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research

Story, dialogue and caring about what matters to people: progress towards evidence-enriched policy and practice

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Background: Evidence-based practice in social care and health is widely promoted. Making it a reality remains challenging, partly because practitioners generally see practice-based knowledge as more relevant than empirical research. A further challenge regarding the creative, contextual use of research and other evidence including lived experience and practice-based knowledge is that practitioners, especially in frontline care services, are often seen not as innovators, but recipients of rules and guidelines or followers of pre-determined plans. Likewise, older people are not generally recognised as co-creators of knowledge, learning and development but as passive recipients of care, or objects of research.
Aims: This study aimed to address the above issues, through a collaborative and appreciative endeavour involving researchers; social care and health practitioners; managers; older people and carers in 6 sites across Wales and Scotland.
Methods: We used participatory action research methodology, applying a dialogic storytelling approach, which enabled participants to explore and address 7 already published research-based 'Challenges' regarding what matters most to older people with high-support needs.
Findings: Participants discovered and addressed five elements required in developing evidence-enriched practice; the creation of supportive and relationship-centred research and practice environments; the valuing of diverse types of evidence; the use of engaging narratives to capture and share evidence; the use of dialogue-based approaches to learning and development; and the recognition and resolution of systemic barriers to development.
Discussion and conclusion: Although existing literature covers each element, this project was novel in collectively exploring and addressing all five elements together, and in its use of multiple forms of story, which engaged hearts and minds, positive outcomes were achieved.

Key words evidence • storytelling • dialogue • knowledge exchange

Key messages

- People meaningfully engage with research evidence if they feel valued and have agency to lead their own learning
- People engage with research evidence when they can relate it to their own knowledge and experience
- Research evidence presented in story format is accessible and can act as a catalyst for dialogue-learning
- Dialogue-learning, stimulated by stories, supports the co-creation of knowledge and policy

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> People think that stories are shaped by people. In-fact it is the other way around. (Pratchett, 2013: 12)

Background

Within the context of health and social care services, this article explores an innovative approach to navigating the perspectives of diverse groups of participants and disparate, and at times conflicting, types of knowledge (here collectively termed as evidence), in seeking to implement research-informed change in organisations. The overall approach was a participatory research project, involving older people, carers, diverse social care and health practitioners, managers and researchers. Here we consider how participants, not all of whom agreed with each other, collectively gathered, shared and responded to different types of knowledge. Going beyond linear understandings of research implementation, we sought to progress an inclusive, dialogic and emergent approach to learning and development. We were particularly interested in the potential role of storytelling in seeking to negotiate (Strauss, 1978) complex change in organisations.

The use of evidence in health and social care services is widely promoted. Making it a reality remains challenging (Huxley, 2009; Greenhalgh et al, 2014; Ghate and Hood, 2019; Locock and Boaz, 2019). If research is to have impact in the real world, we must expand our understanding of what constitutes evidence beyond research knowledge, and how it can be used (Gerrish et al, 2011, Hall and Tandon, 2017, Beresford, 2018, Wieringa et al, 2018, Metz et al, 2019). For example, Gerrish et al (2011) distinguish four components of evidence: research knowledge; including research-based policy documents; practitioner knowledge and experience; organisational knowledge; and the lived experience and voice of service users and carers. Challenges arise when these diverse types of knowledge conflict, leading to the question 'what counts as knowledge and whose knowledge counts?' (Hodgson and Canvin, 2005). Hall and Tandon use the provocative term 'epistemicide' (De Sousa Santos, 2007), to describe when one type of knowledge dismisses another and suggest that 'what is generally understood as knowledge in the universities of our world represents a very small proportion of the global treasury of knowledge' (Hall and Tandon, 2019: 7).

Knowledge exchange has emerged in response to growing understanding that successful uptake of research knowledge requires interaction between researchers, decision makers, and other stakeholders (Lavis et al, 2003). While respectful of practitioners, it supports critical reflection and can be effective in challenging discriminatory social and cultural norms and 'group speak' (Littleton and Mercer, 2013; Green, 2016). The concept of exchange certainly opens up possibilities for moving beyond the type of evidence-based 'guidelines' issued to practitioners, towards 'mindlines'. These have been described as 'guidelines-in-the-head, in which evidence from a wide range of sources has been melded with tacit knowledge through experience and continual learning to become internalised as a… guide to practising in varied contexts' (Gabbay and le May, 2016: 402). They are based on a more fluid, transformational and relational view of evidence which accommodates context and acknowledges multiple types of knowledge as collective evidence (Gabbay and le May, 2004).

In the context of health and social care services, the value of kindness and caring dialogue can easily be overlooked (Ballatt and Campling, 2011; Unwin, 2018), despite the fact that dialogue within organisations is necessary for the well-being of employees and in turn, to enable diverse colleagues to work towards better outcomes for the people they support:

> … the quality of reach of dialogue within organisations needs to be sufficient for practitioners to feel valued and listened to, and for different parts of the organisation, including frontline practice and information people, to understand each other's contributions to achieving outcomes. (Miller and Barrie, 2016: 5)

Beyond the need for dialogue in general, researchers and others who wish to use research knowledge in practice must seek to open dialogue with those they wish to engage in evidence-informed policy and practice development. Lessons from social pedagogy caution against imposing knowledge on unwilling recipients (Horton and Freire, 1990; Riebe et al, 2016), and lessons from philosophy remind us that 'truths are accepted as facts only when they become interesting' (Wierenga et al, 2018: 932). Dialogue is required both to open up space for exchanging knowledge and experience and, importantly, to build the *relationships* and *interest,* which are necessary for engagement of all participants in change. The relational aspect of dialogue is often understated, but is central to overcoming fears, assumptions and defensiveness which can block new learning (Andrews et al, 2009; Escobar, 2011) and the transformation of policy and practice. Dialogue is not just about talking; it is a caring, values-based activity (Booth and Ainscow, 2016).

In considering the use of evidence in health and social care services for older people with high support needs (the topic of this article), there are two additional challenges that need to be acknowledged and addressed. The first challenge is to overcome the historical discourse regarding older people, which highlights deficit, loss and dependency (Bowers et al, 2013), particularly for people living with dementia (Bartlett and O'Connor, 2007). This shapes the culture of care and support services, within which older people are often seen as passive recipients of care (Cahn, 2000; Nolan et al, 2006) rather than active participants in knowledge exchange and care transformation. As a result, the things that matter most to older people may be ignored, to the detriment of their well-being. An example of this is when safeguarding focuses on the concerns of professionals rather than people with dementia, which can lead to what has been termed 'silent harms' (Clarke et al, 2011) associated with over-protection and risk aversion. This tendency towards low expectations can significantly undermine older people's sense of identity, agency and significance (Morgan and Andrews, 2016), failing to support balanced reciprocal relationships and associated mental well-being (Fyrand, 2010). That the approach remains prevalent is reflected in the literature on research, learning and improvement where, with notable exceptions, the involvement of older people with high support needs is rare (Tanner, 2012; Blood, 2013).

The second challenge is to overcome the low status and expectations of frontline care practitioners, which is reflected in their pay, working conditions and education (Innes et al, 2007). Media coverage of social care services, such as care homes, is often negative, dwelling on the worst examples of poor practice (Welsh Government, 2015), although initiatives such as *My Home Life* (Owen and Meyer, 2012) challenge this by highlighting good practice. As a result, the emphasis is often on non-questioning compliance with standardised procedures and predetermined learning outcomes, rather than practitioners crafting diverse types of knowledge and wise, contextualised practice (Schwartz and Sharpe, 2011) for the benefit of the people they support.

As a result of these two challenges, both older people and frontline care practitioners have traditionally rarely been invited to co-create knowledge and co-produce policy and services. In organisational cultures based on compliance rather than creativity, they often end up as 'policy victims' rather than 'policy entrepreneurs' (Glasby, 2012), which can stifle innovation and undermine well-being (Wilson et al, 2018).

What is required is the development of a common language (Edwards, 2012) facilitated through meaningful dialogue across *all* stakeholders (Bate and Robert, 2007; Petch et al, 2014) if we are to see diverse types of knowledge, including research, used in the co-production of policy and practice. Dialogical practice, based on stories as stimuli, offers an avenue towards redressing some of the unintended harms of policy and practice focused on process and technical solutions rather than relationships and contextualised, responsive practice (Trevithick, 2014).

The benefits of opening up reflective spaces to enable transformative dialogue about care and support for older people which is more attuned to their concerns have already been demonstrated (Ward and Barnes, 2016), as has the understanding that care is a collective responsibility (Tronto, 2010): 'A relational ontology in which interdependency is understood as a defining feature of human life' (Ward and Barnes, 2016: 907).

Here, we explore the use of story in bridging the gap in knowledge exchange. Recognising that human beings are storytelling animals who make sense of the world through narrative understanding (Lyle, 2000; Davies and Powell, 2010; Gottschall, 2013), we explore the role of story as a powerful tool in conveying complex and multi-dimensional ideas, as well as building caring relationships and enabling connections to be made between different types of knowledge and experience. This has the potential to lead to meaningful policy and practice developments that are *enriched*, not simply directed by evidence.

Study design

Background

This paper discusses a two-year participatory action research project (Andrews et al, 2015), where researchers worked alongside older people and carers, diverse social care and health practitioners (including social workers, social care workers, occupational therapists and nurses) and service managers, in six sites across Wales and Scotland. Funded by the Joseph Rowntree Foundation and Health and Care Research Wales, they sought to work together to address seven 'Challenges' derived from extensive research on what contributes to 'A Better Life' for older people with high-support needs (Blood, 2013). The 'Challenges' were:

- Promote a more positive image of old age – no them and us;
- see the person behind the label or diagnosis;
- recognise that helpful support is founded in and reflects meaningful and rewarding relationships;
- enable the opportunity for older people to give as well as receive;
- share responsibility with older people (for example, in making decisions and promoting collective well-being);
- strengthen the individual and collective voice of older people;
- recognise that 'little things' as well as significant innovations can make a big difference.

The fact that the findings of this five-year programme of research were framed as 'Challenges' is significant in that they were intended to promote discussion and dialogue, rather than standardised compliance with recommendations. Our project was funded specifically to explore this approach, which is consistent with social pedagogy in not seeing intended learners as 'empty vessels' to be filled: 'Now that use of expert knowledge is different from having the expert telling people what to do, and I think that's where I draw the line. I have no problem with using information that experts have as long as they don't say this is what you should do.' (Horton and Freire, 1990: 130).

The 'Challenges' were also adopted as principles underpinning the approach taken in progressing our project in terms of form and content. Stories were sought which could help to illustrate and address the 'Challenges', and dialogue was encouraged, to enable the voices of older people, carers and practitioners to be heard.

Methods

Ethical approval for the research was given by Swansea University. Respecting the citizenship of people with dementia (Bartlett and O'Connor, 2007), we assumed their capacity to consent and participate, but this was always on their terms. The project ran over two-and-a-half years, based on an action learning model developed by the Scottish Community Development Centre called the LEAP framework (Barr and Daily, 2007). This was selected because of its inclusive and accessible approach grounded in community development, which we saw as transferable to knowledge democracy (Rowell and Feldman, 2019) and participatory organisational change. This framework followed the action learning cycle of 'analyse, plan, do and review'.

Figure 1: Exchange model (adapted by Miller and Barrie, 2016), from original by Smale et al, 1993)

Here we sketch out core activities, detailed elsewhere (Andrews et al, 2015) of our 3-phase approach. Project facilitators sought from the outset to create and maintain a sense of involvement and 'safe' participation for all. The exchange model of assessment underpinned the approach (Figure 1).

Phase 1

Phase 1 launched with an introductory event involving two or three practitioner/manager representatives from each project site to introduce the Joseph Rowntree Foundation (JRF) programme *A Better Life*, the 'Challenges', and the project design. We then held audio-recorded focus groups in each of the six sites, involving eight to ten local older people and carers, where the 'Challenges' were shared as both statements and associated stories/vignettes, many based on real life examples, anonymised and sometimes blending more than one example to provide illustrations of each challenge. This approach was based on the understanding that effective learning is best grounded in and built on the narratives and priorities of the people involved, while also introducing respectful challenge and critical reflection (Horton and Freire, 1990; Mercer and Littleton, 2007). Participants were asked whether they had any similar or contrasting narratives to include as evidence, and these were recorded and subsequently transcribed. In all focus groups, participants responded to stimulus stories with their own examples. For example, in a group of carers of people with dementia in Scotland, one woman told a story about how her dad, who had been in the navy and had always been very well organised and tidy, had taken on the role in the household of cleaning all waste materials for recycling. She noted that the material recycled was probably the cleanest received by the recycling plant and her dad was at his calmest when undertaking this role. This woman connected her dad's need to continue to contribute to 'seeing the person behind the label' and to 'being able to give as well as receive', and this first story was followed by many others told by carers in the group.

The focus groups were followed by project planning events at the six sites, each involving 10–15 people (a mix of diverse practitioners, managers, researchers, older people and carers). Participants further explored the 'Challenges' alongside the additional stories gathered from local focus groups. Participants in turn contributed their own experiences of the 'Challenges', generated ideas for service and workforce development, prioritised their ideas, and selected *one* topic per site for learning and development in Phase 2. The topics were:

- Relationship-centred practice – understanding it and putting it into practice;
- positive and rights-based approaches to risk management with people with dementia;
- developing meaningful activities in care homes and day services;
- supporting interdependent caring relationships through the development of meaningful short breaks;
- addressing loneliness and making an integrated resource centre a part of the community not apart from the community;
- developing personal outcome-focused recording for assessment, planning and review of support for older people.

Forty-two semi-structured telephone interviews were undertaken with participants from all six sites at the end of Phase 1, providing further opportunity to explore interaction between evidence, stories, dialogue, learning and progress with the 'Challenges'. Thus, cycles of stories were used to connect with people's knowledge and experiences, which in turn generated new related but distinct stories from different perspectives.

To further facilitate the inclusion of all, participants were introduced to validated and practical techniques regarding dialogue-based learning (Mercer and Littleton, 2007) and democratic decision making (Escobar, 2011). One such technique was Community of Enquiry (Golding, 2015), that builds relationships, knowledge sharing and collective learning through generating and exploring a conceptual question in response to an evidence stimulus.

Phase 2

Monthly half-day action-learning events at each of the six sites continued over a period of six months, involving 5–15 members, again reflecting diverse stakeholder membership, that is, older people and carers, practitioners, managers and researchers. The project facilitators introduced appropriate research knowledge in response to the interests and learning needs of participants. For example, in the site exploring relationship-centred practice, participants requested evidence around well-being and the importance of relationships. In response to this, they were introduced to research on social ostracism (Williams and Nida, 2011) in the form of a short film based on the research findings and personal experience of a social psychology researcher. The story format clearly engaged both the minds and hearts of participants, as a result of its intellectual *and* emotional content. Representatives from each site shared learning at a networking event at the end of Phase 2.

In February 2015, a second series of facilitated focus groups at each of the six sites, involving 4–10 Phase 1 participants, discussed progress and suggestions for follow-up work. They were also asked to complete two profiling tools. Firstly, the Senses Framework (Nolan et al, 2006) helped to gauge whether and how the project had enhanced participants' sense of security, continuity, belonging, purpose, achievement and significance. Secondly a model for evaluating participatory research

(Hanson et al, 2006) identified whether involvement had resulted in participants feeling valued and included, and whether their collective ideas had borne fruit in practice. Thirty-eight semi-structured telephone interviews were undertaken with participants at the end of Phase 2, with a focus on evidence usage.

Phase 3

With additional funding from the Joseph Rowntree Foundation, Nick Andrews, as Principal Investigator, facilitated follow-up learning and development activities between May 2015 and June 2016, seeking opportunities for collaborative approaches to policy and practice development. This work included a range of learning and development initiatives, including a care homes learning and development resource based on capturing and sharing 'magic moments' – micro-narratives about what matters most to care home residents, which resonated with the 'Challenges': www.careforumwales.co.uk/uploads/MagicMoments_PDF.pdf.

Findings

Focus group and interview data from Phases 1 and 2 were subject to a Framework Analysis (Ritchie and Spencer, 1994), highlighting five key elements (outlined below) that enabled progress towards achieving the project sites' aims. The findings were published in a JRF Project report and four-page Summary (Andrews et al, 2015). Development work, including Phase 3, was advanced more quickly in the project sites where *all five* elements were well supported and addressed. The five elements were as follows.

Element 1: valuing and using a range of evidence

Consistent with the participant-led approach, the facilitators supported the use not only of research knowledge but also practitioners' tacit knowledge, older people's and carers' lived experience, and managers' organisational knowledge (including policy direction). The approach essentially blended the exchange model in a learning context with use of diverse stories, giving all participants a voice (Figure 1). A notable example of this was the development of an 'evidence compared' table at one project site (Table 1), where the focus was on addressing the 'Challenge': 'All good support is founded in and reflects meaningful and rewarding relationships'.

This table revealed clearly that organisational knowledge (as set out in policy) was at odds with the evidence from research, older people's experience, and practitioner knowledge. It became a very effective catalyst for dialogue, and contributed to a change in organisational policy regarding professional boundaries, which is discussed in more detail later.

Element 2: creating an enriched environment of care and learning

The role of bottom-up experimentation and creativity can be threatening, particularly in organisations with a top-down and risk-averse approach to performance (Patterson et al, 2011). Organisations seeking to nurture innovative improvements must create an enriched environment of care and learning (Nolan et al, 2006) before expecting

Table1: Extract from 'evidence compared' table used to stimulate dialogue

Key 'A Better Life' Challenge: we must ensure that all support is founded in, and reflects, meaningful and rewarding relationships			
Evidence from older people and carers	**Evidence from frontline staff**	**Organisational evidence – current policy**	**Research evidence**
'One young girl (a homecare assistant) became great friends with mum – they just hit it off. My mum loves this young girl to death and she loves my mum – it was just a natural blossoming friendship through their professional relationship'	'I do think it is nice to be able to share… clients will ask us, what have you done over the weekend and personally, I don't see anything wrong… I think you have got some boundaries that have gone a bit OTT and it is so sad that if someone was to ask me "Are you married? Have you got any children?" and for me to say "I am sorry, I cannot discuss this with you"'	3.1 Becoming the friend of a person who uses our services is an inappropriate relationship that focuses on the needs of both people. A professional relationship should focus solely on the needs of the person who uses our service. Becoming a friend of that person is inappropriate.	We are social beings and being socially ostracised in any way results in either despair or rage – people need to feel that they belong and matter. This is expressed most powerfully through high quality reciprocal and inclusive relationships (Williams and Nida, 2011)
			Mental well-being is linked to having balanced reciprocal relationships where the person is not 'over-benefitted' or 'under-benefitted'. This requires a culture of 'give and take' (Fyrand, 2010)

anyone to proactively and creatively engage with evidence and innovate (Hill et al, 2014). At the start of the project, visible senior management buy-in was therefore secured in each project site, in the form of letters of support. Senior managers not only gave permission for experimentation, but also became personally involved in the research through being participants in focus groups and Communities of Enquiry. For example, in one Community of Enquiry at the site referred to under Element 1, an extra-care service tenant began to cry when she shared her story about losing all her family and friends, and how she now felt when staff said to her that they were not allowed to be her 'friend' because of the organisation's professional boundaries policy. In response, a senior manager in the group made a commitment to support a policy change that underpinned a more relational approach to practice, and this was extended across the organisation.

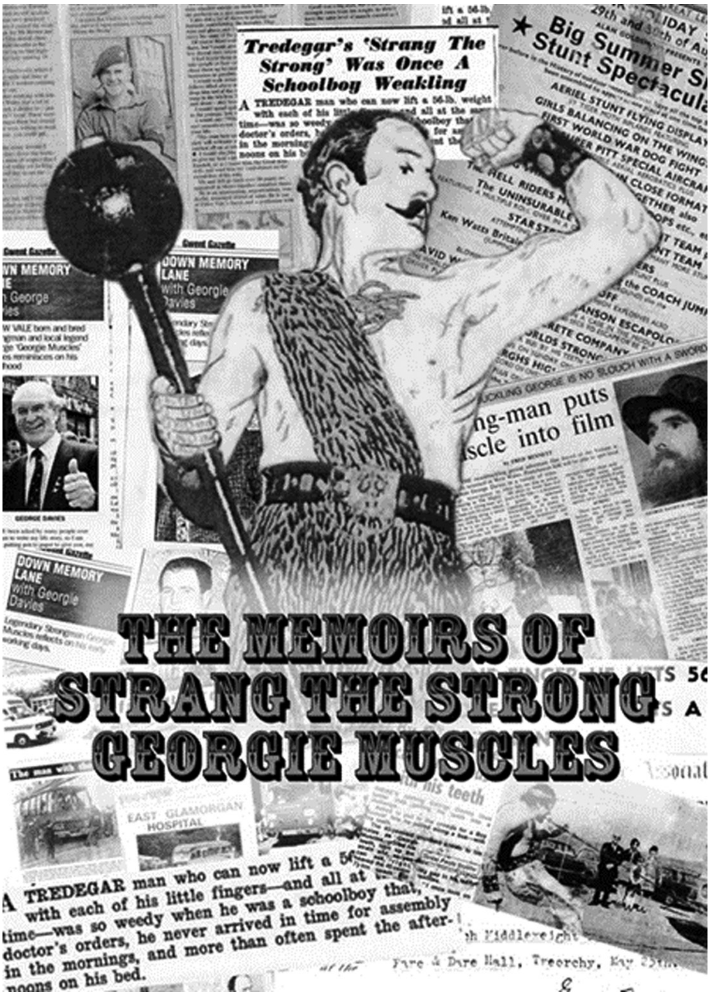
Creating an enriched environment of care and learning also required purposeful recognition of the *interdependent* well-being of older people; carers and practitioners, *all* of whom need to experience a sense of security, continuity, belonging, purpose, achievement, and significance (Nolan et al, 2006). The importance of feeling *valued* was identified throughout as critical to enabling all participants to explore and use evidence. This was illustrated by an older person with dementia in one of the first focus groups:

> Listen, I am nobody, only my name and what I have done… I would like to be involved and I would like to help you all. I can give you advice, but I think it is better not to involve me in this… because of my age and my failure in memory, whatever… because of my uselessness. (Georgie)

This man, whose story was previously unknown by services, became a key contributor to the project, subsequently producing an anti-bullying book for children based upon his life story (Davies and Beer, 2015 – Figure 2). This book, and the story of how it came to be written, became a key catalyst and learning stimulus in demonstrating and addressing many of the 'Challenges', as discussed later.

Participants across all six sites often talked about their lack of agency. A common statement by participants (older people, carers, and practitioners) was "We're not allowed…". One older person described how she was not allowed to pour a cup of

Figure 2: Cover of book (for content see https://www.peoplescollection.wales/items/443985)



tea for the person next to her, because of health and safety rules. Some participants working in frontline social care services recounted how, prior to the research project, they often felt undervalued and disempowered, describing themselves as being "unqualified" or "only a care assistant". They talked about being "sent on training courses" or "seen as being negative if we don't agree with the managers", rather than being encouraged to develop their own ideas and interests. With exceptions, they stated that prior to the research project, they did not feel understood or supported by senior managers and other professionals.

Our learning and development sessions were, therefore, often focused on building relationships between the different stakeholder groups and achieving the necessary changes in organisational attitudes that could permit an enabling environment to emerge. The collaborative, dialogic and caring approach to the research project gave practitioners, older people, and carers renewed confidence and motivation to, as one participant stated, "make the world a better place".

Element 3: presenting evidence in meaningful formats

We identified that in order to draw research knowledge into the mix of knowledge exchange, it needed first to be formatted in narrative ways that engage both the head and the heart, rather than presented as a list of bullet-point recommendations.

In the initial telephone interviews at the end of Phase 1, participants across all project sites struggled to recall the actual 'Challenges'. However, they readily recalled both the fictional and factual narratives from the focus groups and other events that conveyed those very same research-based principles. They also described how the narratives challenged their thinking and practice, especially when there was a poignant emotional component.

One of the most powerful factual narratives that encapsulated most of the 'Challenges' was about Georgie (quoted above), who had talked about his "uselessness". Through a process of assisted life-story work, he went on to talk about his early life as a professional strong man who had raised lots of money for charity. It transpired that he had become a strong man because he had been bullied at school, and he wanted to share his story with children in a similar situation. He had a carrier bag of photos that he wanted to put together in a book, which became his Phase 2 project work. With help from an artist, he went on to write a simple anti-bullying book for children, based upon his life, and this was later used with primary school pupils (Figure 2). In addition to creating a sense of achievement and significance for the man concerned, this activity provided a powerful exemplary narrative that was used as a catalyst for dialogue-based learning and development during Phase 3 of the project. The book was published and made available to a wider audience via the People's Collection website, hosted by the National Library of Wales (Davies and Beer, 2015).

The power and effectiveness of research presented as narrative was also demonstrated in Phase 3 development work. For example, through a collaborative approach, practitioners in care homes were able to share practice evidence which resonated with and brought to life the 'Challenges'. Working with their managers and dialogue-learning experts at the University of Cambridge, they developed a storytelling learning resource called 'Magic Moments' (see Table 2 for an example story).

Table 2: A Better Life 'Challenge' as expressed through local stories in care homes (for book with more stories see http://www.careforumwales.co.uk/uploads/MagicMoments_PDF.pdf)

A Better Life 'Challenge': See the person behind the label or diagnosis	
Associated local story: A Connection with the past brings a tear to the eye – 'After managing to find a farmer who was hand-rearing one of his lambs, a four-day-old lamb arrived at my nursing home in a bucket, bleating and indignant. I took him round to all of the residents and the delight was evident on each and every face. One of my final stops was to a 97-year-old blind lady whose dementia had been compounded by a psychotic episode. This had left her quite traumatised and unwilling to engage. I put her hand on the lamb and she kept it there. Gradually her fingers wound into the thick wool and she held her arms out to take the lamb from me. She pulled it to her and buried her face into it breathing in the warm, oily scent. After a minute a tear fell down her cheek and she lifted her head up and said, "I was in the land army, I cycled six miles every day to the farm where I worked and I was in charge of the lambs. Their fleeces would help defrost my fingers. I'd forgotten..."'	

Element 4: effectively talking and thinking together about diverse types of evidence, which may conflict

Practitioners participant from all six sites related frustrating experiences of meetings failing to support meaningful conversations that allowed genuine scrutiny of the practicability of using evidence in policy and practice:

> We have lots of meetings, but nobody ever meets in the real sense of the word. (social worker)
> We used to talk with our managers, but now we have to sit through policy briefings. (frontline social care worker)
> We are either told off, or told what to do. (care home manager)

We have already referred to our use of Community of Enquiry as an approach which encourages expression of different opinions, working towards consensus through the collective and respectful probing of the assumptions behind, and implications of, the diverse opinions and sources of evidence that emerge. Community of Enquiry is underpinned by a set of ground rules, which ensure that everyone's voice is heard and respected (Lipman, 2003; Christie et al, 2007).

At the site working on relationship-centred practice, a Community of Enquiry involving older people, carers, diverse practitioners, researchers and managers generated the question 'Can staff be friends with service users and their families?' The initial stimulus for this enquiry was a children's story book called *Wilfrid Gordon Mcdonald Partridge* (Fox and Vivas, 1987), which tells the story of a young child who becomes friends with a care home resident living with dementia. Through this Community of Enquiry and other narrative and dialogue-based discussions throughout the organisation, both practice and policy began to change. The organisation developed a new Sharing Lives and Professional Boundaries Policy, incorporating all the evidence sources and allowing client-practitioner relationships to blossom.

Element 5: recognising and addressing structural obstacles

Participants identified systemic problems which needed to be addressed such as excessive, poorly designed paperwork (Warmington et al, 2014), and resource management systems that reduced time to spend with people, or a culture of risk aversion, often in the name of health and safety but probably linked more to fear of litigation. The term 'undercover kindness' was coined for many of the practice narratives; examples of practitioners bending the rules to do the right thing for someone, but not telling anyone for fear of repercussions. This is consistent with critiques of New Public Management in general (Tomo, 2018) and the use of targets and incentives that can undermine wise and virtuous practice (Schwartz and Sharpe, 2011). Another obstacle was narrow understanding of concepts such as independence (for example, based solely upon physical capabilities and the need to save money by reducing social care services) or respite (for example, based solely on burden and the need for separation).

Lessons from the approach to project planning

While the project commenced with the development of a LEAP logic model project plan (Barr and Daily, 2007), many positive outcomes were unplanned and unpredictable. They came about through a responsive, dialogic and emergent approach, which is consistent with co-produced theories of change, which need to be fluid (Ghate, 2018). While there was merit in discussing the intended purpose and outcomes at an early stage of the project, participants resisted the initial request to complete their own online logic model plans and talked about "being project-planned to death". They wanted freedom to be creative and "go with the flow", which is consistent with a complexity approach to project management and evaluation (Auspos and Cabaj, 2014; Mowles, 2014).

Sustainability of the approach developed and move towards evidence-enriched practice

The five key elements (Table 3) identified became the foundation for the Developing Evidence-Enriched Practice (DEEP) approach, which became a programme of work under the Wales School for Social Care Research. Since the project, the DEEP approach has been well received and applied across a range of social care organisations. It has also been embedded in the Good Work: A Dementia Learning and Development Framework for Wales (Care Council for Wales and NHS Wales, 2016) and the Social Care Research and Development Strategy for Wales 2018–2023 (Social Care Wales and Health and Care Research Wales, 2018).

Table 3: The five elements of the Developing Evidence-Enriched Practice (DEEP) approach

Element	Summary
Valuing and using a range of evidence	Taking a democratic approach to knowledge exchange, which values and uses diverse types of evidence, including research knowledge, practitioner knowledge, lived experience of service users and carers and organisational knowledge
Creating an enriched environment of care and learning	Securing senior management support and facilitating the creation of inclusive and safe spaces, within which participants feel valued and able to share their thoughts and feelings in relation to learning and development
Presenting evidence in meaningful formats	Presenting all types of evidence in formats that are engaging and stimulate both an intellectual and emotional response, for example, stories, poems and provocative statements
Effectively talking and thinking together about diverse types of evidence, which may conflict	Using validated dialogue learning techniques and skilled facilitation to support the inclusive and equitable exploration of diverse types of evidence within the context of practice
Recognising and addressing structural obstacles	Identifying and addressing systemic issues that undermine or obstruct the use of evidence in practice, for example, bureaucratic processes and organisational culture

The term 'evidence-enriched' was chosen because it implies adding *value* to practice rather than 'telling it what to do' (evidence-based) or just 'chipping in' (evidence-informed). The term is also consistent with the established concept of enriched environments of care and learning (Nolan et al, 2006), which likewise prioritises relationships which nurture the interdependent well-being of all stakeholders.

Discussion and conclusions

Storytelling is a very human form of communication. Most leaders understand that stories can initiate action and communicate values (Denning, 2006). Narrative repetition or the retelling of stories has been studied for its effects on maintaining consistency and reaffirming beliefs (Dailey and Browning, 2014). Whatever the aim of storytelling and retelling, it is found that resistance can follow if people feel they are being coerced. Resistance can take the form of open rejection or subtle forms of cynicism and irony (Dailey and Browning, 2014). However, a storytelling culture is required for learning and change to be widely adopted and sustained (Davidson, 2017). The key is a respectful approach.

While much has been written about the power of story in promoting change in organisations (Barker and Gower, 2010), about the power of story in communicating research findings (Keen and Todres, 2007), and about the role of dialogue in organisations (Hill et al, 2014), our research explored a story-based *dialogical* approach to promoting evidence-*enriched* policy and practice across multiple organisations in health and social care. In so doing, it recognised that dialogue is more than the process of talking and exchanging knowledge; it is about '"responding to others as if they really matter and building dispositions to seek out, value and learn from the differences between us" (Rupert Higham, personal correspondence). It is a deeply caring activity that values everyone who is involved, whilst recognising and encouraging the expression of multiple and diverse perspectives' (Higham et al, 2014). Starting out with 'Challenges' rather than recommendations, we prioritised *participants'* knowledge and reality.

A key element in the success of the project was the quality of facilitation by the researchers, who were at the same time research knowledge brokers (Lightowler and Knight, 2013). The approach required a caring and inclusive attitude, diplomacy, and the ability to help diverse individuals in homogeneous groups feel welcome. The aim was to create spaces in which participants felt valued and safe to share and explore what they really thought and why, while also being able to collectively question the assumptions and implications behind what was being shared. While one of the tasks of the facilitators was to bring research knowledge to the project, there was no assumption that this was superior to the other forms of knowledge brought by other participants.

While some authors suggest that those who work in social care mistrust research (Orme and Powell, 2007; Petersen and Olsson, 2015), our research found that participants took an interest in and were keen to engage with research findings when they related to their reality and matters of importance to them. The centre-staging of participants' main concerns through dialogue and narrative helped shape their exploration, not just of research knowledge but also the views and experiences of older people and carers, the expertise of practitioners, and organisational knowledge including internal policies.

A dialogical approach to storytelling helps to build a common language and vision (Edwards, 2012). When all participants in a group are invited to contribute and exchange stories, there is potential to build a set of shared values and principles, in language which makes sense to all participants (Riebe et al, 2016; Miller, 2018; Drumm, 2013). Stories in this context are not just about the celebration of victory narratives but must also bring to the surface tensions, dilemmas and barriers to achieving a good outcome (Escobar, 2011; Littleton and Mercer, 2013). In the context of health and social care services, such tensions and dilemmas include navigation of risks and outdated and sometimes rigidly imposed rules and processes (often associated with bureaucracy), which are viewed as impeding the pursuit of common goals.

Stories can help to soften cultures of compliance and open up ways of thinking creatively and collectively about pursuit of common goals. It is not, however, just the singular story that creates this space, but rather a culture of storytelling, dialogue and exchange built around multiple voices and diverse stories. Thus stories become the building blocks forming the foundation or culture that binds together an organisation and all who come into contact with it. If research knowledge can be woven into the stories told within an organisation and blended with the knowledge, experience and wisdom of the actors who engage with it, then the possibilities for an enriched environment of care and learning open up to all involved (Nolan et al, 2006). The quality of facilitation is clearly critical here, in ensuring the culture of mutual respect is maintained and that all perspectives can be heard.

Perhaps one of the most significant uses of story exchange within organisations is as a tool to facilitate 'unlearning' (Thomas and Seely Brown, 2011). Organisational culture, or the 'way we do things around here', is notoriously difficult to shift because of that tacit, taken for granted element to our knowledge (Littleton and Mercer, 2013).

Because we don't always know what we know, unlearning can be more difficult to achieve than learning. Where individuals have adopted practices without conscious awareness of absorbing them, they are unlikely to be amenable to rational argument. An emotional or intuitive connection is required to break through the tacit understanding, and stories can help with this (Sole and Wilson, 2002). This is now increasingly recognised as dependent on organisational culture and embedded systemic processes which impact on frontline behaviours and practices (Rycroft Malone, 2004; Nutley et al, 2000; Patterson et al, 2011; Lightowler et al, 2018).

In our project, meaningful and respectful conversations between participants provided the vehicle for considering and tackling systemic barriers towards success. These included well-meaning national and organisational rules and regulations that did not always fit well with contextual decision making and what participants felt was most important in promoting well-being. It also required an approach to project planning that was emergent and responsive (McMillan, 2008; Auspos and Cabaj, 2014). While agreeing intended outcomes helped engage diverse partners in defining each project's purpose, many of the most valued results could not have been predicted.

Permission to explore and experiment, as well as to engage in dialogue, is essential. Senior managers have to support participants to be creative and able to experiment with ideas, through showing appreciation and acknowledging and celebrating successes (even little ones), and through exploring the learning from less successful efforts too. Trusting relationships need to be developed between everyone involved, through opening dialogue in team meetings and supervision, including discussion of organisational values and sharing examples of good and challenging practice, so that people can be honest and feel safe.

If research knowledge is to fully impact on services, it must engage in effectively melding different sources of evidence within the context of practice (Flyvbjerg et al, 2016). Deciding 'what counts as knowledge and whose knowledge counts' (Hodgson and Canvin, 2005) often entails challenging inherent power structures (Alinsky, 1971; Beresford, 2018; Hall and Tandon, 2017). Research knowledge can never be implemented or imposed. Rather, we found it had to be folded into discussions as it became relevant over time, and blended with other forms of evidence to develop 'mindlines' (Gabbay and le May, 2004; 2011; 2016), the collectively internalised, 'knowledge-in-practice-in-context' that informs day-to-day practice.

While this made it difficult to isolate which part of the process resulted in change, practitioner participants generally reported positive personal impacts, including satisfaction from their otherwise often undervalued work and, most importantly, improved quality of life of the older people and carers they work with. Perhaps the most significant ingredient in this approach to policy and practice development was the use of multiple forms of story, which engaged hearts and minds and challenged assumptions about the value of different voices and perspectives. In other words, the centrality of multiple *stories* enabled formal evidence to be blended through *dialogue* involving diverse perspectives, in a context of *caring* about what matters, to achieve the evidence-*enriched* practice which otherwise often remains an elusive quest.

Research ethics

Formal ethical approval for this study was granted by the College of Human and Health Sciences Research Ethics Committee, Swansea University on 31st January 2014.

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Contributor statement

NA conceptualised the study. NA, JG, AM, EM, AP and MO designed and undertook the study. NA, JG and AM conducted data analysis, with contributions from EM, AP and MO. NA and EM wrote the first and subsequent drafts with comments from JG, AM, AP and MO.

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Conflict of interest

The authors declare that there is no conflict of interests.

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