WHAT WORKS SCOTLAND

Action research report

January 2017

Exploring collaborative learning, research and action in public service reform: Aberdeenshire Health and Social Care Change Fund *Beyond Action Learning* initiative

Co-produced by Fiona Soutar, NHS Grampian;
Jane Warrander, Aberdeenshire Council; and
James Henderson, What Works Scotland.

What Works Scotland (WWS) aims to improve the way local areas in Scotland use evidence to make decisions about public service development and reform.

We are working with Community Planning Partnerships involved in the design and delivery of public services (Aberdeenshire, Fife, Glasgow and West Dunbartonshire) to:

- learn what is and what isn't working in their local area
- encourage collaborative learning with a range of local authority, business, public sector and community partners
- better understand what effective policy interventions and effective services look like
- promote the use of evidence in planning and service delivery
- help organisations get the skills and knowledge they need to use and interpret evidence
- create case studies for wider sharing and sustainability

A further nine areas are working with us to enhance learning, comparison and sharing. We will also link with international partners to effectively compare how public services are delivered here in Scotland and elsewhere. During the programme, we will scale up and share more widely with all local authority areas across Scotland.

WWS brings together the Universities of Glasgow and Edinburgh, other academics across Scotland, with partners from a range of local authorities and:

- Glasgow Centre for Population Health
- Improvement Service
- Inspiring Scotland
- IRISS (Institution for Research and Innovation in Social Services)
- NHS Education for Scotland
- NHS Health Scotland
- NHS Health Improvement for Scotland
- Scottish Community Development Centre
- SCVO (Scottish Council for Voluntary Organisations)

This is one of a series of papers published by What Works Scotland to share evidence, learning and ideas about public service reform.

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- Nick Bland, Co-Director, What Works Scotland
- Claire Bynner, Research Associate, What Works Scotland
- Lizzie Finlayson, Clinical Lead, Marr Area, Aberdeenshire Health and Social Care Partnership (HSCP)
- Janine Howie, Social Work Manager, Aberdeenshire HSCP
- Fiona Johnston, Physiotherapist, Aberdeenshire HSCP
- Cameron Matthew, Divisional General Manager, NHS Grampian
- Patricia McLachlan, former Head of Service, Older People and Physical Disability, Aberdeenshire Council
- David Rodger, Chief Executive Officer, Aberdeenshire Voluntary Action
- Erin Wood, Strategic Development Officer, Aberdeenshire Community Planning Partnership (CPP)
- Linda Wood, Home Care Manager, Aberdeenshire HSCP

The standalone 'participant' quotes in the main report have been provided by some of the consultees above who were involved in the Beyond Action Learning project.

Contents

Overview 1

The context: the Scottish Approach to public service reform 1

Learning from the Beyond Action Learning approach in Aberdeenshire 1

Notes for readers 2

Glossary 3

Abbreviations 3

Research notes 3

Main report 4

1. Introduction: in search of collaborative solutions 4

2. Background on the *Beyond Action Learning* project and our approach to this collaborative inquiry 6

Our approach to this collaborative action inquiry and co-produced report 8

3. Ten insights from *Beyond Action Learning* 9

1) Senior management commitment and leadership is fundamental to collaborative change 10

2) Starting where people and services 'are at' in order to build common understanding and trust 11

3) Learning to listen to each other so that more difficult discussions can follow 13

4) Bringing together action learning and improvement approaches to empower staff 15

5) Using improvement tools and data to inform and influence decision-making and strategies 17

6) Empowering staff to challenge policies and services 18

7) Creating the space for people to 'wrestle' with complex policy and practice issues 19

8) Focusing on relationship-building and empowerment 22

9) The value of co-working when facilitating collaborative learning and action 23

10) Collaborative learning and action is ever-evolving – keep thinking ahead and changing 24

4. Brief reflections on the *Beyond Action Learning* approach… in creating spaces for dialogue on collaborative learning, research and action 26

5. Further reading and resources on practices relevant to collaborative learning, research, improvement and action 28

Overview

This is a co-produced report on the learning from the *Beyond Action Learning* project in Aberdeenshire (2011-13).

The context: the Scottish Approach to public service reform

Partnership working and 'wicked issues'

Public service reform in Scotland, as outlined by the Christie Commission's 2011 report, can broadly be understood as working to develop suitable and effective forms of partnership working across public services, the third/community sector(s), and communities and service users. These multi-layered partnerships are seeking to address 'the wicked issues' faced by the state and society: the complex, changing, seemingly intractable challenges generated by inequalities, a growing and an 'ageing' population, and public spending constraints.

Collaborative approaches to supporting partnership working

The Christie Commission has emphasised the value of collaborative approaches, and What Works Scotland is therefore focusing on exploring the role of collaborative learning, research and action – the 'family of action research approaches' – in supporting such public service reform.

Learning from the Beyond Action Learning approach in Aberdeenshire

The *Beyond Action Learning* project ran from July 2011 to March 2013 and sought to support the integration of health and social care across the then Aberdeenshire Community Health Partnership and Aberdeenshire Council Social Care Services – both now integrated as Aberdeenshire Health and Social Care Partnership. It involved over 170 staff members from across a range of health, social care and other public services. Two facilitators led the process and adapted an 'action learning set' approach – which supports shared learning and problem solving – to suit local needs and policy aspirations for collaborative partnership working. They also drew on tools and thinking from 'improvement methodologies' to support staff in using data to improve service practice and policies.

This co-produced report seeks to support dialogue on the development of collaborative and inquiring approaches to partnership working by illustrating ten key areas of practice through discussions with the *Beyond Action Learning* facilitators. Discussions that highlighted ten important questions for those seeking to pursue such an approach to consider.

Key questions to ask when developing and facilitating collaborative learning, research, improvement and action initiatives. (Created with https://picktochart.com)

Notes for readers

Glossary

Action Learning Sets (ALS): These are small groups, of six to eight people in number, that provide the safe space for individual members to explore issues they face, and receive challenge and support from others on these particular situations in order to develop their understanding, improve their practice and to share their learning.

Action Research: See Collaborative Learning, Research and Action below.

Collaborative Learning, Research and Action – or the broad family of 'Action Research' activities: Can include a wide range of methods and tools that seek to bring together elements of collaboration, participation and/or cooperation; inquiring, learning and/or researching; and concern for action, practice and/or change. These can include various forms of 'action research' e.g. participatory and collaborative action research; 'action inquiry' e.g. cooperative inquiry, collaborative action inquiry; and practice-focused discussion and reflective processes e.g. collaborative learning, action learning sets.

DMAIC: Is a five-phase service improvement process in which the participants:

1. *Define* the problem and goals for improvement
2. *Measure* process performance
3. *Analyse* the process to find causes of variation and poor process performance
4. *Improve* process performance or redesign it by addressing and eliminating the cause
5. *Control* the improved process and future process performance.

Improvement methodology: A broad range of tools and approaches from improvement science, first developed within the private sector but now used widely in the public sector, e.g. Six Sigma, Kaizen and Lean, which generally seek to assess, measure, improve and monitor organisational processes, often in relation to notions of efficiency, simplification and cost-saving.

Abbreviations

- ALS – Action Learning Set
- CPP - Community Planning Partnership
- DMAIC - Define, Measure, Analyse, Improve and Control … see glossary above for explanation
- HSCP - Health and Social Care Partnership
- WWS - What Works Scotland

Research notes

The conversations and quotations in this report have been edited by the researcher through dialogue with the facilitators as part of the co-production process.

Main report

1. Introduction: in search of collaborative solutions

Doctor, doctor, I'm running around in ever decreasing circles, and can't find a solution…

*Ah yes, you are suffering from a **wicked problem:** easy to diagnose, not so easy to cure I'm afraid. Try a strong dose of collaboration: seriously widen your circle, extend your conversations. Given time and commitment, together you'll spiral forwards …*

'Wicked issues' and 'wicked problems' are becoming part of the language and imagery of public service reform. [1] A focus on complex, seemingly intractable problems – for instance, in relation to stubborn economic and social inequalities; increasing demand for public services via an ageing and growing population; and public spending crises – now provide the broad landscape for complex, demanding and troubling challenges within such reform.

Easy to acknowledge but on closer inspection potentially an incomplete, ambiguous and dynamic picture. In aspiring to find solutions to such wicked issues, the emphasis in Scotland has shifted to dialogue through partnership working, community participation, stakeholder engagement and local democratic accountability.

In fact, the 2011 Christie Commission report points firmly to collaborative approaches to public partnership working in Scotland. What Works Scotland[2] is seeking to explore the role of **collaborative and action-orientated approaches** in supporting and informing such reform. We are open to understanding such work broadly as part of a family of approaches to **collaborative learning, research and action** or 'action research'. Further, the Commission's focus on a broad swathe of practices of community planning partnerships – often summarised as prevention, participation, partnership and performance[3] – means that What Works Scotland is likewise interested in the breadth of public service provision.

The *Beyond Action Learning* action learning and improvement project presented in this report is therefore very relevant as it fits within this broad family of collaborative approaches given its emphasis on group discussion, exploration of evidence and empowerment of staff; *and* is focused on multi-agency local partnership working across a range of health and social care services. The project ran from July 2011 to March 2013 and worked to support the integration of health and social care across the then Aberdeenshire Community Health Partnership and Aberdeenshire

[1] We don't provide a decisive definition or discussion of 'wicked issues' or 'wicked problems' here – recognising it simply as a 'space' for on-going discussion of both the nature of a situation, issue or problem(s) and of potential solutions, resolutions or reframing. Those considering such thinking and practice in more depth could draw from the work of Keith Grint (Warwick University) or Tim Curtis (University of Northampton).
[2] What Works Scotland is a research programme coordinated jointly by the Universities of Edinburgh and Glasgow, and funded by the Economic and Social Research Council and the Scottish Government whatworksscotland.ac.uk/
[3] The Christie Commission 2011 report in fact generates a much richer discussion of public service policy, practice and reform; view report: http://www.gov.scot/resource/doc/352649/0118638.pdf.

Council Social Work Services – both now integrated as Aberdeenshire Health and Social Care Partnership. It involved over 170 staff members from across a range of health, social work and other public services.

Two facilitators led and supported the process: Fiona Soutar, then Strategic Change Manager with NHS Grampian, and Jane Warrander, Senior Improvement Officer, with Aberdeenshire Council.

The extent and length of the work undertaken allowed the facilitators, Fiona and Jane, to build a considerable depth of practice-based knowledge. This report draws from their experiences and from an evaluation survey of participants undertaken at the end of the project. It generates insights and discussions that will be relevant to all those working to explore collaborative, partnership-based and empowering approaches to public service reform.

The report provides:

- further background on the *Beyond Action Learning* project and our approach to this collaborative inquiry – section 2.0
- ten insights or learning points via the facilitators' discussions of their work – section 3.0
- concluding thoughts on the project as helping to create spaces for exploring collaborative approaches to support public service reform – section 4.0
- further reading and resources on practices relevant to collaborative learning, research, improvement and action – section 5.0

2. Background on the *Beyond Action Learning* project and our approach to this collaborative inquiry

Within the context of the increasing aspiration for a public service culture of collaboration, Aberdeenshire Council and NHS Grampian worked together to develop the Aberdeenshire Partnership Change Plan 2011/12 and actively engage with the Scottish Government's Reshaping Care for Older People programme.[4] The Plan committed to developing an Aberdeenshire Health and Care Learning Network that aimed:

> *To enhance practice … (by) creating opportunities for GPs, local team managers and practitioners to come together to constructively challenge and improve practice, behaviours and pathways of care for older people, towards a shared outcome of shifting the balance of care.* [5]

The learning process was led by two facilitators, Fiona Soutar and Jane Warrander, and ran through two phases from July 2011 to March 2013. Ten groups were formed, each from the multi-disciplinary team working within the catchment area of each of Aberdeenshire's community hospitals. Across these 20 months, 172 people participated regularly in a series of local meetings. Groups met every six weeks for about two to two and half hours, and varied in size from about eight people in one group/area to just over 20 at two of the others.

Each group brought together a full range of key public service managers and staff working across health and social care services, including:

- NHS managers and social care managers
- care management and home care practitioners
- hospital and community nursing staff
- GPs, practice managers and area clinical leads
- occupational therapists, physiotherapists and pharmacists
- others from the voluntary and housing sectors.[6]

In phase 1 (July 2011 to March 2012), the initial plan had been to use a **traditional action learning model**[7] and work with the same groups of between six to eight people over a period of time; listening intensively to the often complex problems they were facing and helping them work

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[4] More on Reshaping Older People's Care programme – and its concern for health and social care reform in the context of demographic change and health inequalities www.gov.scot/Topics/Health/Support-Social-Care/Support/Older-People/ReshapingCare

[5] The Change Fund Action Learning Sets were part of the Aberdeenshire Partnership Change Plan 2011/12.

[6] The area meetings involved a wide range of strategic and operational staff including: NHS Area Manager; Care Management Team Manager; Care Manager; Home Care Team Manager; Home Care Manager; Community Hospital Medical Director; Senior Charge Nurse(s); Community Nurse(s); Area Clinical Lead; NHS Occupational Therapist (OT); Local Authority OT; Physiotherapy; GPs from admitting practices. Three areas involved Practice Managers and one area had two voluntary sector representatives. Local Authority Housing Department and CHP Pharmacy staff, and others, were included on distribution lists.

[7] See, for instance, University of Birmingham Health Service Management Centre's introduction to Action Learning Sets: www.birmingham.ac.uk/schools/social-policy/departments/health-services-management-centre/work/action-learning-sets.aspx

towards relevant actions and solutions. However, due to varying sizes of the groups and the changes in particular people attending – the same services were represented at each meeting but different team members might attend – this traditional approach wasn't fully feasible. Nevertheless, the principles and values of action learning were applied to the facilitated discussion that developed within the groups.

During this first phase, action-oriented discussions were generated around the complex and difficult to solve issues that people were facing – **wicked problems** that are hard to get to the root of – and so very relevant to the integration of health and social care. These included seeking to improve:

- **communication and relationship-building across multi-disciplinary teams** and between primary and secondary care services that can support understanding of differing roles, priorities and pressures … and facilitate discussion of underlying assumptions.
- **delayed discharge times from hospital** – through integrating a range of services and use of data;
- **integrating services to support people in the community** – for instance, bringing together: anticipatory care plans, day services, medicine management, rehabilitation and enablement, tele-healthcare, and a signposting service.

In phase 2 (April 2012 – March 2013), five of the areas/groups also explored the use of an improvement methodology that aims to get to the root causes of problems, create solutions and make recommendations on how best to use resources. All of the ten areas initially involved continued to focus on improving their practices through communication and sharing learning; implementing policies and procedures; and meeting strategic aims.

Crucially, the facilitators surveyed the participants at the end of the process in order to deepen their learning.[8] Survey results illustrated widespread experiences of empowerment of staff, with 89% of the respondents reporting that the process had enabled them in particular ways, such as increased confidence and/or ability to:

- contribute knowledgeably and influence local improvement (57%)
- challenge the status quo (50%)
- try different local approaches to resolve issues and improve processes (50%)
- take action to influence local improvement (42%)
- collect local data to evidence the local situation (37%).

On average, each of the ten areas generated and completed over 60 actions aimed at improving outcomes for all stakeholders during the course of the project.

These included:

- changing systems and processes to reduce barriers, duplication, variation and waste

[8] All participants were emailed a questionnaire at the end of the process and encouraged to return it anonymously. About a third (35%) completed the survey with 60 of 172 evaluation forms issued returned.

- achieving greater understanding of the challenges, priorities, constraints, frameworks and drivers that impact on each service
- sharing understanding and respect for personal values and drivers
- improving communication and increasing motivation to work together to resolve issues
- reducing the tendency of staff to see problems as either a 'health' or a 'care' issue, instead seeking a joint approach to problem solving.

Our approach to this collaborative action inquiry and co-produced report

The Beyond Action Learning facilitators and the What Works Scotland researcher who have produced this report – with the support of the consultees – have used the following collaborative inquiry approach:

- the facilitators' had already produced a final report and evaluation survey from the *Beyond Action Learning* project back in 2013 and this supported the researcher in interviewing ('a conversation with a purpose') them to find out more.
- the researcher writes an initial draft report and discussions with the facilitators and a What Works Scotland Co-Director allow the team to work towards a consultation draft.
- local consultation work with those from Aberdeenshire HSCP, Aberdeenshire CPP and What Works Scotland – including those working at a strategic level; those who participated in the *Beyond Action Learning* process; and those with experience of collaborative learning, research, improvement and action processes – supports development of a final draft.
- once the final draft has been established, the report's co-producers and others within Aberdeenshire HSCP, Aberdeenshire CPP and What Works Scotland consider how to use this initial learning more widely.

3. Ten insights from *Beyond Action Learning*

Discussion with Fiona and Jane has generated a range of learning from their *Beyond Action Learning* approach that support further discussions of facilitating public service reform and change through collaborative learning, research, improvement and action processes. This learning is shared through the series of ten 'conversations' or insights that follow – and which respond to the ten key questions below.

Note: The skills and tools involved included facilitation, coaching, improvement strategies and evidence/data use. A brief description is given in the text but readers who would like to learn more should draw on the reading suggestions at the end of the report – and seek relevant training to develop their practice.

1) Senior management commitment and leadership is fundamental to collaborative change

Strong leadership, upfront commitment and expectation of staff engagement, and the building of support across all partners by the senior managers was crucial.

> **Fiona**: There were two distinct partners at the time. There was the Aberdeenshire Community Health Partnership (CHP) with a General Manager and the Aberdeenshire Council Social Work Department with a Head of Service; within the CHP, GPs were represented by a Clinical Lead. Those three people worked together very closely in order to move the organisations further towards integration … The buy-in, the idea, had come through the three of them, all of whom had been involved in action learning previously, although not together. They had valued what action learning had taught them and what they'd taken from it.

The senior managers continued to actively engage with the project across its lifespan and challenge the whole management system to be open to the concerns of operational staff.

> **Jane***:* It is a whole system and that includes management and it's very important that they all buy into the whole process. I think we were lucky in that the majority of them did, but a few operational managers felt their territory being compromised and were quite obstructive. The fact that it was a senior management aspiration helped. What you need is to break down the boundaries between operational management and staff. And you need to be able to flow between operational and senior management at executive level: as soon as you put in the constraints of hierarchy you haven't got the freedom to see the whole picture.

> **Fiona**: My stipulation was that those who participated in the meetings needed to be close enough to the activity to really know and understand the issues and also have the authority or autonomy to make or try changes. I do believe that we had the people at the right levels involved. The trick with engaging managers, at any level, is to enable those closer to the activity to present their cases to management in such a way that managers then find it easy to support the idea. This is where Jane's introduction of robust improvement methods really moved the work forward. Having only managers at the meetings wouldn't have been particularly helpful.

Through the Change Fund and senior management support, backfill funding for GPs – that provided locum staff to cover for GP time spent at the group meetings – was available and meant that GPs were able to be extensively involved.[9] GPs, for instance, had the highest rate of evaluation return (54%). In the evaluation survey, almost 90% of (all) the respondents said they had been supported by management to participate.

[9] GPs are business owners (or work for the Practice). Most are not employed by the NHS, and so any time away from their business impacts on income as well as service provision and their ability to meet Government targets. In general, to support GPs to join in you need to be able to provide cover. Other staff involved in the process were (almost all) NHS or Council employees who built this activity into their normal working time.

2) Starting where people and services 'are at' in order to build common understanding and trust

The facilitators discovered early on that understanding of agreed policies, procedures and processes by the staff was generally lower than they had expected. It was therefore crucial to invest time at the start in supporting each group to reach a shared understanding of these policies and procedures.

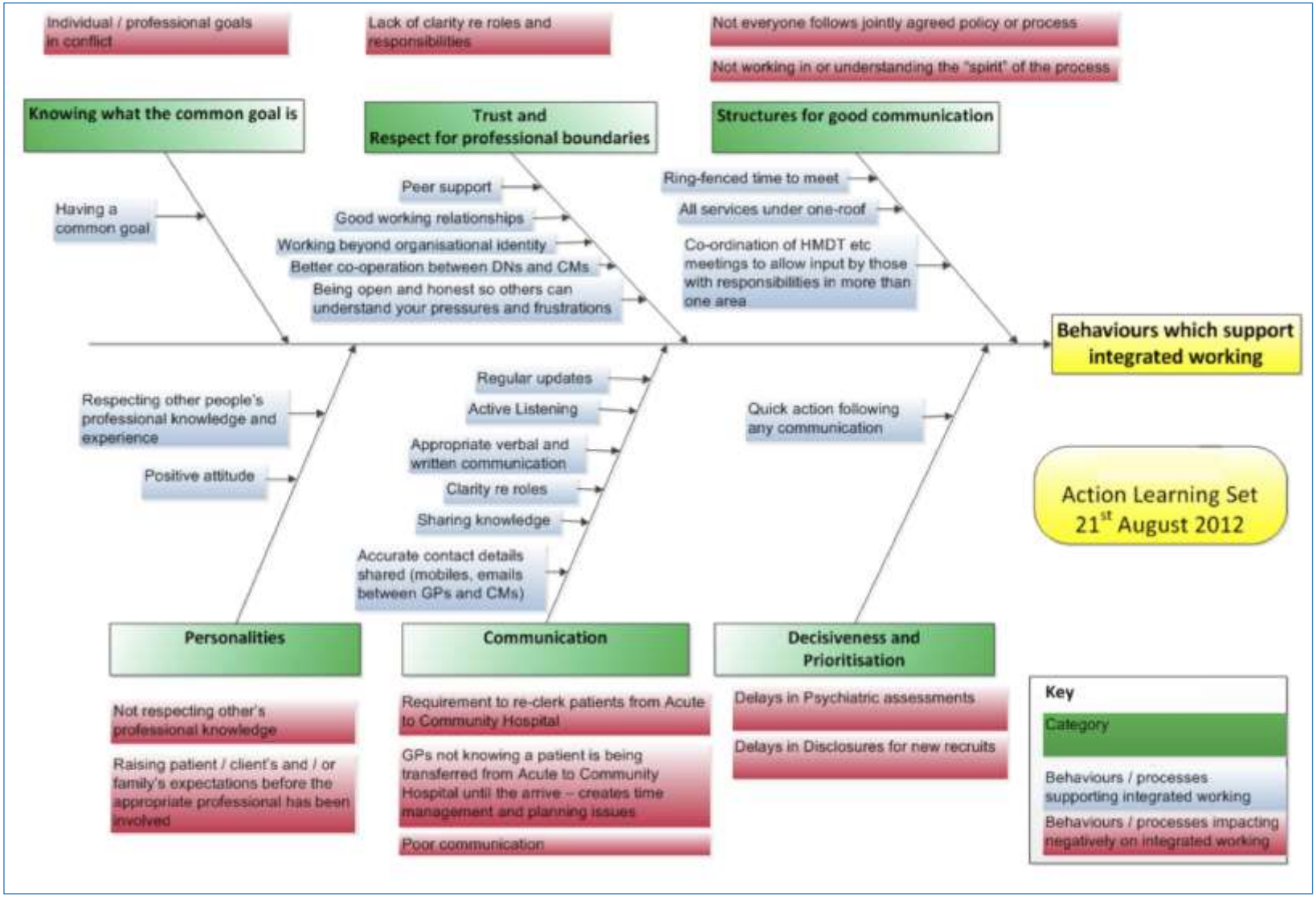
Fiona: What we identified consistently, certainly across the NHS, was that it was very good at coming up with a policy, but that there was then no implementation plan. So, here was the policy and all people were expected to go and read it and put it into action. Yet there was no support to do that and no monitoring to see whether or not it had actually been done. It was as if there was no thought from the higher levels of the organisation that staff might not do as the new policy required; and therefore no reason to check that it was being followed. People could carry on knowing this new policy was on the shelf but decide 'we're going to carry on doing our own thing.' … You get so much information overload and again there wasn't that support to implement the policy.

Jane: That had a direct link to the framework that I then later set up for health and social care integration around the six administrative local areas [after this project in 2014-15]. It was learning that made me realise that we had to have support down at the operational level to be able to cascade the vision, the principles and the outcomes of integration, rather than it just coming out in some sort of vision document. So, that we would have people on the ground who were 'talking the talk and walking the walk'.

A range of tools and practices helped to further generate common purpose and growing trust and respect within the groups:

- Recording and summarising the discussions to share with the participants in order to sustain a common focus from meeting to meeting.
- Meeting away from the 'shop floor' and generating a safe and respectful space and group culture – including through the use of ground rules.
- Meeting regularly and for long enough to support the developing discussions but not so often or for too long that 'things' became over-talked or that meant that some people didn't have the time to attend.

> *"The discussions were wide-ranging and it was essential that someone [the facilitators] could distil these into relevant themes … This distillation provided valuable focus for group members who otherwise would, undoubtedly, have gone off at tangents or round in circles in their subsequent deliberations. I think this was key to getting good attendance at subsequent meetings."*
>
> Participant



'Fishbone' diagram outlining participant discussions of actions that would support integrated working.

3) Learning to listen to each other so that more difficult discussions can follow

The *Beyond Action Learning* approach provided the 'space' for facilitated discussions that could explore and pursue the issues the participants held to be top priority and in need of resolution.

Fiona: One of the key things about action learning sets is that you don't give advice. It doesn't matter if you've been in that same position before and had that same experience. You don't give me advice because "I'm not you" and you're coming from your frame of reference rather than from mine. So, it's about listening deeply, listening well, suspending judgement and about being able to ask questions which help to unlock things in people's mind; to help them move things forward in ways which will work for them.

By increasing levels of trust between different people, services and partners, the group and the facilitator could then talk more honestly together about the challenges and complexities they faced.

> *"… this all-important trust grew from the opportunity for local professionals to communicate with each other away from the shop floor. Trust was not a given or a pre-existing condition. The space – safe because it was facilitated – was the block on which trust grew amongst respective professions in each locality."*
>
> Participant

Fiona: So, people had built up their trust and formed relationships where they could be honest with each other and, for example, talk together about the difficulties: "what you did with that person irritated me or really made life very difficult for me, because I then had to do..." This enabled us to open up space for people to have that conversation and to understand why that has happened; to stop it being all very unhealthy and to encourage honesty and feedback… A whole load of stuff which allowed us then to look at processes and make them fit for purpose, and to do away with lots of variation and duplication that we were experiencing.

This culture also provided the space for more open dialogue about policy, data and related targets.

Jane: I think because of the trust that Fiona had built, and the openness between the people, that they felt stronger as a team of people to say, "yes, that might be the target, however, we know that this is what's happening in our hospital." So, it empowered them to actually say, "we know what is best for the patient and if we don't hit the target 100 per cent of the time, we can confidently tell you why". Usually it was 'special cause variation'[10] and you can't get away from Mr Smith being in the hospital for 92 days because we're waiting for guardianship.

[10] An exceptional variation, rather than a common one, that can then be 'removed' from the inquiry into the common causes of key problems.

The evaluation highlighted that through the Beyond Action Learning process just over 50% respondents reported relationships within multi-disciplinary teams were better or significantly better, and had improved care and the quality of services.

Comments included:

- ‘hospital multi-disciplinary team meetings are running more effectively’
- ‘able to speak and discuss issues more openly’
- ‘an understanding of why things don't happen’
- ‘feel it allows better co-operation and more understanding of each services’ issues’
- ‘better understanding of how services fit together or can fit together’.

Process mapping in action

“Recognising the different views on what was confidential and what we needed to share in a welcoming, open, humour-allowed atmosphere enabled progress. Agreeing to disagree by listening to alternative attitudes led to stronger more honest team working.”

Participant

4) Bringing together action learning and improvement approaches to empower staff

In the second phase, the facilitators introduced improvement methodology tools and thinking that help explore data, measure change and improve services and performance.

Underlying their thinking was a DMAIC (see Glossary) process that gives structure to developing and using data for improving services. The facilitators didn't seek to explain the model in detail, rather to use the tools to support staff in thinking about their use of local and central data.

> **Fiona**: The work and the expertise that Jane brought with service improvement methodology really strengthened what had been built at the beginning, because we had that sort of container where people were beginning to trust one another. And this then gave them something which they could use much more powerfully.

> **Jane**: I came in with the service improvement stuff, which for some people is really quite hard to stomach, but for the majority of them they grabbed it and ran with it. It just validated what their gut was telling them the whole time. They felt that it gave them a voice… The data just empowered them[11] … It gave them local ownership of their issues rather than being told from on high from the bean counters that actually you're not doing well enough. They could turn round and use the data and identify their own areas for improvement and also respond to management.

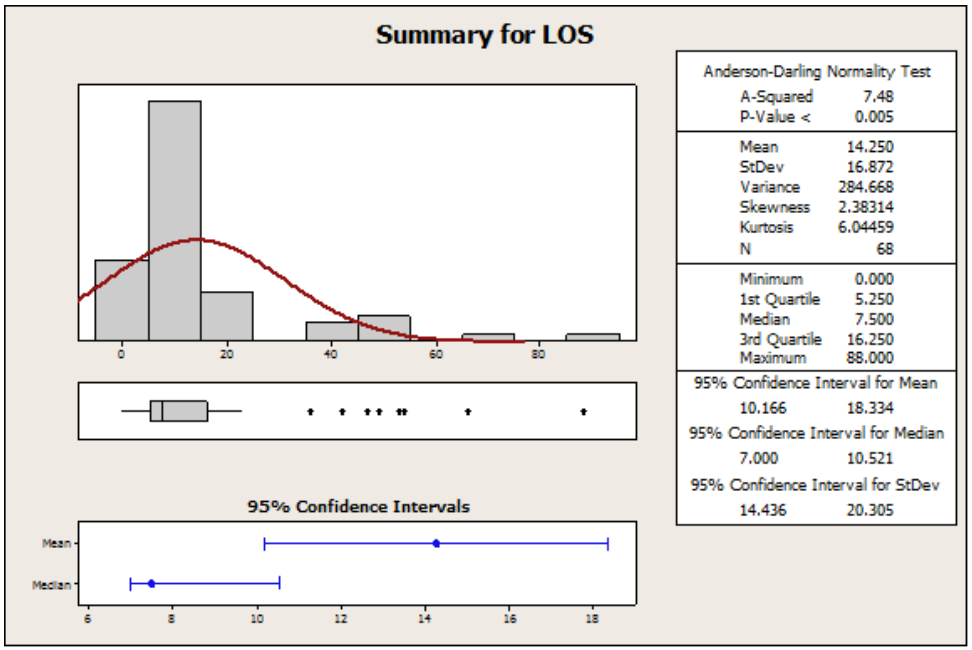
One valuable example of how the facilitators were able to use data to help the staff teams was in working towards a 'length of stay target' at a community hospital.

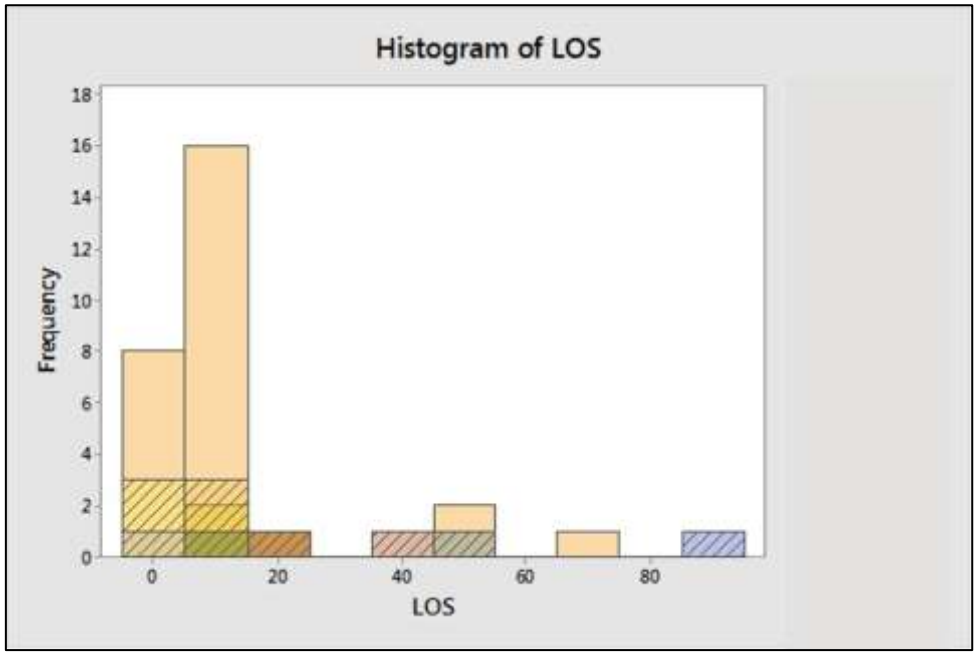
> **Fiona**: One of the biggest successes we had was in one community hospital where the staff were frequently being told that their 'length of stay' (LOS) was far too long compared to what the average ought to be, and when we looked at the figures it was absolutely true. But, nobody had ever really worked with the data and for us it was quite, certainly for me, a lightbulb moment to realise that not everybody understands that in order to have an average you've got to have points at either end of the scale. Sometimes those points on either end of the scale, those outliers,[12] are things that you cannot do anything about no matter how much you might try.

> **Jane**: It was quite technical what we were bringing in … [about] how is this process performing. It takes into account these outliers and it's just one of those tools 'in the bag' that actually blasts the whole myth out of the water. It was empowering for them and I believe that that senior charge nurse is still doing that.

[11] Data provided from the 'centre' by NHS Grampian and local data collected by community hospitals and other practitioners – examples of such data use are provided within the ten insights or discussions.

[12] Within a set of data there may be one or more items that are far away from the normal range of values, figures, descriptions, and this is likely to be for reasons only relating to them and not more generally. These are 'outliers' and can impact powerfully on average figures to create the wrong understanding of what is actually happening and why – in this case in relation to the average length of stay in hospital.





Top left - Graphical summary 1a: this graph shows the mean (average) **LOS – or 'Length of Stay'** – is 14 days but the median (data mid-point) is much lower at 7.5; so indicating the pull on the mean from the outliers (unusual experiences). This information allowed staff to explain their intuition that a far greater number of patients were meeting the 12-day LOS target.

Bottom left - Graphical summary 1b: the same hospital and time period as 1a but this time showing and alternative and more helpful use of the **'Length of Stay'** data. The admissions to hospital from home (the unhatched parts of the graph) indicate that 18 out of 20 home admissions are discharged in 15 days or less. By emphasising data from common occurrences – in this case, home admissions – staff consider together 'what was working, what wasn't and why'.

The evaluation survey found that:

- 65% of respondents reported that they had collected local data to support this action learning and improvement work.
- 85% indicated that local data had helped them to understand local performance and identify areas for improvement.
- 57% of respondents had not used centrally-held data prior to *Beyond Action Learning*, compared to 60% of respondents who had gathered some local data previously.

5) Using improvement tools and data to inform and influence decision-making and strategies

By bringing improvement tools together with the action learning, the facilitators were able to support the groups to generate shared knowledge and convince managers from across different services of opportunities for public service change and improvement.

Fiona: I think one of the really good pieces of work that came out of this was in a community hospital where they had had their OT (occupational therapy) and physiotherapy hours cut. What the hospital knew was that consultants at the Aberdeen Royal Infirmary (ARI) were reluctant to discharge people who needed OT and physio to this hospital because there was such little provision there. They would rather hang on to people in an acute setting, but it's much more expensive to stay in an acute bed than it is in a community hospital bed. If you were admitted to this community hospital on a Thursday after four o'clock, you wouldn't actually get any OT or physio intervention until Monday, because no physios or OTs worked there on a Friday. If Monday was a public holiday, you've got four or five days potentially where you are there with no physio or OT, and actually what you need is to be helped to mobilise, and for many people, up and walking and moving.

By actually doing some data gathering and asking questions, we worked out how many of the people going back home in the last six months it would have been reasonable to transfer from the ARI to this Community Hospital. And if the physio or OT had been there, how much more quickly would they have been discharged; what would have been the financial savings; and what would have been the likely outcome of them getting home earlier. We demonstrated that there was a huge saving to be made and that it was worth funding more OT and physio hours in the community hospital and working with colleagues in the acute sector to get people through the system much more quickly.

You can sound like you're moaning that you don't have enough hours if you haven't actually put it together in a paper. So together the group wrote a paper. GPs added to it. Care Managers added material about what happens when somebody is 'mobilised': when they go home they may need fewer hours of input or fewer people, and so fewer resources to support them. We had all of these contributions which made quite a powerful read and ended up with them being granted funding for more physio hours to see what difference it would make.[13] It was very powerful for them.

Jane: It truly hit the goal of shifting the balance of care because it was a demonstration of shifting from acute to coming back out into the community. …It was unsticking them as well, because staff feel powerless in those positions if they can't make any change because bureaucracy doesn't allow them to. It's actually sitting down and saying, "well, there are other ways of doing this; there are ways of challenging the red tape." Senior managers are only too happy that people do that; it's just that they don't get the space and the time to do it.

[13] Unfortunately, this funding was then later stopped as it had come from non-recurring Change Fund monies, and the issue has taken further time to resolve.

6) Empowering staff to challenge policies and services

The facilitators worked to create a culture of staff empowerment, in part by teaching them to gather local data and evidence, and in part by supporting them in gaining the confidence to raise issues of concern with their managers… rather than simply ignoring these issues.

Jane: One of the reflections I have is around the external targets that were imposed. In thinking more about the 'length of stay' [target for each patient] and the comments from hospital staff at the time, "we just make it 12 days because we know that that's the target". What they were doing was actually twisting the process to make it fit the target rather than it being centred round the person in hospital … But, they felt they were being hit with targets; they felt that those targets were a stick to hit them. For the local authority, I suppose it's the inspection process, but for NHS services those targets are hefty and were used in my mind in the wrong way. You know, they were punitive rather than empowering, and targets should be empowering.

Fiona: It's much better to be honest about the reasons why you're failing to meet a target, than to be found out later to have been lying about it. That's where I was coming from, but it was really quite difficult to get people to take responsibility for actually being honest about that, because in some areas they've behaved in that manner for so long. They felt, as Jane has said, that NHS targets were sticks with which to hit people, and they thought they would get into trouble if they went and said, "I can't do this because I'm failing in this" …they often didn't feel they would be supported and felt that they would be penalised for being honest.[14] If I was to go [and talk to management], it kind of took the onus away from them. But, that wasn't our job. We could raise some of those things. We could highlight some concerns … but actually they were the ones that needed to do this. … [I said] "I'm sure your manager would probably rather hear a bad news message from you than read about it in the paper when they thought it was all going okay."

Jane: It goes back to having experienced people working with these teams. As an experienced facilitator you know that you cannot allow a relationship to build where the facilitator is seen as the cure-all, the panacea.

> *"the Action Learning Sets provided us with more clarity about other people's roles and expectations, and we certainly felt we had the power to influence change for our own area and our own issues …"*
>
> Participant

The evaluation responses highlighted that about 88% of the respondents were empowered in at least one way and a third of the respondents were empowered in five or more.[15]

[14] Both the facilitators and consultees recognised that barriers to change and empowerment were active in both health service and local authority services and institutions.

[15] Areas of personal empowerment that the participants were asked to consider in the survey included: challenging the status quo; acting to influence local improvement; contributing knowledge; trying different local approaches; using data; challenging unhelpful processes; and feeling more supported by management.

7) Creating the space for people to 'wrestle' with complex policy and practice issues

The guidance on medicines management was being re-written at that time and so the *Beyond Action Learning* process helped to inform its development. In the process, it illustrated the challenges of bringing together different services to consider the tensions within complex, risk-laden areas of service provision and related policy-making.

Jane: I could spend the whole of the rest of my life on medicines management. It's an area that could do with some very serious improvement because it's just such a minefield: there's pharmacy, there is acute, there is community hospital. It runs across the whole thing. If somebody is ill, they are bound to be on medication.

What we did in one area was bring the issues to the surface. Did we solve any of them? I don't think so actually, because there was a real tension between the different disciplines in there. We highlighted some of the areas. I was then called in much later to help sign off the medications management guidance. I didn't help them sign it off. I basically said, "No, go back to the drawing board because this is not good." For me, it demonstrated the confusion that exists around medicines management. I think part of the confusion is that people were scared because there was a hefty risk with medication. I think it's an area that could really do with some help.

Fiona: For example, social care colleagues felt that you could have these 'flying saucers' which would pop open, 'Pivotell care' – an automatic pill dispenser – to help remind people. They were desperate to bring that in, the perfect solution, and that would mean that a paid homecare worker wouldn't need to go in for a five-minute visit just to give them their medication … But, the pharmacists absolutely said, "no, no, we can't use those, they're too risky. People will be decanting stuff from one to another and we don't know if they will still be correct." This highlights the different levels of risk aversion and what people are seeing as risks [in different services and professions]. The potential solutions were being 'rubbished' by one part of the organisation and without actually getting [people] together and talking about how it might work and who might it work for…

Jane: Yes, it was a complete denial; not even going there and just written off without any sort of exploration. Now, is that because we didn't have pharmacy on the action learning sets from the beginning?[16]

Fiona: We experienced similar things with electronic sensor alarms, where you've got a relative who is prone to wandering, and you know it sets off an alarm if they go out or whatever. Some people think that's absolutely fabulous, and other people say, "oh no, you're infringing their rights and taking away their freedom and it's like 'tagging' people, so we couldn't possibly use that." There is all that social stuff getting involved as well which you

[16] Both facilitators and consultees recognised that a wide range of views were held on the risks in relation to medicine management across a number of different services, and for a number of different reasons.

needed space to [discuss]. The fora that we created enabled some of that to happen, but we weren't there to take it as far as it might go.

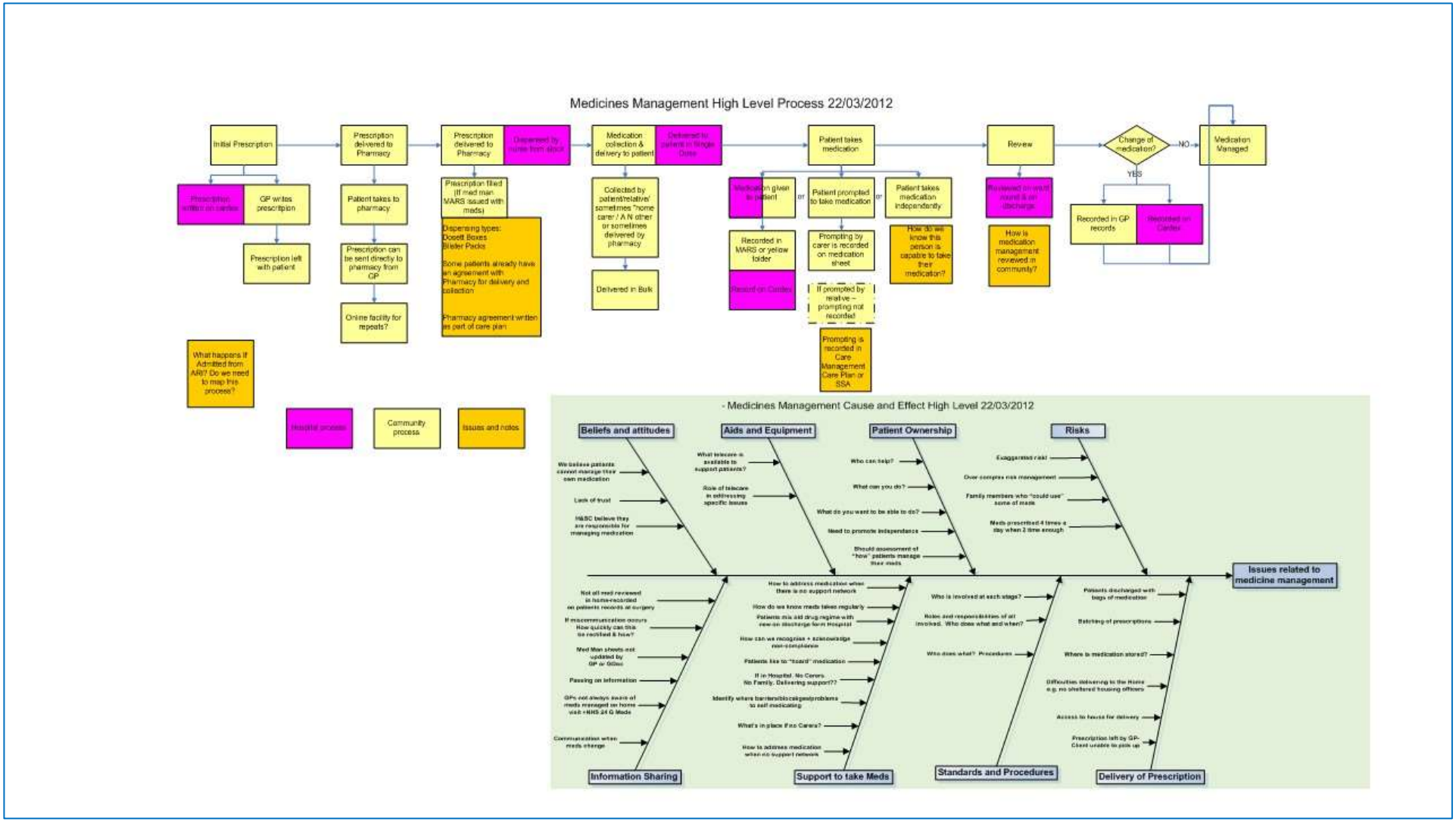
Jane: Some of those, I think, were policy decisions, weren't they? And they were sort of getting mixed up [in discussions] at an operational level… We experienced the turmoil that the staff experienced because those policy decisions hadn't been taken and yet there was a difference of opinion in the room.

See the Medicines Management High Level Process diagram below.

The evaluation illustrated these sorts of ongoing tensions and ambiguities in working to improve policy and practice, for instance:

- Almost three-quarters (72%) of respondents felt the learning process had contributed to improving practice, behaviour and a 'pathways of care' process (for older people).
- But a quarter (28%) of people said improvements had been blocked by attitudes; actions not followed up; lack of communication; and/or an inability to make changes to structures and processes.

> *"these groups helped to shift or establish a culture of mutual professional respect and parity of esteem amongst professionals … it seemed to me that people emerged from this process with a better understanding that you spoke of other professionals and their practice in a respectful way even if you were bewildered by their behaviour sometimes …"*
>
> Participant



Mapping the medicine management process allowed the multi-disciplinary team to identify and discuss the complex issues involved and consider opportunities and blocks to change.

8) Focusing on relationship-building and empowerment

In this project, the facilitators designed their process so that its primary focus was on improving working relationships across health and social care teams.

They decided it would be easier to do this if there were real issues to address that would create some tension and demonstrate some of the less helpful behaviours experienced in day-to-day practice. In this way, they focused on empowering people to make changes in the 'here and now' that made sense to them.

Jane: From the beginning it wasn't about going in with [setting] a baseline really, I don't think that was ever the intention, was it? So, it was quite difficult to measure what improvement was happening. Hence, we did the survey so that the people could have their own voice.

Fiona: When we found that there was a process that wasn't working or something that could be improved, we didn't stop and do a data collection exercise, a project plan if you like, and then put an improvement plan in place. We said, "well what can we do now? Can we stop that process now? Or can we stop that step?" So you could have looked back and said, "well, this was the old cumbersome process and this is a much slicker one now – but there wasn't a baseline against which to measure."

Jane: No, we didn't have time to do that because it was two and a half hours every six weeks. The aim of the whole project was not 'process improvement', it was something different.

Fiona: It was set up in the beginning to improve relationships between the agencies in order to smooth the path for integration, and on that journey we identified a number of things which needed attention and could be done. And we picked them off as we went, in order of importance to the people in the areas. … We didn't ask, "well what's the bang for our buck in doing this and how much is it going to be worth it?" It was, so these people are engaged; these people are motivated; these people want to do it; let's support them.

Jane: …and, gave them a flavour of what's possible.

> *"The most productive Action Learning Set I was involved in was about improving relationships … Some of the staff members that participated in that particular ALS still mention it as pivotal in changing the relationships in that team so I think that evidences how powerful the experience was…"*
>
> Participant

9) The value of co-working when facilitating collaborative learning and action

The facilitators valued strongly working together as co-workers; finding common purpose, building shared understanding and working for change together.

Not all co-working will run as smoothly so quickly, but their experience provides useful pointers such as valuing each others' contributions; being open to discussion; and working together to recognise changing group dynamics.

Jane: Both Fiona and I are improvement [methodology] trained, so there is an understanding for both of us about the methodology. So, when I would go off in a direction with something from improvement, Fiona would know exactly where I was going with it. There was no sort of hang on a minute Jane, what the hell are you doing there. We were very joined up in our thinking and …our aim and vision were completely together.

Fiona: I think we had a common language and different areas of expertise, and it's not common in partnerships you get that. Not only did we have a common language and different areas of experience, we both absolutely valued and appreciated the need for the expertise that the other brought. There was never any point where we would be fighting to do this bit or that bit. We could just sense which bit we needed to be focusing on with this group at the time… So, we were very, very fluid and respectful and respecting of what each other brought.

"I'm a firm believer that working collaboratively when everyone is engaged and has the will to support the change has the best outcome, especially when there is a willingness to learn from and appreciate where each partner within the group is coming from."

Participant

10) Collaborative learning and action is ever-evolving – keep thinking ahead and changing

The facilitators, in reflecting on the end of their process after almost two years of project work, illustrate the difficulties of getting services and organisations to sustain their commitment to shared learning processes; and so the importance of taking the longer-term perspective and advocating creatively.

> **Fiona**: One of the things that probably disappointed us both at the time was as the year came to an end there was no real contingency plan for what was going to happen when we stopped. We were very clear that we never wanted to build a culture of dependence in the action learning, it was about empowering people to go and do it themselves. But, there wasn't actually anything after we had gone. We had suggested some things that might happen. …We weren't looking to be funded for more time to do more of the same. I certainly felt that wasn't the right model; it had run its course and something different needed to be supported. However, there was a gap of about a year when there really wasn't anything [in place].[17]
>
> **Jane**: A couple of the community hospitals had said that they were going to continue but they didn't. I suppose what we had thought, or what the groups had thought, was that there would be a facilitator from within. In reality that doesn't really work because people have always got agendas. Every organisation should have people who can do that [facilitate] on behalf of groups. If you go into the private sector, the likes of Shell, they're riddled with facilitators who do exactly that.
>
> One of the senior managers, who was actually the Chair of the Care Pathways group, they saw very clearly once again, that this kind of approach would be a good approach for people [to support integration of health and social care]. So we developed the structure and I remember very clearly Fiona and I saying that we cannot allow people on the ground to be left wondering what the hell is going on; to be handed a policy and told to go and implement it. It was that conversation which actually prompted the building of a scaffold of local reference groups[18] for integration; with the added benefit of bringing a third sector person into the mix [as an integration facilitator] so that we could start really opening that door too.

In one hospital catchment area, two third/community sector staff members were involved in the *Beyond Action Learning* process.

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[17] The facilitators and consultees, for instance, highlighted the falling away of some of the practices developed e.g. use of data to effectively influence decision making and demonstrate reasons for action

[18] Aberdeenshire Health and Social Care Partnership have used a development of strategy of six local reference groups to generate cross service and sector discussion to support the integration of health and social care – from which 20+ local health and social care teams are emerging.

One of the outcomes there was a Community Links Worker pilot project which was established with the local community/third sector and sought to work in partnership with local people, community groups and health and public services. It ran for almost three years until the end of 2015, and is the focus for an action research project between Aberdeenshire HSCP, CPP and third sector with What Works Scotland. The report was published in November 2016[19].

> *"Retraining people to be confident taking risks in what has become a dangerously, detrimentally risk-averse society could be your next challenge? It is what has to happen."*
>
> Participant

[19] Learning about community capacity-building from the Community Links Worker approach in Insch, Aberdeenshire (2013-16): a collaborative action research inquiry (cycle 1) whatworksscotland.ac.uk/publications/learning-about-community-capacity-building-from-community-links-worker-approach-aberdeenshire

4. Brief reflections on the *Beyond Action Learning* approach… in creating spaces for dialogue on collaborative learning, research and action

What Works Scotland is exploring the role of collaborative action research and the related family of collaborative learning practices in supporting, informing and reflecting on public service reform.

We are keen to learn from the experiences of both those involved broadly in **collaborative learning, research, improvement and action** and those concerned to pursue **collaborative partnership working**.

Two of the key themes for What Works Scotland in developing our understanding of this range of approaches are:

- **Relational working:** building and sustaining relationships within a team of 'inquirers' or 'learners'; organisations and their partners; and the wider body of stakeholders; and
- **Critical working:** questioning assumptions and evidence; empowering all those involved; and recognising the wider social context and related inequalities.

In this report, the *Beyond Action Learning* facilitators and project offer a wealth of experience to support discussion on both these themes.

Their discussions and collaborative working on 'wicked issues' have been developed within their particular working context and so are not a simple set of principles or formula for success – the right ways and wrong ways of doing things. Instead they provide *actual* illustrations of the complexities, dilemmas and potential benefits of these forms of practice. In so doing, the project can support broader discussion and learning for those involved in community planning and public service reform, whether in strategy and policy; operations and front-line service provision; or as the diversity of stakeholders and communities impacted by, and contributing to, reform.

The project's experiences can support further discussions about the 'how' of and the potential benefits from collaborative learning, research and action, for instance:

The relational – seeking to build and sustain a range of relationships and dialogues with different people and structures: with those working in different services in local teams; with senior, strategic and operational management; with those further afield in other services and in communities; and through co-working and linking to wider collaborative networks.

The empowering – questioning assumptions, strengthening staff morale and engaging with management and policy on the 'wicked issues': so that staff teams feel confident to ask crucial, challenging questions of themselves and of management, policy-making and

strategy development; and in sustaining longer-term and creative dialogue within organisations and partnerships.

The technical – supporting dialogue through considered use of data, evidence, knowledge and related tools: so that those working within and managing services are better able to explore shared issues of concern within their work and its context.

In bringing to life the details of actual collaborative learning and action processes, the facilitators offer the space for thinking further about how to 'hold' these three key elements together in the day-to-day work of 'putting Christie into action'.

Their discussions also flag up areas for deepening investigation and discussion including the 'how to' of:

- building senior management support
- building trust across multi-disciplinary teams
- risk-taking and seeking creative, flexible solutions
- staff empowerment within financially constrained public service reform

Our discussions in co-producing this report also recognised the need to engage with the wider organisational and societal policy contexts, for instance in relation to staff terms of employment; third/community sector roles and community empowerment; and social and economic inequality.

James Henderson, Research Associate, What Works Scotland

5. Further reading and resources on practices relevant to collaborative learning, research, improvement and action

Action Learning Sets

University of Birmingham Health Service Management Centre's Introduction to Action Learning Sets http://www.birmingham.ac.uk/schools/social-policy/departments/health-services-management-centre/work/action-learning-sets.aspx

Action research

Richard Brunner et al. (2016) Challenge Current Practice and Assumptions! Make Waves!! http://whatworksscotland.ac.uk/wp-content/uploads/2016/06/National-Event-Report-Feb-2016-Publication.pdf

Chris Chapman & Mark Hadfield (2015) Supporting Collaborative Action Research http://whatworksscotland.ac.uk/wp-content/uploads/2015/07/Supporting-CAR-Approach-working-document.pdf

John Heron and Peter Reason (c. 2000) The practice of cooperative inquiry http://www.peterreason.eu/Papers/Handbook_Co-operative_Inquiry.pdf

Collaborative leadership and learning

Nick Bland and Cathy Sharp (2016) What Works Scotland Working Paper: Practising collaborative leadership http://whatworksscotland.ac.uk/wp-content/uploads/2016/05/Pioneer-report-publication.pdf

Dialogue and deliberation

Oliver Escobar (c. 2011) Public Dialogue and Deliberation http://www.qmu.ac.uk/mcpa/CDial/PublicDialogueAndDeliberationOliverEscobar2011.pdf

Wendy Faulkner (2011) Dialogue in Public Engagement: a handbook https://edinburghbeltane.files.wordpress.com/2011/11/dialogue-handbook-final.pdf

Evidence use

Sarah Morton and Alex Wright (2015) Getting evidence into action to improve Scottish public services http://whatworksscotland.ac.uk/wp-content/uploads/2015/02/WWS-MortonWright-Working-paper.pdf

Improvement methodologies

Zoe Radnor (2010) Review of Business Process Improvement Methodologies in Public Services http://www.york.ac.uk/admin/po/processreview/AIM%20Review%20of%20Business%20Process%20Improvement%20Methodologies%20in%20Public%20Service.pdf