Impressions of action and critical action learning: Exploring the leadership development of senior doctors in an English healthcare organisation

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Abstract

This paper aims to explore the influence of one cycle of a learning set experience in a postgraduate medical leadership development programme from two perspectives. Firstly, from the self-reports of nine senior doctors working in leadership roles in England in the National Health Service (NHS). Secondly from a researcher perspective as we present our research process, findings and perceptions on the use of Action learning (AL) and Critical Action Learning (CAL) for leadership development in the complex and unpredictable context of the NHS. The paper affirms other study findings (Ram and Trehan, 2010) that CAL in the development of participants' collective reflexivity has the potential to deal with emotions and power relations in organisational life. An original contribution lies in advancing the idea that CAL can help build resilience in doctor leaders and groups in uncertain conditions able to challenge current care delivery and make a change in organisational performance.

Introduction

Within the English healthcare system, there are diminishing fiscal resources, public concerns over patient safety and the quality of care (Francis, 2013) and a growing aging demographic population with complex care needs (Oliver, Foot, & Humphries, 2014). To respond to these challenges, it is necessary to determine different ways in which to work and lead within health and social care services. For doctors, this requires taking clinical and leadership roles that are more strategic, as well as delivering frontline care and enabling improvements in care (Kings Fund, 2013).

In response to the need for change, one National Health Service (NHS) Foundation Trust (comprised of two hospitals) sought to provide a more locally based leadership development programme for doctors that have medical director and consultant roles. It was hoped that this group of people would be the first to begin to initiate a change in the organisational culture, which would impact positively on performance, establish new networks for collaboration and the integration of services, and improve the quality and resilience of care delivery needed at organisational, team and individual level. In the NHS senior doctors in leadership roles are important personnel in building this resilience.

The model of delivery commissioned incorporated a learning set module within a bespoke one year leadership development programme leading to a Post-Graduate Certificate in Strategic Management and Leadership. Action learning (AL) is an experiential learning method in which participants learn by doing and then reflecting on what they have done. The curriculum is established from the participants' learning needs and experiences, unlike traditional leadership development programmes offering theoretical leadership models or frameworks. Participants work on real tasks in small teams (learning sets). Revans (2011) describes learning as having two components. One part consists of programmed instruction, where a teacher or instructor provides information to the learner. The other component consists of the understanding that arises when learners use questioning to help each other explore the situations they face; this second component can be referred to as AL. Pedler (2005) notes that much of AL in the public sector – which is where the NHS sits, remains strongly individualist in focus, and he revisits Revans's proposition (Pedler ,2011) suggesting that learning sets should go beyond individual development and connect more widely with relational and organisational challenges. Vince (2008) warns of the collusion that can take place in conventional action learning when participants avoid challenging difficult organisational issues by learning inaction. Vince (2008) advocates the practice of CAL, because more critical   attention is paid to power relations and attendant issues of politics and emotion. For this paper and research, when we talk about AL and CAL we are not implying different 'things', we stress that CAL pays attention to and develops additional awareness of certain factors of how people relate to each other, embracing the critical thinking, feelings and reflections of participants on their current practice position and experiences. This may be important for a development programme which aims to nurture the collaborative exploration of alternative and integrative approaches to care delivery as part of organisational transformation.

The programme was held on one day a month for one year and comprised of three events: (1) a reflective commentary and discussion led by the Trust's chief executive; (2) learning sets of five to six people (3); and lecturer-led input to support a work-based project centred on integration of services that formed a key area for learning set discussion on progress.

An external evaluation of the programme was commissioned by the NHS trust and undertaken by a NHS management consultancy group (Arup Consulting, 2013) . The evaluation shows strengths in the programme, especially the use of learning sets, but highlights that more evidence of their benefits are needed. As curious researchers and practice facilitators in workforce development programmes we want to look further at the nature of benefits and contribution of the sets, what is significant for the commissioning

organisation in the NHS setting of the study, and to offer further insights by depicting both the participants and our own learning. Here we explore the influence of one cycle of learning set experience from two perspectives. Firstly, from the self-reports of nine doctors in clinical leadership roles. Secondly from a researcher perspective as we set out our research design, methodology and data analysis process. In presenting the programme participant's experience of the learning set experience and our research process and perceptions on the findings, we provide a critical exploration of the use of AL and CAL in the complex and unpredictable context of the NHS. The paper affirms other study findings (Ram and Trehan, 2010) that CAL in the development of participants' collective reflexivity has the potential to deal with emotions and power relations in organisational life. An original contribution lies in advancing the idea that CAL can help build resilience in Doctor leaders and groups in uncertain conditions able to challenge current care delivery in the workplace. In doing so it offers a new understanding of what can be expected in using the approach as part of a leadership development programme in similar conditions. We start by setting out the complex historical and policy landscape of leadership development in which this study sits.

Leadership development for medical professionals in complex organisations

Within the UK, Scotland, Wales, England and Northern Ireland have different NHS jurisdictions. In England, the Nicholson challenge of making efficiency savings of £20bn, while increasing safety remains unsolved (Nicholson, 2008), as evidenced by events in the Mid Staffordshire NHS Foundation Trust (Francis, 2013). Significantly despite changes to medical education(NHS England, 2004), doctors are still largely educated to become expert professionals in clinical work holding advanced technical skills operating in a hierarchical system. This is a challenge for doctors in the transition from professional to leader in the NHS. Such doctors are in the gap between managerial and clinical communities(Marnoch, McKee, & Minnie, 2000), and face the differences between clinical priorities and financial controls,(Degeling, Maxwell, & Coyle, 2003; King's Fund, 2013). Being equipped to lead means addressing the discomfort of moving from the "known" safe individual technical response to a problem using impersonal authority to that of the "unknown", unsafe, personal and group perceptions of problems and solutions to create organisational learning and systemic change (Haeusler,2010).

Action Learning and Critical Action Learning in the NHS

AL has long been associated with the UK's NHS in the studies of Revans (Revans, 1980) and has been adapted and applied variously by management academics (Kozubska & Mackenzie, 2012) and developers to further support the resolution of real problems, and in other organisational research (Lynch & Verner, 2013; Phillips & Byrne, 2013). Additionally the work of Coghlan and Brannick (2014) and Pedler (2011) are well known examples of how the AL approach has been adapted and disseminated. As is evident from relatively recent studies of leadership development practices (Blackler & Kennedy, 2004; Bowerman, 2003; Pedler & Attwood, 2011), AL has sustained a reputation beyond that of a management fad, and it now remains an appropriate learning strategy for leadership development(Brook et al, 2012).

Critics of AL see these claims as exaggerated, and suggest the intention of tackling challenging organisational issues is not necessarily realised. Actions beyond and outside the set require risk taking that may place individuals in conflict with others and established cultural norms. To address this, attention to politics, emotion and power are needed (Ram & Trehan, 2010; Vince, 2004 Reynolds & Trehan 2003 Reynolds & Trehan 2008). within the complex and shifting situation of the NHS, where a solely functionalist mind-set towards development is problematic, and that we should complement our insights from critical, dialogic and interpretive perspectives beyond AL to CAL.

These critiques of AL and CAL are pieces of research of note. They indicate that both AL and CAL can support the development of participants' self-awareness and reflection and as such are symbiotic. AL provides experience of good quality group interaction to support individual reflection and learning whilst a CAL orientation enables a recognition and questioning of the emotional impact of power dynamics of the context. For us CAL is a change in emphasis in AL it is not a separate activity or something new (Warwick et al, 2017).

What is important in this paper is exploring how the literature can inform our thinking about which dynamics of the set process matter in meeting the commissioners' goals of increased collaboration and resilience . Our starting point is that where things change for individuals and groups in a learning set, is in the questioning and challenging of current leadership experience through reflexivity. Reflexivity being a practice of thinking critically of actions related to others and paying attention to the ways in which we come to envisage future practice. Our interpretation of the literature is that CAL offers this opportunity for reflexivity where action is dialogic and relational, and it entails the unsettling of our conventional leadership responses and practices.

Reflexivity

Pollner describes reflexivity as, 'an "unsettling", i.e. an insecurity regarding the basic assumptions, discourse and practices in describing reality' (Pollner, 1991: p370). Being reflexive involves an essential unsettling of beliefs, modes of acting and being, in order to notice those deeply ingrained assumptions that characterise habitus (Bourdieu, 1990) and form part of our life experience . When we shift from our everyday practices and previous experiences into different unexperienced and unanticipated ones like the Doctors in the learning sets of the programme, being 'unsettled', and confronting 'assumptions', 'discourse' and 'practice' are important, as are issues of paradox, risk and vulnerability (Warwick & Board, 2013). This is because they allow attention to be paid to the confusing, ambiguous, disturbing and challenging nature of human experience and power relations. These are

characteristics that Hugh Willmott was keen to explore in giving action learning a more critical twist (Anderson & Thorpe, 2004; Trehan, 2011; Vince, 2004).

Alvesson and Spicer (2012) identify dynamics of social expectation derived from both the internal and external sources of an organisation which suppress criticism and reflection together with what is permissible to speak and think about. In the CAL process this is important as it is in the conversation with others that such noticing of those dynamics can occur and the processes of reflexivity enabled. Although dynamics can be self-reinforcing they can also be destabilised particularly when either party cease to ask searching questions. In this sense, reflexivity (the processes of thought and action) comes to affect both the individual *and* the organisation itself by the ripples the actions take (Warwick, Palmer & McCray, 2017), and thus has implications for both.

These processes can be challenging (Brook et al, 2012) difficult and risky, particularly when faced with an implicit or explicit organisational dynamic that might subdue this endeavour (Alvesson & Spicer, 2012). It is therefore important for facilitators to create 'safer' conditions for an individual's thought and practice action to be considered collectively (Warwick & Board, 2013). From this position, reflexivity enables leaders to critically engage with ideologies, power and practices that they take for granted and find hard to challenge. For our research and in meeting the first of the programme commissioner's goals around collaboration we find this forms a valuable allied source of insight for CAL. Moving to a second objective of the commissioners, the resilience of the delivery of care at individual, team and organisational level in their NHS organisation. Senior doctors in leadership roles have an important role in building this resilience. Their readiness and stamina to cope with additional pressures, business change, emergencies and complex patterns of care are crucial to challenging current care delivery. We are interested in finding out if a learning set experience involving reflexivity where ingrained practices and assumptions may be challenged safely, can increase Doctor's capacity to cope with the stress such challenge can cause in the NHS organisation. Subsequently can such experience enable leaders to deliver care with the associated specific localised changes required? (Fillingham & Weir, 2014).

Resilient Leaders in Healthcare

Doctors may have developed individual resilience skills in working with patients in a clinical leadership context (Stevenson, Phillips, & Anderson, 2011), and as scientists they may have been educated to follow bureaucratic technical procedures and rules which may not be immediately applicable in leading service transformation. Pipe and others (2012) observe that workforce development programmes in healthcare environments with a focus on problems and the retelling of challenges are not helpful. They suggest that a reframing of how employees look at healthcare and its complex and uncertain challenges is required and a more optimistic position taken. This involves a focus on individual employee resilience as an aspect of Positive Organisational Behaviour (POB) (Luthans, 2002)with the associated psychological capacities being efficacy, optimism and resilience (Ibid, p.695) and a view that people can learn these POBs. In order to pursue and challenge behaviours ingrained in practice, Frederickson et al. (2008) believe that resilient people can proactively prepare for hardship and adapt to stressful circumstances by using their psychological resources

appropriately. Within the wider NHS the focus and interpretation of individual resilience includes links between safe practice and burnout (King's Fund, 2012) and employee engagement(McCray, Turner, Hall, Price, & Constable, 2014). Schaufeli and others (2006) present a correlation with burnout and poor professional efficacy which may impact on safe practice and also the capacity to drive and implement change. We are familiar with a considerable literature which explores and measures individual resilience(Block & Kreman, 1996). However, as we have noted, in the NHS setting individual, group, team and organizational resilience are important constructs. Research into the resilience of teams is relatively new(West, B, Patera, J, & Carsten, M, 2009), as is resilience in groups (Berkes & Ross, 2013) .Further, whilst Pipe et al., (2012) observe that much of the POB line of research takes a position that these behaviours can be learnt, there remains a lack of agreement in the literature on what resilience is and a gap between how resilience operates for individuals and what mechanisms work in transferring this to groups and organisations (Zellers, Justice, & Beck, 2012). Of specific interest in our literature search is the work of Shin and others (2012) who note that researchers are now concerned not only with the importance of recovering from a stressful event that involves minimum impact on the emotional state, but with emphasis on new learning for future situations. As we noted earlier, in the workplace, the application of adaptive behaviours to mitigate stressful situations may prevent burn out (Maslach, 1993), and that leaders who can build a mental, physical and emotional capacity for dealing with difficult and complex situations may be better prepared for decision making and coping. However, leadership in the context of transformation of organisations may present a different set of challenges to Doctor resilience. That is why the work of Shin et al., (2012) is of interest to us. Shin et al.,(Shin et al., 2012) use conservation of resources theory (Hobfoll, 2001) to explain how individuals cope with transformation. According to Hobfoll, individuals establish a set of resources in response to a world which is inherently threatening, and such resources include personal strengths and social attachments to enable coping with challenges. These attributes are often strongly held by doctors in their specialisms, and are significant for positive role satisfaction (Strömgren, Erikson, Bergman, & Delive, 2016). Equally, doctors often hold a high level of sense of meaning about their work which is significant in resilient individuals (Pulley, 1997). In organisations, individuals work to maintain their resource capacity and become stressed if their access to these resources is lost or under threat. It is acknowledged that transformation or change (Hobfoll, 2001) within a workplace and new leadership roles may trigger some of these responses in clinical leaders if their traditional medical support networks and responses are diminished, even in individuals who are psychologically resilient in their medical role. Shin et al., (2012, p16) and McCray et al,(2016, p1132) suggest that organisations can help leaders build resources and resilience to organisational change via organisational inducements, and potentially by organisational interventions of support throughout the change process. Their research shows that implementing such practice enables a greater commitment to change, and that investments in development and emotional support builds positive responses to the change process if successful. These in turn can build capacity for organisational resilience in care delivery. These findings are reported here because they are helpful to us in furthering our exploration of the value of AL and CAL, which in enabling the exploration of emotional and political growth may have a contribution to make in building NHS individual, group and organisational resilience and thus achieving the programme commissioner's goals.

Research Design and Methodology

Our study aims to explore the experience of AL and CAL on nine doctor leaders and their organisation, and secondly what this research offers ourselves and our practice. As researchers, we are an interdisciplinary group of academics, involved both in designing the leadership development programme with the NHS trust concerned and undertaking associated research. For us, the learning set approach brings together organisational development, practice and individual learning. This will potentially influence the performance and commitment of individuals, which will in turn contribute to organisational effectiveness (Shum, Bove, & Auh, 2008). The use of a narrative inquiry methodology helps us to focus on the significance that people ascribe to their experiences and thereby provide, 'insight that (befits) the complexity of human lives' (Josselson, 2006, p4). Seeking to build stories from the intention, language (Riessman, 2008: p11) and the 'hows and whys' of incidents experienced by people as they come together.

Coming from within social constructivism, the approach values both our previous practice and research experience and ensures that we are cognisant of the continuously changing contextual complexity of policy history, economic reality and culture of the research setting for us and our research participants (Guba & Lincoln, 2005). As we engage with the participants' reflexivity we note our own. Pollner (1991) points out that reflexivity does not lend itself to being separated from the researcher's own experience, to be studied from afar and for fixed conclusions to be made. We have taken this point seriously and addressed our learning at all stages in the methodology. In particular where knowledge we are gaining from our research inquiry and our practice wisdom is taken into account. Shotter and Tsoukas (2014; p388) use the Aristotelian concept of *phronesis*, i.e. knowledge and wisdom derived from practice in considering how we might develop an understanding of the unfolding dynamics between our inner selves and what is happening around us. In this respect reflexivity is a process that enmeshes our past experiences, the present and their contexts with an imagined future hope, along with practical immediate decision making.

We are interested in Norbert Elias's (1978) discussion of power; in that it is a feature of all human relations. In doing so our research methodology enables us to challenge notions of absolutist objectivity as we invite participants and each other to reflect on and construct experiences. The study draws attention to human interaction, and the notions of power that could be viewed as being logical and premeditated, together with the emotional and anticipated use of power as influenced by histories, culture, existing relationships and intentions. Our position as both practice based programme designers and researchers, and the effect of this on the research process (Anderson, 2017) and outcomes (Muir, 2014) are recognised as we present our method and review our actions and learning. We take account of Alvesson et al's (2008) preference for instrumental reflexivity (Weick, 1999) where researcher "reflexivity is not primarily an end in itself, but a means to improve research in some way" (Alvesson et al, 2008, p 495).

The sample

The study sample method was purposive. Participants are nine members from an eleven-member senior medical doctor cohort enrolled in a postgraduate leadership programme; the other two members of the cohort were unavailable to participate in the study due to work commitments. Participants were selected because they had engaged in the leadership development experience of the research study and could explore it in depth (Sanders, 1982).The cohort are seen as an important group of change agents in the NHS trust capable of leading business change required for integration. Their medical disciplines are wide ranging. Prior to the programme, two participants out of the nine in the sample had attended a previous formal (but not accredited) leadership development programme. The remaining participants had attended short seminars, sessions and presentations. Four members had experienced some form of AL prior to this programme, one of which had been linked to leadership development. Seven members of the sample described their leadership training as largely 'on the job' and had not chosen to be leaders. This characteristic is of interest to us as researchers as we explore the development experience of the NHS doctor leaders and ask what (if any) aspects of it might change their position and thinking on leading.

Method

The interviews

The qualitative interview was chosen as the empirical data collection tool. This was because as a method it has often been used effectively within the health sector (Bolton, 2004; Øvretveit, 2009; Stanliland, 2009; The Health Foundation, 2014) Further Bryman and Cassell (2011) writes that in leadership development research, qualitative interviewing brings to the fore the context and the interviewee concerns. They note that because of this, the programme educator has much to gain from qualitative research and the value and insights it offers for context specific development programmes like the one in the NHS trust of this study. That said we were guided by Brinkmann and Kvale's (2015) advice that we should approach the interview as an ethnographic situation and defamiliarise ourselves with it. We are aware of Alvesson's (2003) caution regarding the "authority" placed on the interview as a valid source of knowledge as we explore the participant's response to their leadership activities, in and beyond the set, (Browning & Morris, 2012). The first part of the interview was structured to gather biographical information relating to each participant's profession, education and career to date, and each participant was asked about their leadership experience, role development, learning style preferences and educational models experienced prior to the educational programme). In contrast, the second part of the interview was unstructured so that participants are able to move along their own narrative path (Chase, 2005) and to pursue topics that are important to them (Mason, 2006), but which may have been unknown to the

interviewer. We arranged for a research assistant (Karousou, R.) to undertake face to face interviews in each of the participants' workplace.

Data Analysis

We find the general guidance and thematic framework of Ritchie and Lewis (2003) helpful. This is because it illustrates transparency in relation to researcher interpretation and presentation of theme based data and helps to track any decisions about the importance of particular text made (Smith & Frith, 2011). We have taken a paradigmatic approach to the data analysis (Polkinghorne,1995) of the participant's narratives. This involved each of the three authors reading the interview transcripts separately and noting any salient moments (Katz & Shotter, 2004) words and phrases (Shotter, 2006; Shotter & Tsoukas, 2014) prioritised by the participant within the flow of conversation. This resulted in the creation of a set of common descriptions and participant stories from the data which were organised into themes. These themes were derived from the earlier literature review where we critically explored AL and CAL and their application in the NHS leadership development context. Reflexivity is important when current practice and assumptions about that practice needs to be questioned and transformative change is required. We also explored resilience in care delivery because the NHS trust programme sought to increase the resilience of participants, teams and organisations. We asked, firstly what does the data say about the presence and intensity of reflexive experience for the set members in our study? Secondly how does the data enable us to notice the social power dynamics that are both a part of the set and the workplace, as we capture leader action? We propose this as a shift from AL to a CAL experience illustrated in tables 1 and 2 below. Finally how do narratives of the learning experience where ingrained practices and assumptions may be challenged safely, offer insights into participant's perception of their own, team and organisational capacity and resilience to cope in the NHS? , and subsequently enable leaders to deliver care with the associated specific localised changes required? (Fillingham & Weir, 2014). We present this from a AL and CAL orientation and is illustrated in tables 1 and 2 below.

Table 1 Qualities of Learning Experience attributed to action learning and critical action learning orientation and resulting theme: Reflexivity

Action Learning attributes	Critical Action Learning attributes	Theme
	Dealing with emotional and personal issues	
Generating openness and honesty	Relating to the self unexplored in normal context of practice	

Listening and paying attention		
To the detail		
Gets under the veneer to the meaningful	Sharing self with others beyond daily professional interaction	
Affecting listening and communication skills	Safety was maintained	
	Very intrusive and unsettling	
Self-identity and confidence explored positively	Impact was unsettling but can cope	
Found set liberating reassuring and supportive	Empowering having taken this step	
Security and trust and confidentiality is high	Critical challenge of leadership	
	critically yet collegiately	
	Critique what is going on- post set reflections have been powerful	
A safe place to discuss issues	Leadership responses, rationale and behaviour changed	**Reflexivity**
Supportive environment	Result of listening and building relationships is critical questioning skills	
	Awareness of how talk and listening in the set affects other people	
	Sense making of action both inside and outside the set	

Table 2 Qualities of Learning experience attributed to action learning and critical action learning orientation and resulting theme: Resilience

Action Learning attributes	Critical Action Learning attributes	Theme
Link with performance and place to discuss	Place to discuss performance actively and note performance (fails and gains) equitably	
Action points very motivating	Value of use of feedback and set adviser in relation to commentary on leadership events	
	I know I can achieve	
	Shift in thinking and prioritising	
Receive comments on use of tools	Link between intention and possible action was explored	
Get feedback	Place to discuss freely how organisational factors impact on performance	Resilience
Appreciate set feedback		
	A sharing of solutions / coping and alternatives for different	
	Problem was less of a problem	

leadership situations was of value **Reviewing possible action to be taken was helpful** **Perception of problems is now different**

Insert Table 2 Qualities of Learning experience attributed to action learning and critical action learning orientation and resulting theme: Resilience here

Findings

The reflexive set experience

The starting point for most participants is how the set leader embeds listening and attending as core features in generating openness and honesty. Participant AL6 and recalls:

'We related to each other in a way we had never perhaps related before, so we got under...you got under the veneer of people. You've got people there whose veneers I was very familiar with but less familiar with what went on underneath' (AL6).

For us this data signals that listening and paying attention enables participants to think in the moment or 'now' and we interpret this type of data and the individual experience it captures as a common feature of AL. Because of this we place similar examples from the narrative in the orientation of AL in table 1.These findings are not a surprise to us as researchers in the AL and CAL field and are supported in our literature review. Where our curiosity increases is when in our data analysis process we see a sharpening of intensity, captured as the participants depict how the social dynamics change:

'Not just listening for the sake of listening or paying lip service or pretending to listen or just...you know. But actually listening and listening to the detail and the importance and judging the importance of that detail and internally processing that in a way that is helpful to me and to the organisation and the patients that I treat, and it comes back to that' (AL4).

We note a shift towards reflexivity in the set experience, as we identify data which has a CAL orientation. For participants the process of listening to the detail of set dialogue is key, as participants reflect on the potential impact of this change:

'So that's interesting I suppose, it's given me a kind of reflection within the workplace, because for me it meant that I took a step back in reflecting a little bit more about, "do I really understand what is going on around me?" And the levers and the importance of various other things that are happening' (AL6).

In the data the participant narratives move toward an emphasis on the critical process within CAL, i.e. "the unsettling", as they deal with issues of emotion, personal and power relationships in the setting:

'And I have thought, blimey did you...did I hear that right...did you really say that...did it mean to come out quite like that?' And sometimes you want to applaud them for doing so. I guess those comments are all part of the learning process, if you consider that the Learning Set is there to facilitate you learning more about yourself and more about the environment in which you work and about how you support and interact with others' (AL1).

Participant AL6 recalls:

'I suppose, it's given me a kind of reflection within the workplace, because for me it meant that I took a step back in the set reflecting a little bit more about, "do I really understand what is going on around me?" And the levers and the importance of various other things that are happening. Giving yourself a little bit of time to digest and then you know, perhaps responding if it is appropriate. It gave me some deeper understanding of some of the local and regional sort of political and sort of...political agendas and things which I wasn't really aware off before' (AL6).

Several interviewees acknowledge that many of the issues discussed with others in the set are difficult because of long-held power relations, beliefs, or assumptions, or that the issues were just previously unnoticed. AL8 data excerpts are used to explain :

'there's no doubt that initially when people were finding their feet in the group that there was, not a reluctance to bring things to the table, but there was perhaps a...I mean the order with which people were allowed to speak was perhaps a little deferential to start with for the seniority'

But that the conversations facilitated an exploration of the political nature of organisational life, which was enabled by the interaction of actions that were agreed in the set and implemented :

'Whereas now people, not necessarily shoot first and ask questions...or shoot from the hip or whatever analogies you want to use. They would say, 'right what are you going to do about that?' And putting it straight back and giving you challenges' (AL8).

And the subsequent changing of the organising dynamics of power relations in the workplace and how these were further reflected upon in the next set meeting, lead to further action and the shift from I to we in the changes described:

...'I've had in the last week, had some feedback from somebody, a senior manager, it was just saying that actually, because I've changed the way I work with my Chief of Medicine, so the next level up and have tried different things that have been suggested within the Action Learning Set, and then things that I have been thinking about. And that has been very effective, because it said that actually where we have changed the division of structure they weren't really brought into it and they didn't really see why. However because of the changes in what we're doing because we have been so proactive, it has made a big difference' (ALS8).

We read how CAL enables participants' time to synthesise personal learning and aspirations about themselves and leadership, alongside the challenges of leading collaboratively in a complex, multi-layered organisation. Participant AL2 reports:

'We were able to challenge what we all thought about the major issues for the Trust, and there was an awful lot of digging quite deep on a personal level about our own personal performance and our own personal aspirations' (AL2).

Underpinned by reflection as participant AL7 describes ;

'*it (ALS) does make you consider how you should grow and develop and become a different...not necessarily a different person but a person who certainly can reflect'(AL7).*

With the opportunity for growth here illustrated by participant *AL5 :*

'My intention is to completely build on what is started, so if I only sustain it, I think I've failed. So what I think this has really done has given me not just a foot on the first step, but I think what it's enabled me to do is leapfrog up a few steps and get a much more clear idea of what I am trying to do as a manager and as a leader within the organisation'(AL5).

We capture unsettlement, which provides further CAL orientation and attributes for the table 1 data. Participant AL2 notes:

'I am more a looking down a microscope person not a patient / client interaction person. So, I like challenges, and for me I suppose this was a challenge in a sense to face my inner demons which is no bad thing' (AL2).

Whilst the openness resulted in frank revelation :

'Depending on the ability of the participant i.e. myself as to how much truth I tell, as to whether I really open up or not, or whether I'm guarded. And I think many of us are guarded, we're not going to open up to everything. We will tell people what we think we want to tell them, because we all have our dark areas where we don't want to go'(AL8).

With the experience of revealing and engaging within the set being at times uncomfortable:

'... each session I would think "I really don't want to be here doing this." But it is nice during those meetings when you get positive direct positive feedback from your peers, and if you express self-doubt, particularly if you are expressing any self-doubt as to your ability to actually sort of do something or your effectiveness. I've had a lot of very positive and reassuring feedback, so that's you know quite good' (AL2).

In our analysis it is both the unsettling nature of the CAL experience reported by participants and then, how once safety is established during the process, learning in the sets becomes helpful and sustained beyond the set into the organisation that is noteworthy. Participant AL1 recollects:

'I was actually surprised with how comfortable and safe I felt doing it with that particular group of colleagues once we were a couple of sessions into it. And interestingly with those particular colleagues those sorts of conversations are now taking place within the workplace environment as well, so I think from that point of view they have been very positive' (AL1).

Resilience

As we move towards other attributes of the participants' learning set involvement, we respond to our question: Does a learning set experience where ingrained practices and assumptions may be challenged safely, increase participants' perception of their own, team and organisational capacity and resilience to cope in the NHS organisation? Concurrently, is the data showing any transition from AL where feedback and thinking is at the individual level, to CAL with its organizational and collaborative dynamic? This transition is identified in the data where participants expressed a shift in the perceived nature of the problem enabling learning and leadership. For us reading the data is illuminating. Table 1 shows how what we label AL orientation attributes , are predominately a social exchange based on feedback from other set participants. These include motivating feedback on action taken during and between set meetings For example when the 360 feedback was discussed in the set. AL1 reflects*:*

'It's not about being "bad", it's about people recognizing and accepting that your leadership journey is just that. It's a journey and you can't possibly score very well at everything until you've arrived, and of course on that journey you never do arrive' (AL1).

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On further reading other forms of learning are taking place which we include under a CAL orientation in our data in table 2 within the theme of resilience. This includes new learning about ways of seeing a problem collectively with data extracts here from participants AL3 and AL5:

'...it was encouraging to somebody to look at a problem in a different way, or deal with it psychologically in a different way, so that the problem became less of a problem' (AL3).

'We all joke about it being group therapy, and it feels like that because you come out of it feeling 'actually, no I can achieve...all these things we've talked about I know I can achieve.'

Whereas when you start off, it is quite often, 'oh I don't think I can achieve all these things, it's too much for me to try and do!' (AL5).

Whilst participant AL6 charts a shift in thinking about how to get help:

'the *temptation is to say, 'right with every problem that I've got, I will go straight to the top.' Well you know, we know that that doesn't work because that person at the top has got a bigger fish to fry. So I am learning the hierarchy of the organisation, I am learning who to approach with specific problems better, and feeling much more confident about going to that person and saying, 'I think this is what you can help me with.' And looking for their help in steering this challenging project'*

Connected to a concern with how to develop positive leadership behaviours to encourage greater resilience in the organization, participant AL4 reports that:

'...and those are outcomes that require quite a lot of strength, whether it's an introverted quiet listening and you know providing a proposal, or if it's you know mustering the troops and getting everyone on board through a kind of motivational, inspirational sort of approach. I mean they require a certain kind of inner strength, and that was probably something that came out quite a lot I would say in people's reflections. 'How much do I have; how do I get more? (AL4).

Whilst new strategies for coping are noted, illustrated here by AL3:

'If I am say struggling to cope with something, I have got more kind of weapons to use and more ways of coping. And if, I because I tend to take things very personally, actually I have learned to balance that more and appreciate that lots of other people do it as well' (AL3).

And participant AL4 shares a shift in both behaviour from individual to a team and in perception from technical to creative thinking in their capacity to lead in the workplace:

'Working as a team, being able to think laterally and think...oh laterally and widely are the same thing, what am I trying to say? Think laterally but also remain focused on an objective (AL4).

Whilst AL9 summarises the change in response:

'I am more willing to face situations which I would have shied away from in the past so I am arranging various meetings and discussing issues that are arising and facing them up front. That's the change in the workplace' (AL9).

Discussion

Interpreting the doctor leader narratives and how they strive to both understand themselves, others and their responses to high level problems, affirms AL as offering personal development, whilst still remaining within the technical rational response to problem perception. CAL in generating reflexivity, moves thinking about the nature of problems resulting in a maintenance of leader energy and resilience which has an organisational impact in highly challenging situations. Tables 1 and 2 above show how changes identified by participants that we attribute as AL and CAL, can be summarised in terms of how participants' leadership performance was re-framed whilst their reflexivity developed and their resilience increased. The exploration of theory in the literature review and it's synthesis with data that portrays participants' experience in the learning set, is explored further in the discussion below.

Reflexivity

Bourdieu noted that the more expert we are in a particular game, the less it becomes available to us to notice and therefore reflexively engage with (Bourdieu, 1990). This point is identified by several participants when commenting on differences apparent within the learning set as the focus in the sets changed from action learning to critical action learning. The dialogic tension in the explorative process is important (Warwick, McCray, & Board, 2017) and evident in the interviews, giving life in Table 1 where leadership action is explored, 'critically, but collegiately'. To enable this, the CALS process is providing a place of relative safety, to explore these issues over a prolonged period-of-time

In this respect, the safety of the process is important, particularly in how this enables supportive and challenging conversations. Our learning and findings highlight the tension between recognising that safety and confidentiality is important and how the process affects the theme and patterns of wider workplace conversations. These illustrate a process of reflexivity that affects both the individual and group, in other words, a social reflexivity, which is a point that Tucker discusses in exploring Giddens's work (Tucker, 1998). In the findings of this study, although the rules relating to the CALS procedure are again seen as being an important enabling constraint, so too is the nature of social learning (Raelin, 2001). Our findings show that CAL can enable reflexivity, the key features being a public dimension and a change of pace in conversation, where the meaning of 'public' implies being with others in a learning set that is tempered with confidentiality, and where issues that can shock are able to be discussed. In other words, the term 'public' is conditional.

The interviewees reported tensions in their CAL sets, or shifts in how people relate to each other and thereby to themselves. Giddens refers to this as, 'unification versus fragmentation,' (Giddens, 1991) and Raelin (2001) calls this a, 'unification dilemma'; on the one hand there is 'the self' and on the other there is 'the social'. Although Raelin implies this is a problem, we suggest that this is the nub of engagement: in order to work effectively, it must feel 'edgy', bordering between unification and fragmentation.

In summary, we focus and have increased our understanding on the creative unsettlement that is enabled by the security of the CAL process in which challenging (and supportive?)

conversations are held. We are thus keen to explore the social nature of reflexivity, picking up on Mead's challenge that 'the group' and 'the self' are inter-independent. Not only does the CAL process enable subjects to be available for discussion and actions to be taken, but these also have an impact beyond the learning set into wider organisational patterns and in the participant's perception of their resilience and leadership capacity. We now explore this theme of resilience further.

Resilience

Our findings chart a building of additional emotional resources occurs within the set. Participants note a presence of individual and group positive regard, where there is a mutual consensus that actions taken by others are for 'the good'; this increases the level of participation of others in the organisation (Dutton & Heaphy, 2003). For us the work of Ramsey (2005) around multiple narratives is relevant, particularly the notion of hearing alternative voices and gaining a more communal reflection of events, thus enabling participants to notice assumptions they may make about complex situations. This can shift thinking from a description of events as in action learning, to an experience in the context of the future which we consider as the reflexive turn in CAL illustrated in this study by participants describing a shift in their response to problems and problem solving. Our data shows the perception of a 'problem' changing for participants from a logical technical position towards that of a complex, inter-related and uncertain one, where differences in psychological responses are evident. The CAL process, with an absence of 'answers' in the sense of traditional education, offers participants the opportunity to become 'bricoleurs'. Instead of waiting for an ideal set of conditions, and moving from a linear unlearning to learning they learn to address problems and develop with the resources they have access to, and adapt accordingly (de Walle, 2014), with possibilities for questioning the dominant organisational and professional discourse.

In an NHS context, recent history has shown that the issue of risk and risk management is a core challenge and we have noted the NHS demand for a resilient organisation with a readiness to cope with additional pressures, emergencies and complex patterns of care across boundaries. In researching risk in resilient organisations, Hopkins (2014) observes that individual relationships and networks are critical for ensuring information relating to risk flows freely in an organisation and that the desire to review and adapt must be present. It appears that the CAL individual and group process is important in building these aspects of resilience for participants and the NHS as a resilient organisation. This resilience outcome of CAL offers doctors the additional emotional and social resources, to step away from their safe individualistic autocratic approach to the problems of the NHS and use other more collaborative responses to work with others to both define and address the challenges of complex change.

What AL and CAL can accomplish

Our participant's narratives illustrate the importance of receiving comments and feedback, using information from others in the set and sharing problems and solutions. This can be claimed for an AL model of development. What has emerged in the data presented here are

additional attributes of CAL depicting the use of a critical action learning orientation in the form of reflexivity with attention to emotion, power dynamics and politics in the set.

Our study affirms that CAL offers participants as individuals and as a group the use of power collaboratively in resolving complex problems through being more open and taking risks with exposing possible vulnerabilities. This is a way of reducing the impact of positional, professional and political power on preventing collective problem solving. The responses here appear to indicate an appreciation and sensitivity to others being developed that limits the negative effects of ego from being an acknowledged expert in their clinical role.

This reflexivity of participants is illustrated through their self report of taking unsettling emotional and political risks in the set in order to learn, change old habits and challenge current practice in leadership interventions undertaken within their NHS workplace. This depicts a shift away from their reliance upon the traditional technical educational behaviour that was previously played out in the form of hierarchical leadership, CAL has allowed them to examine a more adaptive, shared and innovative (Heifetz, 1994) change response (Haeusler, 2010) in order to effect transformation and begin to improve the resilience of care delivery within the NHS context.

Conclusions

The aims of this paper are to explore the impact of an Action and Critical Action Learning strategy on the capacity of medical professionals to deliver business change and in doing so capture researcher facilitators actions and learning on the findings revealed. The NHS commissioners of the programme seek to develop a group of leaders within a particular situation and context, with the goal of making a change in organisational performance. The responses from the participants presented here affirms the work of other researchers (Ram and Trehan, 2010: p414), that CAL promotes reflexivity and that this is enabled by the safe space of the set, wherein participants can be challenging and supportive; thereby recognising striking moments, a shift in their perspective and the nature of unsettlement in creatively tackling problems. The new contribution of the resilience theme that emerges shows a developing appreciation of how the sets provide a way of building individual and group relationships to reduce risk and make the best of limited resources.

This study is situated in one workplace setting in contrast to Rigg and Trehan (2004) where CAL is used in a university programme with a cohort of students from different organisations and later (Ram & Trehan, 2010) small firms from different settings. Hence our study focused on the self reports of leaders in one organisation, offers a design for assessing organisational change and more public reflection (Vince, 2004) and could offer interesting insights for developing other programmes in NHS trusts with similar conditions. Alvesson et al's 'D-reflexivity' challenge to "orthodox understandings by pointing out the limitations of, and uncertainties behind, the manufactured unity and coherence of texts" (2008, p494) is noted. More research is needed and we feel it is necessary to investigate what occurs in the longer term in relation to the actions that participants take, and to hear what impression this makes on the NHS trust as a whole. Our further research is already in progress.

Contributing to further developing the theory of AL and CAL in a challenging context (the NHS), where professional specialists (doctors) need to apply different forms of leadership development in tackling problems of complex change, our work illustrates how CAL has underpinned each participant's experience of learning from reflexivity. This affects the complex dynamics of an organisation in action (Ram & Trehan, 2010). In addition, it shows how technical experts can develop a heightened awareness of their learning and become part of a new network in practice. We consider from a researcher perspective that it is the processes of CAL, building trust and exploring power to discuss practical leadership challenges whilst creating emotional unsettlement, that has had benefit in this context. What we know is that the CAL set has at times to be unstable for the participants and facilitators. It is acknowledged that this paradoxically involves both unity and fragmentation of the public/private, self/social and of safety/danger. In embracing the process involved in CAL, there is a potential to create change and build resilience. From a seemingly contradictory position, CAL with its challenging and risky nature has enabled new possibilities for organisational performance.

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