for transitions" the individual members enthusiasm was not mirrored by their team leader. I am unable to comment on the Team

Leader's style of leadership in relation to her day to day management of the team because I rarely met with her throughout the twelve month study period. Her behaviour, however, suggested that she needed to exercise a level of superiority over her staff in order for her to feel comfortable as a manager.

While a level of routinized learning occurred with individuals in the team, no process or mechanism was put in place to share this learning. Therefore, the social context of service delivery did not change throughout the study period.

4.3.3 Context in Relation to the Childhood Obesity Project

This bespoke team of individuals designed their new service to meet their own and their service users' needs. The social context in which they operated was one of shared action learning, observation and modelling of behaviour: "I have learnt so much from watching (name of colleague) in the family meeting I now understand why it is important to get a family perspective about how they want to be supported". While the team established themselves as a learning team from the outset their shared dialogue and shared language took time to embed.

At the outset of the study the team were reluctant to challenge the paediatrician when she used what they recognised as inappropriate language. The school nurse for example recorded "I was at a clinic with (name of Paediatrician) and she was talking about 'fat kids' and useless parents." When asked how she had challenged this during an action learning set she replied, "I didn't, how can I? I'm a school

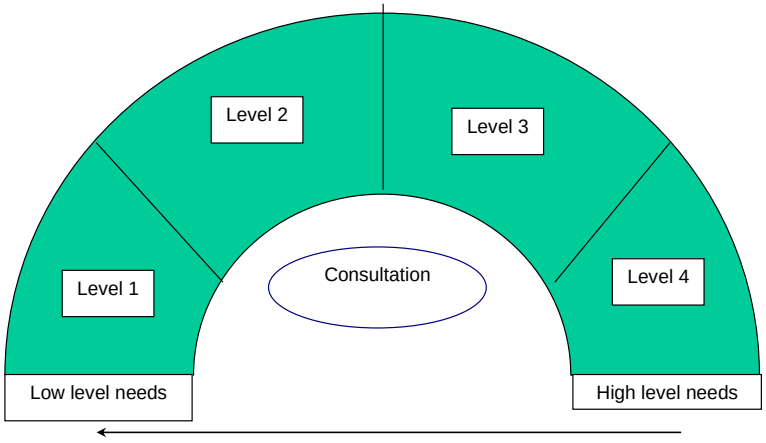
nurse I can't start telling (name of Paediatrician) not to speak like that, but I know that's not helpful and she shouldn't say those things. Well I say that but she doesn't mean it she cares and wants the children to have better lifestyles." The team however felt "empowered" by the learning methods they implemented. By month four they were openly challenging each other, sharing perspectives and learning from each other "I didn't believe I could run a family meeting and come out of it with a plan that the family really believed in but I did and that down to (name of colleague) who just keeps on learning me."

The team by month six were operating in meetings without hierarchical structures which demonstrated the effectiveness of their dedication to the social context in which they were operating. During an action learning meeting the paediatrician stated, "I have changed the way I talk about families now and that is because of you (my name) and how you talk to us. I understand these children have previously been isolated by the way I have referred them to dietician knowing we did not have obesity service. Now I explain that this family assessment is most important not individual dietician."

The penultimate meeting of this team's steering group, however, verified that the learning and social context established by the team was programme specific. The team passionately deliberated with the senior lead from the PCT that the methodology used in the programme provided the best opportunity available for the PCT to create a sustainable strategic approach to reducing childhood obesity. "...as dietician's we know that our current approach doesn't

work for us or families. Using these tools and this process would support a patient centred philosophy to our service delivery across the continuum of support." The dietician used Figure 3 developed by the team for this meeting to support her assertions.

Figure 3: Continuum of Support for Childhood Obesity



- **Level 1** – Leaflets, Education programmes
- **Level 2** - Single Agency support (Dieticians, GP's, School Nurse, Healthy Lifestyle Co-ordinators)
- **Level 3** – Planned regular support with Obesity Support Team
- **Level 4** – Multi-agency support from Obesity Support Team including child and family meeting and lifestyle plan
- **Consultation** - You can contact any professional or agency to ask for help or information. Consultation is a two-way process and regard for confidentiality must always be held. Families must be informed of any outcomes.

The senior manager though did not appear to have the same enthusiasm as the rest of the team. He had not been involved in the process this team had established, nor had he engaged with the study. This led to condemnation of his actions "If we don't continue with this we will be letting families down" and acknowledgements that while the team learning and dialogue was embedded in this team's practice it was not sustainable for the participants outside of the study. This was vehemently asserted by the senior dietician "All of our learning and new practices will be lost within a system that we

know does not work if we are not allowed to continue to inform our services."

The social context of this team therefore was created by the participants to deliver a specific service. The learning that occurred was non-routinised in this context and innovative service delivery was created from a shared, embedded dialogic learning. The team individually identified and shared their belief that this approach should and could inform their substantive roles in a number of the multi disciplinary settings. However, they were equally pessimistic that this would not happen. "As (name of PCT lead) is my line manager and he simply doesn't understand what we have achieved and what we can do with our learning. There isn't a snowball in hells chance of transferring this approach to dietetics. Not unless he leaves anyway (laughter)."

4.3.4 Conclusion to findings related to context

The social context in which these teams operated was reflective of the outcomes they achieved from their involvement in the study. Where leadership in the teams was at its most effective they developed mechanisms for shared learning. Most significant was the development of dialogue. Effective, embedded dialogue was achieved in two of the teams', the Local Authority Family Support Team and the Childhood Obesity Support Team. Here the participants deliberately established systems to learn from one another. These systems included action learning cycles, observational learning, imitation, and modelling through mentoring and the development of what was known as their "common

language". The person centred tools used to underpin this research study were central to the development of these systems and the common language.

In the Local Authority Family Support Team the social context in which the learning took place appeared to have the greatest opportunity to be sustainable in the long term. The team leader was engaged with the process and had been active in driving the team's learning forward throughout the twelve month study period. In this team they celebrated their common language and were active in sharing their skills and knowledge with their service delivery partners and the families who used their service.

The social context in which the obesity support team operated was clearly under threat from my withdrawal as the facilitator of their learning. There were no clear lines of leadership within this disparate team to maintain the momentum they achieved and the team was unlikely to continue to operate in the long term.

The social context in which the Children's Centre Team operated had not changed during the research period. There was no apparent system to support team learning and while the team leader stated a commitment to developing services in partnership with the Local Authority Family Support Team this was not likely to be achieved unless the context in which they operated changed significantly.

4.4 Theme 4: Culture in the teams

Organisational learning is essentially a social and cognitive process. It is the manner in which this learning is developed and modified through the 'collective mind' of the organisation that determines how individual and group actions are executed. Outcomes from this study suggest that success in building a learning organisation depend largely the development of an appropriate "learning culture" and how this is "nurtured". Creating an appropriate culture in which a learning organisation may grow and thrive is not merely dependent on individuals' awareness of the importance of, and need for, learning. Rather, the "learning culture" must embrace the development of a shared belief or "common language."

This study suggests that actions performed by individuals and their teams, alone will not necessarily create a sustainable learning environment in which the service may flourish. Developing and understanding a mindset and "culture" of "shared learning" is of equal importance.

4.4.1 Culture and the Local Authority Family Support Team

The social context in which this team operated supported the development of a "common language" and "shared dialogue" which supported a "culture" of "shared learning." The "new culture" within the team encouraged "mentoring" and created a nurturing approach to team development. The Team Leader recorded:

> "I find, is an excellent tool that aids
> employees that are either new to the post or

> are under performing. I feel it helps the performer to become more effective and reduces the blockers that may be hindering the practice. I think, from my experience, that some inexperienced staff feel that they lack the experience, knowledge, and skill to practice and these approaches, in my opinion, appear to have given them the confidence to develop their practice in line with the framework that's been provided"

It was this "shared belief" that led the local authority family support team through a journey of self discovery which resulted in a more effective way "working together as a team", and with their service users. This enabled the team to flourish and grow together "...these new tools and associated processes are becoming embedded within our team and practice is clearly benefitting." As a team they developed a team vision and a shared understanding of their individual roles and team purpose. The team used their "common language" to value what was important for them to work most effectively together, the support they needed, and how this was provided. The team's "shared learning" led to the creation of an appreciative, enquiring, person centred and solution focused mindset. This culture was created by whole team involvement through the catalyst of committed dynamic leadership.

The culture of team learning supported what was a disparate group of staff to develop a "common language" and with this a consistency to their practice of family support.

> "...previously we all had different ways of doing things, talking to children and families and even each other. We didn't have a structure or framework to help us which meant we all understood our roles slightly differently. The planning with people tools have helped us to develop a common

> language and now we share ideas and tools about how to work with children and families in the staff room having lunch and in team meetings, (name of Team Leader) even uses them in our supervision. I think this has really improved how we work together and the outcomes for our families because we are more confident in what we are doing and we can check things out more easier" (Comment made by a senior Family Support Worker month ten during an action learning set)

These elevated levels of self belief and confidence in the team reportedly raised their standards of practice and enabled them to "empower their service users." An example of this was provided by a Family Support Worker in her reflective practitioner log:

> "Having never met the family before the review, I was reliant on the Social Worker to present the information. It soon became apparent that the family relied on the worker to present her perception of the work undertaken and the impact of this on the family dynamics. After listening to the information presented I decided or should I say it became natural for me to ask the questions of 'What's Working, What's Not Working'. I directed this directly at each parent in turn and requested the other person remain quiet while the other spoke. I was able to gather additional information about each others feeling in relation to their relationship and that of the children. This was done in a way that each member of the family was discussed. This naturally led into an action plan led by the parents that the parents could work to and agree on together without the need for further statutory intervention."

The confidence of this worker enabled her to challenge the practice of a professionally qualified social worker in an appreciative manner. This supported the culture of shared learning in the team "The Social Worker told me how pleased they were about the plan, and asked

how they could receive the training." This, in turn, began to have an effect on the culture of working with families involved with statutory services in this district "Using this tool demonstrably shifted the balance of power away from the local authority to a shared place. The parents were enabled to present information within a child protection arena from their own perspective I felt please that the parents had been enabled to use their own voice within the meeting. They were central to developing their own action plan".

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The team's formal methods of support mirrored their new practices and became an integral part of their team culture. The team leader reported how using the tools and processes within a formal setting "allowed her to supervise her team appreciatively and safely within a reflective, learning environment". The approach was nurturing "I feel that it's more non-threatening towards staff and it allows case discussion at a right balance for developing people's skills and I think that the information they present assists them really", and appreciative "staff are beginning to critically reflect on their own practice and additionally, they receive positive feedback from me about the work that they're undertaking"

All of the team members involved in this study from this team reported how their service, individual and collective practice had benefitted from their "new culture of learning and sharing". While the "common language" and "embedded dialogue" of the team was recognised as a position to inform their future, the team leader was determined to ensure the team's learning was "transferrable and sustainable" after the study was complete:

> "For me as a manager, I am really pleased with the increased self-awareness within the staff team and this has encouraged them to reflect both on the practice that they offer today but also to reflect on the former practice. One of my concerns was the lack of formal training for new staff so what we have put in place as a team is we have champions within the team and these champions are going to support new members of staff, students and other professionals in delivering the tools. For me, being successful as a manager and a team requires a number of skills and I certainly feel that the framework from the planning with people has provided elements of those skills. By giving staff a platform from which to deliver a service that hopefully meets their needs but also the families and not the organisation or its resources." (Manager, Local Authority Family Support Team statement from an end of project presentation)

4.4.2 Culture and the Children's Centre Family Support Team

There is no evidence to suggest that this study had any effect on the culture of this team. Although the team leader spoke in a steering group meeting of the "person centred culture" operating in her team there was no evidence of this. There was some evidence of routinized learning. However, for this to be supported in the context of a learning culture there would need to be some evidence of shared learning and this was not present.

There was clearly a willingness to change the culture from within the staff team "It is important to me that I work in partnership with (name of Local Authority Family Support Team) because I want to offer a consistent service to our users." The culture they operated in was governed by the team leader who exercised the power invested in her through her position of authority to covertly dis-engage from the

study “(name of team leader) writes our roster and unfortunately those of us who do the family support are always rostered off on the support days.”

4.4.3 Culture and the Childhood Obesity Support Team

There was a strong and transparent work ethic, belief and commitment from this team that supported a “culture of team learning”. The culture was nurtured by the cognitive strength of the team and their willingness to learn and share with and from each other “I have learnt so much from (name of colleague) about the benefits of taking our service out into community settings, even though I work with her on a day- to- day basis we rarely get to talk, never mind learn together.” This willingness to learn together was fused by their common goal “we have been having meetings about Childhood Obesity for two years; it is just so wonderful to get everybody together in a place where we can develop our programme, we have so many thoughts to share”.

This team came together for a common purpose and were determined to make a difference for children who were living with obesity “we are developing something unique as a team, our shared reflective logs are brilliant for learning together as we rarely get together as a team.” By the end of month seven, the team had developed a “common language” and their “person centred dialogue” was maturing to the extent that their learning was reported as being accelerated “I can’t believe the difference we have made together in such a short time. To think we did nothing but talk for two years and

now in less than six months we have this brilliant service which families love."

The culture of this team, however, was threatened by a lack of strategic planning. There was a growing frustration in relation to their leadership and the sustainability of the service whose frustration was articulated by the dietetic lead for the project:

> "just to say that it feels at the moment like a rudderless ship the (name of obesity project). The programme has developed over the last 7 or 8 months into what I think is a programme that can lead the way, but what we haven't got and doesn't look like we're going to get at the moment is the funding to be able to, one to manage the service, which we desperately need and that we were promised, and the other thing that we haven't got really is the clarity of how the programme should look now, so the programme's evolved hasn't it over the months and where I think that we need to, what we need to know strategically (from the stakeholders) is where's the programme at and what do we want to do with it? If the PCT aren't going to sustain (name of the project) as part of the overall obesity strategy that I know hasn't been written yet, then we need to be honest with parents coming to the Oscar programme because people will be leavin the pilot very soon with no funding." (Dietetic lead; transcript from an action learning set)

Unfortunately the answers were not available from the strategic lead who attended the steering group on behalf of the PCT. Whilst he had been involved with the obesity project for many months there was a distinct lack of clarity about his decision making or commitment to the programme as a whole, the staff and the service users:

> "Well this is something I will raise with (name of Associate Director) when I next see her,

> which will be next week now, she's off, but to say that there is potential risk there but we also need to say, look it might well stop, okay, if there's no money, there's no money, there's nothing any of us can do about that, but that's the end of that, there's nothing more anyone can do" (Strategic lead from PCT; transcript from a Steering Group meeting).

Finally, the culture within the team had begun to have an impact on professionals who were working with them. Testimony to this were the comments of a Child Psychologist who attended an action learning set as an observer,

> "I'm just really impressed. I've obviously been to many service meetings before but I've never been to a meeting within services so positive and so supportive for everyone involved. The fact that you even have these meetings and talk so positively about your clients I'm just really impressed and I think these sort of meetings should happen a lot in all services. The thing that I'll take away with me is everything really the way that you coordinate the meetings and the person-centred planning and thinking needs to be in a lot more services. And I'm just really impressed, and I think you've got a really good team and I will have lots of positives to take away." (Child Psychologist, comments made as an observer at an action learning set).

By the end of the study period, however, there was little chance of the funding continuing. The disappointment of this was echoed throughout the team and their frustration was emphasised by the lead dietician "...all of our learning will be lost because there is no way, no way that we will be asked to share what we have learnt, I for one will be going back to work in a service that I know doesn't work and because (name of senior manager) is my, my manager I'm going

to be stuck in a time bubble, a waste land of ideas that are never listened to where patients are a nuisance."

4.4.4 Conclusion to culture in the teams

It became clear in this study that it would not be possible for two of the teams to create true 'learning environments' because of the culture of the team and the context in which their learning was taking place. The Children's Centre had barely been engaged in a meaningful manner throughout the study, while the obesity team were isolated in their roles. By month eight of the research study they were only able to meet together for their monthly, two hour, support group meetings, and to deliver the programme one evening a week. None of the team had any dedicated time to allow them to prepare or plan in between sessions. There was no funding made available to release them from their day to day work and there was a distinct lack of leadership or even administrative support from their senior managers located in the hierarchy of the local borough council and National Health Service. While they had created a culture of learning through shared dialogue and power relationships while designing and delivering the service, their efforts were futile because of the lack of understanding from their senior manager.

Where there was strong leadership and commitment to inclusive practice in the Local Authority Family Support Team there was a basis from which a sustainable service could be built. The solution focused, person centred and appreciative culture developed by the team created an environment where learning thrived. The confidence of the leadership in this service to use the collective intelligence of

the team to inform its development demonstrated the characteristics of a learning organisation.

CHAPTER FIVE: DISCUSSION

In this discussion, a theory of leadership and organisational learning is presented which is labelled ‘Appreciative Dialogic Learning’. This is developed from the findings in this thesis, Habermas’ work on communicative action and communicative rationality and Wenger’s work on communities of practice (Habermas 1984;Habermas 1990;Wenger 1998;Wenger 2000). The introduction addresses how the person centred planning tools (PCPTs) were central to developing team dialogue through the vehicle of action learning. This is followed by a reflexive discussion of the influence of power, Appreciative Inquiry, and cognitive team learning on leadership and organisational learning theory. Finally, the model for Appreciative Dialogic Learning is presented.

5.1 Introduction: a personal reflection

The complexity of what the teams were attempting to achieve through their involvement in this study was not lost on me as I joined their individual team journeys as a facilitator. I was well versed with the application of PCPTs within service delivery (Sanderson, Acraman and Short 2004), and I had experience in using the tools to work in a solution focussed manner with the individuals and teams I worked with on a daily basis. Although I was confident in my abilities as a facilitator, stepping into the realms of researcher with no obvious power over the outcome of the study in any of the services was a step into the unknown.

At the outset of my work with the teams, I had not considered that I might be entering into the field of organisational learning. On reflection though, and with a developing knowledge of the literature in this area, the PCPTs appeared to be an ideal conduit for team and organisational learning to take place. A review of the management literature relating to this subject suggests that while there is widespread acceptance of the concept of organisational learning and its importance to strategic performance there is no widely accepted theory or model for implementing it (Chandler 1962;Duncan 1974;Fiol & Lyles 1985;Jelinek 1979;Miles & Snow 1978;Miller & Friesen 1980)

Senge (1990) talks of three critical dimensions to success in organisational learning: the need to think insightfully about complex issues; the need for innovative, coordinated action; and the role of team members on other teams. What Senge and other proponents of organisational learning do not tell us though is how to achieve organisational learning. Perhaps one of the reasons behind this is, as Brown & Duguid (1991) discuss, that the concepts of working, learning, and innovating have conventionally been considered to conflict with each other. Work practice they argue is viewed as conservative and resistant to change; learning is seen as distinct from working and is therefore problematic to implement in the face of change; and innovation is the disruptive but necessary imposition of change on the other two. To understand that working, learning and innovating are interrelated, compatible, and therefore potentially complementary and not conflicting forces requires a distinct conceptual shift (Brown & Duguid 1991). Personally, I do not believe that this requires a large theoretical shift. As an action researcher, I

believe these forces naturally work together and, by association, need each other to generate new learning and theory.

To achieve the requirement of the teams to ‘think insightfully’ about complex issues they needed to create an environment that was conducive to collective thinking and decision making. In doing so I believed they would be able to gain access to the ‘cognitive whole’ of their organisation and unlock the potential within the teams who came together to share their learning and establish a group intelligence quotient (IQ). My hope was that the teams would no longer need to rely on the independent intelligence of talented individuals, or, as was often the case in the initial stages of the study, the most forceful argument presented during group discussion for decision-making.

I understood that the process of action research was an ideal vehicle to introduce the teams involved in the study to team learning. This discussion is, therefore, a reflexive account of my experience bringing together three interrelated elements: the findings from the study, my prior learning, and the experiential learning I gained from my study.

My experience of using Person Centred Planning (PCP) to inform and underpin dialogue through action learning suggests there are new possibilities opening up for using this approach within the fields of leadership and organisational learning. Several key elements stand out to support this claim. First, as Senge (1990) argues, dialogue is an advance on double-loop learning processes (Argyris

and Schon 1978) and represents triple-loop learning. Dialogue is a means of collective thought and enquiry, a process that can be used to transform the quality of conversation and discussion, in particular the thinking that lies beneath it. Dialogue, in this use, involves learning about context and the nature of the processes by which people form their belief systems (paradigms) and therefore how it informs their actions. Second, my findings show how using PCP to underpin dialogue provides leaders with a new set of tools that support the establishment of learning environments in which learning may take place. These environments are “safely dangerous.” They support risk taking within a safe and controlled environment, allowing learning to inform praxis as an organic tool for service development through action learning. Third, my findings also show how this method emphasises the power of the collective, cognitive whole of an organisation, utilising the shared knowledge and skills of individuals to develop a “common language” for a team. Once embedded within a team this “common language” provides the opportunity for organic service development to become enmeshed in the fabric of the organisation.

Using PCP in this way has enabled some of the teams and individuals I worked with to have open, honest and challenging debates, within a safe environment, to begin to explore deeply held underlying patterns of association and meaning. Finally, my findings show that dialogic learning, informed by PCPTs, supports a potentially powerful mode of inquiry and collective learning for teams and organisations.

I have demonstrated that this method for organisational learning offers an appreciative, solution focussed alternative to traditional methods of problem solving. It can transform the collective thought of individuals into an intervention, which has the potential to allow new kinds of collective intelligence to appear. In times of change within health and social care settings 'thinking alone' at any level of the hierarchy is unhealthy because the problems are too complex, the interdependencies too intricate, and the consequences of isolation and fragmentation too devastating. I have demonstrated that using a person centred approach to organisational learning develops a teams' capacity to think together and promotes collaborative thought and coordinated action. Further, this manner of planning suggests that when a group of people use their shared perspective to reach agreement this supports the development of an "action plan" produced and changed through participation in an organically changing process.

5.2 Dialogue and team learning

The discipline of team learning, according to Senge (1990) begins with dialogue, the capacity of team members to suspend assumptions about their existence and to enter into genuine 'thinking together'. With this in mind, it made eminent good sense to support the action research through dialogue-focussed action learning sets. As the teams (and I) set off on the 'journey of learning' together I was acutely aware that they would need to be focussed on the issues that were most important to them.

I live my life very much as a pragmatist. Pragmatism therefore also

heavily influences my practice and by association, as a practitioner-researcher, my research. When considering at what point I should begin my study with the teams, I convinced myself that the only place I could start was at the beginning. It was my belief that using an open dialogue (Bohm, Factor, & Garrett 1991) for this study was not going to be practicable.

Open dialogue poses several contradictions for practice. While it seeks to allow a greater coherence to emerge within a group or team of people, it does not enforce coherence on the group or team. Beginning a dialogue exposes another contradiction in terms, while the process encourages people to have a shared intention to investigate their practice, it does not have an agenda, a leader, or a task. Dialogue does require a facilitator initially (Bohm, Factor & Garrett 1991) who can help set up the investigation of the team's practice and who can embody its principles and purpose. But by deliberately not trying to solve familiar problems in a familiar way, dialogue opens a new possibility for shared thinking. I was therefore intent on using dialogue but in what I considered a more focussed and pragmatic manner.

My time with the teams as their facilitator was limited to one, two hour meeting, at a maximum of once a month, and this was heavily reliant on the continued engagement of the teams with the study. It is here that using the PCPTs as a vehicle or "structure" as they preferred to call it, for the team's learning through dialogue proved liberating for the participants. The pragmatic emphasis here was placed on praxis and the practical development of the teams' skills

and knowledge base. Key to the sucess of what I refer to as ‘person centred dialogue’ within the LAFST, and to some extent the Obesity Support Team, was the collaboration of all members of the teams involved. Discovering their ‘common language’ and team purpose enabled them to build a platform from which to launch their plans of action through a plethora of methods they designed to support their exchange of reflexive experiences and ideas to improve praxis. This was not always the case for the Children’s Centre however, where dialogue of any kind proved difficult to implement.

5.3 Are you a knight Daddy?

Learning through dialogue is an ancient concept, first introduced in a literary form by Plato the Classical Greek philosopher (Senge 1990;Senge 2006), and one that in theory should be simple to accomplish. As I sat attempting to explain to my children what I do for a living, we thought about talking in a round (a process of asking those present, in turn, to share their thoughts and reflections with the group while being actively listened to). I used this method to inform the action learning process, to “generate a dialogue of equals” (McNiff & Whitehead 2000: 59). My daughter, aged eight at the time, immediately reflected upon her experience of using a ‘talking stick’ with her Brownie group, which she reported had helped all of the girls, in turn, to “say what we were feeling because some children weren’t always nice to each other.”

My son who was six years old also clearly understood what I was attempting to achieve. “Are you a knight, Daddy?”, “A knight?” I replied “Yes because you use a round table like King Arthur in Merlin

(a television programme we enjoyed watching together) in your meetings, that's cool."

Delighted by my children's response and understanding I began to reflect, if a six year old child can embrace the notion of dialogue surely the concept should easily be transferred to the work place. Of course my children have little understanding of the complexities of 'power' and its many facets (or maybe I am not giving them credit?) Again, my son surpassed my expectations of his understanding of what I was attempting to achieve, "He used a round table because he wanted them to think they were the same as him even though he was King. King Arthur didn't want the knights to think he would boss them around all the time when they were planning their raids on the bad guys, because they might have better ideas than he did about how to win their battles of doom". Maybe my son did understand what I was attempting to achieve, but unfortunately, for me at least, I was not acting as a knight in this study. I was acting as a facilitator attempting to develop dialogue with teams where power would play a significant role in the outcome of the study.

5.4 Four stages to Organisational Learning through Appreciative Dialogic Learning

As the study progressed four distinct changes in the stages of dialogue emerged from the dialogic learning of the teams (Bakhtin 1981;Habermas 1984). These appeared to have a direct link to the levels of engagement and style of leadership within the distinct teams, and in the case of the LAFST transformed their service incrementally in quarterly cycles until they achieved a level of

'embedded dialogue' that appeared to have the potential to support sustained organisational learning. These stages of dialogue can be identified as naive, developing, maturing and embedded dialogue.

5.4.1 Naive dialogue: the first three months of the study

During the initial stages of dialogue the teams had several aspects of this research study to contemplate and focus on: the use of PCPTs to inform their practice with their service users and the communication between themselves; being asked to reflect on 'why their team exists'; and to communicate through shared learning. The professionally qualified participants had all experienced elements of using reflection to inform their practice. However, with the exception of the Clinical Psychologist in the Obesity Support Team, none continued to formally use reflection in their practice. Therefore, most participants did what they did on a daily basis without a strategy informing them why they were doing what they were doing, or what the expected outcome was from their efforts.

Establishing the action learning sets brought each of the teams together for the first time, with a shared theme of listening to each other, acknowledging each other's strengths and exploring 'what was important to them' as individuals, and 'how best they should support each other' in order for them as individuals and as a team to reach their full potential. This led to the teams employing a type of egalitarian dialogue (Bakhtin 1981). As individuals, they brought with them a wide range of tacit, unexpressed differences in perspectives. Embracing these, and supporting the teams to recognise the importance of learning and sharing from these perspectives, was

incredibly difficult at first. This appeared to be because the individual team members operated in cultures of argument and discussion where it was common for the person with the most to say or loudest voice to be heard above those less vocal but with significant knowledge and skills (Kline 1999;Senge 1990;Senge 2006).

My role as a facilitator of their learning was to assist the teams to view themselves as a whole and to invite them to join in a dialogue where they were observers and the observed, active contributors and active listeners (Bohm, Factor, & Garrett 1991;Habermas 1984). There was no discernable dialogue (Bohm, Factor, & Garrett 1991) within the teams at this stage of the study as the participants were initially stuck in unproductive discussion together (Senge 1990;Senge 2006). Their rhetoric was influenced by their evolving use of the PCPTs and therefore they made attempts to be 'person centred' but did not understand the nuances of dialogue (Bohm, Factor, & Garrett 1991), attempting instead to 'win discussion' (Senge 1990;Senge 2006) albeit by using a new vocabulary.

Through facilitation, the participants began to share what they "liked and admired" about each other in the workplace in an attempt to gain a more informed understanding of each other (Sanderson, Acraman, & Short 2004). Exercises such as this gave them confidence to begin to challenge what others were saying in a non-confrontational manner (Bohm, Factor, & Garrett 1991), to listen to other perspectives (Kline 1999) and to reach compromises where previously there had to be a 'winner' as an outcome from discussion (Senge 1990;Senge 2006). The intention of these early-facilitated

exercises was to lead the participants into dialogue. As the participants from the LAFST began to understand that they did not always have to be right, they reflected on their practice and behaviour in groups (Bohm, Factor, & Garrett 1991;Freire 1970). This enabled them to challenge previous assumptions about their behaviour and decision making and that of their colleagues which in turn enabled them to move towards shared decision making and an understanding dialogue (Bakhtin 1981;Freire 1970;Habermas 1984).

Conversely, the Children's Centre Team Leader found it difficult to lose her 'power' (Dahl 1986) in order to accommodate a sense of shared learning in her team to the extent that she adamantly defended her decision making and used her status (Handy 1993) to avoid using a 'new language' with her team. This effectively meant that the Children's Centre Family Support Team were unable to move beyond this unproductive discussion, naive dialogue stage of the study stalled by their Team Leaders non dialogic actions (Bakhtin 1981).

5.4.2 Developing dialogue: months three to six

As the participants grew in confidence, the way they spoke with each other in formal and informal situations began to alter. The manner in which individuals in the LAFST and the Obesity Support Team continued to fluctuate between dialogue and discussion demonstrated that they were not altogether confident of their developing 'common language'. However, the fact that they were committed to the process of continued learning was a reflection of their 'collective will' (Habermas 1990;Wenger 1998) to succeed and

the leadership they experienced (Senge 1990;Senge 2006).

As the participants continued to gain experience and trust in each other, their discussions became more open and frank. This proved a necessary part of the process, as the teams were able to approach subjects and the 'hidden agenda' they had previously ignored or shied away from for fear of repercussions.

The protected 'safe' environment of action learning (Wenger 1998;Wenger 2000) provided the context in which the teams could 'out' the skeletons that had lurked in 'unopened cupboards', and address the underlying fragmentation and incoherence within their teams. It appeared as though the culture shift that had taken the teams away from 'doing what they did' on a daily basis to considering collectively 'why they did what they did' was a necessary part of the process. This was not an easy process for many of the participants. Some who were naturally quiet and unassuming felt awkward challenging the perspectives of their colleagues, while others who were usually thought to be 'right' or whose arguments during discussion were often the loudest, if not the most convincing, found it hard to be challenged (Kline 1999;Senge 1990;Senge 2006). Managing this process appreciatively using the PCPTs enabled facilitation within a solution focussed environment allowed the participants to 'disagree with what the person was saying, rather than the individual person'.

Facilitating the group required skilled action planning but this allowed the participants to action plan their route to shared learning through

dialogue (Habermas 1990;Wenger 2000). In the first three months of the study the participants brought with them a wide range of tacit, unexpressed differences in paradigms and perspectives. During the second three months, the participants began to realise what this meant, accept that they could no longer hide their differences and began to use dialogue to explore these differences (Bohm, Factor, & Garrett 1991;Senge 1990;Senge 2006).

The effect of this exploration was significant in terms of how it affected individual members of the teams and the teams themselves in terms of their communication systems and plans of intervention (Habermas 1990;Wenger 2004). Both the LAFST and Obesity Support Team recognised that their services had been “prescriptive” in their intervention with children and their families (Quinton 2004). They also found that they had created services that families had to fit in to, as opposed to designing their services to the needs of individuals and families (Department for Education and Skills 2004a;Department of Health 2000;Quinton 2004). In essence, they had been trying to ‘fix’ families rather than work with them in order to seek solutions to the challenges they faced and to ‘learn with the families’ to identify ‘what was important to them?’ and ‘how best they should be supported’ (Sanderson, Acraman, & Short 2004).

Effectively this second quadrant of learning built on one of the underpinning theories of dialogue that says the effect of people’s shared learning can alter the quality and level of inquiry possible at any particular time (Bohm, Factor, & Garrett 1991). The change in context and culture this developing dialogue brought, enabled a

gradual and deliberate transformation in the teams' practice to take place. As the teams collectively gained awareness of the effectiveness of this process, they used the PCPTs to gradually refine their communication skills (Habermas 1984) and make subtle changes to their methods of intervention with each other and their service users, as practice shifts from being mostly routinised to non-routinised innovative praxis (Miner & Menzias 1996).

5.4.3 Maturing Dialogue: months six to nine

The halfway mark in this longitudinal study found both the LAFST and Obesity Support Team acclaiming their maturing 'common language'. The teams' dialogue began to inform innovative praxis as the teams used the collective strength of their combined cognitive knowledge to engage together in holistic thought. The synergy of this process enabled the teams to make swift progress within their team, and with individual communication and development of their services. Effectively their 'common language' informed a more considered, reflective pace to the development of their service.

The maturing dialogue was used to inform team learning at all levels. The PCTs became central to their 'tool kit' and were used to inform senior management decision making, formal and informal supervision sessions, team mentoring and service delivery with individuals and families. These shared reflective practices reduced the gap between those holding hierarchical positions and the frontline staff to a level where organisational learning became tangible (Senge 1990;Senge 2006)

While there was excitement within the Obesity Support Team in relation to their non-routinized learning (Miner & Menzias 1996) and team praxis, there was equal frustration and pessimism relating to transferability and sustainability of their praxis.

Collectively this team recognised that without the engagement of their Senior Manager their learning was likely to be lost (Handy 1993;Senge 1990;Senge 2006). Individually team members, with the exception of the Clinical Psychologist, were either not confident of their ability to implement their learning, or reliant on leaders stuck in a hierarchical and traditional system which they knew did not work. The confidence, self esteem and evidence base the team had developed was used to support an intensive assault on their traditional practices, aimed at their Senior Manager in an attempt to change the future context and culture of their work. Frustration began to run high in this team as they became sensitive to the effects their dialogue was having on individuals in the team. In particular, they began to seek out the embodied manifestations of their thoughts. In doing so, the realisation of deeper themes that existed behind their flow of ideas rose to the surface as they came to understand the impact their senior manager had had on the team, their service delivery and culture within the wider organisation by holding on to his fragmented and incoherent thought processes and practices. This realisation caused distress for the team as they recognised their separateness from their substantive posts and positions in teams that were unaware of the journey of discovery they had been on.

This team had unwittingly colluded with their separation by utilising me as the facilitator of their thinking. Through the sheer busyness of their work lives, in which this project had been an ‘add on’, they had failed to grasp the potential their newly acquired ’common language’, and the process of action learning they had underpinned with the PCPTs, could have had on the service delivery of their substantive teams.

The loss and pain felt by the team on the realisation their achievements were to be lost was considerable. Collectively, the team had recognised the limits of their vision (Senge 1990;Senge 2006) for service delivery in the absence of ‘appreciative leadership’. However they had not been prepared for the experience of isolation caused by the lack of engagement with the project by their Senior Manager. The behaviour of this manager prevented the team from moving forward (Handy 1993;Senge 2006) with their collective dialogic learning and this affected the team emotionally and cognitively. The team had achieved success to a level that their understanding of team dynamics and service delivery could have been reflected in non-routinized learning, however, only routinized learning took place at a sustainable level (Miner & Menzias 1996) as their learning was isolated to the service specific project.

Where there was a true sense of power sharing through dialogue based praxis the LAFST thrived on a collectiveness that supported non-routinized learning (Miner & Menzias 1996). In contrast to the Obesity Support Team, collectively and intellectually, this team saw no limits to their vision for service delivery. The team knew each

other well and continually strove to achieve excellence through shared learning. The team exuded a sense of collective trust. They used this to great effect through the reflective mechanisms they established that enabled them to practice flexibly using a multitude of methods of communication (Habermas 1984; Wenger 2000) to inform an appreciative approach to dialogic learning. This appeared to work individually and for the team.

This eagerness to 'get it right' allowed appreciative learning to inform praxis and drive their service forward in partnership with their line manager's vision for the future of the service. This resulted in the participants becoming sensitive to the needs of each other and the support they required to enable them to perform at the top of their game, year on year. The team's generative learning (Senge 1990;Senge 2006) and their methods of communication were positively affecting their performance. There was a sensitivity to the manner in which their learning was becoming embedded in their team's praxis.

5.4.4 Embedded dialogue: months nine to twelve

The final quadrant of the research period brought with it a real transformation for the LAFST. The teams thinking and communication had moved to "another level" as their common language engulfed their systems for communication, information sharing, decision making, formal and informal supervision, and processes of induction for new staff members and students. The basis of their development as a team was their overwhelming willingness to share their knowledge, talents, skills and experience.

Through dialogic learning they were able to expand their individual knowledge into a team IQ through engagement, exchange and interaction, shared experience and ideas (Freire 1970; Habermas 1984).

This growth in team knowledge and shared learning informed the improvement of praxis through action learning. Through the collaborative processes, they established for their practice and learned to care for and look after each other using a democratic dialogue (Freire 1970; Habermas 1984) informed by the PCPTs. This enabled the participants to develop a mutual understanding and come to agreement with colleagues and service users on actions, which in turn tested and developed their praxis. The processes this team engaged in linked both inquiry and change mechanisms together allowing them to share their different perspectives and experience gained through twelve months of transformative change. In many ways, this proved to be an example of group intelligence, informing and improving team praxis.

Engagement by the teams with dialogic learning clearly influenced the outcomes of this study. Where the participants did not engage with each other or the team, only routinized change occurred (Miner & Menzias 1996) within fragmented and compartmentalised practice. It appears that where the participants did not interact with the study their individual and team experience was narrowed, benefitting individuals but not the team holistically. Shared learning was restricted in these teams. The democratic processes associated with it were not put into action as the asymmetric power relations that

were present placed invisible structures in the way of improving praxis.

I believe this study demonstrates that to improve praxis with health and social care teams there is a need for emancipation of individuals and teams through reflective and transformational actions.

5.5 A **model for Dialogic Learning**

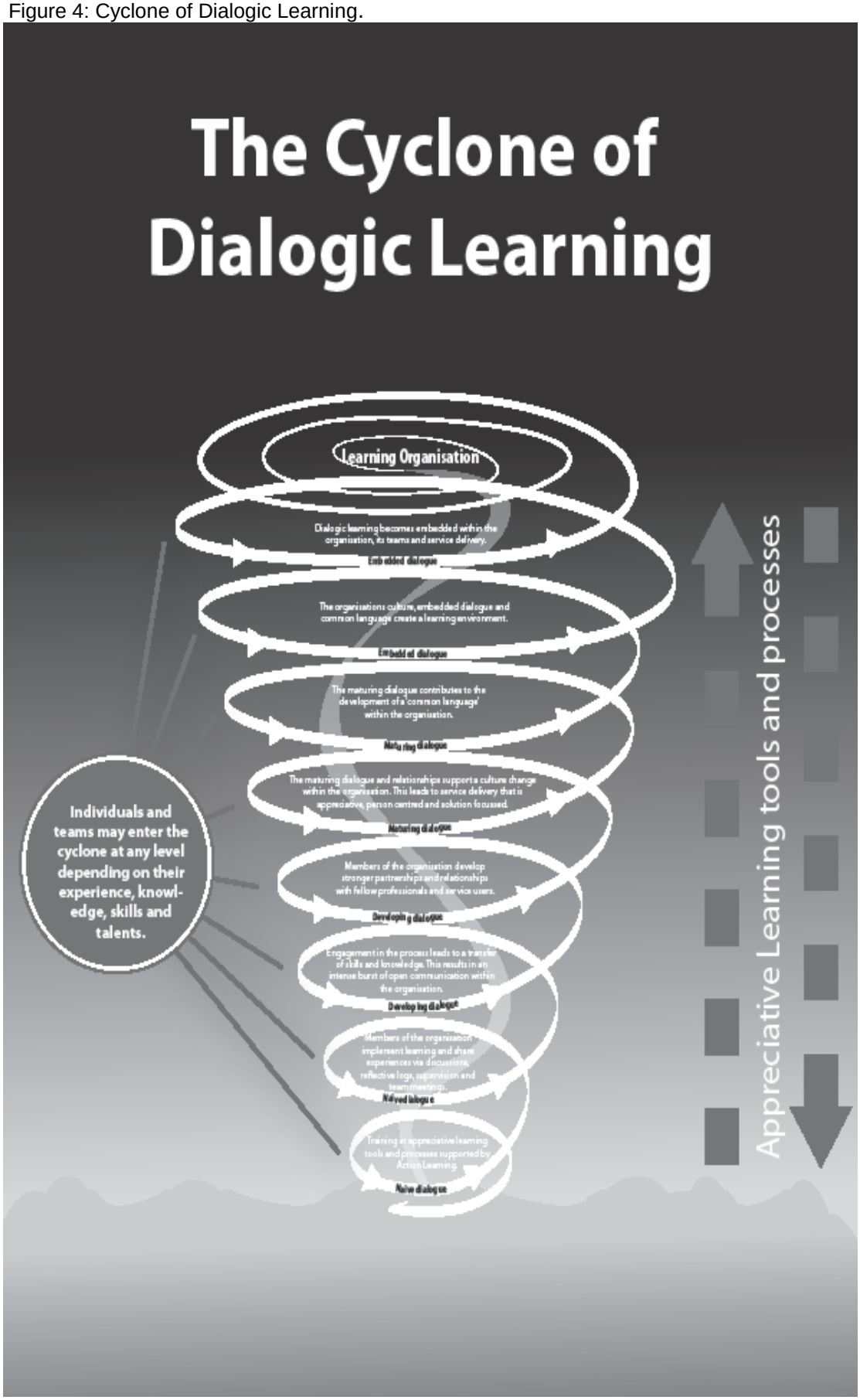
The process of action research is cyclical and iterative. However, the dialogic learning that took place in this study was more complicated than this. This process grew out of the team's cognitive strengths, combined experience and appreciation of how each individual contributed to the 'whole' of the organisation. As the team grew in confidence, their dialogue became more intuitive informing praxis and sustainable change. Using the person centred planning tools to inform their change processes allowed the team to create an 'appreciative common language' that was easily shared and used to inform team and service user learning.

There were a number of natural transition points and these relate to the four distinct stages of dialogue identified above as naive, developing, maturing and embedded dialogue. The manner in which the teams entered, travelled through and exited these stages was dependent on a number of factors, including the team's experience in using the PCPTs, the knowledge, understanding and familiarity of individuals with the use and process of dialogue, their previous experience and learning and the Team Leaders ability to share their power.

The team's appreciative, collaborative learning allowed them to engage with less experienced staff and students more easily and hasten their contribution to the team on a 'fast track' of learning using their common language. This ability for the team to accelerate learning resembled the action of being sucked up through a cyclone of learning. When staff left a team, or engagement did not take place, learning either stayed still or dropped down the cyclone. Leadership of the team appeared to be the necessary catalyst to enable this 'cyclonic' learning to take place. Equally, however, using the PCPTs to underpin their practice allowed a swift introduction to the team for new members who were quickly introduced to the teams' common language and dependent on their previous knowledge and experience were able to join the dialogue at any of the levels (dependent on whether the rest of the team had achieved this level together).

Once team learning and the PCPTs were embedded in team behaviour and functioning their common language and appreciative praxis more quickly took people through the vortex and appeared to established a structure for sustainable organisational learning, (see Figure 4: 191)

Figure 4: Cyclone of Dialogic Learning.



5.6 Accounting for my style of leadership and facilitation

I have never had formal management or leadership training, but this does not appear to have harmed my career in any way. I have gained valuable experience through 'working my way up the ladder' and developed an appreciative, reflective and collaborative style of leadership.

I recognise, however, that the talent I have to motivate and enthuse through reflection and dialogue is far from natural. I have been incredibly fortunate in my career to work for, and with, a number of exceptional managers and leaders. Each of these individuals has offered me something unique in terms of their values, belief systems, and styles and importantly each has appeared to view the organisation they represent, to be "only as good as the people who work for it." I have valued their offers of inclusivity, collaboration and person centredness, which I have used as a portfolio for my own learning. I have then taken what I have learnt and shared it with others. I have listened and learnt from my social engagement with colleagues, changed my perspective, altered my style and methods and continued in this cyclical, iterative method of personal improvement. In many ways, my journey of learning, reflection, sharing, adaptation and re-learning has been a continual programme of professional growth through action research.

It is this journey, both consciously and subconsciously that led to this study, which in turn informs my own living theory of leadership and organisational learning I christen 'Appreciative Dialogic Learning'.

I did not deliberately set out to create a new theory relating to organisational learning. Rather I was led into this part of my journey through dialogue with the teams I facilitated, initially hoping to have an effect supporting them to improve their practice. However, once we began to use the PCPTs to underpin team thinking through their shared dialogue I believed, perhaps idealistically, that the process of learning for the teams would prove to be relatively straightforward. I based my supposition on my own understanding of how straightforward I believed this process to be, along with my previous success in developing teams and being central to the creation of new organisations. For example, I built the Local Sure Start Programme (where I first incubated the idea for this study) from scratch into a unique and successful organisation through my ability to work closely and appreciatively with individuals, teams and organisations. I now recognise that I had naively assumed that my own willingness to dedicate my time and energy to the teams in this study, and to share my knowledge and understanding of the tools and process associated with PCP, would consequentially meet with their combined approval and support. The outcome was quite different.

Two of the teams responded passionately to the proposal that they use the tools and process - originally designed to improve their practice - to progress their understanding of their teams' role and purpose. These teams held a belief that doing so would enable them to appreciate why their team exists, why they do what they do, and how what they do makes a difference. Leaders at all levels of the LAFST and the 'elected' Team Leader of the Obesity Support Team immediately recognised the potential benefits of using this process to

inform individual and organisational development through the development of a critical perspective on practice and they enthusiastically embraced this opportunity by engaging in the study.

The teams' engagement with the study led to the gradual development of dialogue within their services. This developing dialogue allowed them to learn to question their practice together. As the study progressed, the teams' enquiries grew in complexity, and as they practiced their learning together in different environments their practice matured into an embedded dialogical way of learning.

Conversely the Team Leader responsible for the day to day leadership of the Children's Centre Family Support Team demonstrated a general resistance to change within her service which was exacerbated by the suggestion of introducing her team to this method of reflective practice, or as she referred to it "team naval gazing." This manager was used to having high levels of power, control and autonomy over her service through a culture of command and compliance so it was perhaps naive to ask her to suddenly become a reflective practitioner. Initially, in a genuine attempt to keep this person and her team involved, members of the Local Authority Family Support Team (LAFST) engaged in a conciliatory dialogue with them. They attempted this because they felt "let down".

This had been a "joint initiative" they had embarked on hoping to develop a more informed, better joined up service with clear transition plans for their service users. However, in the absence of engagement from the other team they reluctantly moved on

recognising that they needed their energies to be focused on their own team's future.

This brings me to my own style of learning and facilitation, which has been informed dialogically over the last thirty years. At each stage of my career pathway, I have questioned my role and purpose in each of my work environments. I have found myself asking, "Why am I doing what I am doing?" I have sought answers through my peers using their combined knowledge, talent and experience and by seeking to further my learning by attending courses and gaining professional and academic qualifications. I have never professed to know everything about my role and duties, rather my knowledge and practice are a result of a dialogic interaction between what is known to work and what I learn.

Dialogic learning works for me, undertaking professional and academic studies while continuing to practice in health and social care settings has supported my continual quest to seek out and understand 'why I do what I do', and, how 'what I do impacts on and makes a difference to others'.

As I considered how I would approach the facilitation of this study with the teams involved, I was acutely aware of the complexity of the task ahead. Having practiced in this area for many years (both as a social work practitioner and manager of family support services) I was not expecting that the participants would have a shared definition of what was meant by Family Support. The fact that I was given a plethora of definitions by the participants when I asked them

to define their roles for me supported the assertions of Quinton (2004) who, reporting on Messages From Research relating to supporting parents for the Department of Health, acknowledged the difficulty of defining 'support'. Support, he suggests, is such a general term that it is easy to devalue its meaning in relation to service provision. Using the word support implies that services will be effective if 'support' is offered to a family. Without an identified outcome for the support provided, however, there is a danger that it becomes something services do to people when they cannot think of anything more specific to offer them. This is reflected in my findings where all the participants attempted to provide evidence that their work was supportive and worthwhile, but only managed to reflect what it was that they did to families.

On hearing the variety of definitions provided by the participants, I made a conscious decision to offer to support the different teams through shared action learning to understand the context in which they operated and how they as individuals were interpreting the world of service provision. I believed this would enable the participants to gain a better understanding of 'what it was they did' under the umbrella title of Family Support and what they were striving to achieve or 'why they did what they did'. This conscious decision was no doubt associated with my own passion for learning underpinned by my appreciative style of leadership and the philosophy that underpins that. I wanted the teams to discover that together they had the knowledge, skills and talent to be able to form and develop a successful Family Support Service. For them to be able to achieve

this, I believed they needed to be central to the creation of a working environment that encouraged learning to take place.

5.7 Development of person centred pragmatic dialogue

The type of pragmatic dialogue used in this study utilised the PCPTs to support the participation of all of the staff. The aim of using these tools was to inform a colloborative praxis (McNiff & Whitehead 2000) through shared experiences and ideas and the wider involement of the people involved. There is a connection to be made here between this approach and Habermas' theories of communicative action (Habermas 1985) and communicative rationality (Habermas 1987).

What appears to have happened in both the LAFST and Obesity Support Team is the development of a noncoercive , unifying compromise built on their shared learning as the 'common language' they developed moved from a 'naive' dialogue to a 'developing' dialogue. The learning environment created by the participants supported their reciprocal understanding and therefore became conducive to allowing communicative rationality (Habermas 1987) to take place. For change to be effective and timely within these health and social care settings the environment for dialogue needed to be created for the participants, as opposed to waiting for the paticipants to set the agenda as part of a naturally occuring process as Habermas suggests (Habermas 1985). This is what occurred where there was reported success in the study. The teams used the PCPTs to provide a framework for dialogue and therefore to create their 'common language'. Working collaboratively in this manner supported Habermas's (1990) theory of free and equal participation

in the study. The team's "common language" was built on a cooperative search for truth, with no outside coercion except the strength of the better argument.

I would like to be able to argue that the only force, active in dialogue (Bohm, Factor, & Garrett 1991), communicative rationality (Habermas 1987) and this study through the guided structure of the PCPTs is the "force of the better argument", which holds a critical place in Habermas' work (Habermas 1985). However, as I will discuss later it would be naive of me, and I believe of Habermas, if the ever present force of power within these strucures were to be dimissed.

As found in this study, power penetrates even the most open dialogues and therefore it would be meaningless to operate with a concept of communication in which power is absent (Foucault 1988;Nietzsche 1966). This was clearly demonstrated through the non-rational rhetoric (Wenger 2004) of the leaders situated in the Children's Centre and Obesity Projects who appeared more intent on maintaining their personal interests than they were on the concepts of keeping the dialogue free from their domination or indeed consensus-seeking.

Validity and truth, according to Habermas (1993: 31) and Kettner (1993), are ensured where the participants in a discourse respect the five procedural requirements of discourse ethics, which are also the key elements to dialogue and were central to the study. Habermas' model has an emphasis on power neutral discursive participation

which seems somewhat ‘lightweight’ in terms of possibilities for use as a mechanism for organisational change within these health and social care settings . What seems to be missing is a recognition of decision makers and hierarchy. While ‘free dialogue’ (Bohm, Factor, & Garrett 1991) and ‘communicative rationality’ (Habermas 1987) are important mechanisms for understanding the social world, when introduced to organisational learning and change methodologies, they lack the necessary link to praxis.

The successful introduction of dialogue-derived ideas into practice through strategic decision making lines, may require negotiated compromise with decision makers, whether they are participants-in-dialogue or critical friends of the process (Habermas 1990). Addressing power in this negotiated manner is constructive in terms of the organisation attaining an agreed dialogically achieved outcome. To rely solely on attempting to achieve an uncompromised decision in a power neutral environment would be, as Foucault (1980: 89) also discusses akin to cutting off the king’s head and replacing it with a decentred understanding of power. In hierarchical organisations, leadership is key, strategy is necessary, collaboration and negotiation important. It makes sense therefore, that dialogue should be informed by strategy and driven by outcome using the power of the cognitive whole of the individual team members.

The Person Centred Dialogue used in the study introduced a compromise within Habermas’s utopian process: action from dialogue was delivered through a direct route to decision makers. Where this worked well, particularly in the LAFST, the team’s

appreciative dialogic learning was directly implemented into practice through a caring, collaborative praxis. Where this did not have a significant effect was in the teams where negative power, as decribed by Handy (1993), was a central player. The structure provided by the PCPTs created an environment which, if replicated, may go some way to answering Foucualt's assertion made in reference to Habermas:

> "The problem is not of trying to dissolve [relations of power] in the utopia of perfectly transparent communication, but to give...the rules of law, the techniques of management, and also the ethics...which would allow these games of power to be played with a minimum of domination" (Foucault 1988: 18)

The person centred diaologic approach taken in this study has more in common with the thinking of Freire (1970) and Foucault (1988) than Habermas (1987). The role I played as researcher and facilitator, which may be considered as being based upon a Freireian-like pedagogy, made it possible for me to pay attention and listen to overt disagreements during the action learning sets, and also to trace covert disagreements through interpretations of the staff actions and accounts written in their 'practitioner reflective logs'. Following Foucalt (1988), order and unity may be interpreted as signs of dominance and suppressed conflicts. Through my pragmatic facilitation of the teams, I used these data to inform action learning sets. Doing so enabled the teams to turn these traditional assumptions upside down in a thoughtful, supported, stimulating environment which encouraged creativity and the development of theories.

This dialogic form of learning proved emancipatory for many individuals in the team who had either felt oppressed or silenced by more confident, overt colleagues, and those who had previously failed to understand their roles and purpose and had become lost in the systems that previously existed. The stories and shared reflections on practice that emerged from this person centred dialogic approach enabled barriers to be raised and hidden agendas to be recognised, thus allowing the teams to collectively seek different alternatives to team and individual actions

5.8 Communities of practice, person centred action learning and dialogue

In some respects I was viewed as a 'teacher' by the participants through my expertise on the subject of PCP and the position I held as researcher facilitator. I frequently acknowledged and emphasised with the participants that I had expertise in terms of the process but they had expertise in terms of the context. This position, and the action research methodology, links in well with Lave & Wenger's (1991) practice-based theory of learning as 'legitimate peripheral participation' in 'communities of practice.' It could be argued that much conventional learning theory, including that implicit in professional and 'in house' training courses, tends to endorse the valuation of abstract knowledge over actual practice and, as a result, to separate learning from working and, more significantly, learners from workers. Lave & Wenger's (1991) analysis suggests that this knowledge-practice separation is unsound, both in theory and in practice. Action Researchers, however, argue that the simple concept of learning-while-working best represents the fluid evolution

of learning through practice. From this practice-based standpoint, learning may be considered as a bridge between working and innovating.

Communities of practice according to Wenger (2004), are groups of people who share a passion for something that they know how to do, and who interact regularly in order to learn how to do it better. On the periphery, this appears to be familiar rhetoric, similar to that of dialogue (Bohm, Factor, & Garrett 1991) or action learning. This rhetoric continues with familiar claims for learning:

> "...the knowledge of practitioners is not merely the knowledge of an individual. They need to interact with colleagues because they benefit from the stimulation and because knowledge of any field is too complex for any individual to cover. This is where the notion of community of practice comes to play a critical role. Communities of practice are social structures that focus on knowledge and explicitly enable the management of knowledge to be placed in the hands of practitioners." (Wenger 2004: 2)

Central to the development of communities of practice is the belief that the context in which the community operate is vital to understanding, learning and practice, while acknowledging that knowledge is not only acquired in a mechanical way (Lave 1998;Resnick 1987;Sfard 1998). Situated Learning is described by Lave & Wenger (1991) as a collaboration between the cognitive science, and anthropologists research communities which emphasise the socio-cultural dynamic of learning. Learning is described as an 'integral and inseparable aspect of social practice' which involves the construction of identity (Lave & Wenger 1991; ibid, 53) through changing forms of participation in communities of practice.

Wenger and Snyder (2000: 140 - 141) discuss the five important ways they believe communities of practice would 'add value' to an organisation because they: (1) 'help to drive strategy' through their model of knowledge management; (2) start new lines of business (3) they solve problems quickly; (4) they develop professional skills; and (5) they transfer best practices.

Communities of practice are social structures that focus on knowledge and explicitly enable the management of knowledge to be placed in the hands of practitioners. Using the shared cognitive understanding, skills and knowledge of the participants to better understand the workings of the organisation very much reflects the processes of dialogue and action learning. While proponents of 'communities of practice' wax lyrically about the processes used by practitioners, they also support the notion of communities of practice having specific life spans to deal with specific problems (Wenger 1998). However, this approach seems limiting in terms of continuity and sustainability preferring a model that is iterative, replicable and generative such as that used in this study.

Wenger and Snyder's (2000) second claim that communities of practice start new lines of business appears to me to be a somewhat ambiguous claim. In my experience of using dialogue based action learning within health and social care organisations, and as demonstrated through the LAFST in this study, reflective practitioners continually learn from their practice. They collaborate with their colleagues, find new solutions to old problems, refine their skills, and create environments where reflective practice helps them to learn

from mistakes. They receive compliments and complaints, experience unforeseen pitfalls inherent in well-established approaches, and discover new opportunities. Through this process, and again as demonstrated through the LAFST they acquire a unique perspective on the work of their organisation and its relationships with service users and stakeholders. In a similar way to Wenger's (2004: 140) claims that learning "needs to be captured into refined practices that incorporate the lessons of the field." I suggest that it is the actions created from this learning that make a difference to service delivery.

Dialogue supports individuals and teams to engage in candid, open discussions. Person centred dialogue is targeted at appreciatively determining what the team are attempting to achieve, compares 'what is working', with 'what is not working' and supports the creation of an action plan to ensure 'what is working' continues to work and which addresses 'what is not working' appropriately. It is when a team learns how to translate all of this information, through appreciative knowledge extraction processes and turns these into interventions and useful practices for their service users that generate new learning. This new learning may well be an awareness or learning about new lines of practice, but again this is certainly not a sole domain of the community of practice. Indeed, these behaviours and practices are embedded in the appreciative change processes of dialogue and action learning.

The third claim is that communities of practice solve problems quickly as members, according to Wenger and Snyder (2000), know who to

go to in order to resolve problems quickly, what questions they need to ask, and how to ask the question. This type of solution-focused thinking is certainly the type of practice I have been advocating with different levels of success for many years in health and social care settings. I believe it to be effective and achieving this decision for service delivery is good use of the combined thought processes of the team involved. I, again however find myself asking rhetorically whether this could have been achieved through dialogue and action learning. I answer in the affirmative as the combined use of the participants' knowledge, skills and talents are central to these processes.

A further claim is that communities of practice develop professional skills through a hierarchy (Wenger & Snyder 2000) of apprentice learning, journey men and master craftsman. Effective learning they state "depends on the availability of peers, and their willingness to act as mentors and coaches." (Wenger & Snyder 2000: 141)

While it is acknowledged that learning is as much a responsibility for experts as it is for inexperienced workers, it is a concern that organisations accept and advocate that communities of practice should be created by those most motivated to be involved. Even though on the surface this may appear sensible and logical, it appears a somewhat naive concept. A system so loosely based may be open to the contamination of 'power' from perceived experts who wish to maintain a status quo within a change agenda. Indeed, allowing like minded groups to form themselves may also lead to managers creating groups of powerful knowers which Senge (2006)

warns may have the opposite outcome to the desired effect of a community of practice, creating a learning difficulty for an organisation where it does not listen to practitioners on the front line. Further, and importantly, it is not who belongs to the community of practice, but crucially who does not. Kline (1999) warns of the dangers of ignoring, or simply not hearing, the voices and opinions of company workers who feel oppressed and down trodden (or those who simply shy away from group situations). For it is these people who may be able to contribute significantly to the group IQ who need to be empowered to contribute to team learning.

Mentorship and shared learning should be placed high on the agenda of all organisations. Dialogue and action learning are proven and tested processes for achieving this. The appreciative dialogic learning using the PCPTs presented here takes this a step further, potentially embedding systems of learning into the fabric of the organisation's structure.

Their final claim is that communities of practice transfer best practices as they are ideal forums for practitioners to share and discuss best practice (Wenger & Snyder 2000). Without wishing to appear repetitive though, there again appears to be little difference between what may be achieved through a community of practice and what may be achieved through dialogue and action learning. Sustainability and the ability to replicate systems, models and interventions is the domain of a reflective, embedded practice (as used to inform this study), rather than that of a short lived, temporary, potentially fragile community of practice.

While the notion of the “Community of Practice,” can be applauded there are doubts about the sustainability of the process and the outcomes achieved. Communities of practice are task orientated and dependent on groups of like-minded practitioners coming together to share project specific learning and to problem solve (Wenger 1998).

Although Wenger (1998) describes communities of practice as an evolutionary process for learning in groups, this ‘evolution’ may have to be reinvented on a number of occasions as practitioners in the communities of practice or their reason for being change. As Wenger (1998) asserts, they form out of necessity to accomplish tasks and provide learning avenues, and while he notes they exist within, between, and outside defined organisations, there is no suggestion that they are permanent and, therefore sustainable fixtures. This is emphasised by Liedka (1999) who concurs with Wenger (1998) that communities of practice are not formed, they evolve and disband out of necessity of the members.

When a community of practice disbands, they often take with them much of their learning which must be re-learnt when the next group of practitioners evolve for a different reason. It takes time for practitioners to learn together and for their learning to inform and develop their practice. The process and model of learning and sharing that takes place in ‘situated learning’ (Wenger 1998), is as important as the content of what is learnt and how this is shared in terms of building a sustainable model of learning for an organisation.

The Obesity Support Team, prior to my intervention through this research project, had the characteristics necessary, according to Wenger (1998) and Wick (2000) of a community of practice. They were a group of professionals, a collaborative team, who all shared similar responsibilities, in that they had come together specifically, with a single vision, to develop a support programme for children who were living with obesity. This, according to Wenger (the main protagonist for communities of practice) should have been enough to develop a forum for shared interdisciplinary knowledge and practice and an environment that promoted learning through more effective communication.

What was found, however, was that while this 'community of practice' had all of the main ingredients for collaborative learning as promoted by Wenger (1998), their shared knowledge, good will and commitment to each other and their practice had not been enough to enable them to make progress in terms of service development. They appeared to be missing some key elements that would support sustainable change and understanding within their organisation, which simple group membership and shared good will could not achieve alone. These missing elements are consistent with the literature on organisational learning. The findings here support this and demonstrate that sustainable change may be achieved by using dialogue, action learning and the appreciative person centred tools.

The challenge of implementing change within the complex arena of health and social care settings as (World Health Organisation 1997) and Kanter (1995) asserts, requires engagement at all levels of the

organisation. Although the team had membership and commitment from some senior staff, including a paediatrician and clinical psychologist, the vision shared by the team importantly, was not aligned to any strategic organisational vision.

Although childhood obesity was high on the international (World Health Organisation 1997) and national (Department of Health 2004a) agendas (and this team had created a local intervention) they had done so in the absence of an organisational strategy and shared vision for tackling childhood obesity. This team, formed almost as a splinter group from a working party, had existed for two years without achieving its goal of developing the organisation's obesity strategy and were frustrated at the lack of progress. The team had gelled through a common belief that they needed to do something, but their organisation appeared to have a culture of decision avoidance as evidenced by the lack of action from the team's senior manager. This person continually failed to make decisions on the future of the project over a period of twelve months.

Martin (1982) and Schein (1983) propose that an organisation's culture manifests itself in the overriding and established patterns of behaviour. With no shared norms or belief systems between the team and the organisation, influencing action was always going to be challenging for the team (Beyer 1981;Mitroff, I & Kilman 1976).

Without a shared culture across the organisation, there was little chance of this 'community of practice' influencing change.

An organisation's choice of strategic posture is tied closely to its culture (Miles & Snow 1978) as are its actions (Kets de Vries & Miller 1984). Broad belief systems, therefore, partially determine strategy and the direction of organisational change. There should be little surprise then that the senior manager of the Obesity Support Team made no tangible attempts to make decisions. If the team were going to achieve any sense of change for their service delivery, they needed to influence the behavioural and cognitive development of the organisation itself. To learn from the actions of the team, the organisation would be required to restructure its ideological stance (Argyris & Schon 1978;Jelinek 1979;Shrivastava & Schneider 1984). For this to be achieved the culture of the PCT in which the team were sited would need to be receptive to change, for change processes to be embraced.

Introducing the appreciative person centred tools to underpin the process of action research enabled the team (as a 'community of practice' that had effectively become stuck) to share how they wished to achieve their vision with their senior manager, stakeholders and service users. In doing so, they embraced dialogue through action learning, acknowledged difference in perception and behaviours and sought jointly agreed solutions. This resulted in the team achieving locally and nationally acclaimed success. Unfortunately, the outcome for the team was disappointing, due to their senior manager's disengagement. Their success could not be replicated in the organisation. For this reason organisational learning could not occur (Senge 1990;Senge 2006).

The experience of this team, demonstrates the complexity of service delivery in health and social care sectors. Forming a community of practice alone therefore, may be problematic. Attention needs to focus not only on a shared vision but crucially on the processes involved and how the outcomes of team learning are implemented through change. Change occurs when there is a shared vision and the change is managed in a receptive culture (Senge 1990;Senge 2006). For this to happen the organisation needs to acknowledge the importance of creating an appreciative environment and dialogue to team learning. This environment must take account of the cognitive whole of staff teams. Individual styles, motivations, rational, knowledge and skills may all be at different levels of development, but bringing these together within a flexible, sustainable framework increases the potential for successful change processes (McNiff & Whitehead 2000).

The social context in which learning occurred in this study and the factors present, which influenced its occurrence, were important. According to leading theorists such as Senge (2006) and Garvin (1993), a learning organisation requires an environment where experimenting with new approaches is encouraged and errors are not perceived as failures but as opportunities to learn and develop together. This was most certainly the case in the most successful of the three case studies, the LAFST, where the team defined my role as a facilitator. Team leadership was demonstrably supportive and it encouraged critical reflection at all stages, enabling the participants to learn from mistakes and misjudgements as they occurred. In many ways, the team learnt how to practice together (McNiff & Whitehead

2000;Senge 2006). This process was far from natural for the team who worked hard in order to embed their learning.

This emphasised the need to see team learning as a skill rather than something that happens when teams get together. The LAFST developed a system built on the notion of “practice fields” (Senge 1990;Senge 2006). They used their action learning sets to develop their collective learning within what Schön (1983) describes as their virtual world; a constructed representation of their real world where they were allowed the freedom to experiment within a safe and protected environment. It was within this social context that they tested out their individual and team theories for improving their practice and service delivery.

The use of the appreciative PCPTs to underpin the action learning sets in this study created what the teams called a “framework and structure” for their team learning which were far more than ‘practice fields’ (Senge 2006). Although both communities of practice and practice fields involve learning with authentic content and by solving authentic problems, practice fields separate the authentic content from the real situation (Squire & Johnson 2000). Practice fields include activities such as simulations and role-playing. Contrary to practice fields, learning in communities of practice is neither separate from the activity nor the meaningful social arrangements in which the activity takes place. In this sense, learning is participatory. The process in this study moved beyond shared processes of learning how to learn, and developing ways of sharing this knowledge, to

embedding a culture of appreciativeness and inclusivity through dialogue and praxis.

5.9 Hierarchy and its place in learning

Communities of practice are overtly created on levels of hierarchical relationships. This relationship is known as 'legitimate peripheral participation' (Habermas 1990), which conceptualises novices at the periphery and experts at the centre of a community of practice (Gherardi & Nicolini 2000;Wenger 1998). These expert-to-apprentice relationships are central to the conception of communities of practice (Soden & Halliday 2000). Facilitating communities of practice through hierarchy, allows two aspects of collaboration to develop: Bielaczyc & Collins (1999) argue that peer interaction and expert to apprentice interaction support the processes of negotiation and co-construction of the community of practice. Through these relationships Wenger (1998) asserts that members of a community of practice construct a common history through negotiated meaning.

In traditional educational situations, all learners are required to learn the same thing at the same time. However, in communities of practice, Wenger (1998) argues that those lower down the hierarchical pecking order play an important part by developing and using skills that require collaboration and by mixing different types and levels of expertise. Bielaczyc and Collins (1999) highlight that these are not skills learnt through traditional methods of education.

While it seems clear how communities of practice may work well in some industrial or sole purpose settings, their use in the fields of

health and social care may be more problematic. Hierarchical positions in these environments are regularly used to overpower those perceived to be in lower level positions. That said, hierarchy is central to implementation of any new learning that occurs within an organisation and therefore has to have a place in the decision making process. Indeed, it could be argued that there are three clear places in this process where hierarchy is important:

1. at the beginning of the process when a shared vision is developed and ownership of the process accepted across the organisation,
2. during the process when clarity is sought in relation to strategy, policy and decision making,
3. at the end of the process when learning is implemented in practice.

However, crucially hierarchy has no place in dialogue, where its presence can stifle innovation (Senge 2006), prevent people from making a positive contribution (Kline 1999) and create an unhelpful power imbalance (Handy 1993). The method of non-hierarchical dialogue used in this study worked well for the LAFST. Here the Team Leader was a constant figure during action learning sets, yet expertly managed her dual role, bringing her hierarchical knowledge to the group when proposals were put forward from dialogue, and having the devolved decision making power from senior managers who believed in (and had ownership of) the process. Using hierarchy in this manner did not dilute dialogue but helpfully enabled instant

access to decision-making and actioning proposed changes within the team environment and their service.

Similar success occurred at the team level of the Obesity Support Team where senior health staff drove the process forward at a very local, project level. However, decision making at an organisational level lay with senior managers and it was at this level that power had a stifling impact. In the Children's Centre Team, hierarchical power was present and the service became 'learning disabled' (Senge 2006).

5.9.1 Learning in the context of the study

While individual learning is important to organisations, organisational learning is not simply the sum of each member's learning (Fiol & Lyles 1985;Hedberg 1981). Indeed, little transferrable learning would have occurred in this study if the individuals and teams had not established the appreciative methods for sharing and developing their understanding through action learning, practitioner reflective learning logs, team meetings and so on. These systems and processes developed to share and learn together were designed to ensure that the organisation (or team) benefitted from the learning alongside the individual. Where these systems became embedded in the fabric of the organisation, as occurred in the LAFST, they not only maintained the learning system in a way that influenced the whole of the team, but also established a process of appreciative dialogic learning that influenced the practice of their partners and stakeholders.

There are two levels of learning commonly referred to in the organisational learning literature: lower level and higher level learning (Fiol & Lyles 1985). Lower level learning occurs within a given organisational structure, with a given set of rules and leads to the development of some rudimentary associations of behaviour and outcomes. However, these outcomes are usually short term, localised and therefore only have an impact on aspects of what the organisation is attempting to achieve. Cyert and March (1963) suggest this level of learning is usually achieved as a result of repetitive and routinised behaviours, such as those which occurred in the Children's Centre, Early Years Team, where the Early Years' teacher took her own learning from her participation in the study and implemented it successfully within her part of the service. This, according to Duncan (1974), is typical of organisational contexts in which lower level learning takes place. In this case, the teacher was well established in an Early Years setting.

Lower level learning also occurs in areas where the management believes it is able to control the situation (Duncan 1974); again this clearly applies within this setting. This apparent control over the environment is more characteristic of lower and middle levels of management than of upper levels (Fiol & Lyles 1985), as occurred in this team. However, lower-level learning is not to be confused with lower levels in terms of hierarchy within the organisation. This process of learning may take place at any level of an organisation, and its focus is usually placed where it has an impact on a particular activity provided by the organisation. In this case the Early Years' teacher used the appreciative person centred tools she learnt

alongside the Children's Centre staff to inform only her part of the service; this routinised learning is referred to by Argyris and Schön (1978) as 'single loop learning'. There was no attempt made to share her learning across the organisation or her wider team.

What occurred in the LAFST, and albeit to a far lesser extent in the Obesity Support Team, was higher level learning. This method of learning specifically sets out with an intention to adjust the overall rules and norms established within an organisation as opposed to just attending to specific activities or behaviours (Fiol & Lyles 1985).

The outcomes from higher-level learning are intended to have long-term effects and impacts on the organisation as a whole. This type of learning occurred through the dialogic use of heuristics enabled by the use of the appreciative PCPTs in this study, the skill development that occurred as a consequence of this approach, and the insights gleaned, to support continual sustainable change in the teams. Because this process used the 'cognitive whole' of the organisation to inform the process, as opposed to the routinised, single service, lower level learning that occurred in the Children's Centre, it resulted in an easily replicated process that facilitated non-routinised learning to take place (Miner & Menzias 1996).

There is evidence within the literature that because of the complexity required from a process aimed at large scale change within an organisation that some type of crisis in the organisation may precede the acceptance of this type of learning (Miller & Friesen 1980;Starbuck, Greve, & Hedberg 1978). In the findings here the

LAFST reported inconsistency in their practices. Some staff were struggling to understand their individual roles and team purpose to the extent that the Team Leader was considering taking a number of them down a punitive, performance based disciplinary route. The Obesity Support Team were attempting to change the focus of their service delivery to a team based, family focused construction as opposed to a number of services who were struggling to effectively work together on many areas of childhood nutrition.

These teams used the process introduced through the study to develop their frames of reference, or what Bartunek (1984) describes as interpretive schemes; new cognitive frameworks within which to make decisions. Indeed, it was within what the teams in the study referred to as their "new structure and framework" that they were able to utilise the cognitive whole of their team to explore both 'what is working?' and 'what is not working?' Using the appreciative PCPTs to inform this process enabled an honest assessment of their service. This often resulted in the team having to learn about parts of their service that they believed once worked well, but did not do so any longer, and change them accordingly; a phenomenon known as 'unlearning' (McGill & Slocum 1993;Nystrom & Starbuck 1984).

The process in this study moved beyond shared processes of learning how to learn, and developing ways of sharing this knowledge to embed a culture of appreciativeness and inclusivity through dialogue and praxis.

One consequence resulting from lower-level learning in organisations is they may become dysfunctional if allowed to create the superstitions, associations, or norms that support dysfunctional behaviours (Fiol & Lyles 1985), such as occurred in this study through the senior manager responsible for the Obesity Support Team. He believed his service should respond to difficulties faced by families using a traditional dietetic model, even though members of the team were assertively reporting that this method was ineffective. This senior manager's apparent irrational belief in his personal vision for his team, and thus the Obesity Support Project, fed upon (and supported) his inability and unwillingness to change (March & Olsen 1975;Pfeffer 1981).

While it may appear that the team were reluctantly supporting this senior manager, the evidence from these findings indicates that they were controlled by his use of 'position power' (Handy 1993) over the team. Classically this manager and the Team Leader of the Children's Centre Family Support Team, focused on identifying ways of not changing by game-playing and problem avoidance (Cyert & March 1963;Lyles & Mitroff 1980;Nystrom & Starbuck 1984). The behaviour and the culture they had developed were ingrained in their practice and therefore were always going to be difficult to change.

Contrary to this, the Team Leader of the LAFST, and crucially her Senior Manager, recognised that their extant practice was not working and therefore needed to change. They used the tool 'what is not working' in an attempt to understand what needed to be 'unlearnt' or changed in their organisation. Being open to unlearning had a

positive and productive effect on the team which allowed new higher level learning, and re-adaptation to take place (Lawrence & Dyer 1983;Meyer 1982;Nystrom & Starbuck 1984). This resulted in a 'common language' and appreciative methods of change management.

5.9.2 Learning to learn as teams

Learning has always been something of a passion for me, a 'must do' in order that I may fully understand my role in the workplace as an individual, with my colleagues and peers and essentially with the people who use the services I work in. As an individual, I have taken responsibility for my own learning, and through good fortune and perseverance with supportive managers and solution-focussed employers, I have created my own learning environment. Regrettably, my individual learning has all too often remained just that - my learning - as few of the organisations I have worked for have established robust systems for sharing individual learning across teams. I have naturally attempted to share my learning with others, being successful on several occasions, although this has become easier as my status has increased, thus providing me with the opportunity to put my own processes for shared learning in place.

My hope for this study was that the teams would learn how to learn together and that their efforts would have a positive effect on their peers within the organisation. I believed that a ripple effect, much as one sees when casting a pebble into a still pond, would gently wash over the organisation as the positive results of appreciative, shared learning came to fruition. The result of which would be the

propagation of appreciative PCPTs as the system underpinning the learning across the organisation.

In most teams, according to Senge (1990; 2006) the energies of individual team members work at cross purposes. This is not a reflection of their commitment or their desire to work hard. Indeed, individuals in the team may all believe they are working to their maximum potential in terms of their individual roles and purpose. However, if there is not a shared understanding of their team purpose and its desired outcomes then their individual efforts, no matter how well intentioned, cannot effectively translate into a team effort. This is certainly reflected in the findings here, where the majority of the participants believed they understood their roles and purpose but when asked to share them individually they provided a multitude of different perspectives.

By spending time with individuals in all of the teams I was left in no doubt that individually all of the participants wanted to deliver an equitable and high quality service to all their service users. However, without a common understanding of what they were trying to achieve, their work was dependant on the utilisation of their individual skills and talents. Service users therefore received a different level and quality of service dependent on the experience, qualifications, understanding and knowledge of the individual assigned to work with them.

This apparently haphazard approach taken by well meaning practitioners who do not have a shared vision is described by Senge

(1990; 2006) as being unaligned, and results in individuals unintentionally working against, rather than with, each other. The teams in this study were attempting to align themselves by gaining a common understanding of their team purpose, a shared vision for their practice and an understanding of how collectively they could complement their work as individuals in the team.

A leading figure in the development of organisational learning Senge (2006: 219), asserts, "...there has never been a greater need for mastering team learning in organisations than there is today." The nature of the industry associated with the team is unimportant. People who need one another to act (De Geus 1988) are becoming the key learning unit in organisations. The reasons that teams need to learn is that, at some levels individual learning is irrelevant for organisational learning as "individuals learn all the time and yet there is no organisational learning" (Senge 2006, 219).

Using the PCPTs within an action learning environment created a "framework and structure" for appreciative learning to take place. The environment felt "safe" for the participants who grew more confident in trusting each other with often complex, personal, professional and confidential information. Safety and trust are key elements for teams or organisations who are attempting to build a learning environment (Grisham, Bergeron, & Brink 1999;Palloff & Pratt 1999). The appreciative nature of the PCPTs appeared to be crucial to success. Where participants were dialogic, used the tools 'what is working?' and 'what is not working?' and shared perspectives to gain collaborative solutions to team problems they felt they had

permission to learn from their ‘mistakes’, be brave and innovative rather than feeling uncertain and that they would be blamed. This supported a higher level of learning being achieved.

Using appreciative dialogue through a variety of communicative methods, supported by the knowledge of what each team member ‘liked and admired’ about their individual practice, appeared to support the team to make continually positive and productive changes to their team practice. Conversely, the Obesity Support Team and Children’s Centre Teams apparently mistrusted senior management, which resulted in a team environment that was demonstrably less innovative, safe and where they were “not encouraged to use the tools in work.” This lack of trust and safety resulted in routinized learning (Miner & Menzias 1996) and both teams demonstrated dissatisfaction in individual workers and team attrition.

Where most successful, the appreciative action learning process influenced all areas of team communication, learning, record keeping, maintenance and development. This meant that the LAFST learnt dialogically through formal and informal individual face-to-face engagement, team meetings and using technology through electronically shared practitioner learning logs and dialogue centred action learning sets. This use and development of the teams’ ‘common language’ based on the PCPTs resulted in the participants feeling in control within a constantly changing environment. Utilising their electronic communication methods (alongside the more traditional face-to-face routes to inform their dialogic learning) the

team began to consider web-based, shared learning where other health and social care staff could join them in an interactive learning environment. This type of collaborative learning environment is defined by Seufert (2000) as a meeting place of technology and social groups.

Using this method of shared communication, informed and underpinned by the PCPTs, to build upon the appreciative action learning and action research methodology, appeared to cement the team's learning and take it from a maturing dialogue to an embedded dialogic practice. The team kept their reflective logs on a shared drive on the organisation's computer server; these served as a valuable resource for the team to remotely share their learning, helping to build upon and embed their mechanisms for dialogic learning.

The appreciative nature of this approach to dialogic learning is demonstrative of the theory presented by Fukuyama (1995) and McNiff & Whitehead (2000) that successful organisations are built on social capital, energetic good will, and commitment by individuals who have decided to work together for a particular purpose. This idealistic view of workers joining to constitute a powerful body of change is admirable but success requires a great deal of persistence and hard work from all involved in the process. It perhaps naively overlooks the potential barrier of a leader out of synchronisation with the team.

Actions performed by individuals, teams and whole organisations will not necessarily create a sustainable learning environment in which the service may flourish. Developing and understanding a mindset and culture (Love, Huang, Edwards, & Irani 2004) of shared learning to create a learning organisation is equally important.

The strategic lead for the obesity project appeared to use his position within the organisation to wield power over the participants; this may have been through ignorance or fear of the process with which he so emphatically failed to engage. The outcome in terms of sustainability for the project was catastrophic as this person was the only route the team had to cascade the flow of information about the project through the organisation. The person's power effectively meant that the obesity project became an invisible asset (Handy 1993) as its potential was trapped and dependent on his decision-making. The Children's Centre Team Leader's use of 'power over' (Dahl 1986) her team effectively meant that only isolated, routinised learning occurred (Miner & Menzias 1996).

5.9.3 Facilitating learning through dialogue

There are inherent dangers for dialogue in teams operating within the complex setting of health and social care. Addressing multiple issues around individuals and groups may take team thinking off at many tangents without targetting specific issues. Understanding this, at the outset of the study, I had spent preparation time with the teams introducing them to some of the key elements of dialogue, removing metaphorical hierarchical hats, listening, sharing perspectives, being prepared to have persectives challenged, talking in rounds and

developing the plethora of rules which set up an environment conducive to team learning.

Initially, participants from all of the teams had found elements of dialogue difficult. However, once they had “got over the embarrasment of being a focal point”, and “frustration of having to allow others to talk without interruption,” they had begun to find the process useful and powerful. As individuals they visibly became more relaxed and in doing so began to share what they really thought about their service; their worries, concerns, celebrations and ponderings for future change. As the Local Authoirty Family Support Team and Obesity Support Team began to engage with the sessions, I found myself facilitating them in a manner that subdued open dialogue, but supported their dialogic development. The focus of the action learning sets was placed, I acknowledge in true pragmatist style, on ralllying the team together and developing practical, useful knowledge and local theories. This enabled them to establish solution focused methods and processees for clear action planning which enabled more informed, clearer problem solving.

Had I facilitated an ‘open dialogue’ (Bohm, Factor, & Garrett 1991) I would not have had the opportunity to guide the participants along their desired pathway. Instead they would have ‘trodden their own path’ but I doubt they would have made the rapid strides they did with facilitation. This is where the PCPTs became fundamental to their dialogical interaction; their learning by doing. At the begining of each session the participants took part in a round of shared dialogue, during which they stated something that had ‘worked well’ for them

over the previous month, and something that had ‘not worked so well’. As the team listened and respected each other’s contribution I wrote down their contributions on a flip chart, checking that I had reflected their words appropriately once they had concluded. Once everybody had spoken, the team voted on issues that had been raised in order to determine their desired outcome, or their action plan for the next period.

The team’s theories were tested out using the PCPTs, and in turn these were underpinned by an Appreciative Inquiry. As the facilitator of the context of their learning I supported the teams’ espressed desires to explore ‘what was working well’, alongside ‘what was not working’ in their teams. Action planning then took place to address the issues that were ‘not working’, but also to ensure that ‘what was working’ continued to work. This was undertaken in a safe environment for the team to share their thoughts and aspirations for their service. Non agreement was managed in the same way as disagreements, with ‘what the person said’ being highlighted as opposed to having an argument with the person themself, and this supported close critical analysis of proposals for change before they were ‘tried out’ in the real world of sevice delivery.

Implementing the agreed action plans in the real world was critical to the success of using the PCPTs as a structure to develop new interventions through dialogic learning. Implementing action plans was key to the whole process. Once thoroughly tested out in theory within the safety of the group, the teams tried out their new ideas in practice and reviewed what happened in order to learn from their

experience and generate new learning as they searched for improvements of praxis. While there was no hierarchy in terms of individuals having power over (Dahl 1986) others in their dialogue, there was a level of collaboration with those in decision making roles (in the Local Authority Familiy Support Team). This proved important in ensuring that learning from praxis could quickly be absorbed into the teams routine day-to-day operations. Conversely, where there was no level of identifiable collaboration with the decision makers (in the Children's Centre and Obesity Support Teams), change proved less likely to occur. This included no change of circumstances identified through praxis as being potentially harmful for service users, "we have the opportunity to help families change their lives for the better, but [name of Senior Manager for Obesity Support Project] isn't listening to us or interested in our work". The Obesity Support Team who struggled to fully implement their shared learning used the process in an attempt to find workable improvements to praxis. However, they were only successful locally and internally in a routinised manner. Any attempt to take their learning outside of the parameters of the specific time framed project were "sabotaged" through hierarchical use of negative and position power (Handy 1993).

5.10 The relationship between discussion and dialogue

In order to explore dialogue and discussion as they occurred in the study I, as others before me (Bohm, Factor, & Garrett 1991;Senge 1990), found it helpful to consider the distinction in meaning between these two important types of discourse. I was aware that for a team to achieve continual generative learning (McNiff & Whitehead 2000),

as occurred in the LAFST, both discussion and dialogue needed to have taken place within and between team members. The power of these discourses according to contemporary physicist David Bohm lies in their synergy (Bohm, Factor, & Garrett 1991).

Successfully practicing the discipline of dialogue involved individuals in the team interacting together in a way that allowed them to learn from the whole of the team. Discussion with its roots with 'percussion' and 'concussion' (Bohm, Factor, & Garrett 1991) may take place between individuals as well as in the team. In a discussion, people usually hold relatively fixed positions and argue in favour of their views as they try to convince others to change to their viewpoint to win the argument. As Bohm & Peat (1987: 241) assert, "at best this may produce agreement or compromise, but it does not give rise to anything creative." Senge (1990) suggests that winning a discussion in this manner results in one person having their views heard and accepted by the team at the expense of another person. This clearly describes what was occurring across all three teams at the outset of the study. In the theory proposed here, this part of the process can be called 'naive dialogue'.

Although the discussions that people were having had all the characteristics of dialogue, it was usually the strongest person in terms of their confidence, or most confident in terms of how loud they spoke who 'won' the discussion. This was accepted as the norm in all of the teams, none of whom had recognised that a good percentage of their team did not contribute to the 'discussions', and therefore were not involved in team decision making.

The word ‘dialogue’ is reported to originate from two roots within the ancient Greek language, “dia” which means “through” and ‘logos’ which means ‘the word’ or more particularly "the meaning of the word”. Ancient Greek Philosopher Plato is reported as the person to first use dialogue (Bohm, Factor, & Garrett 1991;Senge 2006). Senge (1990) further suggests that dialogue may represent a free-flowing of meaning through a group, allowing them to discover insights they could not achieve individually. In this sense dialogue is not so much a specific communicative form of question and answer, at its heart it is “a kind of social relation that engages its participants” (Burbules 1993: 19), opening them to the flow of a larger intelligence. In the case of the LAFST this was the combined intelligence of the team. Once the participants understood the reasoning behind a facilitated dialogue, and halted the predilection of some individuals’ domination of discussion, their team dialogue developed incrementally with their learning.

As the study progressed it was found, as Bohm, Factor, & Garrett (1991: 3) had before, that “any number of people may engage in dialogue, and that - one can even have a dialogue with oneself”. It did however provide a basis to understand why dialogue was so central in this study to processes of team and organisational learning. While Bohm, Factor, & Garrett (1991) discuss dialogue in its purest form (allowing the nature of the group to dictate the subject, pace and flow), the pragmatic nature of the dialogue facilitated here was determinedly more focused than this. It was subject and service specific, but nevertheless allowed the participants, who sat in a circle talking together, to explore their views on the subject openly and

freely with a shared understanding of the outcomes they were attempting to achieve.

Both discussion and dialogue are important elements of the discourse that occurs in teams as they develop mechanisms, which allow dialogue to take place above and beyond discussion. The purpose of dialogue is to involve group participation, which collects a number of views and perspectives. These are then shared and explored within the group. This takes participants beyond the realm of 'winning individual arguments' towards group thinking and engagement. In dialogue, individuals gain perceptions of the world in which they operate that would simply not be possible to achieve on their own. As Bohm states in an unreferenced quote taken from a series of "Dialogues" that appear in Senge (1990).

> "A new kind of mind begins to come in to being which is based on the development of a common being….People are no longer primarily in opposition, nor can they be said to be interacting, rather they are participating in this pool of common meaning, which is capable of constant development and change." (Bohm in dialogue quoted in Senge, 1990: 241).

With this in mind, it is important to reflect on the process of 'person centred planning' (Sanderson 2000;Sanderson, Kennedy, & Richie 2002) and the different journeys taken by the teams in the study.

Theoretically 'person centred planning', the associated 'thinking tools' of 'Essential Lifestyle Planning' (Sanderson, Acraman, & Short 2004) and the process used in the study (name 'Planning with People') appear to lend themselves nicely to developing dialogue in teams.

These approaches offer a different way of gathering information for individuals and families about what is important to them, what they want for their future and what support they will need to enable them to achieve their desired goals (Sanderson, Acraman, & Short 2004). This is then written up as an 'action plan' (Sanderson, Acraman, & Short 2004) that identifies time scales, personal and professional responsibilities, and preferred outcomes. Once a plan is developed, it becomes an 'organic document' that requires revisiting as regularly as required to make sure identified steps and goals are achieved. This should ensure the achievement of desired outcomes for all participants in the process.

The process involved in developing an action plan that reflects the personality, wishes and dreams of individuals (Sanderson, Acraman, & Short 2004) relies heavily on dialogue. Perspectives of what is important to a person, and the support they will require to achieve their desired future, are shared between individuals, family members, care staff (where appropriate), and professionals (Sanderson, Acraman, & Short 2004). Dialogue achieved through facilitation using the specific language and questions that make up the PCPTs, is then used to bring about synthesis of these perspectives which are then written up as an agreed care plan for an individual, and shared action plan that supports consistency and sustainability.

This appreciative process heavily influenced the journey taken by the teams in the study towards developing an approach for organisational learning. Understanding the different elements needed to create a learning organisation requires an understanding of the

learning process involved at the individual and collective level (Robey & Boudeau 1999), and how this was either promoted or opposed by the contextual factors in which it was delivered. Based on an understanding that individuals are the organisation's primary learners it was clear that the actions of individuals in the teams (Love, Huang, Edwards, & Irani 2004) would be crucial during the early days of the study when they were attempting to become a learning organisation. This was particularly significant in the case of leaders (Senge 1990;Senge 2006), as it was they (and their actions or non-actions) that were central to the success, or otherwise, of the teams in their attempts to become learning organisations.

Whereas routinized individual and collective actions in the Children's Centre and Obesity Support Teams engendered incremental learning, non-routinized actions within the LAFST became a critical source of innovative and creative learning (Miner & Menzias 1996). The learning that took place in the LAFST, through the action learning process (Winter & Munn-Giddings 2001), was gained through their repeated actions. The team used the appreciative PCPTs in a manner that generated dialogue through several phases of development. These phases of dialogue are central to this thesis and these stages can be termed naive, developing, maturing and embedded dialogue. This dialogue enabled them to identify new solutions and increasing possibilities for their practice using their combined team IQ (Senge 1990).

The team learning was iterative and incremental in its evolution of style, sharing and delivery. As individuals within the LAFST gained

confidence, their practice and shared experiences reflected the beginnings of non-routinized learning and engendered a growing demand for new knowledge, interpretation and action (March, Sproull, & Tamuz 1991;McNiff & Whitehead 2000;Nonaka 1994) that enabled the team to make sense of unfamiliar and non-repeated activities. This team's shared learning and embedded dialogue supported team performance that far outstripped the expectations placed upon them at the beginning of the study. The team understood and embraced the importance of having an appreciative approach to each other and their service users that informed a continually improving and developing organisation and a framework for sustainable, iterative learning to take place.

5.11 Learning about power and its influence on the study

On reflection, perhaps I entered into this process of Action Research with high levels of naivety. Prior to the study I had worked predominantly with person centred planning in practice with children and their families, and as a facilitator and friend developing essential lifestyle plans with people living with learning disabilities.

As the focus of the study moved away from direct service delivery, into the complex field of leadership and team development, I reflected on my previous experience which suggested that the teams would welcome action research methodologies. The LAFST's Team Leader commented, "This process has helped us to create a theoretical framework and operational structure to the way we work." This concisely reflected comments from my previous work with teams. This comment however was made within the context of her

own style of solution focused leadership and ideology of how she wished to lead her team. Similar, indeed almost identical, comments were made by members of the Obesity Support Team, “the framework and structure you have provided for us with the person centred tools is fantastic, we are now really family focused and understand what being person centred means”.

Unfortunately this team were reliant on their senior manager who used his power as an objective force, in a behaviourist manner (see Dahl 1986), by having ‘power over’ his subordinates. He used his ‘position power’ (Handy 1993) to prevent the team from doing what they wanted to do, even though they had evidence from shared learning they felt could positively inform and influence future service delivery that they wished to communicate to his superiors. This misuse of power proved to be disappointing to the team who believed that the work they had undertaken could prove inspirational within their field. They believed that the evidence they gained through their ‘real world research’ (Robson 2002) should be used to ‘bring about change’ for their organisation. They viewed the change they sought as having a cause and effect relationship between what they had learnt and how their learning could be transferred into other areas of the work place.

The power, however, was not negotiable. The result for this team was disappointment and a sense of loss, “we had such a wonderful opportunity to make a difference and he has just thrown it away,” and frustration, “these families, I feel like we have set them up to fail, we are just abandoning them.”

The use of negative power (Handy 1993) by the Team Leader of the Children's Centre also proved problematic. The team leader had repeatedly spoken of her uncertainty for the future of the family support service and appeared preoccupied with the changes she was envisaging. These characteristics fit well with Handy's (1993) assertions that negative power often comes to the fore at times of low morale, irritation, stress, or frustration. The manner in which she utilised this harmful use of power was reinforced as she used her position as a leader in the organisation to control the flow of information through to her superiors. The senior manager she reported to indirectly through her line manager was optimistic for positive outcomes from the study. Unfortunately though, due to the nature of the hierarchical reporting systems in the organisation, she was easily 'kept in the dark' about the lack of engagement of the team as the Team Leader's embellished reports painted a very different story. This was a symptom of how simple it is for hierarchical organisations to set themselves up to fail through poor communication systems.

In this team, the flow of information had been effectively 'cut off' at the source because other members of the team did not have a direct dialogic pathway to access senior managers in the organisation. It would seem that 'the final nail in the coffin' in relation to this team's success was the fact that the Team Leader had sole responsibility for organising the team's involvement through writing staff rotas and timetabling activities for the Children's Centre. In doing so, she appeared to deliberately organise the physical and social environments in which the research should have taken place in order

that her team were unable to engage with the study at a meaningful level.

My role in this study was not hierarchical and therefore I was unable to use the power of my position (Handy 1993) to influence the outcome in terms of the teams' learning, as I had been able to in my 'day job' which bestowed me with a leadership role. The position I took in each team was very different and in each case it appeared that my standing as a facilitator within the team, coupled with the level of power each team leader was prepared to share with their team participants, had a direct influence on the outcome of the study.

As noted in other studies (Collins 2001;Handy 1993;Senge 1990) the leaders in this study were central to the success of the projects and their attempts to become learning organisations. The importance of actions taken by the individual leaders have been clearly identified in the findings. The manner in which they used different types of power to influence the study also stood out. The manner in which these leaders related to their teams defined my role as a facilitator.

The Team Leader of the LAFST was a dynamic and empathic individual who drove the process of action learning and change forward in her service. She believed that a unified team would be in a position to make a real difference for the people that they supported. Her status and reputation within the team allowed her to enter freely into an open dialogue without the restrictions of hierarchical barriers. It was her stated belief, supported by assertions, that the team's collective intelligence far exceeded the IQ (Senge 1990) of

individuals in the team. Her leadership and commitment were at the fore even though she faced a level of apathy from some staff, especially during the early part of the study. It was during these initial stages of the study that this leader turned to my facilitation to support her beliefs. She actively encouraged the team to use my 'expert power' (Handy 1993) to support their learning during their action learning sets.

Expert power is the power that is vested in someone because of his/her acknowledged expertise. As Handy (1993: 130) asserts "in a meritocratic tradition people do not resent being influenced by those whom they regard as the experts." Through the act of bestowing this expert power upon me as the facilitator, the Team Leader skilfully diverted the attentions of those who were less enthusiastic about changing the way the team interacted together on to the process. The result of these actions for this team was their acceptance of my expertise. The team willingly accepted my suggestions and facilitation, readily implementing the results of their embedded shared and dialogic learning and contributed to my presentation of a new epistemology for organisational learning.

While my assertions that the combined effort of the Team Leader and myself influenced the outcomes this team enjoyed, I suggest what occurred was not entirely a result of the power we utilised in a positive way. What I believe took place is closely associated with (Burns 1978)Foucault's (1980) analysis of power. He rejected the idea that power should be viewed as an object. Instead, he asserted that power is not a derivative; it does not exist in agencies or

structures; it is present in the relationships among people as they try to find their own identities and build these on the identities of others.

These team members did not exist in social isolation in their team; through their shared dialogic learning, they negotiated their team identity. The 'new' team that evolved and embedded their dialogue within the organisation was a result of their shared team politics and values. In this case, the team's shared power was central to the development of its 'new identity' but this was not constructed from an entity known as power, rather, power was the identity. As the team embedded their dialogue in their practice, they lived dialogically. The team themselves through their cognitive whole became the identities of the organisation as without them the organisation as it became would not exist.

This view underpins the theory for organisational learning. It is suggested that organisations may only embark on a journey to become a learning organisation once they have accepted the importance of using the cognitive whole of the workforce. Where the PCPTs worked well in this study the Team Leader had a relationship with her team that went beyond the role of manager and subordinates. She demonstrated empathy and a sense of genuine care for the individuals in her team. Her leadership qualities were intense as she drove the team's dialogic learning forward. Those who worked for, and with this Team Leader, recognised and appreciated her commitment to the team with comments such as, "we wouldn't have had the success we have had without (name of Team Leader) being on our backs in the first few months. I suppose that's when I

didn't get what we were trying to achieve," being common during our action learning sessions and frequently recorded in the team's practitioner reflective logs.

The Team Leader's clear commitment to the team and the process of action learning supported her to develop a natural, appreciative, reflective, learning environment for the team. The team embraced their learning and implemented the person centred processes throughout their service.

Reflective learning became embedded in practice throughout the organisation, sharing their thoughts on their practice in their practitioner reflective logs electronically, using the person centred tools to support and inform action learning methodology in their staff meetings, in supervision sessions and even during informal discussions while having lunch or a coffee together. They found that using these methods of communication on a daily basis enabled them to build dialogue progressively until it was complex enough to inform 'new ways of being' for the team and with their service users. Developing dialogue incrementally in this way enabled them to create their 'common language'. This was not a magical process, nor did it involve complex methodology. However, the effects of it were transformational in terms of their shared understanding of their individual and team roles, team purpose and the relationships they established with their services users.

The team leader's approach echoed the concept of transformational leadership (Burns 1978) as she inspired the team to change their

expectations, perceptions and motivations to work towards common goals through the strength of their vision and personality.

Transformational leadership “occurs when one or more persons engage with others in a way that leaders and followers raise one another to higher levels of motivation and morality (Burns 1978: 20). The effect this Team Leader had on her team was such that she gained the team’s collective and individual trust, respect and admiration (Bass 2005).

This team’s dialogue supported their transformation from being a disparate bunch of well meaning individuals, into a dynamic team with a shared vision and understanding of what they were trying to achieve. They appeared to genuinely care about their desired outcomes and this shone through in the team’s new identity. The team created an identity that exuded power, which they channelled through their individual learning and relationships into a sustainable method of dialogic learning committed to the organic process, birth, and rebirth of their embedded dialogue, systems of reflection and action planning. They truly became a learning organisation.

When I discuss how the team appeared to genuinely care for each other, I refer to their actions of reciprocal interaction and dialogue and the manner in which they shared their learning. If, as I believe, an organisation is effectively just a concept without the people who work in it, then as McNiff and Whitehead assert (2000: 104) “power is people, how they are individually and how they are together”. As people’s identities are continually in process of becoming, learning

organisations are sites where people use dialogue to negotiate which identity they will become. Power need not be situated in one part of an organisation, with a learning organisation, it is universally present: " power is not a game to be played; it is the nature of the game itself" (Dyrberg 1997: 93)

Attaining the levels of dialogue this team achieved required dedication and commitment. Initially the team operated within a structured hierarchical culture where they acted out their individual roles as directed, or they learned how to behave through observations of others in that role (Harre & van Langenhove 1999). This approach worked for those whose titles demanded respect, for example, 'Senior Family Support Worker' as it made them feel important and gave them authority to operate 'power over' people (Dahl 1986). However, it did not work for the service, as by their own admission the very people who held the power did not fully understand their own or the team's reason for being.

As the team learnt through their 'cognitive whole' using conversational processes on a variety of interventional, intrapersonal, interpersonal and cultural levels to inform their praxis, they realised they could achieve their shared desired outcomes. Through these discourses, guided by the structure of the PCPTs, the team created their own identity and their dialogic learning created the context in which they worked.

The reality for the other two teams in the study was very different: their hierarchical structures remained rigid and central to their

functioning throughout. These two organisations had fixed structures, ‘there was a place for everybody, and everybody had their place’. In comparison to the shared, dialogic learning approach of the LAFST, this felt disrespectful to individuals who were not enabled to share their intelligence with the team and were viewed as dependent on authoritarian leadership.

The barriers to organisational learning were transparent as these leaders established deep power relationships and formed a team identity where the individual team members were expected to fulfil the roles created for them. The ‘position power’ (Handy 1993) bestowed on these leaders by their respective organisations allowed them to further wield their decision making power by withholding important information and feedback about their respective teams involvement in the study; information which may have been used to benefit their services.

In the absence of the steadying influence of a senior leader, the team responsible for the Obesity Support Project also willingly accepted my status of holding ‘expert power’ (Handy 1993) in terms of facilitating their thinking.

Initially, I felt privileged as this team granted me ‘personal power’ (Handy 1993) also referred to as charisma. The team appeared to respect the popularity I had gained through my person-centred work in other areas of their Primary Care Trust.

Initially, the Obesity Support Team was tremendously successful, creating a new service with very limited financial and physical resources. Sustainable success, however, was thwarted by the senior manager's use of 'negative power' (Handy 1993). This manager's position power (Handy 1993) allowed him to act as an 'expert filter'. His delayed reporting of the team's success to the Primary Care Trust's hierarchy halted progression through lack of funding. The senior manager only referenced his own perspective of cost effectiveness when reporting back within hierarchical circles, as opposed to offering a shared understanding of how the process could be adapted to benefit their service delivery methods at no or little expense to the organisation. This resulted in his subordinates making negative comments about his intellectual abilities, priorities and commitment to the development of service delivery. The result of this use of 'negative power' proved demoralising for staff and resulted in what appeared to be a premature end for the project.

The use of 'negative power' (Handy 1993) was also predominant in the approach of the Children's Centre Team Leader. This person repeatedly spoke about the uncertain future for Children Centres and her concern about the future role for family support in her service. She too used 'negative power' (Handy 1993) to filter and distort information about the study. During action learning sets, this Team Leader was repeatedly asked if she had shared concerns about her team's lack of engagement with the study, with her superiors who were eager for the study to be a success. The action she took harmed her team making a meaningful contribution to the study. The information she did share about her team's involvement was

untruthful and this took some months to be recognised. Once the true extent of the team's lack of involvement was appreciated, her superior's response was to introduce peer-checking procedures through the Team Leader of the LAFST, as a chief reporting mechanism. Unfortunately, this only occurred towards the end of the study and therefore had no impact on the findings.

5.11.1 Shared power central to the success of Action Learning

When I considered combining PCPTs with the process of action learning to underpin this study, I had not thoroughly acknowledged the significance that relations of power may have in terms of identified outcomes for me or the participants. 'Power' was raised as an early issue in all the teams and continued as a central theme in terms of success enjoyed and challenges faced by the teams. I should have recognised this, as I acknowledge that power has for many years been one of the most central and contentious concepts in the social sciences.

Lukes (2005: 1974) asserts that there are "three faces of power": The first, overt power is typically exhibited in the presence of conflict in decision-making situations, where power consists in winning, and prevailing over another or others. This 'first face of power' resonates with Dahl's (1986) assertion of power being exerted 'over' others in social relationships.

Lukes' (1974; 2005) 'second face of power' places it within social contexts, building on the work of Bachrach & Baratz's (1962) covert

power and consists of having control over what gets decided, by ignoring or deflecting existing grievances but continues to be studied in relation to behaviour. However, the idea of power expands from the concept of an individual holding 'power over' another, to individuals devolving 'power to' others. In this sense, power may now work in two ways as it is socially constructed and negotiated and thus provides individuals with the choice of how they use their power.

The 'third face of power' Lukes (1974) argues is the power to shape desires and beliefs, thereby averting both conflict and grievances. Lukes (1974) offers a critique of what he views as the inadequacies of the first two 'faces of power' which he suggests are behaviourist and subjectivist, with the use of power perceived solely in relation to decisions taken by individuals. Lukes (1974) third face of power is characterised by 'no decision' where power does not necessarily stem from decisions but from patterns of social relationships. Because individuals are sometimes unaware how their relationships influence them to use or be the objects of power, there is a possibility that their power may become systemic and modelled culturally within a group or become institutionalised within a team or organisation. Practice influenced by an individual's 'inaction' (as in the case of the Obesity Support Team) is still a case of a power of domination where power is located and used within a hierarchical social order.

The notion of power being an object is not compelling. Power, as evidenced in these findings, is found in identities created from dialogically formed relationships. Where the participants engaged in

a dialogue about their practices they developed their sense of individual and group identities. As their levels of dialogue matured and became embedded in their practice, their power reflected the quality of their relationships. The team's power became autonomous and their appreciative, person centred discourses influenced all aspects of their service.

The process of action research encouraged the participants to become 'active knowers' (McNiff & Whitehead 2000), individually and collectively taking responsibility for finding solutions to their workplace based challenges through their "common language." In an action research study, knowledge work implies knowledge of self as well as knowledge of facts and procedures: the development of personal awareness, the capacity to learn and adapt, the ability to work with others. Terms such as 'development', 'capacity and 'ability' are terms of influence, aspects of discourses about power all of which were brought to the fore during the course of the study. However, without the structure of the person centred tools it is unlikely this team would have been successful in implementing their learning.

The team initially required more than a facilitated dialogue to support their collaborative thinking. They needed to develop their own 'thinking environment' (Kline 1999) and the person centred tools gave them this structure. Without the need for direction or coercive facilitation, individuals in the team found their own way in terms of learning by using the headings of the tools to inform their acquisition of knowledge. They recorded their evidence and shared their

reflective practitioner logs in a variety of environments. In doing so they shared their claims for improving practice and sought validation from their peers. Recording and sharing their learning in this way supported their dialogic learning and created a peer validated, sustainable, iterative method of knowledge acquisition and sharing.

Supporting an action research methodology using the structure of the person centred tools was central to this team demonstrating how they were able to transform their newly acquired 'ways of knowing' into cooperative practices (McNiff & Whitehead 2000). The extent of their success must be accredited to their Team Leader who recognised that the power of success and growth for her team lay in the relationships the team developed, her relationship with the team being central to this. In contrast the failure of the other two teams in the study to achieve any tangible levels of sustainable change lay in their leaders preference to control the service through a 'power over' (Dahl 1986) relationship and to maintain their status as 'expert knowers' (Handy 1993).

5.12 Engagement through praxis

Where 'engagement' occurred in the study there was a measure of perceived success in terms of the teams implementing the PCPTs and processes.

I believe the reason engagement did not occur in any real sense within the team based at the Children's Centre may be attributed to the manager operating with a different 'mental model' than that

present within the other two teams. Senge (2006: 16) explains that "...new insights fail to get put into practice because they conflict with deeply held internal images of how the world works, images that limit us to familiar ways of thinking and acting." Dialogic Learning and Person Centred Planning. In this case, the Team Leader who overtly stated her commitment to the study to her line manager covertly expressed her cynicism about the study within 'confidential' action learning sets. Her actions of non compliance suggest she was never intending to engage meaningfully with the study. This concurs with the assertion of Argyris, Putman, & Smith (1985) in Senge (2006: 164) that while people do not always "behave congruently with their espoused theories (what they say), they do behave congruently with their theories-in-use (their mental models)".

Where engagement did occur the conversations staff had together changed to seeking out solutions as opposed to being 'problem based'. This supported staff to develop stronger partnerships and relationships with fellow professionals and service users and was evident in a kind of 'principle-centred and collaborative praxis'.

The praxis within the teams who had used their action learning sets to learn to 'care for themselves' (Lee 1997) using the person centred tools as a form of reflective self evaluation developed a mindset that embraced organisational learning and creativity. This supported team praxis and engagement with the process and a developing confidence within the team as they shared their learning within what quickly became a solution focussed environment. The teams' praxis underpinned by, what I perceived as a sound and impressive

ideology, allowed them as individuals to feel comfortable in experimenting with “new” types of conversations with their service users.

These “new” conversations appeared to open a “different type” of dialogue with service users which empowered a shared decision making process. This dialogue changed the manner in which the service users accepted and worked alongside the team. They moved from a “defensive, problematic” stance, which placed a barrier between the service and the person receiving it preventing “meaningful interaction” from taking place, to a positive and productive dialogue which engaged the service and the family together, creating a relationship which prompted one service user to ask “Why doesn’t everybody work like this?”

The team’s engagement with the process generated reflection, and in turn this created new actions and a cyclical process of new learning developed. The team’s collaborative praxis became established as a habitual practice which was intimately related with an autonomous, respectful and ‘caring praxis’ (McNiff & Whitehead 2000).

The team shared and applied their newly acquired knowledge and caring praxis and, through reflective learning, they began to use their developing theoretical understanding of the process during informal meetings. Using “team reflection” in this manner helped the team to slow down their thinking processes and to challenge some of their existing practices, which fed into familiar ways of working, thinking, and acting. In doing this they altered their team’s “mental model”

(Senge 1990;Senge 2006) through the introduction of the tools to inform their staff meetings and formal supervision sessions.

Eventually the tools and associated processes embraced the whole of their service delivery and communication systems, embedding their ‘common language’ through a shared dialogue, thus ‘institutionalising their practice’ (Senge 1990; 2006). This change in the ‘mental model’ of the LAFST was attributable to leadership within the team.

Without the whole process being owned and driven forward with enthusiasm and gusto by the Team Leader, it is unlikely that there would have been a sustainable level of engagement and commitment from the team members. Reports within the ‘Practitioner Reflective Logs’, and comments during ‘action learning sets’, demonstrated the amount of energy the Team Leader needed to help the team achieve the levels of change. Her leadership was proactive and progressive ensuring that the person centred tools and processes permeated every aspect of the team’s functioning until it became embedded in the fabric of the organisation. A Family Support Worker succinctly reported this, “…we used to work as individuals and had no real framework to work in, now we use each other as mini experts in the tools and have our common language.” Using the team’s shared skills and knowledge brought a consistency to their service delivery the team had not experienced before.

This reliability in terms of service delivery and dependability in terms of teamwork supported the team members’ application of their caring

praxis in interventions with service users. Individuals spoke of a "greater belief" in their team interventions and of "deconstructing" the previous "top down culture" of their service delivery which had reportedly "marginalised" and "oppressed" their service users. Using the same tools in praxis as those used to inform their team learning underpinned a truly holistic approach to the team's work. Together they placed a strong focus on developing meaningful dialogues with service users, which took longer in terms of practitioner time and effort, but resulted in a demonstrably stronger focus on eliciting the service user's personal and family perspectives of their social care needs. This process proved successful in "placing families at the centre of their care plans" which in turn "reduced the power differences" through shared ownership of care plans.

5.13 How do the Person Centred Planning Tools inform leadership and organisational change?

The same principles of parity and fairness that apply to AR and AL apply to the processes of person centred planning and dialogue. Essentially a dialogue is a conversation between equals. Therefore, dialogue is power and hierarchy free.

While I was confident that the PCPTs would generate and inform dialogue across the teams during action learning, praxis and reflection, I was mindful that concerns have previously been raised about the success of using dialogue in organisations. The nature of this doubt is placed within the factors of colleagueship and hierarchy, the latter of which Bohm (1965) asserts is diametrically opposed to dialogue. As demonstrated in this study, it is possible to facilitate

dialogue in teams while maintaining the necessary element of 'playfulness' (trying out new ideas in a safe environment and seeing their potential to support praxis in the real world). Bohm's (1965) concerns related to arenas where fellow workers would become overly concerned with "who said what", or "not saying something stupid". While it is clear why Bohm (1965) held these reservations about using dialogue successfully in organisations it did not deter other authors from appreciating and testing out the potential benefits (Mazutis & Slawinski 2008;Senge 1990).

Creating an environment where dialogue is able to flourish within a shared team environment required the participants to be empowered to think freely and uninhibitedly. Within health and social care settings there is often 'fragility' within individuals because of the sensitive nature of their work. It is therefore imperative that any 'controlling authority', no matter how carefully or sensitively applied, is left out from the process. If hierarchy, control or power are present within dialogue it becomes vulnerable to being manipulated (Bohm, Factor, & Garrett 1991). While it is important to acknowledge this vulnerability in the process, this is not consistent with the spirit of dialogue.

In order to ensure that dialogue is effectively implemented within team and organisational learning the findings accord with Senge (1990) that there must be a 'facilitator' who "holds the context" of dialogue together. As I facilitated the action learning dialogue of the teams using the 'person centred tools' I was able to ensure that the

teams and individuals maintained ownership of the process and the outcomes.

Sessions were facilitated in a manner that maintained the participants' focus on the action research process and the dialogue evolved from their action learning; the facilitation enabled the 'free flow of meaning' to pass through the groups by diminishing any resistance to the flow.

It is clear from the findings that engagement and meaningful dialogue within the research sites for this study became synonymous with each other. This occurred when I began to facilitate the teams' learning. Team learning, dialogue and the process of person centred planning cannot be viewed nor perceived as 'one off' events, or things that we do to, or with, others. Rather they are organic processes that grow and develop with the team or organisation that use them. This concurs with Buber (1965) who placed dialogue in a central position in his philosophy and saw dialogue as an effective means of on-going communication (rather than as a purposive attempt to reach some conclusion or to express some viewpoint(s).

The dialogue referred to here is far more than just a record of conversations or transcripts of interviews. This dialogue captures the interaction between what the participants learnt through the action learning, the processes of training and acquiring new skill sets, perspectives and ways of working and their existing knowledge. Once embedded as team praxis this person centred dialogue proved beneficial to all of the services as it informed a dynamic, appreciative

approach to team leadership and performance alongside service provision.

CHAPTER SIX: CONCLUSION

All improvement requires change, and improving quality in health and social care settings involves changing the way that things are done, changes in processes and in the behaviour of people and teams of people. Whether a quality improvement programme encompasses the whole organisation in “macro” change, or whether a team of people is reorganising a single clinic on a “micro” scale, the same principles of change management apply.

Where successful the process in this study moved beyond shared processes of learning how to learn, and developing ways of sharing this knowledge, to embedding a culture of appreciativeness and inclusivity through dialogue and praxis. I believe this is what distinguishes the process I used in this study from other interventions. Reflecting on the experience of the three teams I studied it is clear that this is not easily achieved through praxis. Nonetheless, as the pace of environmental change accelerates, health and social care organisations will be required to find more rapid change processes for organisational renewal. The great promise I believe my model of appreciative, dialogic learning offers is the capability to generate self-sustaining momentum within an organisation toward actualizing the values that lead to superior performance.

6.1 Towards Organisational Learning

Broadly, this study has overseen the integration of three evidently distinct bodies of literature; Person Centred Planning, Appreciative Inquiry and dialogue facilitated through action learning. The synergy

created by the fusion of these three approaches suggests that the dialogic learning emanating from the study has noticeable and important connections for, and to, organisational and interpersonal learning.

Given the complexity involved in becoming a learning organisation it is not surprising that around 80% of organisations attempting substantive, organisation wide change fail to fully implement the process (Buckingham & Coffman 2001), yet many persist because when it works the benefits to the organisation are irrefutable. Through this action research study I suggest a new process that, if replicated, may prove beneficial to the implementation of organisational learning within health and social care settings.

Based on my findings, I propose the implementation of an appreciative style of leadership, underpinned and informed by a number of PCPTs. This would require the organisation to have a shared vision, a commitment to enabling teams to understand their shared purpose (and the role of individuals in the team) in order that they may be successful in supporting the team to achieve it purpose. Success in attaining this requires clearly identifiable team and individual goals, targets and outcomes. In order to accomplish this, leaders will need to understand ‘what is important to’ team members, and ‘how best they should be supported’ in order for them to be successful at a personal level. This should be complimented with knowledge of the diverse skills and talents that individuals bring to the team, and how best they may be harnessed.

This style of leadership, supported through the medium of ‘action learning’, when implemented effectively and flexibly, would appear from the findings of this study capable of continually informing practice and supporting learning from practice to deliver personalised services. The success of personalised service delivery in this study was closely associated with the maturity of dialogue within the teams providing the service. This process supported the team development to be as personalised as the service they delivered. This approach to dialogic learning informs an ‘organic’ process in which participants appear to learn from supportive, mutually productive, developmental relationships. Such relationships are complementary and important components of team development that have long been associated with organisational effectiveness. Dialogically developed relationships are central to the theory of organisational learning as they respect the organisational values and support progress towards achieving organisational objectives.

In my experience, extant practices for learning appear to bypass such relational development in favour of either practice field experimentation or conventional non-relational methodologies. The approach used in this study introduces a concept of individual and team mentoring. It uses person centred planning as an especially viable tool for the relational development and generative processes expected by learning organisations. This concept of team learning appears to stem from a dialogic understanding of the nature of relationships and contrasts sharply from the conventional understanding of professional developmental relationships. In so doing, this understanding contributes to the development of a type of

progressive dialogue, which once teams follow through its different levels becomes embedded and contributes to authentic transformational practices. This process, if repeated, may prove effective for organisations who aspire to learn.

It is argued by Dick (2004), and evidenced in my findings, that extant practices for organisational learning divert focus from relational development, community building and cultivation of dialogic processes, in favour of a more traditional emphasis on organisational knowledge products. All of the participating teams made use of conventional mentoring relationships through what they viewed as viable organisational mechanisms for both relationship and community building and the sharing of learning practices. These were understood, utilised, and enacted around monologic themes, with an over reliance of practitioners 'cascading' their learning throughout the organisation with no agreed means to do so (in terms of dedicated time or opportunity) and no checking processes to ensure learning had been shared.

While there was an expectation for individuals to share their learning from training events, there was not an expectation that their learning should be shared and informed by exploring the perspectives of their peers, nor that they checked understanding and meaning with their colleagues. The fusion of the specific tools and action learning process within this study, supported dialogue (Bakhtin 1981;Buber 1965) and introduced a methodology for Appreciative Dialogic Learning that appears particularly suited for organisations aspiring to

become learning organisations (as well as presenting opportunities for further practice based research).

Action research literature is rooted within human services, particularly within health and social care. There are texts that advise how individuals (Stringer & Dwyer 2005; McNiff & Whitehead 2006) should undertake action research, how it may be used to inform organisational change (McNiff & Whitehead 2000) and to empower service users to take part of their own research subjects (Ramon 2003). What I believe this study adds to the literature is an example of 'how to do it' and how organisational learning can be achieved using a framework that complements the familiar process of action research.

I came to understand that organisational learning cannot take place outside of the cognitive reasoning of individuals. However, I needed to understand whether this learning is an experience of cognitive refinement (Kolb 1984) or a continuous process of behavioural adjustment (Cyert & March 1963). Miner & Menzias (1996) suggest that both these schools of thought have equal relevance and are indeed complementary to each other. Therefore, during this study the cognitive and behavioural aspects were not separated due to the mutual reinforcement between the two (Fiol & Lyles 1985), but an integrative aspect was required. The integrative aspect in this study was introduced through the action learning process (Winter & Munn-Giddings 2001) and shared person centred tools. As the participants became more familiar and confident with the tools, they began to use them with families on a daily basis.

During the first three months of the study the participants began to familiarise themselves with the person centred tools and the process of action learning. Initially it was common for them to concentrate on using the tool they felt they had most affinity with and were most at ease practicing. While the teams, as a whole, were enthusiastic about their ‘new tool kit’, their recording of information and understanding of how it may be used to better inform their practice remained relatively naive. This naivety was demonstrated as much by what was omitted from their records and dialogue about their interactions, as it was by their actions.

Encouragingly though individuals were collecting more information from their interactions. However, this appeared only to inform better recording as opposed to detailed action plans. As the teams began to gain a better understanding of their work through shared learning, this began to change. Through team dialogue, they began to gain a much deeper, clearer understanding of how they were developing as individuals, and as a team, through their collective understanding. This enabled more effective planning with families than they had previously achieved.

This process of shared learning was most successful where dialogue between team members and with their service users continued to develop. This, in turn, began to inform the teams’ dialogic learning. It enabled individuals to make a clear move from gathering information to using the new richer, fuller information to inform shared decision making and action planning processes between individuals, the team and with their service users.

Effectively the LAFST achieved symmetrical communication (Carr & Kemmis 1986;Grunig & Hunt 1984) which demands, like dialogue, that all members of the team are considered as equals and contribute equally (but differently) regardless of their rank or position within the hierarchy of the organisation (Carr & Kemmis 1986).

The success or otherwise presented through this process of dialogic learning was dependent on the management of the communication and information gathered between the team and their service users. The two 'world views' represented by these models characterise the purpose of the communication processes as asymmetrical (egocentric) and symmetrical (altruistic or others-oriented perspective) (Grunig 1987). Organisations with a symmetrical worldview represented in this study by the Local LAFST and, to a lesser extent, at team level, the Obesity Support Team, used their developing dialogic learning to inform interactive practice.

Through this connection of learning and practice, team cognitions and attitudes supported team dialogue in a manner that created a real synergy between the participants that proved symbiotic. The foundations of the symmetrical worldview that underpinned praxis in the LAFST lay in their development of dialogic learning. As they used the action learning process to develop their 'common language', their communication between team members and with service users provided a shared understanding of their teams purpose and individual roles. The team's shared learning created a sense of holism, where they learnt 'what was important to' each of them in terms of how they supported each other to work to their maximum

potential in a personalised environment. The personalised system of dialogic learning created by the team supported interdependence, a moving equilibrium, equality and autonomy that allowed their non-routinised behaviour to reinforce new and innovative practice.

Dialogue, shared through decentralised leadership, encouraged individuals to take responsibility for team learning and service development. Once the team's dialogue had become embedded through praxis it also underpinned conflict resolution between team members and with service users through a type of group liberalism (Grunig 1987).

Conversely, organisations with asymmetrical worldviews, as demonstrated through the leadership of the Children's Centre, and senior manager of the Obesity Support Team communicated with their teams using the negative power presented to them through their positions (Handy 1993). Leaders such as this attempted to change the cognitions, attitudes, or behaviours of their team members and consequently the organisation through closed communication systems (Grunig & White 1992). Typically in the teams with the asymmetrical worldview the behaviour of individuals in the team was routinized (Miner & Menzias 1996), while leadership was efficiency based, elitist, reluctant to accept change, traditional and governed centrally (Grunig 1987).

In summary, where symmetrical communication was achieved in this study, dialogic learning was central to the process. From the outset, leadership at all levels of the LAFST was intent on initiating a

process they believed would change their service positively and productively. A commitment to change, and to personalising their service, created a focal point for achieving symmetrical communication. The assumption at work here was that each individual in the team had knowledge, skills, capabilities or talents in a particular area that needed to be identified and utilised effectively. Without this in place, it would be extremely difficult, if not futile, for organisations to achieve a significant change in their practice. These conditions (Handy 2000;Kline 1999;Zuber-Skerritt 2001) were demonstrably met in the LAFST, which was fully backed by senior managers responsible for, and committed to, implementing the identified outcomes and policy development that would allow non-routinised change to take place. Significantly, where these conditions had not been met in the Obesity Support Team and Children's Centre, their asymmetrical communication supported only routinised change to their service delivery.

6.1.1 Dialogic Learning a model of Organisational Learning: the stages of dialogue

The use of dialogue by the teams in the study developed in its complexity as their understanding of each other and their shared vision developed. At the outset of the study most of the participants from the Local Authority and Children's Centre Teams "thought" or "believed" their organisation had a vision statement but none were able to identify any components of the statement or comment on what it was trying to achieve. Although all of the participants from the PCT led Obesity Support Programme were able to recite the 'strap line' for their organisations 'vision statement', "To Save a Million

Lives", none were able to identify their individual role, team role or team purpose in supporting the organisation to achieve its vision. This is a common occurrence as many organisational visions are shaped by those within hierarchical positions who then dictate their vision to teams and individuals without translation of what they are attempting to achieve (Handy 1993;Senge 1990;Senge 2006). Creating a vision in this manner is counterproductive, no matter how 'heartfelt' it may be (Senge 1990).

Building a shared vision involves engaging with all members of the organisation in a shared dialogue aimed at understanding why they exist, what they are trying to achieve (their team purpose) and what they need to do individually and collectively in order for them to be successful (their individual and team role).

In his study of health based organisations Garside (1998) found this foundation for developing learning within public organisations to be missing. He suggested that a process which links the vision of the organisation with the vision of individuals and teams on how they intend to achieve the organisations' named outcomes, would be valuable in the field of health care and support.

My findings suggest that dialogue is an essential element in supporting the development of teams' understanding of their role and purpose in delivering family support services. As this study progressed, the teams all engaged in different levels of dialogue. It was the level of engagement accompanied by the level of commitment to the process by the individual leaders, which appeared

to be central in their perceived levels of success.

In this and the previous chapter, the aim has been to introduce a theoretical understanding of how embedding appreciative practices through a synthesis of three dialogue based theories of human and organisational development, (person centred planning, Appreciative Inquiry and organisational learning) can alter and positively enhance ways of working.

Using the PCPTs and associated processes to underpin an Appreciative Inquiry allowed me, as a facilitator, to begin this study of the individual teams' discovery by celebrating their highest achievements, core values, and shared aspirations. In my experience, these important factors are rarely sought or shared within health and social care settings, where service delivery is something that is done and where there is little time for staff to reflect on 'what is working well' and 'what is not working well' in their service. It is a methodology that began a dialogue between the individuals, expanded through the teams and (where most successful) built dialogically to embrace and declare service wide intentions and actions. Informed by social constructionism, this study asserts that individuals in the teams who share their learning across the organisation in relationship with each other can and will co-create a more effective future.

The methodology appears deceptively simple, yet where it worked well the outcome was a system that supported sustainable whole system change in an appreciative learning environment. The

solution-focused system reverses the expectations, practices, and limitations of traditional problem solving methodologies. However, although deceptively simple to implement, it also challenges 'power relationships' requiring a basis of power sharing. Consequently, it requires a significant shift in attitude, language, and leadership style that proved difficult for two service leaders to accept.

The manner in which the leaders involved in this study exercised their power had a significant impact and was closely linked to the performance of the teams in terms of actions and praxis. The application of power proved to be either a catalyst for synergy where the team members thrived within an appreciative, shared learning environment or as an obstruction to reflexive practice. The Team Leader of the LAFST strove to share her power with (Follett 1924;Handy 2000) her team, which enabled her to maximise their full potential by recognising their individual skills, knowledge, and talents and utilising them to meet the best interests of the team and service users. The opposite effect was noted in the other two projects where to different degrees the teams were managed in a stifling 'power over' (Dahl 1986;Follett 1924;Handy 2000) environment. Used positively, power bestowed the ability on the team to reach practical agreements through shared perspectives and coordinated understanding among the service providers and their service users. This appreciative use of power supported the development of a common language and created a platform for action through praxis.

Consciously sharing power with her team was not an easy pathway for the Team Leader of the LAFST, especially as there were a

number of tensions and conflicts evident at the outset of the study. However, creating an environment and systems that promoted reflective practice enabled the team to acknowledge their tensions and conflicts and to work out together what they needed to do to reach a compromise. This transformative action supported the team's dialogic learning and informed praxis.

CHAPTER SEVEN: RECOMMENDATIONS

7.1 Recommendations from the study

Managing change in Health and Social Care Settings through Dialogic Learning has proven difficult to achieve. This study suggests (contrary to a commonly held belief that change must involve the whole organisation and be undertaken simultaneously) that working in silos may prove beneficial. Services are not seamless (although this is what service users may ask for) they need clear seams (or framework and structure) to underpin individual roles and team purpose. Leadership is also important to change management, yet there is inconsistency across health and social care services in terms of levels of training available for leaders, and leadership styles. Working in silos allows teams and individuals to make a difference within a part of a service and then to share good practice with others (when they are ready to do so, and others are ready to receive it) which may be copied and replicated.

Introducing change through shared learning appears to influence service development by spreading what 'is learnt' as good practice. Once reflective, dialogic learning practices are embedded, individual and team development becomes systematic.

I recommend therefore that organisations consider the strengths of their leaders and introduce change incrementally through receptive, reflective leaders using action learning to inform the process.

For change management to be effective organisations should

consider making resources available for their leaders to support them with the theoretical understanding and knowledge they will require to be successful. Important areas for investment I suggest are:

- Provision of allocated time and space for reflective practice to take place and be supported
- Strategic and operational leadership skills
- Implementation of programme management
- Strategies for staff support and management

7.2 Recommendations for future research

I originally designed this study to explore the benefits of using Person Centred Planning to inform service delivery across three separate but related services. This resulted in a fusion of three approaches to social inquiry informing a dialogic approach to organisational learning. I believe it would be useful to explore this developed approach in a number of different health and social care settings against other change methodologies in order to confirm, or otherwise, its usefulness as a tool for change management. I would strongly suggest that any future researcher adopting this approach should consider the following facets:

- Has the organisation developed a shared vision?
- What will success look like for the organisation?
- How will the team members receive training in the philosophy and use of the person centred planning tools in the context of organisational change?

- What is important to the organisation about how it delivers its services?
- What support does the organisation require from its staff, partners, stakeholders, and service users in order to be successful?
- What is important to the organisations staff, partners, stakeholders, and service users about the services they receive?
- What are the desired outcomes for the study in terms of service provision and service user experience?
- How will team learning and service quality be measured in terms of outcomes for the organisation and people who use their services?

The potential role of action research to incorporate direct participation in strategic planning cannot be ignored and needs to be embraced by health and social care organisations as a means to integrate education, research and practice development.

Organisations need to ensure that the learning from various locations where services are provided, (such as peoples' own homes, residential establishments, hospital wards, community based clinics) is pulled together and integrated through action learning, in order that it may inform change holistically.

7.3 Recommendations for Health and Social Care Practice

7.3.1 Creation of a flourishing culture for health and social care service delivery

The priority placed on high quality health and social care services means that the service providers are often working in complex, and sometimes difficult, circumstances. Competing organisational and service user demands, within a culture that is traditionally resistant to change, can arouse a variety of feelings in teams and individuals who work within them, including anxiety, fear and stress.

All organisations need their employees to perform to the best of their ability. The traditional style of management within health and social care has been to create systems that identify staff weaknesses as opposed to appreciating what they are good at and do well.

Teams are made up of individuals who have their own unique characteristics. Harnessing what people do best, in a system that manages around their weaknesses, enables individuals and teams to develop within an appreciative and supportive environment. Leaders who understand what motivates and drives individuals to be successful can focus on these strengths to create a flourishing organisation.

7.3.2 Creation of a shared organisational vision

A clear understanding of its purpose, desired future outcomes, and how it intends to achieve them should generate an organisation's shared vision. In health and social care organisations, each team will

have its own identified purpose that clearly defines its role in supporting the organisation to achieve this vision. In turn, each individual has a shared responsibility to the team achieving its purpose.

These individual and team roles are essential if the organisation is to achieve its desired outcomes. When a team thoroughly understands its purpose, individual team members become motivated and highly productive. In addition, individuals more easily agree on the important things that they need to work on to achieve desired outcomes for service users and the organisation.

7.3.3 Managing support mechanisms for successful teams

All successful organisations have clear structures and frameworks that staff must fit in with. These are underpinned by policies and procedures that staff are expected to adhere to. The management of this is key to developing successful teams. Teams comprise of unique individuals, and unique individuals require different things from people who lead them. If staff are to perform to their maximum potential then leaders need to understand what is important to them as individuals and how best to support them.

7.3.4 Becoming outcome focussed

Working towards an organisation's desired outcomes is a complex process. Therefore there should be clear and identifiable goals and targets established to enable the organisation to measure the success or otherwise of progress being made towards their desired outcomes.

It is important that the organisation considers how they will record and measure the performance of the organisation, teams and individuals working within it. How they will review the work of the organisation, teams and individuals within it, and design action plans that ensure what is working continue to work, and provide a rapid response to change what is not working.

7.3.5 Developing reflective practice in a learning environment.

Reflection is just another name for an organised approach to thinking. Most people reflect on things that have happened throughout the day or in the past. When people purposefully think about some event or experience with a view to improving how we act or react, this is *reflective learning* or *reflective practice*. I recommend the use of practitioner reflective logs to help organisations, teams, and individuals to understand, think about, and learn through practice and experience.

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APPENDIX 1

Ethics Approval Letter:

Cumbria and Lancashire B
Lancashire & South Cumbria Agency
Room 1.08
3 Caxton Road
Fulwood
Preston
Lancashire
PR2 9ZZ

Telephone: 01772 221428
Facsimile: 01772 221435

02 March 2007

Mr Clive Acraman
Children's Centre Manager
East Lancs PCT
31/33 Kenyon Road
Lomeshaye Industrial Estate
Nelson
BB9 5SZ

Dear Mr Acraman

Full title of study: **The Application and Evaluation of Person Centred Thinking Tools, Essential Lifestyle Planning and Family Essential Lifestyle Planning within service delivery for children and their families.**

REC reference number: **07/Q1309/13**

The Research Ethics Committee reviewed the above application at the meeting held on 23 February 2007. Thank you and Mrs Walmsley for attending to discuss the study.

Documents reviewed

The documents reviewed at the meeting were:

Document	*Version*	*Date*
Application	5.3	09 January 2007
Investigator CV		
Protocol	2	
Letter of invitation to participant		
Participant Information Sheet: staff	LREC assigned version 1	
Participant Information Sheet: Parent	LREC assigned version 1	
Participant Information Sheet: Child/Young Person Park	LREC assigned version 1	
Participant Information Sheet: amily Support & Young People	LREC assigned version 1	
Participant Information Sheet: Children & Young People	LREC assigned version 1	
Participant Information Sheet: Foster Carer	LREC assisgned	

	version 1	
Participant Information Sheet: Parents	LREC assigned version 1	
Participant Information Sheet: Staff	LREC assigned version 1	
Participant Information Sheet: staff	LREC assigned version 1	
Participant Information Sheet Park Staff	LREC assigned version 1	
Participant Information Sheet: amily Support Parents	LREC assigned version 1	
Participant Consent Form: Foster Carer	LREC assisgned version 1	
Participant Consent Form: Park Parents	LREC assigned version 1	
Participant Consent Form: Staff	LREC assigned version 1	
Participant Consent Form: staff	LREC assigned version 1	
Participant Consent Form: Park Staff	LREC assigned version 1	
Participant Consent Form: Family Support Parents	LREC assigned version 1	
Participant Consent Form: staff	LREC assigned version 1	
Participant Consent Form: Parent	LREC assigned version 1	
Participant Consent Form: Child/Young Person Park	LREC assigned version 1	
Participant Consent Form: Family Support & Young People	LREC assigned version 1	
Participant Consent Form: Children & Young People	LREC assigned version 1	
Supervisors CV Nigel Parton		
Liability Insurance		19 January 2007

Provisional opinion

- The committee were informed that you would meet with the children before the research and discuss the study with them.

The Committee would be content to give a favourable ethical opinion of the research, subject to receiving a complete response to the request for further information set out below.

Authority to consider your response and to confirm the Committee's final opinion has been delegated to the Chair.

Further information or clarification required

- It was agreed to simplify the information sheet for the children as they would not have the same level of understanding as the adults and therefore did not require the same amount of depth about the study.

- Although there is now an assent form for the children the committee felt that it would be beneficial to also include a space for the parents to sign the assent form as well and it was agreed to include this.

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 30 June 2007.

Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to submit the Site-Specific Information Form to any Research Ethics Committee. However, all researchers and local research collaborators who intend to participate in this study at NHS sites should seek approval from the R&D office for the relevant care organisation.

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

07/Q1309/13	**Please quote this number on all correspondence**

Yours sincerely

Dr Patricia Wilkinson
Chair

Email: Davina.Halliday@lasca.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments.*

Copy to: Mr Stuart Hayton
East Lancs PCT
31 - 33 Kenyon Road
Lomeshaye Industrial estate
Nelson, Lancs
BB9 5SZ

Dr J Haworth, R&D Department for East Lancashire PCT
Cumbria and Lancashire B

Attendance at Committee meeting on 23 February 2007

Committee Members:

Name	*Profession*	*Present?*	*Notes*
Dr Patricia Wilkinson	General Practitioner	Yes	
Dr G Goode	Consultant Cardiologist	No	
Mrs K Ball	Principle Pharmacist	Yes	
Mrs M Clifton	Lay Member	Yes	
Mr J Dalton	Lay Member	Yes	
Mr V Goodey	Medicines Information Pharmacist	Yes	
Mrs D Gray	Nursing	Yes	
Mr M Hammond	Lay Member	Yes	
Mrs A Hart	Statistician	Yes	
Mr D Hughes	Lay Member	No	
Mrs C Hutchinson	Nursing	No	
Mrs E Jolley	Lay Member (Legal Background)	No	
Mr Alex Maitland	Lay Member	No	
Mrs J Marshall	Nurse (Pain Relief)	Yes	
Mrs D Radcliffe	Physiotherapist	No	
Dr A Todd	General Practitioner	No	
Mr V Raut	Consultant Orthopaedic Surgeon	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Miss D Halliday	Committee Coordinator

APPENDIX 2

Participant information sheet and consent form:

University of
HUDDERSFIELD

Dear

As you are aware, the work of Family Support Team is being used to inform a piece of research that I am undertaking as a full time research student at the University of Huddersfield. It is central to this research that I collate, and comment upon the views, perceptions and understanding of team members, of the process and implementation of using a person centred approach to your service delivery. To compliment, compare and contrast this I shall also be talking to service users as we have discussed.

In order that I may use information that I gather, from your work, in my research and to demonstrate probity in the process I need to gain your signed consent. This consent needs to be on two levels:

1. That you agree that I may use information gained from your services involvement in the project, in my research.

2. That you agree that I may use your direct quotes from Action Learning Sets, shared reflections and individual interviews to inform the study.

The interviews and Action Learning Sets that you will be a part of will be recorded in two ways, by written record in note and flip chart form, and via tape recorder. Tape recorded Action Learning Sets and meetings will be transcribed verbatim. Your written reflections will be stored on a central hard drive and will be available to you throughout the research period. These will be shared with the team and used to inform Action Learning Sets.

It is important that you are aware that you may ask me not to use information you disclose through out any of these groups, interviews and shared reflections. If you wish to leave a group or interview at any time, for any reason, I will always respect your decision to do so. Equally if you do not wish to be interviewed or take part in the Action Learning sets, I will respect your wishes.

If you agree to take part in this study at any level your confidentiality will be assured. None of the information I use will identify any member of the team to others, but it will help them to

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University of HUDDERSFIELD

understand the processes involved and how this impacts on your service delivery and outcomes for children.

If you would like to be involved in the research and agree for your anonymised information to be used as described above, please complete the slips below.

I look forward to hearing from you,

Yours sincerely

Clive Acraman

Clive Acraman
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University of HUDDERSFIELD

I ..... agree to the use of anonymised information from my service in relation to [redacted] Family Support Team to be used to inform the research programme associated with it.

Signed..... Date .....

I agree to take part in the Action Learning Sets established for the research programme associated with [redacted] Family Support Team, and to being interviewed by Clive Acraman. I also understand that direct quotes from the interviews and shared reflections will be used as evidence within the research findings.

Name..... Signed.....

Date .....

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APPENDIX 3

Early examples of Data Analysis:

Person Centred Planning Reflective Log

Name:
Date:

Event	Obesity Support Team	Comments
Reflection/Analyse What have you tried	Have recently completed my first child & family meeting implementing person centred techniques such as working & not working & action planning.	Process Engaged – sharing information involvement
What have you Learnt listening	That listening is a really hard but important skill to master! That it is difficult to draw information out of people. – learning	to develop dialogue
What are you pleased about engagement positive enjoy positive	I enjoyed the meeting mainly because it seemed like we were actually going to get somewhere with the young person. The whole process was so personalised and the young person seemed to enjoy the process too. I sensed that it was a boost to her confidence having the meeting centred on her. Process Confidence – engagement.	Positive engagement Personalised person centred
What are you concerned about? lacks confidence developing dialogue	I was a little concerned that I may not be able to lead/facilitate on the sessions in the future. It is a definite skill knowing what questions to ask and how to ask them. I am however confident that this could be improved upon with practice.	professional development
How did you feel?	The majority of my work to date has been with groups of children & young people rather than on a one: one basis. I have been looking forward to working out of groups as it can sometimes be frustrating that you do not get the time to spend on children who need your attention - you cannot get to the root of the problem	time problem focussed

Person Centred Planning Reflective Log

Name:
Date:

Moving towards a shared understanding perspectives	I found it quite hard to let the young person come to her own conclusions in her own way. empowerment I had my own views on how I thought she could increase her activity levels, change her diet etc, but had to step back a bit and not enforce my views too much. Again, I think this may become easier with practice. It was refreshing in a way to turn it back to the young person and say that actually they need to make some of the decisions themselves and be responsible for those decisions.	difficulties sharing power Professional understanding culture Praxis engagement empowerment

Title: Interview with Jean and Ruth M II — Not real names
Interviewer: CA Acraman

CA So can you tell me please what your interpretation is of obesity support, what do we mean by obesity support, either of you?

Jean Um, right, um, it's really helping the, er, the child change their, um, eating habits. — change

Ruth Providing information. — Not family focussed seen as isolated issue?

Jean Providing information, yeah right.

Ruth Yeah.

Jean And looking very much at the individual family circumstances in our sort of dietetic expertise to change their eating habits within the capabilities in terms of finance on an ongoing basis. — individual families — Service centred professional power — Social inclusion

CA Yeah, okay. Ruth, have you got anything to add to that?

Ruth Well I suppose also just, just finding out where they're.... — Assessment?

CA What sort of support would you offer?

Ruth Just in common when they come to the appointment, we only have limited appointments. — time

CA And how many appointment sessions would people have?

Jean Well we offer one; er, the initial referral is a half hour appointment. Thereafter we're quite restricted to 15 minute follow-ups which is very difficult. — Service centred — unrealistic time scales

Ruth Hmm, very.

Jean Umm, and um, although some families are very good attenders, do benefit from that limited contact. — Service centred — limited — beneficial

Ruth Hmm.

Jean I would say the majority, um, get lost to follow-up because it's not really, um, a terribly new experience, it's limited, the support we can give in that 15 minutes is really quite limited. We do refer them on to Junior Beep, um, but again it's, um, it's a fragmented service, it's not integrated. — unrealistic timescales — Lack of engagement — fragmented — Not integrated

CA Okay. What is Junior Beep?

Jean It's doing the exercise on prescription so it's an exercise referral scheme. So, but it's subsidised by the PCT.

CA Okay.

Jean But again it's, that's quite a limited service and children don't always want to go, there's a lot of non-attendance because. — No choice — lack of engagement

Ruth It might be that the day doesn't suit them or the time. — Access issues — lack of flexibility — No choice — Service centred

Notes from an Action Learning Set Obesity Support Team

programme without a support plan. Clive and to talk to Dr. about how we respond to these families. It was thought a minimum should be an encouraging letter from Dr. to the family promoting the positive aspects of and offering a family meeting with . a's involvement is key as it is thought many families are not ready for a package of exercise and nutrician advice before they tackle more prominent difficulties such as; Bullying, Lack of Self Worth etc. – understanding the wider issues holistic approach

Positive
Whole family approach
encouraging
partnership

Dr involvement and contribution to Oscar support groups highly valued by the team and sorely missed. Dr. to be asked to continue as a part of the team and attend these meetings. – Lack of Professional engagement

How will we know if it has made a difference?

Clarity
involvement

will have clarity about our future involvement with Child A and his family

developing practice

The team will have a strategy for any family/ child/young people who do not what to continue working with the programme

If possible, Dr will be attending .. meetings for her continued professional input. – Attempt to re engage professional

Next step
Reflective logs

Who can help and how, where and when will support be given?

reflective practice
shared learning
reflection

Everybody has a responsibility to share their learning and reflections on practice. Everybody will complete reflective logs when it is convenient to them the preferred lay out is that of the template, however if uncertain about information should go please just write! Clive should be sent these at his NHS Address.

Shared learning

Team members are invited to bring their logs to support groups to share and learn with other team members. Remember that it is as important to share success as it is to share challenges. culture of sharing encouraged.

APPENDIX 4

The Relationship of Action Research with Person Centred Planning Tools:

The Relationship of Action Research with Person Centred Planning Tools

McNiff and Whitehead's (2006) Eight Stages for undertaking an action research project	**PCP Tool**	**Data Collection Tool**	**Other relevant comments**
Take stock of what is going on	• What is working? / What is not Working? • 4 + 1 Questions • Good day / Bad Day • Routines • Doughnut	Transcription of semi structured interviews Action Learning Sets Practitioner Reflective Logs.	The PCP tools enable researchers, practitioners and leaders to identify 'what is important to' service users / staff about the service they experience / deliver and how best to support them to ensure service delivery is appropriate and personalised Information to support these questions was elicited from the perspective of all involved by creating a learning environment to enable participants to contribute fully and freely to their dialogic learning. .

Identify a concern	4 + 1 Questions What is working? / What is not working?	Action Learning Sets Practitioner Reflective Logs	Building on the information obtained from What is working and what is not working? Participants reflected on their practice using the : **4 + 1 Questions**: **1.** What have we tried? **2.** What have we learnt from what we have tried? **3**. What are we pleased about? **4**. What are we concerned about? These questions support the continuing nature of service delivery and change throughout the study. Using these tools ensures that learning from practice includes planning to continue with what works well is held as central as attending to concerns of what is not working well.
Think of a possible way forward	**Action plan from**: • 4 + 1 Questions • What is working?' and 'what is not working?' from the perspective of all involved.	Family meetings Support contracts. Transcription of Action Learning Sets – Team Action Plans.	**+1.** Knowing what we now know, what are our next steps Action Plan: Action Planning is central to this process ensuring the resulting service is understood and delivered from a shared perspective. This supports meaningful service delivery and service change mechanisms

Try it out	Implement Action Plans from Action Learning Sets.	Subsequent t Action Learning Sets. Monitor through Practitioner Reflective Logs	The participants spent the time in-between sessions implementing their learning, developing their common language. This process of dialogic learning informed praxis and shared action planning.
Monitor this action to gather data to show what is happening		Practitioner reflective logs. Action learning sets.	All participants were encouraged to complete Reflective Practitioner Logs (underpinned by the 4+1 questions) after each intervention.. Action learning Sets were held regularly to explore what was working and what was not working. Action Plans using a series of 'Next Steps' were agreed to ensure 'what was working' continued to work, and to address 'what was not working'.
Evaluate progress by establishing procedures for making judgements about what is happening		Family meetings Support contracts. Staff supervision Service user files / staff recording. Action Learning sets	Methods of gathering data were established. Action Learning Sets allowed the participants to test out theories in a 'safe environment'. Family Meetings gained the perspective of the child, their family and friends as well as paid professionals in order to develop a shared support plan. These plans were reviewed and interventions altered as appropriate to support service development. The process was continually monitored and evaluated through the Action Learning Sets shared Practitioner Reflective Logs to inform the research process.

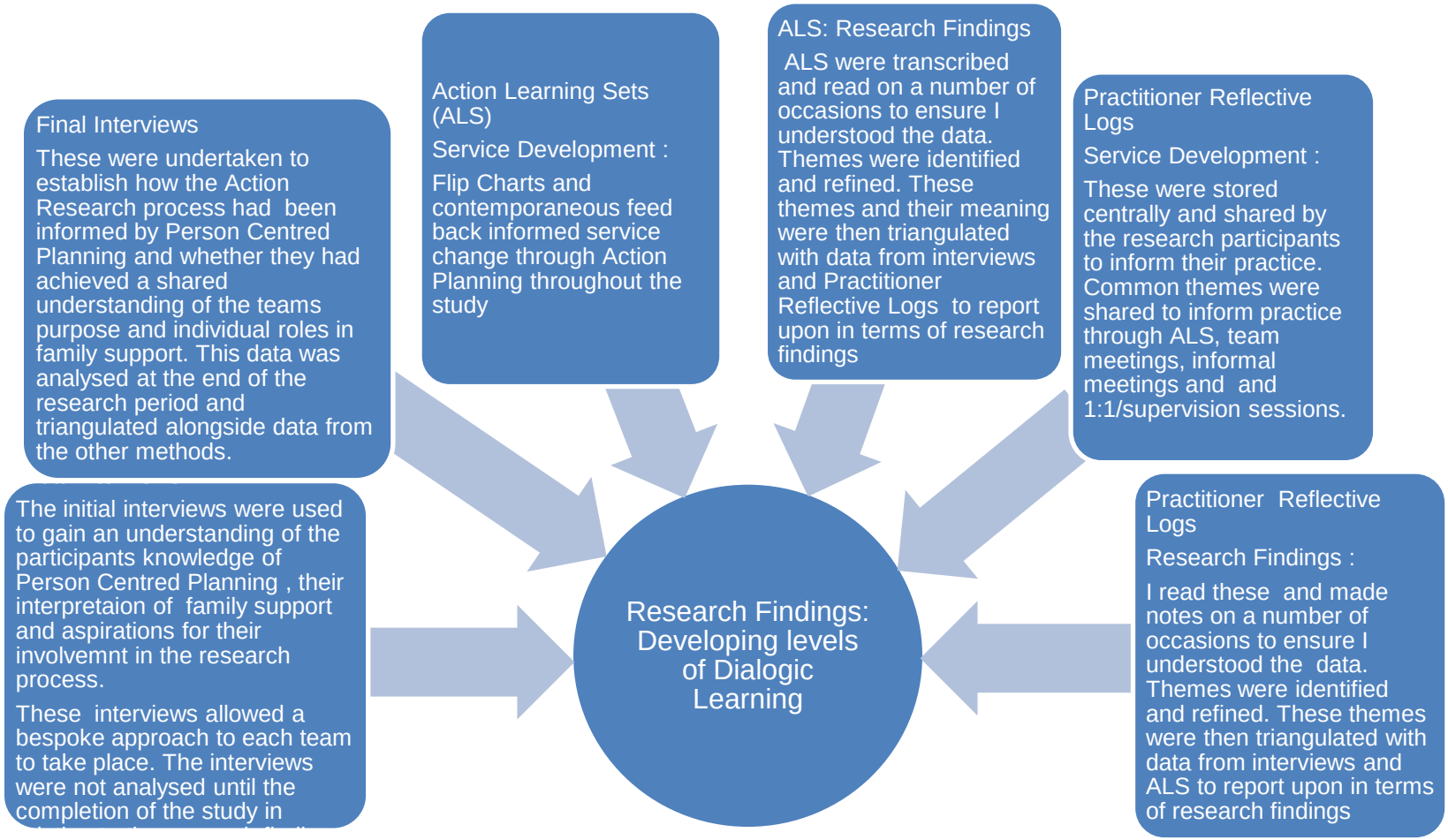
Test the validity of accounts of learning	'What is working?', 'What is not working?' 4 + 1 Questions. Family Meetings Team meetings Service Reviews	Action learning sets. Service user's files /staff recordings. Improved outcomes / patient experience for service users. Increased plaudits Reduced complaints,	Outcomes were agreed and written up in the form of a shared 'contract' of support for the participants, individually through supervision, as a team through action learning and for service users through Family Meetings. Outcomes were agreed and tested through the action planning and review systems put in place. An organic, appreciative system for following up on actions was established which supported shared learning, decision making and informed the teams dialogic learning. How this occurred was identified through the synthesis of thematic analysis reported on in the findings.
Modify practice in the light of the evaluation		Action Plans from: Action learning sets Steering Groups	A steering group consisting of senior managers and team members was set up for each project. The role of the steering group was to oversee the research findings, and implement change when necessary as the projects developed. How this was achieved in practice was different for each team. The Local Authority Family Support Team Leader held devolved decision making by the Senior Manager this allowed her to make autonomous decisions which supported service development without delay. The Obesity Support Team effectively created a new and innovative service, unfortunately due to the lack of Senior Manager support this service was not sustainable. The Children's Centre Team Leader was not engaged at a level to make significant modifications to practice of the whole team, however, the teacher did

			implement a change to practice in Early Years delivery. This process was led and supported by the Team Leaders ensuring probity in the process, making decisions based on evidence from the staff and managers of the services.

APPENDIX 5

How the Data from Each Method Informed the Findings:

How the Data from Each Method Informed the Findings



APPENDIX 6

Example of a Reflective Practitioner Log as used in the study:

Reflective Practitioner Log:

Name: **Date:** **Service:**

Event	Intervention (Explain what you did, what happened, how did you feel?)	Comments/thoughts/actions/outcomes
What have you tried? (Person Centred Planning tools, activities, conversations etc		
What have you Learnt or found out?		
What are you pleased about? What worked? What difference have you made?		
What are you concerned about? What didn't work?		
What are you going to do next? What are your next steps?		