

Communities of practice

WITHIN the international debate about improving health, others look to the United Kingdom model as an interesting experiment, with its paradox of a supposedly primary care-led service but centralised controls on the cost, quality, and organisation of the service. Recently, the ideology of competition is again being argued as the answer to inefficiency in health care. We are currently in the era of performance management. Those in power have yet to decide the balance between micro-managing health care workers from the centre and empowering them to get the work done themselves.

In the past, management consultants were paid, both to prescribe tools for solving problems in the NHS and to put them into practice, but the experience of using these people was mixed. Now the NHS has created its own internal consultancy in the form of the Modernisation Agency. This new body has selected a few tools to put the government's prescription of the NHS plan into practice. Targets have been set though the National Service Frameworks and a policing role has been created in the very new Commission for Healthcare Audit and Inspection (CHAI), with the not-quite-so-new Commission for Health Improvement (CHI) having to renegotiate its role between sergeant at arms and facilitative coach.

In talking about tools for organisational change in the NHS it is easy to forget that the organisation consists of people and that the 'prescription' for organisational change may need to be carefully tailored to their local needs as well as their patients'. It can be paradoxical, relating genuinely to individuals while simultaneously trying to have them meet performance targets. It would be interesting to learn how far this is recognised by those who see themselves as agents of organisational change.

Organisational development

The rhetoric of modernisation brings with it the agenda of quality and performance management. Evidence for the correct approach to improve quality is controversial and the NHS now has a Service Delivery Organisation Research and Development programme (SDO R+D) to provide the 'science' to support it. In the Modernisation Agency the current favourite has been the model of Breakthrough Collaboratives, the origins of which are in the health quality movement in the United States.

The SDO R+D jury and others have yet to decide how well the model of Breakthrough Collaboratives is going to work and no doubt this will remain a politically contentious issue. Just how much people can force others to do things differently through the direction of any change model or plan is up for debate, although some senior politicians apparently see command and control as the right model. In exploring organisational change models, Stacey argues that the qualities of engagement and participation may be more important than the change model itself in supporting the emergence of genuine and new patterns of activity.¹

The government wants us to hurry up and be compliant with the medicine they have prescribed. As a part of the

'organisational patient,' we may have opinions about how much use their elixir is going to be for us locally, and what constitutes a safe and sensible pace to drink it.

Complexity

There is a growing interest in the unpredictability of outcomes that occur in complex environments. The weather is a complex system. By its nature, accurate forecasting beyond a few days is not possible. Attempts have been made to transpose these insights from the natural sciences into understanding the way people interact in organisations.² The models remain contentious but none the less are informing the debate about how people think one can make change happen in health care in the USA³ and the UK.

An example of the unpredictability of outcomes in a complex environment was the previous system of fundholding and the internal market. Paradoxically, in a climate with the ideology of competition at its heart, it was from the local collaboration of fundholders and the realisation of their collective power, that a primary care-led health service emerged. Nobody could have predicted from the original design that fundholders would collaborate, in the way they did. Fundholders were active participants in inventing the 'practice' of fundholding.

The practice level

The 'practice' of primary care is complex and rich. This is particularly true for the health of the elderly. In caring for a single elderly individual there will be a collaboration of people from numerous disciplines and agencies: acute medicine, old age psychiatry, social services, private provision, primary care, community care, and independent and family carers.

The practice of thinking about caring for the population of elderly people is just as complex. While the public health agenda of health improvement is very important, it is incomplete. At a population perspective, domains of organisational form and function include expertise in health economics, health informatics, health and social policy, organisational development, knowledge and project management.

So how do we effectively share peoples' understanding and particular expertise in this complex multidimensional environment of the organisation? The epistemology of communities of practice is beginning to shed some light on this.⁴ These are analogous consultation skills to those we promulgate in primary care but within the larger organisation. It is a considerable skill to be able to support effective conversations among people with different understanding and professional identity but with overlapping areas of interest. These skills are necessary if there is to be intelligent accountability⁵ of the expert patient, the expert doctor, the expert public health physician, and the expert manager.

Mechanisms for implementing change are hotly contested areas in the political and the intellectual fields of health management. In this month's *BJGP* journal, Iliffe *et al*⁶ invite us to take a closer look at another model of service development. It evolved out of work by the King's Fund in the early

1990s on Community Orientated Primary Care⁷, which itself developed in response to the need to reorganise a fragmented service in Israel 20 years ago. In the 1990s, with the purchasing of services in primary care, fundholders needed to learn about the population perspective. A route for helping to draw together the disciplines of public health and primary care was offered through the work of the King's Fund.

Iliffe *et al* offer a cyclical methodology, with similarities to that of the breakthrough collaboratives, in which four general practices had the privilege of a network of professionals to support and engage with them in the clarification of health improvement measures, appropriate for their particular population of elderly people. This was combined with an exploration of mechanisms for their implementation. They acknowledge the dangers of extrapolation from the four practices in the study. This is important because if you look at the people in organisations closely enough you will always find differences, which could account for successes or failures in organisational change, making generalisation of the model difficult. Iliffe *et al* describe the incorporation of the innovations in 'local practice' in the then Health Authority and local Primary Care Groups. It would be interesting to know in more detail, in what way this has happened; how much it was the experience, learning, and local knowledge of the people involved in the project, that allowed the integration of their new experience into broader activities on their patch, and how this process can be supported.

Generally, it is not easy to recreate changes that are occurring in one part of an organisation, in another. This is the problem of diffusion of organisational innovation.⁸ Learning, change, and meaning are fiercely argued about in the disciplines of sociology and organisational development. To highlight the existence of some new ways of thinking, it would be interesting to know how much the adoption of the innovations described by Iliffe *et al* was related to the model of 'community-oriented primary care' described, and how much to the situated learning⁹ that arose from the participation, or the patterning of communicative interaction¹⁰ among people. These authors are looking for new ways to make sense of the processes of relationship among people in organisations. I argue that they mirror and unknowingly attempt, to translate the discipline of primary care with its commitment to genuinely supporting the ongoing relationship between the doctor and the patient, into the realm of the processes that occur among people in groups. I believe primary care has more to offer than it realises.

In the spirit of collaboration and communicative interaction we have set up a collaborative website to which you are invited. (<http://pcsc.kcl.ac.uk/rcgpcd.htm>) We welcome you to read and join in the online discussion, which Steve Iliffe and myself are running. We invite you to discuss what we have written, to offer your understanding of how change does or doesn't happen in organisations and to think about what creates a successful community of expertise.

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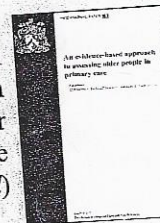
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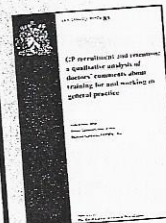
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British Journal of General Practice, August