Managing Professional Development Using Action Learning: Case Study, Nursing in the UK

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A Primary Care Group in the North West of England commissioned the facilitation of action learning sets from a local University. The aim of the sets was to support primary and community nurse practitioners who were in different disciplines (e.g. district nursing, health visiting, general practice nursing, community psychiatric nursing etc.) to work more collaboratively with colleagues on projects in either staff development, or service improvement.

This paper discusses the work of two action learning sets. One set introduced clinical benchmarking, which is a UK government sponsored initiative aimed at improving the quality of care and services provided. This group undertook the benchmarking process in relation to record keeping. The second group examined the current status of clinical supervision amongst primary and community care nurses and developed a strategy to take this aspect of professional development forward in a more effective way. This paper examines the development of both of these action learning sets. In addition, it will examine some of the issues and benefits that arose with taking an action learning approach to nursing development, and the usefulness of this approach for other health care practitioners.

INTRODUCTION

In the United Kingdom (UK), the National Health Service (NHS) has undergone continuous structural changes in its organisation and orientation (Warne 1999). Current policy guidance locates primary care at the frontiers of health care modernisation (DOH 1997; 2000a). Primary Care Trusts (PCTs), comprising of previous Primary Care Groups (PCGs) (which were formed by General Practitioner practices being brought together) are set to become the driving force for change across the NHS, having much of the responsibility for commissioning and providing
health care. Given this turbulent health care context (Stark et al. 2000), primary health care professionals and organisations have to explore new ways of working and thinking (DOH 1997; 2000a; 2000b). The role of nurses in primary and community care has steadily increased in importance (Koperski et al. 1997; Kernick 1999; Bond et al. 1999). Promoting nurse leadership, in order to manage the changes and challenges of the NHS modernisation process, is currently on the government’s agenda (DOH 1999; 2000a; 2000b). With this in mind, managers of a PCG in the North West region of England, who had responsibility for nursing development, decided to use action learning sets as a means to organisational change. They held the philosophy that practitioner led approaches to learning were ideal methods for health care professionals in which to engage (Rolfe 1998; Meyer 2000).

The sets comprised primary and community care nurses who were leaders in their discipline (e.g. district nursing, health visiting, general practice nursing, community psychiatric nursing, specialist nursing). Four action learning sets were developed from this group of nurses; however, this paper specifically concentrates on the experiences of two sets. The actual changes in the organisation as a result of the two projects undertaken will be outlined. The projects were in the areas of clinical supervision and clinical practice benchmarking. Further, the paper will focus on the process of action learning and the suitability of this approach for health care professionals given current health care contexts.

**ACTION LEARNING**

Action learning initially was a UK phenomenon (Mumford 1995), founded by Reg Revans (1971) but it is now used across the world. It was primarily use in industry, however, it is currently popular in higher education (including nurse education (Haddock 1997)), as evidenced by several courses claiming to use an action learning approach on Web sites both in the UK and abroad.

The model rests on the premise that the learner develops ‘questioning insights’, based on experiences at work, to find solutions to work related problems/issues. While traditional learning relies on providing knowledge in the form of solutions that are already known by the teacher, the solutions in action learning are actively sought via a cycle of identifying and implementing courses of action, monitoring the results, refining the action, testing again and so on. Thus, it is an emergent process, whereby
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5. Share and refine knowledge, experiences, practice; embed and revisit over time

4. Critically review/monitor situation as a result of the action taken

3. Implement a course of action, based upon new learning

2. Share with set members problem/issue to be improved via action and develop ‘questioning insights’

1. Engage in the action learning set; focus learning by identifying work based problem/issue

Development of action learning sets

Professional development via action learning

Figure 1: The action learning cycle

the learner learns new ideas, skills and attitudes by being steeped in the active involvement of the learning process.

The learning process takes place within an action learning set. The set is facilitated by an action learning advisor, whose role is important particularly at the beginning of the process to increase cohesiveness, confidence and commitment (Spencer 1998). The set comprises typically of 4–6 individuals, perhaps of differing functional backgrounds, but who are of roughly equal status (Dixon 1998). The members meet approximately once a month to present their problems. The other members of the set help the learner to develop questioning insights by using their ‘local knowledge’ to probe the problem/issue being raised (Beaty et al. 1993). Other set members may be working on the same or different projects (Froiland 1994), but all learn with and from each other.

The organisation in which set members are located must be conducive to individuals trying things out (taking risks), reflecting upon the results and sharing experiences with others in a non-threatening environment (Peters and Waterman 1982).

THE DEVELOPMENT OF THE ACTION LEARNING GROUP AND SETS

Since action learning is used when there is a need to find a solution to real problems, as opposed to a simulation, and it is used when learning is voluntary and learner driven, it appeared to be an ideal approach for the
Twelve primary and community care nurses, of roughly the same grade, representing several nursing disciplines formed an action learning group and began to meet approximately once every two months. These practitioners had recently completed leadership training and were eager to put these new skills to use.

The author was commissioned to act as a facilitator (advisor) to these practitioners for 10 months. It was felt that a person external to the organisation may be more objective to the issues that were raised within the sets. Being free of organisational ‘baggage’ was seen as an important factor that may help to disrupt/challenge dominant and ritualistic ways of being and thinking. The facilitator also had experience working with nurses on action learning and action research projects in the past (Stark 1993). The facilitator’s role was to ensure progress was maintained; to encourage, model and reinforce reflective analysis and questioning insights; to nurture a supportive, yet challenging and respectful environment for learning.

THE PROJECTS

At the start of the process the practitioners were asked to identify a nursing development issue/problem/area that they wanted to change/improve/influence using action learning. The practitioners were asked to bear in mind the following criteria (based on an action learning philosophy as cited in the literature – McGill and Beaty 1995; Pedler 1997; Dixon 1998):

- The change would be directed towards practice, organisation or working methods.
- The practitioner sincerely believed the change would directly or indirectly improve the services for patients.
- The change would present opportunities for personal and organisational learning.
- The change would contribute, directly or indirectly to integration, flexibility or new ways of working for nursing teams.
- The practitioner was committed to and had an interest in bringing about the change.
- The practitioners held a management responsibility for the project.

Several individuals selected the same area and more than one area. Due to these overlapping interests it was decided the group would subdivide into four action learning sets, each person in the set working on the same topic. Some practitioners opted to work in more than one set.
The division of the action learning group, into four action learning sets, created an effective ‘layering’ of the action learning process. Each set met regularly; meetings varied from once a week to once a month depending on the nature of the activities within the action learning cycles. As previously stated, the action learning group met approximately once every two months. The action learning process occurred both in the sets and in the group. Thus, the practitioners not only had the learning process reinforced, but they learned about other project areas that were also highly relevant to their professional practice. As previously stated this paper centres on the work of two projects, these are outlined below. The other projects focused on (i) nurses and the public health agenda and (ii) nursing empowerment.

**Project 1 – Clinical Supervision**

Set members were concerned with the seemingly haphazard way in which clinical supervision was offered and received by primary and community care nurses. They wanted to take a lead and suggest a way forward for more effective clinical supervision for nurses within the newly developing PCT framework. The project involved assessing the views and experiences of nurses in relation to their current clinical supervision and potential way/s forward. This took the form of a survey being administered to all primary and community care nurses in two regional health localities \(n = 394\), response rate \(= 183\) (46%). The survey produced much data on the current state of clinical supervision for these nurses. For example several different models of clinical supervision were being used. Some nurses had regular supervision, about once a month, while others claimed they never have clinical supervision. Most individuals did not want their clinical supervisor to also be their manager. Most nurses wanted to select their own clinical supervisor. And so on. These findings were written up in the form of a consultation document for the PCT Developmental Board/s. The document recommended a more effective approach to clinical supervision for nurses, given the evidence collected by the set members.

The learning about learning in this set was immense and sometimes painful, as they confronted attitudes and behaviours in themselves that they criticised in others. For example, some individuals criticized the poor attendance at meetings that they set up (hence, hindering progress with initiatives), but were often absent themselves at the action learning group meetings. Since the set members were clinical supervisors they sometimes had to face harsh criticism from the survey respondents in
relation to their experiences of current clinical supervision i.e. managerial in focus and occasionally disempowering rather than empowering. These findings added significantly to the paucity of data on the effectiveness of clinical supervision practices, particularly in nursing. To this end, set members are also writing papers for publication.

*Project 2 – Clinical Practice Benchmarking*

The Essence of Care document (DOH 2001a) outlines a clinical practice benchmarking process that helps to improve the quality of essential aspects of care. Benchmarking offers nurses a toolkit that will allow them to compare and share best practices in order to improve continuously the care offered to patients. The practitioners in this action learning set, however, were unsure of how to implement the benchmarking process and since the process was new in health care, there were no previous experiences in this context from which they could learn. The action learning set provided a useful opportunity for these nurses to maximise the learning process and learn with and from each other.

The set undertook to benchmark clinical practice in relation to one factor within one aspect of care (record keeping) as outlined in the Essence of Care document, in a range of primary care and community nursing groups. Members were successful in developing a mutually supportive forum for practitioners. Further, they successfully improved the structures and processes for record keeping within the practice areas in which they worked. Set members are now supporting colleagues undertaking similar work. They have also shared their learning process with others nationally via a conference and a publication in a national nursing journal (Stark et al. 2002).

Much learning took place for all the practitioners, not only in relation to the subject areas selected for their projects (i.e. benchmarking, clinical supervision etc.), but also in relation to leadership and organisational change. The group’s learning cycles, for example, began to identify generic themes concerned with barriers to change, resource issues and practice issues vis-a-vis nurse development. These are discussed here.

**Empowering Factors Affecting the Action Learning Process**

Both action learning sets achieved and, in some cases, exceeded their objectives. The objectives were written in terms of realistic outcomes in relation to the topic they selected. Achieving these objectives resulted in
several aspects of learning taking place in relation to both the personal and professional development of nurses. These included:

- Fostering supportive, open and respectful working alliances, which also increased the practitioners’ motivation to improve in the area of nursing development. A team effort gave the practitioners a sense that they could bring about change.

- Developing their leadership qualities. For example, a small but quick ‘hit’ in relation to success with the benchmarking process made the practitioners feel that they could make a difference.

- Raising confidence. For example, being invited to speak at a national conference and having an article accepted for publication gave the practitioners a sense that they were undertaking valuable work in nursing development.

- Increasing their knowledge and learning. For example practitioners expanding their knowledge in relation to the range of clinical supervision models currently being used in primary and community care nursing.

- Developing a deeper level of reflection (Bunning 1992) – by questioning their action and the action of others, also question their values, beliefs and traditions. Practitioners began to question whether, for example, their model of clinical supervision was empowering or disempowering for their supervisees.

- Developing diagnostic and listening skills and self-awareness. For example practitioners learned that their standards in relation to record keeping were not meeting their patients’ needs.

- Learning the importance of monitoring and evaluation exercises. The learning cycles required the practitioners to evaluate courses of action at each stage. These discussions expanded their understanding of the situation and lead to a much more informed and structured approach to learning and development.

- Developing research awareness and skills. For example the practitioners in the clinical supervision set learned how to construct, administer, analyse and present the findings of a survey.

- Learning about the process of writing for publication as well as the journal review process for a national nursing journal. The benchmarking set undertook this process and then ‘taught’ the members of other sets the process via the action learning group meetings.
In addition to these personal and professional development issues resulting from working in the action learning sets, further positive aspects at an organisational level were evident. For example:

- The action learning sets increased the level of genuine collaboration between colleagues in line with government’s agenda (DOH 2000a). The sets had community and primary care nurses, from different disciplines, working together on projects for the benefit of the local community that they serve.

- Two geographical localities worked in partnership and shared resources to capitalise on work done separately for the benefit of the whole. Such working is laying excellent foundations for ensuring co-ordination of planning and integration of service delivery (DOH 2001b).

- While the practitioners did feel they were more empowered to implement change they also realised change was slow, and required a sustained collaborative effort to encourage colleagues to not only welcome change, but also take an active part in the learning process to bring about any change. All practitioners agreed that much of their empowerment was learning the politics of what could/could not be done/challenged within their organisation.

- The work has resulted in nursing leadership and development being on the agenda for PCT Developmental Boards in change of restructuring primary and community care in the region.

**ADVERSE FACTORS AFFECTING THE ACTION LEARNING PROCESS**

Clearly, the two action learning sets resulted in several positive developments for the nurses involved. Further, the sets did achieve their objectives. However, at times, the actual learning process was difficult and practitioners struggled with several issues that had an adverse affect on this process. Some of these tensions are outlined here.

- The nurse leaders involved in the action learning knew each other for several years – having interactions during the course of their everyday work, undertaking professional development courses together, attending the same meetings etc. These relationships helped them to be ‘comrades of adversity’ (Revans 1982) – a crucial element
in action learning and is concerned with the ways in which individuals help one another to resolve problems. On the other hand, however, some found this historical legacy and unspoken ‘politics’ and ‘pecking orders’ anxiety laden at times (Atkins et al. 2002). Strong characters were prone to dominate the programme of work and the process of learning. This lead to defensive behaviour and rhetoric – ‘I’ve tried that and it doesn’t work’ – and an impaired learning process for either themselves or other set members.

- Practitioners were sometimes reticent to criticise others both in the action learning group and set, perhaps in fear of offending/embar-rassing, or creating a situation where others may feel they can criticise them. Thus, there was a tendency to retreat into discussion (Morris 1991) as opposed to the more difficult (and more risky) task of critical reflection and questioning. However, there may have been an element of not knowing what questions to ask (see next point).

- Some practitioners were unaware of, or unwilling to acknowledge gaps in their knowledge and expertise. The facilitator found it extremely difficult to push deeper their critical reflection of self. Her questioning was deflected. It appeared to be too painful, uncomfortable and difficult for the nurses to turn the mirror on themselves and take a deep and critical look at their own behaviour and attitudes. It was much easier to blame others or the organisation in general, for the current situation. They were less willing, for example, to explore the possibility that their behaviour may be reinforcing the conditions that they were criticising, or that their attitudes could be disempowering as opposed to empowering other nurses, and so on.

- At times there appeared to be an innate complacency with some of the nurses and they often found it difficult to resist the tug to conform to familiar and ‘programmed’ ways of working and thinking, despite the contrary belief which they articulated and an apparent enthusiasm for change.

- Attendance at the set and group meetings was erratic. This made continuity of the projects difficult. We had to spend much of the meeting getting those who had not attended the last sessions/s up-to-date. Two key reasons were given for this lack of attendance:

  1. Other pressures of work were a big issue. This was especially the case for practice nurses and some clinical supervisors.
Movement within their job – several practitioners experienced role disruptions. This seems to be a negative phenomenon particularly evident in the NHS (DOH 2000b). Disruptions involved; practitioners leaving the area for a new job; being seconded to a new role; acting in a new role; obtaining a new role; undertaking professional development courses (over an extended period of time) and so on.

- Some practitioners were members of another learning set. With hindsight, since time was restricted for meeting, it was perhaps unwise for individuals to be part of more than one action learning set. At the time, set membership was voluntary and the commissioners of the study did not want to discourage practitioner enthusiasm.

- An important role for the facilitator was to reduce anxiety and develop an acceptance amongst set members that ambiguity and ‘not yet knowing the answers’ was a healthy and natural state for action learning. Further to nurture the meta-skill of questioning insight in order to examine critically what is and see opportunities for what could be or what should be. This takes time and a sustained effort to build up trust within the set and group. The lunchtime meetings were usually interrupted and characterised by practitioners arriving late, leaving early or not being able to attend the meeting at all. Therefore, this quantity and quality of time, to become emerged in the action learning process, was limited.

- On occasions the facilitator failed to break the dependence others had on her and shift in the responsibility for the learning to the practitioners (Vince and Martin 1993). The sets required ‘work’ to be done between meetings (collecting and reading literature, writing questions for the survey, liaising with other ‘experts’ and so on). The facilitator feared that if the practitioners were given too much to do then their voluntary participation in the set might be threatened.

Another important interpretation was that the facilitator was unwilling to relinquish her control in the sets. This subject is widely written about in the action learning literature (Kozubska 1989; Bennett 1990; Casey 1991; Donaghue 1992). The facilitator was conscious that her time was being commissioned to work with practitioners. Thus, she felt that the commissioners needed to see some outcomes for their money. With hindsight, there was perhaps a misplaced assumption to be concerned
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with achieving tangible outcomes in the form of reports, benchmarks, papers and presentations, rather than focusing on the learning process as an outcome in itself.

**ACTION LEARNING IN HEALTH CARE CONTEXTS**

This paper has discussed the process of using action learning for nursing development with primary and community care nurses. While the process had elements of success with the clinical supervision and benchmarking projects outlined in this paper, there were several inhibiting factors identified when using this approach to learning. This then leads to the following questions being raised:

- Is the process of action learning appropriate for use in health care contexts?
- And, to what extent can it make an impact on practitioners and their organisations?

The author believes action learning does have a valuable contribution to make in nurse development, the practitioners themselves and their organisations:

- Action learning begins with real projects ‘on the ground’.
- It engages practitioners in a sustained learning process, learning with and from each other.
- It has the benefit of achieving both personal and organisational objectives.
- It may help to bridge the gap between theory and practice.
- It can provide a useful antidote to the isolation often experienced by primary and community care nurses – nurses learning together, with practitioners who are experiencing similar things.
- It can provide an opportunity to develop analytical and questioning skills.
- It encourages leadership.
- It focuses on learning how to learn – how a person functions. Nurses need to become skilled at recognising and managing this process, since it is the process that determines the quality of the content (what they achieve). Without this, nurse leadership and development may be slow to change.
It is easy, however, to list the benefits of action learning, but in order to be successful the process needs a receptive environment in which to flourish. The current health care context tends to be imbued with practical and political realities that may hinder the effective use of this approach to development and change for both the organisation and its employees. The NHS culture is traditional and hierarchical and operates using clear ‘top-down’ policy and procedural manuals and guidelines (Stronach et al. 2001). This organisational approach runs contrary to the ‘bottom up’ philosophy underpinning action learning. So, while the practitioners may embrace action learning, if the organisation is less willing to change, then progress will be minimal, and worse, a demotivated and resentful workforce may result.

Success with action learning requires a commitment to the learning process, sharp analytical questioning and also creativity in conceptual thought in order to gain insights (Bunning 1992). This requires time in a supportive and stimulating group environment. Health care workers, in particular nurses, are seldom given the luxury of protected time away from their practice setting to work on problems (DoH 2000b). This time is unlikely to be a priority when the NHS is short of some 13,000 registered nurses (RCN 1999), with an average vacancy rate of 12% (Roberts and Fielding 1999). Further, as highlighted at the beginning of this paper, the NHS is in a constant state of flux with new structures, demands and targets being imposed on health care professionals relentlessly. The experiences of the sets highlighted that this led to sustained role disruption for practitioners, involving movement of either themselves or their colleagues or both. Such an organisational climate is not conducive to the time and continuity necessary for effective action learning.

Not only is the nursing workforce experiencing an acute shortage, the nurses in the force work are under pressure to be ‘all things to all people’. The Briggs report (1972) outlined a foundation for developing the modern nurse – reflective, critical thinking and one whose uses research and evidence based practice in her increasingly autonomous role. Since the Briggs report there has been a major shift in nurse education and training in the UK from the apprentice model and into higher education. Educationalists and practitioners remain undecided as to the success of the higher education model in producing the type of nurse advocated by Briggs (refs). The recent Research Assessment Exercise in 2001 (HEFCE 2001) clearly highlighted that nursing is still in its infancy in relation to research. Nursing has traditionally been a task orientated profession...
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(becoming proficient in technical skills), as opposed to being focused on process (being interested in how a person functions). Unless nurses recognise the value of the process, it is unlikely they will become skilled at recognising and managing this process. And, since it is the process that determines the quality of the content (what they achieve) nursing leadership and development may be slow to change.

The health care culture appears to be steeped in often unspoken and sometimes unrecognised (being blind or turning a blind eye?) issues of power, status, authority and competition between disciplines and within hierarchies. Unless these are made part of the learning processes then, again, change may be slow to occur. Unfortunately, nursing is often characterised by what nurses claim to already know and this knowledge often blocks them from new knowledge – ‘we always …’, ‘we do …’ ‘we’ve tried that …’. Concealment and subversion enables practitioners to feel more comfortable about themselves, but it reinforces, rather than challenges, the oppressive culture and, in turn, stifles learning and development.

Staff development in the NHS is often in the form of short course, one-day workshops or academic courses in universities. This form of professional development often embodies the ‘expert’ in an organisational language that emphasises a dependency relationship (Thorpe and Taylor 1991) and, again, reflects a ‘top-down’ culture. Further, ‘experts’ tend to follow a well-trodden path that draws on past experiences. ‘Leaders’, on the other hand, chart new territory with commitment, dedication and thoughtful clarity of vision. Thus, if action learning is going to be successful in health care contexts the organisation needs to shift from the ‘expert’ model to a ‘leadership’ model. As has been demonstrated in this paper, this model begins with real projects ‘on the ground’ whereby practitioners are empowered (by the organisations) to engage in a sustained learning process. The author believed that this approach would stimulate the motivation necessary for positive organisational change.

**Summary**

Primary and community health care within the NHS is currently experiencing a turbulent organisational culture characterised by constant change. The government has indicated that nurses could and should take a lead in providing primary care within the new organisational structures (DOH 2000a; 2000b). This is a prime opportunity for nurses to forge a
leadership role and create an organisational culture receptive to nursing development and innovation. Current professional development for nurses, therefore, needs to equip them with new ways of thinking and working. This will require them to resist responding to the urgency of the moment and respond to more long-term learning. Further, they will need to resist entering into round-robin discussions involving blame, reliving past crisis, emotions and failures and instead ask what they learned from these behaviour patterns and attitudes.

This paper outlines an approach to learning that could help them to cope more effectively with both individual and organisational leadership and change. Action learning aims to solve ‘on the ground’ problems that cannot be solved by training. However, the experiences of the practitioners involved in two projects described in this paper, highlight that currently aspects of the culture within primary and community care nursing can impede action learning. For example, political (organisational power hierarchies) and psychological (emotional) components can hinder or discourage learning. Unless the organisational culture becomes more conducive to such approaches to learning and development, then nurse leadership and empowerment may remain a rhetoric that does not match with reality.

REFERENCES


