Guest editorial

This special edition of *Leadership in Health Services* focuses on *action learning* in health services. The demand for such a special edition might be seen as a contemporary response to the exhortation of the originator of action learning, Professor Reg Revans, who told us that when we are trying to work out how to lead organisations through periods of accelerating change, when we don't know how to approach let alone solve a problem and when the textbooks cannot give us much help, we should embrace our ignorance and work collaboratively with others using the principles and practice of action learning.

I have heard, read and been involved in many a heated discussion as to what action learning actually is and have concluded that Revans' reluctance to define it may have been a stroke of his genius at work because he foresaw that without a tight definition, various interpretations and practices would emerge, and they have as you will see in this edition.

I was delighted that Professor Ken Eason agreed to contribute here and his article *Action Learning Across the Decades* takes a 50-year perspective with a retrospective look at his early career work as a research assistant social scientist working on Revans' famous Hospital Internal Communications (HIC) projects in London hospitals. He brings us up to date with powerful lessons, influenced by his work with socio-technical system thinking and "user centred design", and he shows how technological innovation has been successfully introduced to improve care provided to people with learning difficulties. Professor Eason, I assume, has been influenced by the systems thinking perspective of Revans who, maybe influenced by his background as a physicist, was one of the first to articulate how the organisation, in his example a hospital, worked or failed, as a "system".

The HIC project was a proven success achieved against some considerable resistance from clinicians and only recognised sometime after its completion. Almost 50 years later explicit recommendations were made to use more action learning in healthcare services by the King's Fund Report *Patient-Centred Leadership – Rediscovering Our Purpose (2013)*. This followed the Francis Report (6th February, 2013) of the findings of a major inquiry into the deplorable failings in patient care of Mid-Staffordshire NHS Foundation Trust. Given this recent recommendation to make more use of action learning, it is perhaps surprising how sparse the reports of subsequent action learning initiatives in health services actually are.

Health services are in all cases described here, provided in a pressurised, political, mulit-disciplinary and often life-critical situation. It is refreshing to read Dr James Traeger's account of his work as a facilitator of action learning in what he describes as a "beleagured system", working with a London-based NHS Trust. His first-hand account provides a real insight into the practicalities of facilitating an action learning set with an emergency department team in the front line of emergency care, who by definition have little, if any, structured time for reflection. This raises some key questions for facilitators to consider in terms of the tightrope they often have to tread between challenging and supporting participants in action learning. I was struck by the cultural similarities described by James Traeger 50 years on from the research work Ken Eason described also in London hospitals, in particular the power dynamics between

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different medical professions and the difficulty in enabling what Revans called the "upward communication of doubt".

Dr Rob Warwick, Adam Palmer and Janet McCray in *Action Learning: Ripples Within and Beyond the Set* provide a fascinating case study in reviewing an action learning programme linked to a postgraduate qualification in clinical management offered to an NHS Trust. This also explored the challenges yet ultimately the benefits of working in an action learning way from the perspective of a senior clinician and a facilitator as part of a multi-disciplinary learning set. This article highlights how the focus of discussion in an action learning set might shift from looking inwardly to what is occurring in the set to looking externally to what is happening in the wider organisation.

In his article *Advancing Health Care Quality and Safety through Action Learning* Simon Mathews discusses how in the case of John Hopkins Medicine in the USA, action learning principles can be seen to underpin the improvement of quality and safety challenges in a large academic medical health system. While this may not have been promoted as an action learning initiative *per se* there is no doubt that key action learning principles were adopted such as questioning, a requirement for action and the development of a "learning ecosystem" which integrated with the organisational structure.

Similarly, an action learning mind-set can be seen in Patrik Nordin's Finnish case study *Value-Based Healthcare Measurement as a Context for Organizational Learning – Adding a Strategic Edge to Assess Health Outcome?* This explores how a Big Data tool was applied for measurement of quality of care for patients with a chronic disease. A theme articulated in several of the articles here is evident; the application of an action learning mind-set led to outcomes that were not anticipated. Here, this concerned the way in which data could be used to support decision-making about care. Putting the patient at the centre of the development and learning process when innovating for improvement in care is also a recurring theme.

There are fascinating accounts of deliberate action learning programmes with quite different aims. Tracey Patterson discusses an action learning-based programme where the participants are drawn from diverse sources in the community with the aim of promoting effective community health leadership in the USA. This explores the important role of sponsors in action learning.

Karen Gillet discusses how action learning has been integrated into a development programme initiated by a hospice group to support improvement in end-of-life care. This raises a key point around how participants perceive the programme, recognising that there is a need to stress the significance of those activities in action learning which occur outside of the classroom. It is also seen how participants in an action learning programme can become a real force for positive change once they feel empowered.

Anna Folker provides insight into a programme to reduce health inequity in society which was applied across a number of Danish municipalities. This article makes good use of the Knowledge Mapping approach I have developed to help connect "sky"-based research with "ground" based evidence and recognition of "underground" forces as work. This programme as with others described here recognises the importance of looking at the problem from the perspective of the user of health services, in this case the socially disadvantaged members of society who suffer from health inequity.

The tight prescription for action learning that I often find trainers or organisational consultants in search of may prove elusive. However, I see a thread through all of the

articles included here which demonstrates that there are certainly a number of core principles and values that underlie an action learning approach. As a reader, you will come to your own conclusions regarding these, and I hope you will add to the debate by sharing your own experience and reflections.

I am struck by the fact that such an eclectic and international group of contributors, united by a passion for improving the lives of others, organisations and society, writing under the broad church of health services, have referenced similar determinants and characteristics of success.

The purpose and outcomes of these programmes and initiatives are profound. They concern matters as important as extending and saving of lives and improving the quality of life and death.

Richard Hale
Action Learning International, Bristol, UK