Making the invisible visible: how a voluntary organization is learning from its work with groups and communities

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ABSTRACT   Many organizations find it a challenge to measure and evaluate the impact of complex organizational interventions. In this second of a two-part article (part one, "Connecting through communities: how a voluntary organization is influencing healthcare policy and practice", appeared in the last issue of this journal), the authors relate how UK-based charity Macmillan Cancer Relief has been experimenting with a new approach to evaluating how it works through learning communities of health professionals as well as patients and carers in order to benefit people living with cancer. Traditional evaluation methods rarely capture the intangible, qualitative results of this kind of work, much of which consists of groups of people learning by talking to one another about their experiences. Yet it is important to find ways of tracking the value of investments made in such processes as otherwise the investment may not be sustained and the relationships and knowledge developed may be lost. The approach described here, which has come to be known within Macmillan as the "learning framework", aims to make visible the normally invisible patterns and ripple effects of working through communities of practice. This method of evaluation is collaborative, "emergent" or iterative, and narrative-based.

KEY WORDS: organizational learning, research methods, evaluation, narrative, sensemaking, communities of practice, collaborative working, knowledge management

In the last issue of this journal we described how, over the past 12 years, UK charity Macmillan Cancer Relief has been working with groups and communities of health professionals, and increasingly with patients and carers, to generate learning and to influence healthcare policy and practice. In this, the second part of that article, we tell the story of how the organization has been developing innovative approaches to describing and evaluating these same activities. These approaches have enabled those involved to document and simultaneously learn from the change process.

A conversation about evaluation begins

evaluate vb1 to ascertain or set the amount of value of. 2 to judge or assess the worth of. (Collins Concise Dictionary, 21st century edition)

In the second half of 2003, we (the authors) began a conversation about how Macmillan might go about "evaluating its medical strategy". At the outset, we had no shared understanding of what was meant either by "medical strategy" or by "evaluate". Before long it became clear that the medical strategy was concerned primarily with the way in which Macmillan works with and supports doctors, including general

practitioners (GPs), in order to benefit people affected by cancer. According to internal documents, the purpose of the strategy was to "contribute to bringing 'people-centred practice' to all doctors treating and caring for cancer patients throughout the UK". As one of the means to this end, the medical services team, which is responsible for Macmillan's work with doctors, was cultivating groups and communities of health professionals, patients and carers – in order to spread learning, influence UK healthcare practice, and ultimately improve the experience of people affected by cancer.

During our early conversations, it crystallised that what the medical services team was looking for now was evaluation *for learning.* Shortly afterwards, therefore, we replaced the term "evaluation" with "learning framework". What this essentially meant to us was that we would be developing not only an appropriate research method but also a "common language" to articulate how Macmillan is working with groups and communities of health professionals and patients. We wanted to explore the value of this way of working – to Macmillan, its partners and its ultimate beneficiaries, people affected by cancer. The aim of this exploration was not simply to look back and learn but also to look forward and spot opportunities for improvement.

As the work of learning communities typically consists of groups of people talking about their experiences, learning from one another and often taking action locally, it can be hard for those funding it to "see" the results. Thus, the phrases "making the invisible visible" and "surfacing the invisible" quickly emerged in our discussions as early examples of the common language we were after. (In more conventional language one might talk of the need to "demonstrate impact".)

In a nutshell: why develop a learning framework?

Over time, the purpose and value of the "learning framework" crystallised into four main elements:

1. It helps people *understand* what are viewed by some as "new ways of working" (described in part one of this article as "connecting through communities"). Those who need to understand include Macmillan's managers and staff, as well as Macmillan's partners (those doctors, nurses, patients and carers, and others in the groups and communities referred to in this two-part article).

2. This understanding in turn helps to establish a shared view as to whether the work with groups and communities is *a good investment of the charity's funds*. Can one demonstrate impact? This is vital since establishing a new way of working (e.g. cultivating learning communities) is a complex intervention that cannot be satisfactorily measured using traditional methods.

3. The learning framework helps to *improve the very processes it is evaluating,* and does so continuously rather than waiting for a "report and recommendations".

4. It also helps to clarify whether *other parts of Macmillan might want to adopt and adapt* these methods of evaluation. Many parts of the organization (e.g. the "user involvement team") have been working with groups and communities for some years already, but the initiative to start describing and better understanding the value of

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working in this way came from the medical services team. Other parts of the organization may with time decide to adopt similar methods of evaluation, as they too see the potential for such methods to enable them to "surface the invisible". Thus, the learning framework came to serve as a pilot project within Macmillan.

The way the learning framework took shape was naturally influenced by the experience and interests of the group involved in these early discussions:

- Alison Donaldson's main professional and academic interest lies in the role of writing in the conversational life of organizations, and particularly the value of narrative in making sense of complexity and learning from experience. She is a writer herself and has been greatly influenced by recent thinking around complexity, sensemaking and action research methods.
- Elizabeth Lank has long experience in facilitating collaborative working in and across organizations and is particularly interested in how to set up and cultivate communities of practice to encourage knowledge sharing. She is convinced of the need for qualitative methods in assessing the value of knowledge sharing and believes they should gain greater acceptance as part of formal evaluation processes.
- Jane Maher, as Macmillan's Medical Advisor and a practising oncologist, has been working with Macmillan for about six years, helping the organization achieve greater results from its work with doctors. She discovered a resonance between her experience of how learning and change emerge from the stories told in groups and communities of doctors and patients and the notion of "communities of practice", which she had encountered through an educational programme run by Etienne Wenger as part of a National Health Service (NHS) Modernisation Agency programme for leading clinicians.
- Glyn Purland, as a senior manager with Macmillan, has worked with Jane Maher from the beginning to develop and implement the medical strategy. He is budget holder for the learning framework pilot work, Macmillan senior management lead for a number of related strategic partnership projects, and has long experience as a manager in the NHS.
- Lorraine Sloan, as Development Manager for Macmillan's medical strategy, has a keen interest in continued learning from the way Macmillan is working with doctors. She has introduced patient and carer involvement into the medical strategy and has extensive experience and skill in facilitating groups and making connections.

An "emergent" method

From April 2004, the conversations we had started evolved into an official "learning framework programme" within Macmillan, and the five individuals above began to meet regularly as "the learning framework team". We did not start with a "grand plan", realising that this form of evaluation would be "emergent" by nature – that is, it would take shape as we spoke to people, explored what the groups and communities in question were doing, and identified stories that would make their work visible. Of course we did plan – taking the view that planning is a vital conversational process, often more important than any written plan it produces.

We also undertook to respond to and learn from what happened along the way, constantly asking ourselves what should be "captured"(mainly in writing), to what purpose, and what should be shared with others (whether in writing, in workshops or in other informal conversations) to stimulate learning across Macmillan and beyond, including the network of health professionals connected to it. We recognised that this would allow us to grasp opportunities for organizational learning as they arose rather than trying to predict precise outcomes of our work on day one or "waiting until the report was ready".

Strictly speaking, the term "learning framework" describes the evaluation method we have been developing. However, the processes we are describing (referred to in part one as "connecting through communities") are in themselves learning processes, so sometimes the term is used to encompass the whole process – forming communities, facilitating the conversations and learning that occur within them, and creating narratives to make the invisible visible.

Main components of the learning framework

The work continued to unfold throughout 2004 and early 2005, and what follows are the main elements of the process that emerged. This is written with the benefit of hindsight and is not intended as a template for others to follow, but it may provide food for thought for anyone contemplating how to approach "evaluation for learning".

1. *Agreeing the initial scope of the evaluation.* In our initial discussions, we agreed to begin with a relatively limited piece of work – namely, to create a narrative about one particular group, Macmillan's GP Advisors. The GP Advisor role went back to the early 1990s and the story traced the evolution of this group and its influence on the UK's health service. The value of starting with this discrete piece of work was that a narrative could be constructed by talking to a small group of people, and it allowed us to explore and demonstrate important developments over time in Macmillan's work with doctors. It also provided a flavour of how the narrative approach can capture complex processes and stimulate learning. This piece of work subsequently led to wider application of the learning framework to a range of different groups and communities supported by and connected with Macmillan.

2. *Forming a team / involving the right people*. The original learning framework team emerged from the early conversations and consisted of the five individuals referred to above. Glyn and Lorraine represented the roles of "organizational sponsor" and "community facilitator" outlined in part one of this article and were vital linking people. Glyn was the organizational sponsor for the medical strategy and the learning framework pilot project. Lorraine was the facilitator for some of the groups and communities we were setting out to follow and describe. She increasingly found herself focusing attention on and stimulating "what goes on between meetings". This was crucial in helping groups move from ephemeral conversations to real influence. The team also had excellent administrative support to help co-ordinate and follow up on meetings and conversations.

3. *Meeting regularly* to review the work and develop the "common language". We met as a team approximately once a month for about four hours to discuss general progress, the emerging "portfolio" of narratives, publication activities,

opportunities to engage with and stimulate learning in further groups (a nurses' group, patient groups, Macmillan managers, and so on), as well as opportunities to create new groups. Between these meetings we stayed in touch via email, telephone and teleconference, or met informally according to need. All of these conversations were vital in enabling us to develop a language with which we could engage different groups of people within and beyond Macmillan – a language that introduced them to new concepts while not putting them off with too much theoretical or managerial gobbledygook.

4. *Identifying and recording narratives* that would be useful for learning. Just as the groups we were writing about created tangible "knowledge products" (e.g. the document called "Our principles of people-centred care" mentioned in part one), over time the learning framework team developed a written portfolio of narratives and discussion documents. These helped people understand and visualise what the medical strategy and the learning framework looked like in practice, and what all this contributed to the lives of people affected by cancer. The titles of some of the narratives provide a flavour of the kind of stories that we identified as useful: "Engaging with influential doctors" (the GP Advisor story referred to earlier); "The social life of a document" (describing how a patient and carer group created a valuable written product and played a part in introducing it to other patients, carers and health professionals); and "Connector narratives" (giving examples of what members of the learning communities achieve by developing relationships, sharing experiences and stories, and connecting with their personal networks – the "ripple effects" of group interactions). We discovered that it is not a simple matter to collect meaningful connector narratives: though it is quite easy for participants in a group conversation to give an example of something they learned, later on they do not necessarily recall or even know what ripple effects have resulted.

5. *Writing iteratively and involving the members* of the groups and communities in the creation of "their story". Rather than just interviewing group members and writing up a report, we took our drafts back to the group or community it related to, sometimes several times, to give them an opportunity to make suggestions, add new stories or even veto the account. We were particularly careful, when writing, to involve the participants in drawing out "lessons learnt" and "conclusions". By going back to the group with a draft we also stimulated a further round of reflection on its work and achievements. Often this helped members to recognise and acknowledge their own value and gain a sense of "closure", of a task well done. For example, patients and carers who participate in groups and communities do not always realise what an influence they have. We also found that a shared narrative could play an important role in surfacing tensions and moving on. In some cases we recorded group conversations, allowing us to use the exact words uttered by group members, making the written end products both collaborative and lively. Last not least, the process of redrafting continued to refine the language associated with the learning framework, thus making it more intelligible to others not directly involved. Even the writing of this article has helped to develop the thinking and language of the learning framework team.

6. *Spreading the learning.* As soon as we had written a couple of drafts, we took care to keep the portfolio alive not only by updating it but also by introducing relevant narratives to people who might learn from or act upon them. We did whatever we

could to give our narratives and discussion documents a "social life" by initiating discussions about them with interested individuals and groups. For example, we convened an informal workshop in December 2004 to share our writing and thinking with a small group of influential Macmillan managers, representing interests ranging from human resources through knowledge management to user involvement. We also facilitated a number of discussions with the groups and communities we were following, to help them determine their own way forward, taking into account the learning emerging from the narrative writing. For example, the GP Advisor group members agreed that, as well as being task-oriented, it was important for them to review regularly how their working relationships were going. We applied this principle to this group and others by facilitating more personal, reflective discussions during their meetings.

7. *Expanding the team and engaging "allies".* After about nine months, in January 2005, the first additional member joined the team: Jane Bradburn, Macmillan's User Involvement Advisor. "People-centred care" is central to Macmillan's medical strategy, so user support and involvement are vital facets of its work. Jane Bradburn had been working with groups of people affected by cancer for many years – indeed the medical services team's approach mirrored her work – and she quickly recognised the potential value of the learning framework. She felt strongly that it should be applied across Macmillan's work, not just confined to the medical strategy domain. Our narratives helped her and others to see the relevance of the learning framework to their areas of work.

8. *Pursuing wider publication.* We recognised from the start that sometimes people in organizations take external publications about their own organization more seriously than internal reports. We think of this as "boomerang marketing". When managers see that an internal initiative has earned external acknowledgement and credibility, they then become eager to learn more about it themselves. We therefore started early on to seek out opportunities for publication in medical and management journals, not only knowing we had a story worth telling and sharing, but also realising that this would encourage internal learning and support.

Below we give some examples of our work, followed by a discussion of how our approach resembles and differs from comparable methods of evaluation or research.

Example one: facilitating and narrating the work of groups of healthcare professionals

The value of the rear-view mirror when driving forwards

The first group we engaged with was Macmillan's six GP Advisors, one of the "distilling and connecting" groups described in part one. Our purpose was to reflect on and learn from the first 10 years, establish a record so that people in future could understand this way of working, consider its relevance for other parts of the organization, and last not least, discuss the group's future role. We began the "learning framework" process by attending one of the regular meetings of the GP Advisors in May 2004 and also separately interviewing every member of the group (past as well as current). Within two months we had a draft GP Advisor narrative known as "Engaging with influential doctors". We subsequently circulated our draft to the group and joined

their next meeting, in September 2004, during which we ran a reflective session to help
them review the history of the group and some of the lessons learnt so far. This was an
important step because, as with most groups, this one has had its share of tension and
difficulty, though this has not negated its influence on the health service or the
contribution it has made to the lives of those affected by cancer. We agreed on that
occasion to reserve time in future meetings of the group to reflect on the group's
process and working relationships, in order to try to address any difficulties before they
escalated.

The September meeting was followed by another one in February 2005, in which we
facilitated a discussion about the group's future focus, enabling its members to identify
and agree which issues to pursue in the next two years, as well as which member
would lead on each issue. At that meeting we also suggested that it would be useful to
share "Engaging with influential doctors" with Macmillan senior management, in order
to help them better understand the work of the group over the past 10 years and the
value of continuing to invest in it. The group's members requested one more chance to
read the draft with this particular readership in mind, and this stimulated further
changes and additions.

One form of writing that emerged as we wrote "Engaging with influential doctors" was
the inclusion of different perspectives in the narrative. This was particularly useful
where different people who had lived through the history had divergent ways of
making sense of it. In one case, we set out an agreed chronology of events, followed by
three personal perspectives. This enabled each of the people concerned to express the
story in their own way, yet also see how others saw it. And it leaves a record that
respects these different viewpoints.

Reflection
The choice of our first narrative was important. In practical terms, it had the advantage
that a first draft could be researched and written relatively quickly as it only involved,
at most, about 10 people. We also found that one-to-one interviews and group
conversations both had a valuable role to play. More significantly, the medical services
team was confident that the group was associated with some major changes, and all its
current and past members were willing to talk about their experiences (one even
described the experience as cathartic). The process of creating a historical narrative,
incorporating multiple perspectives, helped participants collectively make sense of
their past as a group and prepare to move on and refocus. The process was
collaborative, in that the learning framework team was closely involved with the group
over a period of months, not only sharing each draft with the group but also facilitating
discussions around some of the issues thrown up by the iterative writing process.

A creation story

As well as tracking the activities of this existing group, we began to experiment with
setting up a new "distilling and connecting" group. Thus, even while we were still
working with the GP Advisor group, we were able to put into practice some of the
learning. The medical services team had decided it wanted to bring together another
small group (about 15 participants in this case) to act as a link between Macmillan and
the community of about 240 Primary Care Cancer Lead clinicians (PCCLs) who work
for NHS Primary Care Trusts across England (and their equivalents in Scotland and

Northern Ireland). The thinking was that this connecting group would work directly
with Macmillan and thus enable the wider PCCL community to have an influence that
they might not otherwise have achieved. Thus, in February 2005, we facilitated a
meeting for about 30 individuals potentially interested in participating in a PCCL
connecting group. During this exploratory meeting, we invited them to discuss a
number of live issues in small groups, in order to have a real experience of what it
might be like to act as a connecting group, as well as considering some more general
points about the group, such as its purpose, membership, links to Macmillan and other
bodies, and practical arrangements. For the learning framework team, the opportunity
to help set up and follow the evolution of such a group meant that we could gather
narrative material from day one, thus capturing the process and stimulating further
learning.

Example two: tracking the work of user groups

The social life of a document

In part one of this article, we described how one of Macmillan's patient and carer
groups created a valuable document or "knowledge product", which became a
Macmillan document called "Our principles of people-centred care". Long before the
learning framework team came along, this document had received considerable praise
and had been distributed to all Macmillan nurses and doctors. What was less well
known was how the members of the patient and carer group had worked with its
facilitator, Lorraine Sloan, not only to create the document but also to introduce it to
their own wider networks across the UK in order to help educate health professionals
and provide people affected by cancer with some words to express their needs at each
stage of their journey.

In order to capture the story of the document's creation and "social life" – a phrase
borrowed from Brown & Duguid (2000) – one of us joined a number of the group's
meetings, equipped with a minidisc recorder and digital camera. In a few minutes
snatched with Lorraine before the meeting, we heard how the idea of creating a
document had arisen out of the need to define "people-centred care", a pivotal concept
for the medical strategy. We then took a one and a half hour slot at the meeting itself
and engaged in conversation with the group, inviting the participants to tell us stories
about how they had seen the document being used. In no time at all, a whole collection
of stories and examples came to light. This brought out the vital role of group members
in connecting to wider networks of health professionals, patients and carers – the
"ripple effects" of the group's conversations. Later we transcribed and edited these
examples and included them in a narrative entitled "The social life of a document". To
date we have gone back to the group twice again to discuss the narrative and record
and capture further stories.

Reflection
Both documents – the original one created by the patient and carer group and our
"Social life of a document" narrative – helped to make the valuable, largely
conversational work of the group more visible across Macmillan. As group facilitator,
Lorraine Sloan, commented: "It is important for the Patient and Carer Group to see the
fruits of their work. Much of the work within the medical strategy is complex and
focused on producing longer-term influence, rather than immediate 'products'.

Therefore it is very important to capture and disseminate anything that gives visibility and credibility to our work so far." The exercise also confirmed the value of recording the words of people affected by cancer and building them into the resulting narrative.

Illuminating the ripple effects as they occur

We are now also tracking the work of another group of patients and carers, called the Cancer Genetics User Reference Group. This group was set up to get users involved in a joint Macmillan/Department of Health initiative aimed at improving information and services offered to people who are worried about their family having a history of cancer. The project, which continues until 2007, involves seven pilot sites around England, each of which has its own user representatives who are also part of the central User Reference Group.

Each of the seven pilots is required to undertake some evaluation to account for progress and allow lessons to be learnt. These pilot evaluations are also to feed into an external evaluation by a team at the University of Nottingham, commissioned by the Department of Health. To complement these evaluations, the learning framework team was invited to follow the work of the central user group over the two-year life of the pilot projects, in order to demonstrate in narrative form the influence of user involvement.

In January 2005, one of us attended the second meeting of the central user group to explain our interest in understanding and documenting how such a group not only influences the pilot sites but also brings knowledge back into Macmillan. The facilitator's note after the meeting summarised why this matters:

> *"[The external evaluation] will not necessarily capture the learning process for the user group. Macmillan would like to track some of the work of the group... Macmillan is committed to user involvement. However, the external world is unaware of how valuable your stories are. They are powerful stories because of the difficult situations users and carers often find themselves in... Macmillan is also interested in ascertaining how people make connections beyond the group."*

We viewed this meeting as an opportunity to get to know the group, and to discover how it learns through sharing stories and what kind of narratives we might be able to capture. Even at this first encounter, a number of valuable stories emerged. For example, one user recounted how her local patient group had been attending meetings of the local cancer genetics pilot project and had been able to comment on letters and questionnaires *before* these were sent out to patients. In contrast, another member told how a letter had gone out to patients from her local hospital containing the unnecessarily alarming words "Our records indicate that you have a family history of cancer", triggering a number of complaints. Had the user group had the chance to comment before the letter went out, this would never have happened. The group discussed the case and agreed that the issue was not to find a more suitable form of wording, but to recommend that the pilot sites use other methods – e.g. leaflets, local radio, schools, local press, posters – in future when trying to recruit patients to the services.

> **Reflection**
> Valuable stories are emerging already from the conversations of this user group. We were fortunate in being able to join the meetings of this group relatively early in its life. As a result, we could (i) experience and capture how learning occurred in "micro-interactions" within the group, (ii) inquire into what happened beyond the meetings – e.g. what learning was coming back from the pilot sites into the central group, and what ripple effects were spreading out from the central group into the members' networks, and (iii) by writing narratives that could be read by group's members and contacts, we could potentially amplify some of the ripple effects. Thus, this user group promises to be a rich source of learning and influence. In no way is it "token" user involvement.

How is the learning framework connected to other forms of "evidence creation"?

With the overwhelming emphasis in today's NHS on "evidence-based" practice, it is important to be clear about the validity of a narrative-based form of evaluation. Perhaps the first point to establish is that what we have been evaluating is indeed, in the language of the NHS, a "complex intervention". The Medical Research Council (MRC, 2000) recognises that many healthcare interventions are "complex", that is they: "comprise a number of separate elements which seem essential to the proper functioning of the intervention although the 'active ingredient' of the intervention… is difficult to specify" (ibid: 1). The MRC points out that even seemingly straightforward interventions, such as a physiotherapist treating a knee injury, involve many different factors.

The intervention being studied here is a way of working through groups and communities of health professionals and service users, which has been actively funded and supported by Macmillan, in order to improve the experience of people living with cancer. As an intervention, it is "complex" on a number of grounds:

- It involves working through learning communities of people employed by (and using the services of) *a complex organization* (the NHS), and Macmillan itself is a complex organization.
- Influencing cancer and palliative care involves multiple professionals and organizations and diverse patient circumstances.
- The benefit to people living with cancer is "indirect" – for example, it might involve doctors learning from one another's experience and changing the way cancer and palliative care are delivered; or patient and carer representatives creating helpful guides for people affected by cancer.

Given that the intervention is a complex one, what is an appropriate method for evaluating it? The traditional method is typically to employ empirical techniques, quantitative and qualitative, based on measurement and/or sample surveys. For example, in order to evaluate the Macmillan GP Facilitator programme described in part one of this article, researchers carried out a survey of GP Facilitators at two dates in an attempt to measure changes over time. Statistical analyses and comprehensive reports followed and the findings were discussed within Macmillan. Broadly speaking the authors were positive in their assessment of the Facilitator role, although it was

hard to measure any significant direct effects. Once the reports had been looked at and filed away, they became more or less dormant, to the frustration of both Macmillan managers and the authors themselves. The people who may have learnt the most from the research exercise were the researchers. (To avoid losing the knowledge associated with this work, and to maintain close connections with the researchers involved, Macmillan's medical services team has recently started to experiment with bringing together the researchers from various universities who have collaborated with Macmillan. The result is an active research and evaluation collaborative, whose development is being followed by the learning framework team.)

Empirical methods remain vital in building an evidence base for Macmillan's work, and the organization continues to commission such work. The learning framework complements rather than replaces the traditional methods of measuring impact. Indeed, when trying to influence practice and policy, Macmillan has found that a combination of "statistics and stories" is particularly effective. Statistics provide "hard" evidence (e.g. the proportion of cancer patients dying in their place of choice before and after their GP practice started to record their wishes systematically), while stories bring out the rich context and detail that enables people to understand more fully how health professionals and users, working both separately and jointly, can improve the experience of those affected by cancer.

The way the learning framework has taken shape echoes the "iterative commissioning" described by Richard Lilford and colleagues (Lilford et al, 1999). The authors point out that traditional, linear commissioning methods, in which results are assessed only on completion, have a number of limitations. First, the exact research question and the scope of the research may not be clear at the outset. Second, by the time the research results arrive, they may no longer be relevant – "research may progress too slowly and fail to influence policy and practice" (ibid: 166). Third, potential users of the research may lack ownership of the results. These limitations are particularly apparent with research on complex issues, such as the best methods of providing out-of-hours primary care cover.

In contrast, with an iterative method researchers are not expected, writes Lilford, to provide a detailed description of each stage of the research before it starts. Instead they discuss their work directly with the research commissioners and managers; funding is predicated on the evolving need and the work can be halted at any time. Thus, the iterative method promises more timely, relevant results, more likely to be put into practice. It also means that researchers and users "cease to live in different worlds" (ibid: 167). Finally, it is worth noting that the iterative method is "more labour-intensive for research commissioners, who could achieve greater apparent efficiency by simply funding blocks of research with minimal direction and scrutiny." (ibid: 166).

Action research or ethnography?

Given that what we are studying is a set of *complex* interventions, we have tried to make sure our method is congruent with principles borrowed from complexity theory, especially the insight that interaction gives rise to patterning, both repetitive and novel. In practical terms, this means we develop narratives that illuminate patterns and retain sufficient context to facilitate understanding and learning. This echoes the method of "emergent exploration" described by Stacey and Griffin (Stacey & Griffin, 2005). We

do not start by defining a fixed hypothesis and then systematically testing it (although of course our own particular knowledge and experience do influence what we pay attention to). Rather, we aim to record stories and observations likely to stimulate further learning and improvement.

The importance of narrative is recognised by many people working in the health sector, especially in the conversation between doctor and patient in primary care (Launer, 2002). More generally, the role of stories in organizations has been extensively explored in recent years (Czarniawska, 1998; Denning, 2001; Gabriel, 2000; Launer, 2002; Snowden, 2001). Many aspects of human life cannot be reduced to numbers, just as many experiences and interventions cannot be repeated to produce generalised results. Stories, whether just told in groups or recorded, enable us to do justice both to the complexities of organizational change and to the experience of patients, carers and health professionals. They also help to bring alive the work of groups and communities for those who have not participated in them directly, enabling them to reflect on possible relevance for their own field of work.

The learning framework could be said to belong to the "action research" family of methods, a term generally credited to Kurt Lewin. A recent definition of action research is that it is: "participative, grounded in experience, and action-oriented" (Reason & Bradbury 2001: xxiv). In short, the purpose and value of action research is that it focuses on and aims to improve practice.

Our approach is also similar in many ways to ethnographic research, in that we participate in the activities we are studying, and we try to write about them in the rich, colourful language of daily life (Toulmin & Gustavsen, 1996). Unlike ethnographers, however, our goal is not just to describe but also to help improve practice.

There are also strong connections between our approach and Karl Weick's notion of sensemaking in organizations (Weick, 1995). Weick identifies a number of characteristics of investigations into sensemaking that ring true for our work. For example (ibid: 172-173):

- the researchers "make an effort to preserve action that is *situated in context*".
- "Findings are described in terms of *patterns* rather than hypotheses.
- "There tends to be intensive examination of a *small number of cases* rather than selective examination of a large number of cases" (our italics).

A further comparison worth making is with a technique called "rapid appraisal", which is widely used in the health sector (Murray, 1999). Though this technique is designed as a way of involving the public in developing health services, it has a number of features in common with ours. It too is participative (by involving people from the community being studied in the research, the process itself can facilitate change), context-specific and designed to supplement more formal methods. Additionally, the informants are "not selected randomly but 'purposefully' – that is, asking a range of people who are in the best position to understand the issues" (Murray, 1999: 441).

Benefits of the learning framework – a summary

Continuous improvement
Because it is a collaboration, not the normal form of commissioned, retrospective research, the team is constantly looking for ways to bring people together to learn from experience and try new ideas. In other words, the "results" of the evaluation and research are not held back until the end of the programme being evaluated or the end of the life of the group or community being studied. Instead they are shared continuously from the early stages and throughout the process.

The learning lives on in the organization
As the evaluation is a collaborative learning process between the organization and external researchers/consultants, much learning lives on within the organization, not simply in the reports and heads of people who deliver their report and then move on. Of course the researchers do learn a lot, which is why Macmillan tries to stay connected with them over a long-term period and why it is experimenting with supporting a longer-term research and evaluation collaborative, as mentioned.

Less risk of "comatose document syndrome"
The team is committed (a) to write reports only when they will serve a real purpose, such as creating understanding, stimulating learning and change, or building support for a particular way of working, and (b) to make sure any piece of writing the team produces, or at least the thinking it articulates, gets a "social life" – i.e. that other people in the organization engage with the thinking.

A common language develops
The rich mix of face-to-face discussion and writing enables the team to develop its thinking and explain the work to people across the organization, helping the latter to make sense of how Macmillan is "connecting through communities". The process of writing iteratively is particularly helpful in clarifying shared understanding.

Work in progress

Because the new ways of working require investment (e.g. funding of "backfill" for doctors, travel expenses, time, co-ordination, communication), it is important to undertake some form of evaluation in order to demonstrate that the expenditure has been worthwhile. Without making the invisible connections visible, there is the danger that organizational sponsorship (and funding) will be lost for a process that is in fact bringing much value. As a method of evaluation, the "learning framework" is very much work in progress and will continue to evolve. For example, we will continue to work in different ways with each group or community we engage with, and we intend to try out different media, including video, to capture narratives in future.

The writing of this article was itself a collaborative process. For example, the draft provoked the following questions: "What kind of skills does this work require, and what controls can you introduce to make sure it is 'not just a subjective account'?". By describing the process as emergent and trying to explain it with as little jargon as possible, we ran the risk of sounding as though we "didn't know what we were doing". We will therefore offer an answer to both these questions briefly here.

First, developing the learning framework did require certain levels of skill and experience, present within our team. For example, someone had to be able to:

- recognise that there were some ways of working that were worth capturing and understanding better in order to sustain and improve them
- identify groups of people who had been working together as a community over a period of time and who had achieved something worthwhile
- identify and create useful draft narratives and discussion documents, drawing on both one-to-one interview and group exploration
- be clear about why a narrative is to be created and how it will be used to stimulate learning, rather than writing for its own sake
- track the informal conversations and connections that do not normally get written about
- facilitate group meetings to encourage both reflection (learning) and action, and deal with tensions that arise
- maintain focus on what the work is contributing to the lives of people affected by cancer
- draw on appropriate theories of organizational change and research methodology.

Second, we see our approach as collaborative and therefore "inter-subjective" and this guards against it becoming the subjective account of one individual. We have worked continuously as a team of five (now six) and, as mentioned, have shared our drafts with members of the groups described. As a team we also agreed from the start that our intention was to stimulate learning and improvement, as well as to attract support for the way of working referred to here as "connecting through communities". This is not the same as trying to "prove that this way of working is right". Last not least, the quality of the research depends on the integrity and experience of those undertaking it, but this it true for any research method.

The learning framework has been developed in a *particular* context, namely a voluntary organization trying to work through communities of health professionals and others committed to helping people affected by cancer. Nonetheless, we do feel that we can confidently say *in general* that this is an effective way of developing a common language to "surface and legitimate" learning processes that may otherwise go under-recognised. Given that the ways of working that we are describing and evaluating are "complex interventions", the collaborative and narrative methods used are fit for purpose. Moreover, they can be used to complement more traditional methods of evaluation and research, and to identify improvements quickly and continuously. "Learning framework" methods and skills could find wider applicability across Macmillan and in other organizations.

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