Commissioning Personalised Care in the English Adult Social Care Sector: an action research model to support leadership development.

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Commissioning Personalised Care in the English Adult Social Care Sector: using action research as a framework to support leadership development.

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Abstract

This paper presents the perspectives of English adult social care sector partners on the qualifications and standards required for leaders as they prepare to meet the demands of commissioning and commissioned personalised care across service user groups. Using an action research cycle guided by Coghlan and Brannicks (2010, p 4) organisational centred model (McCray and Palmer, 2009) it benefits from the previous experience, practice learning and reflection in action of the partners and researchers who were involved in an earlier phase of the research cycle. Findings presented are derived from focus group discussions with strategic and organisational leaders from the English adult social care sectors including those for older people, people with complex disability, learning disability, acquired brain injury and mental health. Leadership development needs required for the commissioning of personalised care in a changing context of health and social care delivery are identified. The paper also shows how action research can make a contribution to knowledge and practice by continuous

engagement between researchers and participants through a period of transformation.

Keywords: Reflection, Practice Learning, Social Care, Brain Injury Commissioning, Leadership, Action Research

Introduction

A fundamental shift in policy reflected in the UK White Paper "Our Health Our Care Our Say" (Department of Health, (DOH, 2006) meant that service users and their families and carers were to be at the centre of their care planning and delivery accessing personalised services through the vehicle of an individual budget (IB). The ministerial concordant "Putting People First" (Department of Health 2007a) set out how services and partners would work together to share and action the same vision as services were transformed. Individual budgets (IBs) were piloted in 13 English local authorities from 2005 to 2007 focussing on their use in the personalisation of adult social care (Baxter et al 2011, p 55). The results of these pilots offered a mixed picture of satisfaction and well being for service users in different care groups (DOH, 2008). Despite this, the momentum for further implementation has been maintained and underpins the UK governments' A Vision for Social Care Capable Communities and Active Citizens (DOH, 2010) and the *"Caring for our Future: Reforming our Care and Support"* (DOH, 2012a) which maintains the personalised focus of support to adults in England.

This transformation of service delivery has resulted in a requirement for major change in the strategic decision making, commissioning relationships and delivery of individualised adult social care. This paper will present the findings of the second stage of an action research project funded by Skills for Care undertaken in two local authorities in the South of England United Kingdom (UK). The study presented here is built on the outcomes and evaluation of the earlier project (McCray and Palmer, 2009). This centred on leadership challenges for service providers in the adult social care third sector and identified a need for effective leadership in commissioning relationships.

New contexts of care may require different approaches to leadership and this paper presents a model for leadership development in the transition to personalised care as well as an action research framework that may be adopted by similar partnerships elsewhere.

The core questions from the regional study that underpin this paper are:

1. What knowledge and skills are required to meet current and future needs for leadership in personalised adult social care in England?

2. Are there any gaps when these are mapped against the UK social care industry standards and current educational provision?

3. Which routes and models of education/training are most suitable for meeting leadership development needs in a time of uncertainty and cultural change?.

Context

Cox (2009, p3) describes adult social care in England and the UK as the provision of support to older people, people with learning disabilities , people with physical impairments and people with mental health needs. This support includes home care, residential and day care and advocacy, plus support to families and carers. Whilst this is a significant contribution to the economic and social fabric of society Cox notes that social care is often poorly understood and described (Cox, 2009, p 3). Equally for people with traumatic brain injury, Simpson et al (2002) note that it can often be a hidden disability and Mantell (2010) writes that traumatic brain injury does not easily fit into any one of the categories above. Much of social care is fragmented and the care sector workforce is leading and delivering support in the private, voluntary and public sector.

From a service user and carer perspective personalised adult social care and the notion of individualised cash for care (Glendenning and Kemp 2006, p 1) has been offered, since the introduction of the 1996 Community Care (Direct Payments) Act. A range of models are on offer to service users including the use of personal budgets for in-house (public sector or commissioned private sector support) through to service user employment of personal assistants. As Rabiee, Moran and Glendenning (2009, p 1) note take up was originally limited for a range of reasons including from an organisational perspective, reluctance to change and loss of control and concern about jobs (Rabiee, Moran and Glendenning, 2009, p 1). A national evaluation study (Ibsen) of 13 pilot sites (Glendinning, et al, 2009) showed mixed experiences for

different groups of service users. Nevertheless the concept of personalised care has gained momentum and now it must be offered to all service users in receipt of care and support. In services for people with brain injury the individual person's diagnosis will influence the category of rehabilitation needs (SSNDS 3rd Edition 2010) and level of rehabilitation service provision which may be a factor in determining the timing, extent and application of the personalised service offered. Mantell (2010) reinforces this, noting that the initial allocation of individual service user to social service may dictate their level of service provision and have a subsequent effect on service outcome.

The introduction of this form of care model has implications for all those who lead and manage in adult health and social care and impacts on the industry business practice and leadership processes of the private as well as public sector services in social care. The UK national social care workforce developers recognised this and offered initially a framework of National Occupational Standards in the form of a Skills for Care (SFC) Sector Qualification strategy (SFC 2008). This identified leadership and management and human resource practice as one of five workforce priorities in order to meet the changes set in motion by the transformation agenda. Most of the responses were underpinned by a UK National Vocational Qualification framework. More recently in November 2009, the National Skills Academy was launched with a mandate for adult social care leadership set within a qualifications credit framework (QCF) in a sector where as Cox (2009, p 28) notes by 2025 there will be a further one million people employed.

Commissioning

Huxley et al (2010, p 291) define commissioning using Richardson's (2006, p 2 _ definition as 'the process of specifying, securing and monitoring services to meet people's needs at a strategic level' (Richardson, 2006, p 2). Continuing, Huxley et al (2010, p 291) use this definition as applicable to all services, "whether they are provided by the local authority, the National Health Service (NHS), other public agencies or by the private and voluntary sectors (Audit Commission et al, 2003)". The process of commissioning in social care has been gathering speed since 1991, with the beginnings of the internal market in social care. Early models of commissioning were based on contracting out, and separation of the purchaser, provider roles. Health or local authorities were forced to invite companies to tender competitively against their own in-house services, and choose the tender which was the least costly (Mailly, 1993). Goodard, Mannion and Ferguson (1997) note that in contracting out emphasis was placed on the contract itself. They observe that the process was used both as a management tool and to create competition, when it was used as a threat against internal public sector providers to increase productivity. This shift was to lead to tensions around efficiency and performance improvement, and a change in the role and position of the manager, professional and service user in the contract service delivery process.

On election in 1997, the UK New Labour government policy shifted the emphasis from the contract to a more quality focussed commissioning model incorporating needs assessment, reviews of services provided, priority setting and planning, contracting, service development and performance management. Typically many contracts were still "block" in that volume costs lay with the provider service.

The nature of services in Adult Social Care means that this remains the case in some areas of delivery despite a change in government. Further changes in the commissioning landscape have occurred in 2013 with the introduction of primary care driven commissioning and the going live of Clinical Commissioning Groups at local level with the brief to commission effective health care in collaboration with social care and public health bodies (DOH, 2012b). In services for people with brain injury services are provided by specialised services and commissioned as a core activity of NHS England because they are defined in law as those services with a planning population of more than one million people **(http://www.specialisedservices.nhs.uk/info/specialised-services-accessed November20th2013).** The Specialised Services National Definitions Set (SSNDS) describe these services in more detail. SSNDS number 7 Specialised rehabilitation services for brain injury and complex disability (adult) is of particular relevance here although a need for integration of care may draw on other pathways. People with less severe disability or other milder traumatic conditions may require services commissioned by local CCG groups and / or social care commissioner s (Gridley et al 2012). As these complex system changes take place in all aspects of care and support, the commissioning processes can be immature. Critics note the lack of evidence for approaches and methods taken (Huxley et al 2010, p 29).

Personalisation

In the UK commissioning of services is beginning to encompass personalised support. Here service users may be involved in all or some of the planning and delivery of their own provision (DOH, 2007b) using input from in house or commissioned support agencies as required. The recent change in government has further endorsed the personalised model of provision with use of third sector organisations and economic costing as significant drivers in the provision of all types of service delivery in England.

For those who lead and manage commissioning and provider services in the public, third and private sector, moves to personalised models of support add an additional layer of complication to their remit. Commissioning developments require professionals to change their practice, team memberships and roles in order to network, engage and deliver to performance targets which may have previously not been viewed as part of their role specification. Furthermore the new collaborative partnerships that personalisation has created across communities, agencies and professionals in the public, private and third sector mean that service models and networks are in transition. A number of new challenges are emerging and confront the leader of the social care team. At strategic level commissioning the reforms stress the need for greater partnership working and more joint commissioning with health care services (Leece, 2007, p 198). At organisational level this means greater emphasis on the leadership strategies required for collaboration. Glendenning (2002, p 115) refers to the difficulties commissioning and implementing service models for personalised

care may create in working practices between health and social care services. For people with brain injury and the potential complexity of diagnosis, changes in the level and nature of rehabilitation as well as commissioning arrangements this remains a possibility. Grinley et al (2012) in their study of service improvement and impact on long term neurological conditions, present the experiences of service users who cite a lack of specialist knowledge and interest of GPs which could be a barrier in gaining support for personalised solutions. However Gardner (2011) sets out a framework of good practice for implementing personal care in social care practice for people with acquired brain injury and Green and Dicks (2012) describe a successful model of collaboration to support a young adult with brain injury from birth.

Having noted the challenges facing commissioners and recipients of personalised care and support in a national context we return here to the research content of this paper . This highlights the outcomes of a second cycle in a regional action research project that commenced in 2007 and sponsored by a United Kingdom Quango (Quasi Non-Governmental Organisation), Skills for Care.

Research Design and Procedures

The first cycle of the action research cycle had been the development and evaluation of a leadership programme for managers in the care sector that had been designed, delivered and evaluated in collaboration with Skills for Care and the participants in the programme. The second cycle of this research is reported here. Findings related to commissioning in this paper are from a localised research context and are presented as

none generalise able to inform practice. Learning in relation to the methodological framework of action research is also reported and offers insight into a collaborative research and development activity. The model of action research applied is informed by Coghlan and Brannicks' (2010, p 4) organisational centred model focussed on the context, quality of relationships, quality of the research process and its' outcomes. Coghlan and Brannick describe their research as being guided by Shani and Passmore (1985). They define action research as a process by which applied behavioural knowledge is integrated with scientific knowledge and applied to solve real organisational problems' (Shani and Passmore, 1985p 485). For Shani and Passmore action research is concerned with bringing about change in organisations, building self-help competences of members of the organisations and informing scientific knowledge.

The role of the authors has been to facilitate identification of the leadership issues arising from the implementation of personalised care in the English adult social care sector and in collaboration with sector partners seek resolutions in the form of new skills and knowledge required and possible educational strategy to bring about transformation. Throughout the study the authors were guided in their reflection on the quality and rigour of the action research process by the adaptation and use in research practice of Reasons' (2006) questioning of choice points. These choice points were : reviewing the quality of relationships with those in the sector, meeting practical outcomes for change, maintain conceptual and theoretical integrity by making sure we included a wider range of possible views and options for change and considering the likely impact and longevity of changes made.

Firstly, the quality of relationships . As the researchers have previously had the opportunity to learn with the sector through identifying development needs, designing and delivering an educational programme and reflecting on its outcomes (McCray and Palmer, 2009) these were well established. Secondly, practical outcomes from the study were needed in order to facilitate change (Reason, 2006). Lessons learned from the original Skills for Care programme have informed the response to the data generated in this cycle. These have included different conceptions of leadership and of the possible educational models to develop skills and organisational responses to embedding this to deliver cultural change. Thirdly the authors asked "does the research offer a plurality of knowing including conceptual and theoretical integrity?(Reason,2006) have a range of perspectives and evidence been considered ? Action research can be criticised for reinforcing preconceived views but although the authors were working with the sector to solve problems they are not at this point in the cycle insider researchers. Although they do not hold positional power or seniority in the sector they have the benefit of access to alternative theoretical models for management and development through their work at a university and in previous senior practitioner roles in other organisations. This was helpful in the collaborative process of making sense of what has happened to this point in the development of the sector organisational strategy and in "shaping the future" response (Coghlan and Brannick, 2010, p 17). Finally Reasons' (2006) concern with the significance of the work involved in the project and the enduring nature of change proposed were considered. The authors ensured that the method was underpinned by evidence which was dependent upon critical feedback and challenge by the study partners at all stages in the research process. Additionally formal feedback stages were included to

influence organisational thinking with different insights and perspectives (Gray, 2010).

From this position the authors judged that the rigour of the process was sufficient in order to support the cycle of cultural change anticipated by the partners in the sector.

The Sample

Purposive and snowball sampling was used to select and invite professionals with a good knowledge of the sector and the future challenges faced. Morse (2010, p 231) describes an excellent participant as one who has been through or has observed the experience under investigation. The range of participants represented different perspectives on the issues (Morse, 2010, p 237). Through the Skills for Care industry networks, invitations to attend the consultation events were circulated. Partners and leaders from across the Health and Social Care sector participated. These included strategic and organisational commission leads, team managers from social care and representatives from a user group guiding support for personalised care.

Selection of participants for focus groups ensured that each group included two commissioners, service providers, user group and care manager/ social work leads. Potential problems in relation to organisational status were considered in the planning of the groups. The use of segmentation by role to avoid potential status conflict (Morgan, 1997 p 36) was an option, but was discounted as those selected had expressed an interest in collaboration and new ways of working. Additionally it would have resulted in very narrow discussion. Moderators were briefed to note Kitzingers' guidance on focus group interaction: "the group should be used to encourage people to

engage with one another, formulate their ideas, and draw out the cognitive structures which previously have not been articulated" (Kit zinger, 1994 p 104). In total 48 delegates participated in 6 focus groups at two separate events in two South of England counties.

Focus Groups

Data was collected from the focus groups at the two events which began with a brief presentation setting out the policy context and challenges. The groups worked through 3 stages of discussion and worked to a specific format (Fontana and Frey, 2000). In each group there was a moderator and note taker. Throughout the moderator checked and gained agreement for the responses gained, noting Kitzingers' guidance on focus group interaction: "the group should be used to encourage people to engage with one another, formulate their ideas, and draw out the cognitive structures which previously have not been articulated" (Kitzinger, 1994, p 105).

They responded in turn to three questions:

1 What knowledge and skills are required to meet current and future needs for leadership in personalised adult social care in England?

2 Are there any gaps when these are mapped against the UK social care industry standards and current educational provision?

3 Which routes and models of education/training are most suitable for meeting leadership development need in time of uncertainty and cultural change?

Ethical Considerations

The involvement of participants in action research is essential (Eden and Huxman, 1996) but this has presented ethical issues at all stages. University Research Ethics consent was gained. As the authors are working in partnership with the sponsors and are supporters of the managers' learning, an "ethics of care" is recognised in addition to the usual considerations (Costley and Gibbs, 2006). There is a delicate balance between exploiting generalised knowledge from the project for all parties, for example, strategic leaders, operational managers, the university and ultimately service users, whilst protecting individual relationships and roles within organisations. All participants in the focus groups agreed that information derived could be used to inform the reports to Skills for Care, design any future educational programmes and publication of related research output.

Data Analysis

In this project which was working to a structured format, group to group validation of topics was a significant factor in the analysis. Morgan (1997, p 60) describes this as a combination of how groups mentioned a topic, how many individuals mentioned a topic and how much enthusiasm was created in its' discussion. Notes from the focus groups were documented, transcribed and analysed by the first author. Participants' phrases in the form of sentences and words were scrutinised. A thematic analysis was then undertaken. Boyatzis (1998) describes thematic analysis as a process for encoding qualitative information. Howitt and Cramer (2010, p 328) guided us to ensure that: *"data familiarisation is as key to thematic analysis as it is for other qualitative methods. For this reason, it is generally recommended that researchers carry out their data collection themselves and also transcribe the data themselves"*

Findings

This analysis generated a number of themes (more than ten in total). These included :

- **Leading and defining the vision**
- **Human Resources Managing People**
- **Communication Skills**
- **Inter- professional/agency working**
- **Gap in Industry Standards**
- **Clarity of role spec in Social Care**
- **New ways of working**
- **Marketing**

- **Leading Cultural Change**
- **Policy –Structures- Engagement**
- **Finance**

The themes of Human Resource Management (managing people) Gaps in Industry Standards and Models of Leadership are discussed here. These are presented because as Laurenco et al note (2010) note that when commissioning practices are observed for groups of people where guidance is non mandatory and not linked to targets as in the case of people with brain injury, ensuring this group of service users is a priority may be risky. Thus local partners will need to be highly competent with effective influencing skills across agency boundaries. Competency in the areas of managing people and leadership strategy underpin this whilst the knowledge required for commissioning in new contexts here set within the theme of gaps in industry standards will enable evidence based practice.

Human Resource Management (HRM)

Emphasis was placed upon developing knowledge and awareness of the 'people management' issues involved in adapting to the personalised care environment. The challenge was perceived as ensuring providers take on the level of flexibility required to achieve personalisation of service delivery.

> One participant noted: "*Responding to different markets is a new and unfamiliar area of work. – also commissioners, brokers and advocates – there needs to be clarity also on the role and relationship of these to services and service users(FG2e)".*

> The level of professionalism necessitated for personalised care demands management of a new type of workforce. Participants suggested that there should be more clarity from Industry and Sector leads about who is responsible for managing and developing personal care assistants; including, recruitment, training, support, supervision, registration, monitoring performance and particularly managing system failures and emergencies. Familiarity with and knowledge of technology systems for example, was seen as important and for people with brain injury understanding and knowledge of cognitive difficulty and physical disability such as sensory impairment.
>
> Practice within an expanded range of locations and timeframes would be normative. Key issues in terms of management development included: "*More understanding of Human rights law and European law and the relationship with service users and issues relating to child and adult protection and registration of workforce (FG1a)"*

It would seem that considerable effort will be required to create a reengineered model of service delivery that personalisation needs. Initially investment in building on the commissioning skills identified under the themes of HRM here will skill up the workforce. As Pettigrew (1998) notes public sector professionalised organisations focussed on team working should be equipped to create change as both managers and professionals need each other to manage change. A concern would be the immaturity of commissioning strategies in place and the fall out from contracting

out processes which still impact by separating managers and professionals as both attempt to include the user voice. One participant in a service delivery role highlighted a requirement for: "*knowledge of roles/skills of other professionals and agencies – particularly our relationship with the NHS – and new roles – e.g. brokers, commissioners FG2c").*

Gaps in the Commissioning Role Industry Standards

Paradoxically participants confirmed that national industry standards generally set out clearly what is required for new and emerging roles in personalised care. Notwithstanding this the concerns identified demonstrate the need to reinforce them in the context of the cultural change requirement anticipated. The new issues identified that were not referenced in the standards are: developing accessible information systems for all service users; using knowledge of demographic research to inform strategic planning and commissioning; the ability to create maps of different care pathways informed by the experience of service users; handling issues of power in market relationships, e.g. larger providers having more influence to shape and dominate markets or, within contract negotiations. A participant observed : "*Who does the assessments on which service input is based and what is the impact of self -assessment? Also impacts of different layers and types of commissioning plus the knowledge of the commissioners about services(FG2a)"*

There was a recognised need for commercial awareness of demographic factors, predicting and forecasting demand, and developing and managing markets. Phrases used were "*24/7 care", "think personal" and "customer" feedback*. As the

concept of "market" in the care sector was viewed as new, learning was required in how to work with and gather intelligence from a wide variety of service provider organisations. It is important to give support to small providers and those in the third sector where there may well be a requirement for business development work focussed on achieving quality outcomes. This will involve using knowledge of demographic research to inform strategic planning and commissioning together with the ability to create maps of different care pathways informed by the experience of service users.

Leadership

Participants felt that all involved in the delivery of personalised care would have to think in quite different ways beyond traditional contracts and models of service delivery. In the data terminology used included: "*performance targets, empowerment* and *customer centred leadership*". Considerable skill in Change Management to facilitate the embedding of new organisational and cultural values was flagged. Concern was expressed about the gaps in the sector's preparedness to move to a customer facing business model of service delivery. For example, the requirement for visionary leaders that could inspire change, facilitating a new organisation culture of partnership working and in the preparation of a business case to underpin decision making in partnership with providers. . The theme of leadership" incorporated the language and message of new organisational and cultural values and partnership working. The partnership element underpinning changing leadership roles offers a transformation of role. As Mantell writes "from case managers to care navigators,

advisors, guides and brokers,- providing not only an opportunity but a necessity to re-engage with carers and people who access support (Mantell, 2013).

Data from participants suggest that despite considerable government investment in new models of service delivery, for these participants at organisational level, hard New Public Management (NPM) (Broadbent and Laughlin, 2001) focused on audit, performance measurement and finance and traditional models of both commissioning and provision of services will remain the norm. Reference to the lack of flexibility of some providers and the need to work to support small third sector providers indicates that the legacy of contracting out remains in place. This may be a feature of service design for personalised support and care for people with brain injury. Research exploring the potential for future commissioning effectiveness in long term neurological conditions has indicated that the lack of performance management frameworks may have inhibited change and moves towards personalised care (Gridley et al, 2012 p 89).

Discussion

The evidence generated in this cycle of research indicates that these industry members will need to be prepared to lead and interact in a range of unfamiliar settings in a changing public sector "business" style culture. The strategic intent of commissioning and personalised care needs to be realised through recognising the role that distributed leadership, power sharing and politics play in such a change of culture (Yukl, 2010). Insights in to the challenges revealed by the work of researchers in the area of

distributed leadership and organisational effectiveness can make a contribution here. This can be further developed to an appreciation the demands of complexity in the new climate that require adaptive leadership: "an emergent process that occurs when people with different knowledge, beliefs and preferences interact in an attempt to solve problems and resolve conflicts" (Yukl, 2010, p 505). In this study it is proposed that any future development activity for leaders should mix the different participants in the commissioning process.

The NPM culture may present ethical challenges when it pervades the sector. Lessons can be learned from the negative consequences of the target and costing ethos of private sector practices. Hence ethical leadership will be an important means of maintaining the values of the sector whilst implementing new models of service delivery; how leaders at all levels use their discretion in decision making requires the attention of all involved (Blakeley and Palmer,2010). Again educational models should make provision for discussion of what ethical leadership means for each participant and situation scenarios can be presented that promote awareness of the underlying influences on different courses of action. These dilemmas could be illustrated through exploration of the ethical questions presented in social care leadership (Human and Smith 1995, p 1) and by case reviews of leadership such as those of UK healthcare (Gilbert and Full ford, 2010 p 6). The work of Alimo-Metcalf and Alban- Metcalf (2005, p52) underlines the need to develop a critical scepticism in relation to "a body of 'received wisdom' on the nature of leadership in commonly read texts".

There is an opportunity to bring to the more entrepreneurial era some of the potential strengths of the public sector. Previous studies in local government (Alimo-

Metcalf and Alban- Metcalf, 2001) have also emphasised the complexity of transformational leadership factors that in the UK appear to prioritise valuing teams and individuals over vision and charisma. These are important factors to retain albeit in a new situation.

It might be argued that the situation presented to the key leaders will not lend itself to the predictability of step models of change management (Lewin, 1947; Kanter, 1992; Kotter, 1996; Cummings and Worley, 1993; Ghoshal and Bartlett.1996; Morris and Raben, 1995). Adaptation to the challenges of personalised care will require a learning approach to leading change (Burnes, 1996, 2004; Dawson, 1994) that addresses the unexpected as this is new territory for all stakeholders; through creating or improvising strategies and sharing their success and failure throughout the organisation. This invites consideration of how resilience (Chmiel, McCray and Palmer, 2011) can be developed within organisations and teams to cope with the difficulties presented by collaborative working in a different service delivery model. Existing case study research may be more usefully deployed to support learning rather than offering models as possible answers. An example might be a case study of technological change implementation in a public agency (Stewart and O'Donnell, 2007). This case brings together the themes of adaptive learning, distributed leadership and resilience in account of success and failure across different teams tackling the same problems. What is illustrated here is the often neglected tactical skill in change implementation post strategic decision. Similarly the Chartered Institute of Personnel and Development in the UK (CIPD) provides material for learning from an ongoing longitudinal action research study of public and private

sector organisations where distributed leadership features as a theme in each case study (Miller and McCartney, 2010).

Education and Training Routes for Personalised Care

In considering education and training routes most suitable for meeting leadership development in times of uncertainty and cultural change, the shift towards Soft NPM (Ferlie and Geraghty, 2005) with the focus on a learning organisation model as the lever for change may offer the opportunity to work through constraints and conflicts for professionals. As a vehicle for commissioning transformation, the use of action learning sets deployed in a recent leadership development programme for care sector managers from a range of professions is seen as an appropriate model for supporting experimentation with new issues (Hulme, Cracknell and Owens, 2009 p 537). For example a learning organisation model would encourage and expect collaborative activity with CCG group stakeholders (including service users and carers) to capture information about personalised support for people with brain injury including good practice examples, gaps in evidence, barriers to action including specific user or user facing issues, and the nature of resources and networks across health and social care boundaries.

Newell- Jones and Lord (2008, p 18) adapt Illeris's tension triangle (Illeris, 2002) to explore interprofessional learning. Illeris suggests that learning has three aspects, firstly knowledge that is cognitive, secondly psychodynamic connected to emotion and motivation, and societal related to communication and interaction. When teams of managers, professionals and service users are exploring new ways of

working and changing practice, professional identities and boundaries may as Newell -Jones and Lord (2008, p 18) note become challenged and lead to emotional responses by team members. This can lead to negative outcomes if not addressed and members are unsupported and subsequently not engaged to explore tensions. An action learning set approach may facilitate this process and support members to move toward solutions.

Conclusion

This paper has presented the second phase of an action research cycle in one region of England, United Kingdom. The study has limitations in the localised nature of the research context and the non generalizable nature of the research method. However it offers a methodological framework centred on action research which may inform others seeking to change organisational practice around commissioning for personalised care.

The outcomes of this study will be used to inform a third future cycle of actions in the same locality and industry sector. This involves delivery and a critical analysis of an accredited leadership development programme underpinned by action learning. The design of the programme is concerned with both supporting the affective feelings around change and developing leadership styles and strategies for new contexts. Participants will be invited to undertake real world projects which involve the commissioning partnership. Their reflective commentary and demonstration of outcomes in the form of organisational strategy will be assessed as course work and used as research data in the action research cycle. In this next stage one of the

authors will be both researcher and facilitator (Trondsen and Sandaunet, 2009, p 13) which may give new insights into the process of leadership development and into first person action research inquiry (Reason and Bradbury, 2007).

Whilst industry sector standard qualifications and frameworks may be at the centre of strategic planning for transformation, findings here have identified that additional support will be required to create leaders who can perform successfully to create and embed organisational cultural change. New approaches to leadership development may be needed to facilitate this process. The action research framework presented here has been helpful for all partners in the context of commissioning for personalised social care. It is anticipated that it may be useful for other organisations involved in designing and commissioning personalised support including those for people with brain injury as they undergo further radical reconfiguration.

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