

## Introducing the Learning Practice – III. Leadership, empowerment, protected time and reflective practice as core contextual conditions

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**Keywords:** innovation, learning cultures, learning organizations, organizational learning, primary care, the learning practice

### Accepted for publication:

16 September 2003

### Abstract

**Rationale, aims and objectives** This paper is the third of three related papers exploring the ways in which the principles of Learning Organizations (LOs) could be applied in Primary Care settings at the point of service delivery. **Methods** Here we provide a systematic literature review of contextual factors that either play a key role in providing a facilitative context for a Learning Practice or manifest themselves as barriers to any Practice's attempts to develop a learning culture. **Results and conclusion** Core contextual conditions are identified as, first, the requirement for strong and visionary leadership. Leaders who support and develop others, ask challenging questions, are willing to be learners themselves, see possibilities and make things happen, facilitate learning environments. The second core condition is the involvement and empowerment of staff where changes grow from the willing participation of all concerned. The third prerequisite is the setting-aside of times and places for learning and reflection. This paper contributes to the wider quality improvement debate in three main ways. First, by highlighting the local contextual issues that are most likely to impact on the success or failure of a Practice's attempts to work towards a learning culture. Second, by demonstrating that the very same factors can either help or hinder depending on how they are manifest and played out in context. Third, it adds to the evidence available to support the case for LOs in health care settings.

### Introduction

As a service-led organization staffed by professionals skilled in a multiple of disciplines aimed at producing excellent quality-oriented services to its patients, it is little wonder that the National Health Service (NHS) is built through mechanisms that seek to proffer skill,

expertise, experience and knowledge as key to effective performance. Professional bodies oversee individual skill development, and clinical networks allow practitioners to share experiences, with degree level training programmes and requirements for continued professional development standing as testament to the seriousness with which individual skills are

regarded. Less developed perhaps are the routes by which collective learning (shared learning around a task across professions) and organizational learning (systematic deployment of this knowledge around the whole organization) take place (Rushmer *et al.* 2004b). Yet we know that such learning is theoretically possible (Davies & Nutley 2000; Rushmer *et al.* 2004a), with some evidence of successful development in practice (Antrobus 1997; Wallace 1998). Trying to achieve these things in Primary Care (PC) at the level of service delivery is to engage with the ideas of the Learning Practice (LP) (Rushmer *et al.* 2004a,b). A LP develops where a practice deliberately decides to prioritize learning everyday, at all levels, throughout the practice and across all its members. The ideas and research into Learning Organizations (LOs) provide the theoretical basis for these steps towards collective and organizational learning cultures. Whereby previous papers explained the nature of LPs (Rushmer *et al.* 2004a) and the process of becoming an LP (Rushmer *et al.* 2004b), this paper will review both conceptual and empirical evidence to explore in detail the core contextual conditions facilitative to the development of the LP. Taken together, therefore, the three papers explore the content, process and context of change (Pettigrew & Whipp 1991).

### **Research evidence: a facilitative context for collective learning**

In support of the theoretical notions of LOs, there is now a growing body of evidence emerging from research in health care settings (Birleson 1998; Timpson 1998; Partis 2001). This research claims that LOs can work *if* certain conditions are present: first, strong and visionary leadership (Mallory 1993); second, empowering and involving staff at all times (Bartkus 1997); and third, providing protected times and places in which to learn (Bohmer & Edmondson 2001) and think reflectively (Carkhuff 1996; Antrobus 1997; Greenwood 1998). This paper will explore these three complementary areas as factors that present themselves as core contextual conditions in the development of learning cultures in PC settings. It is notable that the very *same* factors can either help or hinder health care professionals in their attempts to become LPs, depending on how they manifest

themselves *in situ*. For example, leadership can be either supportive and nurturing or obstructive and destructive towards learning attempts. It is therefore arguable that attention to these three interrelated factors will be instrumental in whether LOs *can be made to work* in health care settings as the LP.

### **Strong and visionary leadership**

The following briefly summarizes the central role of an NHS leader in fostering an LP culture. Studies have claimed that within the NHS 'leadership styles must change' (Muller-Smith 1993; Sofarelli & Brown 1998). What was seen as effective leadership behaviour in times of stability (good stewardship) is now seen as insufficient to meet staff needs during times of rapid change (Gundlach 1994). It is argued that within the new NHS the learning and knowledge of the staff are the strategic resources and that any leader's duty should be to re-orient services around that capacity to learn (Timpson 1998).

### *Leadership and communication skills*

It becomes the leader's strategic duty to release the potential of others (Timpson 1998). They should do this by asking 'new questions' (Kim 1993) that reveal the hidden assumptions, contradictions and tensions behind present actions. Such questioning would then encourage not just single-loop learning (adjustment and refinements to the present way of doing things) but also double-loop learning (innovation in service design and delivery – a new way of doing things) (Argyris & Schon 1978; Senge 1990). More than this, these questions would require 'joined-up' answers across professions and existing professional and organizational barriers to 'create new answers in a changing world' (Thompson 1994). Leaders need to be 'expert thinkers' capable of seeing possibilities and conceptualizing alternative patterns of service delivery (Clarke & Wilcockson 2001). The leaders themselves should not be immune from this process of critical questioning; they too must be prepared to undertake critical self-evaluation, so that they are able to take personal responsibility and accountability for their actions (Argyris & Schon 1978). However, effective leadership communication skills should always begin with the capacity and willingness to *observe* and *listen first* (Deutschman 2001).

*Leading through change*

Additionally the impact of the 'leader' on change is central to the success of the change programme, for leaders quash change as often as they facilitate it. The 'attitude of the boss' has been identified as the single most important factor in the likely adoption of new ways of doing things in the NHS (Kroll *et al.* 1996). If 'the boss' is seen to disapprove or not support the new behaviours or approaches, then the learner will not demonstrate them (Kroll *et al.* 1996). The new behaviours disappear by failing to become established in the regime. General practitioners (GPs) and Nurse Managers need to send clear messages that they are firmly behind the changes or change will not happen. Leaders need to move away from focusing on and creating predictability to focusing on change (Fedoruk & Pincombe 2000), helping others to cope through periods of transition (Chan 2001) and building capacity in others to evaluate their own practice (Milstein 2001). In this way effective leading in PC is about leading by example, communicating organizational values and following them, and facilitating innovative practice (Deutschman 2001) so that other professionals can truly help to shape the development of their own profession (Sofarelli & Brown 1998).

*Hard and soft leadership styles: using influence*

Leadership is about influencing others, about persuading, guiding and setting an example (cf. Mullins 2000). Leaders need to be able to show *both* a 'hard' and a 'soft' style of leadership in establishing learning. 'Hard' leadership would involve forcefully changing structures, and altering 'ways-of-doing-things' by being strongly guiding and directing in terms of vision (van Eyk *et al.* 2001) and opportunities. Leaders in LPs would be the drivers and engineers of change, as they can create change by taking practical steps to make them happen. Health care leaders need to design structures (Timpson 1998) and processes that make collective learning physically possible, to provide space, places and times in which learning can take place (Mallory 1993; Bohmer & Edmondson 2001). In these places where learning is shared, ambiguity is unravelled (Timpson 1998) as the vision of what is possible is shared and clarified. This is clearly a call for protected development time.

'Soft' leadership needs differing qualities, being encouraging and compassionate with others in their attempts to try out new things (Thompson 1994; Fedoruk & Pincombe 2000; Trofino 2000; Chan 2001). Staff bombarded by the pace of change over recent years can develop 'reform fatigue' (van Eyk *et al.* 2001), which can be helped by the recognition that a leader can give. Staff can be made to feel that their efforts are appreciated, even if not rewarded directly. The leader gives emotional support (Smith 2001) and helps to create an atmosphere in which it is safe to learn. They lead by example, are willing to mentor (Vance 2000), and are not afraid to show vulnerability, by becoming a learner themselves or to be seen to make mistakes (Bass & Avolio 1994). They shape cultures by behaving as they expect others to, clearly showing that learning is encouraged and expected by all. Shaping cultures so that all the above becomes possible is claimed to be a leader's greatest contribution to any organization (Wallace 1998).

*Who are these leaders?*

A mute point might be 'who should be the leader' in such changes within an LP. The answer again is two-fold. First, informal leaders can present themselves at any level in an organization and need not hold a senior position in the hierarchy (Roethlisberger & Dickson 1939), they can inform, support and guide the changes (as above). In this way leading is dispersed (Bennis & Nanus 1985) throughout the LP, with different staff leading on different initiatives, reporting back to the collective practice so that all can learn from their efforts. The outcomes of any learning experience are thus multiplied. Other benefits ripple through the practice. Staff grow in confidence; motivation builds (Hackman & Oldham 1980) that things can be changed, and tasks are easier to spread across staff as skills develop (Mintzberg *et al.* 1998). One might consider that this would take time and care in moving forwards, gently building confidence and acceptance as tasks overlap and complex tasks are devolved to those who did not previously undertake them (Mintzberg *et al.* 1998).

For structural changes to proceed (e.g. the establishment of a monthly 'learning afternoon', where the practice closes its doors to patients) it will need a person(s), with the authority to sanction the changes to formally lead this change. Leaders in these situations

are often described as those with a formal position in the hierarchy, or some other position of authority and influence over staff (Deutschman 2001); variously authors refer to nurse managers (Chan 2001), other NHS managers (Timpson 1998), and clinical supervisors (Smith 2001) as potential leaders in LOs in health care settings. However, one cannot underestimate the power of the GP as an independent practitioner running a small business in the form of the practice, as being a significant figure in what other practice staff find possible and not possible (Carnell 1999).

### Empowering and involving staff

Leadership as described above is facilitative, aiming to mobilize all the skills, good will and know-how at the disposal of the Practice. These qualities of the leader(s) are inextricably linked with the empowerment of practice staff. If all participants (*all* staff, clinical and non-clinical, practice employed and attached) are involved in the planning stage, where the team decides if it wants to take part, then success is much more likely later on (Jowett & Wellens 2000). Staff find it easier to 'buy-into' the ideas if they can see the relevancy and benefits of the changes to their practice (Case 1996). Three points are important:

- An approach that begins by consulting all practice staff, listens to their ideas and respects their differing professional perspectives is an important indicator to those staff that things will be made 'better' by these moves (Case 1996).
- An LP is unlikely to work unless it is owned by those involved in it; they want it to happen, shape the outcomes (Cohen & Austin 1997) and feel they have some control over the inputs and process (Cohen & Austin 1997; Sofarelli & Brown 1998). Therefore, clearly LP strategies for change and development *must* emanate from within the practice and not be imposed.
- In PC, this might mean taking some time and care to allow staff to learn about the ideas, discuss them and warm to them, before the whole practice signs up to the changes (Lewin 1951; Kim 1993; Thompson 1994).

### Times and places for learning and reflection

Time-out, time taken to examine the effectiveness (or not) of a particular approach or response to a sit-

uation can lead to more effective performance next time (Greenwood 1998). Becoming a reflective practitioner can be the first step towards recognizing the hidden skills (experience, intuition) that exist within PC. This experience routinely goes unnoticed. However, skills, gained through experience, can be passed on to new learners to enhance and speed their learning (Antrobus 1997), or assist job-shadowing and critical questioning (Carkhuff 1996). Reflexive practice is likely to be useful both in administrative roles in health care settings and in clinical roles (Schmieding 1999).

Above we argued that structures for learning must be carefully designed and *made to happen*, otherwise as staff are busy and clinical practice is prioritized, learning will not happen. So too with reflective practice, the working day does not naturally lend itself to 'time-out' to reflect. To be of most use, reflective practice needs to be structured, and not just expected to happen. At the same time, over-formalizing the process may not be the answer either (e.g. through programmed clinical supervision) (Teasdale 2000), as this is hard to sustain, too rigid, not timely and there is little research evidence to its effectiveness. It is likely to have a greater impact if the reflective practice remains to a degree an informal process able to be effected when needed most (Teasdale 2000). Informal work-shadowing and mentoring might be useful here.

### In conclusion: an artificial division of the core conditions

It should be clear that there is great difficulty (and no great merit) in separating the three identified core contextual conditions that are likely to either facilitate or hinder the development of LPs. Leaders are people who act towards others in certain ways (e.g. empowering and involving them); they also (if they have sufficient authority) are able to set aside time and places in which learning and reflection are both expected and encouraged. Leaders also set an example and set up systems for clarifying expectations, and providing the support necessary to pursue these ideals.

It is almost impossible to engage with one of these notions without activating overlap and material in common with the other two. For readers who are

familiar with wider leadership literature this is not surprising. Hard leadership is about providing structure and systems that make things happen (Fleishman *et al.* 1955; Fleishman 1998) and makes change possible by providing and building the road to the goal (House 1971). Whilst at the same time, softer leadership is about supporting and caring and organizing one's interests around the needs and concerns of others in order to make travelling the road possible and enjoyable (Fleishman *et al.* 1955; House 1971; Fleishman 1998). Leadership is also about power and motivation. Power makes it necessary for others to travel the route whereas motivation makes them want to do this willingly (French & Raven 1958).

This paper has artificially split the core conditions into their theoretical component parts in order to examine them and explore in detail the research around their impact. In practice, within the messy live situations in which care is provided, it is less likely that such divisions will be so clear. Leadership may obviously be linked to a person's role and what they do, or it may manifest itself as leadership behaviours being variously performed by different members of the practice at different times (Bennis & Nanus 1985). Only when these behaviours *make a difference*, either through a positive impact (helping) or by becoming a negative influence hindering events do they become overtly noticeable.

A positive leadership impact is likely to be recognized as one that involves others and helps them to do things for themselves, builds their capacity and confidence or as a hard influence that steps in and forcefully removes blockages, creating opportunities and driving things forwards by organizing practice time, roles and systems. In this way leaders champion the changes. Negative influences will close down learning, silence the voice of others and defensively use influence and power to block innovations. At these specific moments, in critical incidents (Flanagan 1954) the core contextual conditions become visible and open to collective reflection and form part of the learning within the practice (i.e. what went wrong, what or who stopped things moving forwards). More than this, any LP to achieve collective learning (and organizational learning) must be able to view, discuss and learn from these events, in order to create a facilitative context for its learning

attempts, reviewing difficulties and conflict along with successes. Mature learners are able to face mistakes and learn from these too; some would argue that the most valuable lessons are to be gleaned from mistakes (Mintzberg *et al.* 1998).

This last concept needs us to challenge the belief that a unitarist culture is needed in health care settings. There is an assumption that for an organization or work-groups to be successful its members should all share the same views and agree on issues – (in this case) that LPs are *all about* consensus and harmony (Garret 1994). Conversely, the opposite is a closer reflection of what an LP would be like. It would tolerate disagreement. Diversity in views and differences in approaches need not be feared or viewed pathologically, for they are the basic ingredients of debate and encourage a better review of all options and guard against taking too narrow an approach (Brehmer 1976; Cosier & Rose 1977). LPs and their members would need to look honestly at what happens to them and attempt to learn from it – whatever it is, and whatever lessons it offers them to learn. Discussed above are the core contextual conditions that might allow this critical and open self-examination to take place and thus make the achievement of a learning culture more likely.

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