



Can Communities of Practice Make a Meaningful Contribution to Sustainable Service Improvement in Health and Social Care?

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ABSTRACT

A Community of Practice (CoP) on discharge planning was established in South East Wales to test whether it could support sustainable service improvement. We describe the methodology, and report on its piloting and the lessons learnt. A member survey produced positive feedback, but the response rate was low and contained no data on improvements generated.

KEYWORDS: COMMUNITIES OF PRACTICE; KNOWLEDGE MANAGEMENT; MULTI-DISCIPLINARY WORKING; COLLABORATIVE WORKING; CHANGE MANAGEMENT

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Introduction

Why is it that, despite the number of intensive support projects and the extra funding that has been provided, effective planning and delivery of health and social care services continue to be impeded when care pathways cross professional

and organisational boundaries? In Wales, the National Leadership & Innovation Agency for Healthcare (NLIAH) Change Agent Team (CAT) was set up by the Welsh Assembly Government (WAG) to work in a number of health and social care communities specifically to address problems with discharge planning and transfers of care. They found that, while collaboration and shared learning of effective practice did happen, it was largely an *ad hoc*, informal process. Our hypothesis was that a more formal mechanism for sharing the learning would fill the communication gaps and reduce duplication.

The mechanism chosen to provide this support came in the form of Communities of Practice (CoP). The appeal of the CoP concept was its scope for bringing together a wide range of staff with a shared interest in dealing with transfers of care, including those working at different levels and on different parts of the patient's journey, and from a range of health and social care professions and agencies. Could a CoP make a meaningful contribution to sustainable service improvement in



health and social care by developing their working relationships and providing opportunities for joint working? What were the potential benefits and pitfalls?

Review of the evidence base

The term ‘Community of Practice’ (*Box 1*) was first coined by Lave and Wenger in 1991, and its focus is ‘on the job’ learning as a social process. It recognises the importance of ‘common sense’ theories, as well as more academic knowledge, as drivers in everyday practice.

It can be argued that CoPs fall into the field of knowledge management known as ‘action research’ or ‘co-operative inquiry’. Heron and Reason (2004) state that co-operative inquiry is about people examining their own experience and action carefully, in collaboration with people who share similar interest and concerns, using four kinds of knowing as illustrated in *Figure 1*, below.

Reason and Heron explain that **experiential** knowing is internalised, difficult to explain and derived from face-to-face interactions with people, places and things. **Presentational** knowledge provides primary expression of these experiences through imagery such as story-telling or the arts. **Propositional** knowledge emerges from ideas and

concepts, expressed as informational statements about things. **Practical** knowledge is knowing ‘how to do’ something, expressed as a skill or competence. They conclude that when these four ways of knowing are congruent with each other, our knowledge base is deeper, richer and more valid.

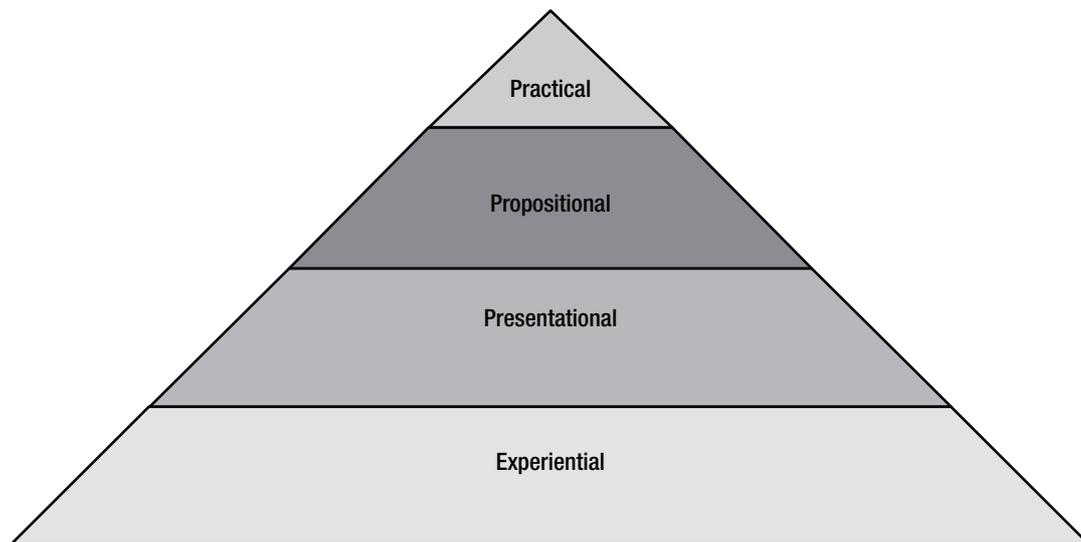
Box 1: COMMUNITIES OF PRACTICE

- A community of practice (CoP) is a network of people who share a common interest in a specific area of knowledge or competence and are willing to work and learn together over a period of time to develop and share that knowledge. Knowledge Management Toolkit, Communities of Practice, National Electronic Library for Health
- Communities of Practice... may be one of, if not the most important, mobilisation mechanisms for an improvement movement in the NHS. Bates *et al*, 2005

CoPs are increasingly promoted as an effective mechanism for the capturing this ‘soft’, tacit knowledge (Hildreth *et al*, 1999). Such knowledge management techniques place:

higher value on the knowledge in people’s heads and finding ways to increase its mobility (Collison & Parcell, 2004).

Figure 1: FOUR KINDS OF KNOWLEDGE IN CO-OPERATIVE INQUIRY





CoPs have been readily embraced in the business world (for example by IBM, Xerox, The World Bank, Ernst & Young, and BP) and are viewed as worthwhile investments that generate innovation and collaborative problem solving. Given that the challenges facing business are increasingly mirrored in the public sector – such as ‘deliver more, and do it with less resources’ (Collison & Parcell, 2004) – there is a clear potential for CoP methodology to have a positive impact on the delivery of quality health and social care services in the UK.

The National Institute for Health and Clinical Excellence, the NHS Information Authority and the Improvement and Development Agency already host Communities of Practice, which are accessible via their respective websites.

Lathlean and Le May (2002) also highlight the potential for CoPs to support improved inter-agency working between health and social care professionals, though they suggest that they are not without their challenges.

Kimble and Hildreth (2005) point out that, amid the enthusiasm and passion generated by supporters of CoP methodology, an element of caution is needed regarding potential pitfalls. They argue that, for truly effective knowledge management, ‘soft’ implicit, unstructured and action-focused knowledge must be balanced with ‘hard’ more abstract, formalised and structured knowledge. They also highlight the potential for CoPs to be introspective and not necessarily aligned with organisational goals.

From the public service perspective, it is necessary to demonstrate a return on investment of taxpayers’ money in releasing practitioners to participate in a CoP. In other words, it would need to be perceived as producing tangible outcomes rather than simply providing ‘talking shop’ time.

The pilot scheme

Aim

The pilot for the CoP on effective discharge planning was established in the South East region of Wales in April 2005. It was sponsored and

facilitated by the NLIAH CAT, in partnership with Welsh Assembly Government’s South East Wales Regional Office.

The aim of the pilot was to establish a CoP as a mechanism for sharing and spreading good practice in discharge planning and management of delayed transfers of care. In particular, it was about capturing the ‘tacit knowledge’ carried around in the heads of experienced professionals, and building relationships and networks across professional, organisational and geographical boundaries.

Approach and methodology

The idea was tested at a regional workshop with a core group drawn from leaders in the field of delayed transfers of care and discharge planning from health and social care. The South East region covers nine local health boards, nine unitary local authorities, four large integrated acute, community and mental health NHS trusts and one specialist trust providing tertiary cancer care and national screening services.

Initial reactions were quite negative, arguing, for instance, that they already had the means to network via email and that they did not share the same concerns. However, when this reaction was challenged, it quickly became apparent that, in practice, they did have many concerns in common that would benefit from shared discussion. While some people had contacts outside their professional and organisational boundaries, few had any further afield, such as in neighbouring trusts or local authorities. There was also general agreement that few opportunities for sharing good practice existed.

Having established a mandate to proceed, the CoP was built around a programme of face-to-face meetings to discuss ‘hot topics’ identified by this initial core group. Typically, these meetings consisted of bi-monthly, half-day workshops with presentations interspersed with time for discussion and networking.

Membership was self-selecting and entirely voluntary. New members were recruited by their peers and through promotional information



disseminated to all the signed-up organisations. The CoP decided which experts should be invited to contribute, and new members were attracted each time a new topic was explored. For instance, there were themed workshops on Continuing NHS Healthcare, Unified Assessment and Intermediate Care, which each attracted new members from these more specialist areas, many of whom continued their membership thereafter. Members were encouraged to 'dip in and out' according to their learning needs and work commitments. Very few members opted to drop out completely once they had joined, even if this meant only staying in touch via the mailing list.

The CoP kept in touch using a database of members which included basic information on each member's work area, experience and/or interests. This was published on a CoP website, which also provided copies of presentations, notes, documents for sharing and useful links.

Costs

It was initially anticipated that the CoP would be hosted on a rotational basis by members' organisations. However, very few had the facilities suitable to hold the numbers required, so the CAT sponsored external public sector venues and refreshments. Although unintentional, the benefits included neutrality and the feeling of being 'fully released from the day job' for the meetings. NLIAH resources were used for facilitation, organisation, circulation of minutes and website development. This meant that the only costs incurred by the health and social care organisations were those relating to release of staff time to attend meetings, or to complete specific tasks and finish work.

Successes

CoPs are, by their nature, self-defining and organic in their development, and the lack of predetermined structure and content was initially unnerving for the first participants. However, once the 'hot topics' were agreed, a great deal of enthusiasm was generated. It became evident that the pilot CoP provided a safe forum in the workshops to have frank and open

discussion, where no question or opinion was judged as too stupid.

Indeed, one of the most successful elements of the pilot CoP was the establishment of what Wenger and colleagues (2002) term 'open dialogue between inside and outside perspectives'. The 'inside perspectives' included those from nursing, therapy, social work and the voluntary sector. While this might have been expected to present barriers to effective communication, the overwhelming atmosphere in the workshops was one of joint endeavour and mutual respect (even in the most lively of debates). The 'outside perspectives' were provided by expert speakers and the participation, at the request of members, of WAG policy-makers in order to provide two-way communication and to bridge the policy: practice divide.

Although it was not consciously orchestrated, participation levels in the CoP naturally followed the pattern identified by Wenger *et al* in that a small core group emerged as natural leaders of debate and drivers of the learning agenda. A further group attended regularly and participated actively in the workshops, while some were peripheral; they attended but tended to 'listen and learn' rather than become actively involved. In CoP terms, all levels of participation are legitimate and members can move through the levels.

In addition to these three levels, the CoP had a larger group of what Wenger and colleagues refer to as 'intellectual neighbours', who maintained an interest on a virtual basis. These were predominantly senior managers who received the information and supported staff participation but did not attend workshops themselves.

Working relationships formed in the CoP led to joint working on projects outside the facilitated CoP meetings, for example shared experiences of setting up community-based, condition-specific nurse-led clinics.

Challenges

The CoP methodology was a significant departure from the more familiar and formalised collaborative programme approach and directive information-



giving that were usually expected from the two organisations involved in establishing the CoP.

The 'free form' approach meant that in the beginning there were mixed expectations from the group. Some members were frustrated that the workshops were not designed to 'give us the answers' but rather to acknowledge that the 'smartest guys are in the room' and to facilitate joint problem solving. A number of the original members dropped out at an early stage, but those who stayed became regular participants and recruited like-minded peers to join.

After 18 months, all the workshops were completed and the first CoP lost momentum. There was growing demand for expansion of the concept and 'actually doing work together' rather than simply sharing knowledge and experience.

It must also be acknowledged that there was initially considerable unease regarding individuals' ability to share organisational knowledge and experience across boundaries. Formal 'permission to share' needed to be obtained from chief executives before employees felt comfortable with participating in the CoP.

Although members asked for an online forum to be set up, it and the website were the least successful elements of the pilot CoP. Reasons provided by members included:

- limited or no access to a computer for health and social care staff during work time
- that practitioners do not have time to browse for information
- that nurses and social workers are 'people' orientated and are more naturally drawn to face-to-face or telephone interaction.

This would support the findings of the literature that emphasise the need to allow time to build personal relationships based on face-to-face interaction, before being able to move towards more virtual communication methods.

While the business sector may be comfortable in providing employees with time and head space to be creative and innovative, the reality of life in the NHS and social services is that such a forum

is likely to be considered an unaffordable luxury. The pressure to align any activity to attainment of organisational goals and targets is understandably intense, and the CoPs developed since the pilot have had to respond to that challenge.

Evaluation of the Pilot CoP

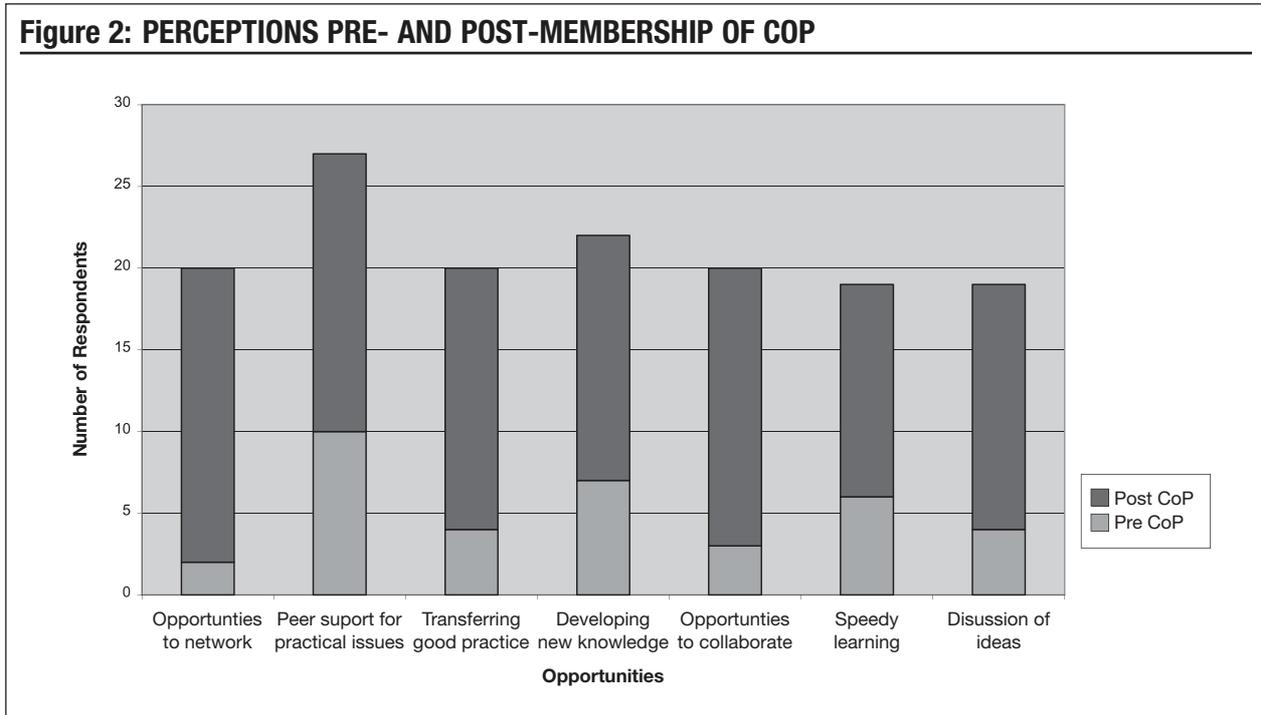
At the end of the first year, a survey of members was undertaken to obtain feedback on the perceived usefulness and benefits of the CoP. In addition, the attendance and membership list was analysed to determine the level of uptake and spread across the region.

In its first year, the CoP had a database of 66 members. They ranged from frontline ward staff to executive directors, social workers, therapists and voluntary staff. All the local trusts and local health boards (LHBs) were represented. There were also two voluntary agencies and seven of the nine local authorities on board.

Questionnaires were sent to all 66 members and also made available on the CoP's website. Eighteen responses were received (27%) of which all but one came from NHS members. Only three respondents used the web version. Eight responses (44%) came from clinical staff. It was disappointing that we did not receive any responses from the local authority or voluntary sector members and that the overall response rate was so low.

Despite the poor response rate to the survey, there were some interesting findings, although it could be argued that the positive responses were biased in favour of a few enthusiastic CoP supporters. However, when we fed back to the group our perception that the lack of response might suggest loss of support for continuing the CoP, we received a number of emails from members asking that we continue, as the poor response simply reflected a view that surveys are a low priority for frontline staff. The results are presented in *Figure 2*, overleaf.

The results showed that 50% of respondents were recruited by colleagues. The rest found out about the CoP from information provided by their organisation or via e-bulletins.



A large majority (89%) reported having had limited opportunities to meet other practitioners and for networking before joining the CoP. The opportunities to network afforded by the CoP were rated by 84% of respondents as extremely or very valuable. Similar polarisation occurred around questions on the level of opportunity for peer support in addressing daily operational issues, for collaboration and transfer of best practice.

The evaluation questionnaire showed that members derived most value from the CoP in relation to their personal professional development and in collaborating with other professionals to solve problems that affected their teams/organisations. However, the pilot was not able to demonstrate any specific outcomes, for example in achieving a reduction in delayed transfers of care (DToC).

A free text question was included to check the extent to which members shared the same understanding about the CoP's purpose.

- Q. What is the common interest of the members of the Community?

This generated a good level of coherence, responses falling into five themes:

- discharge: new ways of working $N = 5$ (28%)

- sharing information/good practice $N = 5$ (28%)
- improving the patient experience $N = 4$ (22%)
- shared learning $N = 2$ (11%)
- shared roles $N = 1$ (6%)
- no answer $N = 1$.

The evaluation questionnaire indicated that a small number of members felt a degree of frustration with perceived non-contributors, but this may be indicative of the evolutionary stage of the Community at that time.

Progress made in implementing CoP methodology following the pilot study

Shortly after the regional pilot CoP was evaluated, its members expressed a desire to expand to become a national CoP in order to broaden the knowledge base and to undertake work projects on an all-Wales basis. This decision was timely, as the CAT had recently published its *Six Steps from DToC to EToC* report highlighting that frontline health and social care staff had become increasingly disengaged from the discharge planning process (National Leadership and Innovation Agency for Healthcare, 2007a). More than 150 practitioners joined this new national



CoP to produce *Passing the Baton: A Practical Guide to Effective Discharge Planning* (National Leadership and Innovation Agency for Healthcare, 2008), which was formally launched in June 2008 with the support of the Welsh Assembly Government.

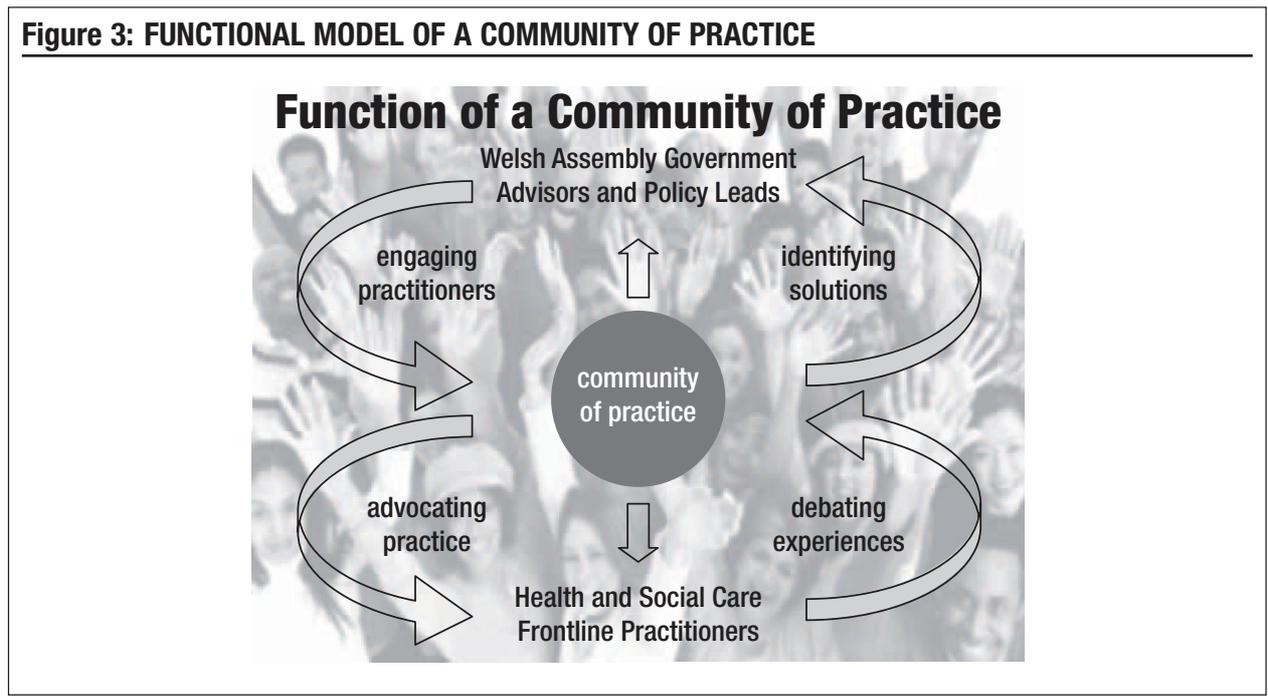
The CoP members have now acted as change agents in their own community by organising an extensive national network of roll-out *Passing the Baton* campaign events and workshops, illustrating the power of social movement in achieving large-scale change in practice.

As word of the success of these original CoPs spread, the CAT responded to requests from health and social care practitioners to facilitate the following.

- The Supporting Practice in Intermediate Care Evaluation (SPICE) programme and national network. A small group of practitioners worked together over a period of 18 months to develop and pilot an effective electronic evaluation tool for intermediate care services. This was formally launched in May 2008 and led to the establishment of a national CoP to share the learning and to influence the further development of Welsh Intermediate Care strategy.

- The Unified Approach to Assessment (UA) and Care Planning CoP. Initially regional but evolved into an All-Wales group, and which has so far produced papers on Professional Codes of Practice and Unified Assessment, *Busting the Myths*, and a national Baseline Assessment of UA Implementation, which informed a formal review by the University of Bangor.
- The Welsh Discharge Liaison Practitioners Forum. Has had an annual work programme addressing the key issues affecting effective discharge liaison and has already produced *Lost in Translation: A Review of the Role of the Discharge Liaison Nurse* (National Leadership and Innovation Agency for Healthcare, 2007b).
- Three regional Communities of Practice for Chronic Conditions Management. These have evolved to become part of the NLIH Chronic Conditions Management programme focused on implementation of the national strategy.

Indeed CoPs are increasingly regarded as an effective mechanism for bridging the policy: practice divide as illustrated in the model in *Figure 3*, below.





Conclusion

This pilot demonstrated that CoPs are an effective means of breaking down cultural barriers to sharing between professions and agencies. However, we found that it was essential to get executive sign-up to the principle of the CoP and to recognise that relationships need to be built before members can focus on specific projects. Many benefits are indirect and can only be correlated with service improvement rather than directly attributed. That said, the evaluation informed us that there was certainly a perception among members that the CoP provided practical and social support and learning to facilitate improvement activity.

It is evident that momentum is best maintained when tangible outputs are achieved, and that health and social care organisations require them to justify investment of staff time. In the light of this experience we recommend that CoP methodology provides a useful and meaningful contribution to delivery of sustainable improvement in health and social care by creating social movement.

Key points for implementation

- Health and social care leaders should learn from the commercial sector to recognise the value of the 'softer' dimensions of knowledge and people management if sustainable service improvement is to be embedded in everyday culture and practice.
- Challenges and barriers between health and social care are perceived, not necessarily real; build on common values and objectives.
- Be ready to compromise on the purist theoretical model to meet the real demands and cultural needs of your target group.
- Mixed expectations need to be managed.
- Don't under-estimate the level of planning and commitment involved.
- Communities naturally evolve and develop their own distinctive characteristics and rhythms; facilitators need to 'go with the flow'.

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