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UNIVERSITY OF SOUTHAMPTON

FACULTY OF HEALTH SCIENCES

A Community of Practice

A case study exploring safety and quality through professional leadership

by

Alison Mary Lewis-Smith

Thesis for the degree of Doctorate of Clinical Practice

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UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF HEALTH SCIENCES

Doctor of Clinical Practice

A COMMUNITY OF PRACTICE

By Alison Mary Lewis-Smith

This research reports an emerging Community of Practice (CoP), informing how knowledge, understanding and learning were shared through professional leaders using stories to influence change and improve the safety and quality of services. The research focused on generating knowledge and dramatising leadership experiences in integrated community health and social care services. A case study design and multiple qualitative data collection methods were used. The analysis of all data sources revealed rich descriptions with several emerging features including: a) Constructing and sharing a meaning for professional leadership through partnership working to foster cross organisational learning. b) Creating an entrepreneurial identity through contextualising new knowledge and skills c) Developing skills and confidence to be instrumental in progressing the safety and quality agenda d) Using storytelling, sharing anecdotes to dramatise experiences and encourage debate creating shared meanings within the Community of Practice e) The Community of Practice created a forum for learning through generating professional capital by sharing experiential knowledge. The theory practice gap has been closed through professional practice and leadership discourse, developing new knowledge to lead and empower practitioners. In doing so it has widened the debate regarding the professional leadership structure in operation and questioned the need to reshape the context in which professional leaders act and are able to influence the safety and quality of services. Professional leaders should have continual investment as a resource to impact on safety and quality improvements, service developments and managing change. Communities of Practice should be acknowledged and established as an opportunity to generate collective knowledge and influence organisational development and change. Storytelling and narrative can be used as a recognised methodology for sharing specific experiences in order to reflect, contextualise and provide the language required to influence the wider organisational strategic direction. A recognised programme of further research should be considered.

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Declaration of Authorship

I declare that the thesis entitled **A Community of Practice:** A case study exploring safety and quality through professional leadership, is entirely my own work and that the work presented in the thesis are both my own and have been generated by me as the result of my own research.

I confirm that:

- The work was done wholly while in candidature for a research degree at the University of Southampton
- Where I have consulted the published work of others, this has always been attributed to them
- Where I have quoted the work of others, the source is always given. With the exception of such quotations, this thesis is always my own work
- I have acknowledged all main sources of help
- None of this work has been published before submission

Signed.....

Date.....

Acknowledgements

I would like to thank unreservedly my supervisor Professor Andreé le May for her gentle but expert, dedicated and focused support, direction and advice during the completion of this research

To the members and respected colleagues of the Community of Practice '*At the end of the day, the process of gaining access and the progress of a case study will rely on partcipants goodwill'* Stake (1994)

and:

My son Benedict who was studying for GCSEs at the beginning of this journey but has since left University and is in gainful employment!

My twin brother Timothy for setting the pace.

My husband William for his enduring support, encouragement, patience and tolerance throughout the whole process.

Abbreviations

AHP	Allied Health Professional
CCTV	Close Circuit Television
CHC	Continuing Health Care
COP	Community of Practice
CQUIN	Care Quality and Innovation
DMT	Delivery Management Team
LA	Local Authority
MIU	Minor Injury Units
NAPC	National Association of Primary Care
NHSI	National Health Service Institute
NICE	National Institute of Clinical Excellence
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Alerts
OMT	Operational Management Team
PEAT	Patient Environment Action Teams
PCT	Primary Care Trust
RCA	Root Cause Analysis
SIRIs	Serious Incident Requiring Investigation
STEIS	Strategic Executive Information System
SUIs	Serious Untoward Incident

Chapter 1 Introduction

1.1 Background to the research

The idea for this research study was born out of two things. The first was my own awareness of the importance and significance of the influencing skills, tacit and explicit knowledge, individual styles and experience of professional leaders working to develop and sustain the patient safety and quality agenda in rapidly changing public health and social care services in England. This awareness was accompanied, despite working as a professional leader myself, by a perceived lack of understanding about how professional leaders influence others, what the common skills and knowledge of professional leaders were and how, once identified these could be shared, enhanced and used locally by an experienced group of professional leaders involved in the safety and quality work of a Primary Care Trust (PCT) and its partner Local Authority (LA).

The second was the publication of 'Commissioning a patient led NHS' by the Department of Health (DH 2005) with its resultant streamlining of services and need for stronger communication and learning between professional groups and organisations. This policy acted as a catalyst for developing my idea into a research project to understand professional leadership better and explore how a Community of Practice might be used to support professional leaders. Also other complex changes in the National Health Service (DH 1999 and DH 2006) escalated the need for robust, credible and visible professional leadership alongside the concomitant need for better integrated partnerships between health and social care as service providers as well as between commissioners (the local authority, voluntary sector and health). Latterly this was also encompassed through the Transforming Community Services agenda including Equality and Excellence 'Liberating the NHS' (DH 2010).

1.2 The role of the researcher

At the time of the research I was working in a Primary Care Trust which was pursuing a strategy of integration between health and social care services, as well as implementing a division between commissioning and provider functions. This was a geographically and demographically diverse

community trust providing integrated services between health, social care, education and the voluntary sector in the south west of England. As a National driver through health, social care and education statutory agencies, it was believed that as a result of working together in such a way, better outcomes could be achieved for the whole population from birth right through to death. At the time of the research the PCT had been created from four smaller community trusts and had cross working arrangements with four district general hospitals. I had previously been in a senior manager's post in one of the smaller trusts but with a clinical background in midwifery and health visiting moved to a head of professional practice role in the newly created larger organisation. I continued to work full time in 'professional practice' in Children's Services for the duration of this study.

1.3 The concept of leadership

The general concept of leadership within the health service was emphasised throughout the NHS Plan (DH 2000) and effective leadership was (and still is) seen as a key ingredient in modernising health and social care and providing high quality safe services. The NHS Institute for Innovation and Improvement stated as part of its mission, that improving health outcomes and quality of delivery will be accelerated by '*innovation and improvements in …..health care leadership'* (NHSI on line 2007). Also an NHS Alliance discussion paper which laid out a vision for the sustainable future of professional leadership within Primary Care Trusts (PCTs) and potentially more broadly across the NHS, stated that '*the then current reconfiguration of PCTs…offers both significant threats and opportunities for the future of professional leadership as an effective, positive and potent force for change within the NHS*' (NHS Alliance 2006:6). The term professional leadership however, is difficult to define as individual professionals and professional groups have attributed different meanings of it (Malby 1998:41). The title 'clinical' leadership is often used interchangeably with that of 'professional' leadership with an acknowledgement that professional leadership appropriate to the NHS requires clinicians to maintain a clinical commitment as an essential pre-requisite (NAPC 2009:3). At the start of this project in 2009 professional leadership tended to be used in conjunction with leadership roles relating to governance, safety and the quality of services and was often linked to a

recognised professional qualification (i.e. that of a doctor, nurse or allied health or social care professional). The role did not necessarily incorporate operational management responsibility and the components of professional leadership were described inconsistently in job descriptions as various skills, knowledge, experience, personality attributes and the ability to create particular environmental factors rather than as a pre-determined and agreed description. I hoped that my study might help to clarify how professional leaders influenced those working to and within a safety and quality agenda. The term 'professional leadership' is used throughout the study to identify those in leadership roles with a recognised clinical (professional) qualification required for that role

1.4 The construction of a Community of Practice

In order to do this I constructed a multi-agency health and social care Community of Practice of professional leaders from the PCT and LA where I worked. I used Wenger et al's (2002:4) original description of Communities of Practice as '*groups of people who share a concern, a set of problems, or a passion about a topic and who deepen their knowledge and expertise in this area by interacting on an ongoing basis*.' to guide this. I also used Nickol's (2003) 'Stages of Development' to underpin the process of the Community of Practice as I observed and recorded how the participants shared information, knowledge, understanding and learning about professional leadership, managing change and improving services and used the data to explore how this was done. More specifically the research aimed to:

Study the emerging Community of Practice through observing and recording stories and narrative told by the people involved, to better understand the processes through which influencing professional leadership is developed and change sustained within a large and diverse community environment.

Explore through the stories, dialogue and case examples how National Health Service and Local Authority employees (clinicians, managers and allied health and social care professionals) professionally lead and work together.

Derive how individual and collective health and social care decisions are made, by observing interactions within the Community of Practice as well as listening to individual's narratives and understanding their view points, in determining the most appropriate ways of working, managing change in practice and demonstrating improved service.

Describe the ways in which experience and expertise is shared and knowledge exchanged through a Community of Practice story board in order to support shifts in services.

Two research questions focused the data collection and analysis in this study:

- *How does the Community of Practice enable participants to influence change through professional leadership?*
- *How do participants use a Community of Practice to share their knowledge and understanding of professional leadership?*

1.5 Thesis overview

The thesis comprises seven chapters. The following chapter reviews literature related to Professional Leadership, Communities of Practice and the use of storytelling. Chapter three presents the study design and methods for data collection and analysis. Chapters four and five show how this Community of Practice became a dynamic vehicle where ideas and knowledge about professional leadership were brought, debated, sometimes challenged, occasionally rejected but often acted upon. Chapter six discusses the findings from chapters four and five in relation to contemporary literature. The thesis concludes with a reflective chapter seven where conclusions are drawn, limitations highlighted and recommendations made.

Chapter 2 The literature review

2.1 Introduction

This chapter provides a general review of pertinent literature undertaken at the beginning of the research study to guide the development of the research proposal and its subsequent implementation. The purpose of the literature review was to identify relevant research relating to professional leadership. I used a sifting and snowballing strategy to expand my knowledge, critique research articles and build on previous publications to inform my knowledge of historical leadership theory and development. Following a lecture during the taught Doctorate programme I was interested in finding out more about the theory and practical application of Communities of Practice and how I might use the model to observe professional leaders in their workplace. In addition, I was aware that story telling being part of everyday conversation and an acknowledged way of communicating, could be used as a way of creating and sharing knowledge. The review therefore focuses on Professional Leadership, Communities of Practice and Storytelling. The key words alongside descriptor combinations in Table 2.1 were used in my strategy to search a number of databases, as well as other available and recommended information sources (Table 2.2).

Table 2.1: Key words and descriptors used in the search strategy for literature

Key Words	Descriptors
Professional Leadership	Clinical, clients and patients, nurses, therapists and social workers, quality and safety Management, skills and knowledge, influence
Communities of Practice	Teams, groups, expertise, knowledge networks
Storytelling	Narrative, Information sharing, managing knowledge, organisations
Health and Social Care	National Health Service, Local Authority, Integration, Policy

Table 2.2 Data bases and identified sources of information

Databases	Other sources
CINAHL (1982 -2009) – Cumulative Index of Nursing and Allied health Literature	**GOOGLE –** as a search engine
BNI (1985 – 2009) – British Nursing Index	**DEPARTMENT OF HEALTH –** policy and development
MEDLINE (1950-2009) – A major index of biomedical literature	**DFE -** integration
EMBASE – has a more European base than Medline	**GOOGLE SCHOLAR**
THE COCHRANE LIBRARY	**RECOMMENDED BOOKS and CHAPTERS**
ASSIA (1987-2009)	
IBBS (1951-2009)- International Bibliography of the Social Sciences	

The following inclusion and exclusion criteria were identified

Table 2.3 Inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
Professional (Clinical) Leadership	
Health and Social Care sector	*Business*
Communities of Practice	
Post 1991 to capture the original publication by Lave and Wenger in 1991 and articles responding to and elaborating on it.	*Virtual communities*
Multi agency working	*Education and teaching*
English only with humans as subjects	
Storytelling	
General literature	*Illness and medical stories*

Retrieved papers and information sources were appraised to determine their rigour and relevance (Appendix 1).

Information on Professional Leadership, Communities of Practice and Story telling are presented below.

2.2 Professional Leadership

The review is limited as definitive literature in this field is comparatively scarce, with academic articles and publications from the NHS, other national bodies as well as opinion pieces and reports published in health

services journals being examined. Little is written on barriers to effective professional leadership across the literature and it is predominantly restricted to opinion pieces and anecdotal evidence in journals for health professionals (NAPC 2009:3). Academic literature tends to focus on broader leadership and attributes of leaders and to a lesser extent on evaluations of professional leadership and governance. It is success stories rather than difficulties that are focused on in the evaluations. This may be significant of larger features of professional leadership; that it is not sufficiently and independently researched to a great extent and that those directly involved may not feel that their (in particular, dissenting) voices are heard. The NHS Confederation paper on the Future of Leadership (March, 2009) also notes that the debate on leadership and talent tends to be "introspective" so that findings from the independent and third sector may also be being missed.

The leadership debate has been ongoing throughout the 20th century and remains alive and active into 21st century. A major breakthrough came when Lewin (1951) isolated common leadership styles which came to be known as authoritarian, democratic or laissez-faire. Hersey and Blanchard (1998) also developed a situational leadership approach with their tri dimensional leadership effectiveness model which predicts the leadership style most appropriate in each situation based on the level of the follower's maturity. As people mature, leadership style may become less task focused and more relationship oriented. But a wider review on leadership since it first became the subject of systematic study identifies models of leadership that have emerged and changed over time, as have the foci of leadership research. This is, not least, because notions of what is regarded as leadership have been affected fundamentally by factors in society. This has contributed to some confusion, as has also the fact that researchers have adopted a variety of definitions of leadership, and methodologies for its study (Onyett et al 2009). The concise Oxford English Dictionary (1999) leadership definition says

'*being in charge or command*, *in command or preceding a group* or *organisation',*

In addition the definition for professional alludes to

‘*a person having impressive competence in a particular activity’.*

Kouzes and Posner (2007) suggest that when ordinary men and women become exemplary leaders they use leadership that is based on self awareness and emotional intelligence, inspiring a shared vision, leading and managing productive change in organisational and group performance improvement, influencing subordinates and peers to act, and improving performance to encourage a healthy organisational culture. Crisp (2005:3) also said leadership is about setting direction, opening up possibilities, helping people achieve, communication and delivering results. But it is also about behaviour, what we do as leaders will become even more important than what we say (Crisp 2005:3).

2.2.1 The concept of professional leadership

Even so the concept of professional leadership remains particularly difficult to define when even professionals have different ideas of the meaning of the term (Malby 1998:41). Professional leadership in primary and integrated care is one of the eleven competencies specified by the Department of Health for delivering essential services in an NHS that strives for maximum health improvement from within available resources (NAPC 2009:3). As a leader in clinical issues professional leadership is a way of focusing and motivating a group to enable it to achieve its aims (NHS Alliance 2007). It also involves being accountable and responsible for clinical activity and outcomes for a group as a whole. A professional leader should provide continuity and momentum in the development and provision of clinical services as well as flexibility in allowing changes of direction to deliver the clinical objectives of the Trust within the confines of overall objectives (Malby 1998:42) through strong and effective leadership in the delivery of the safety and quality agenda. The role is instrumental in coordinating quality healthcare activity, which includes promoting and meeting set standards of care and professional practice as well as ensuring staff engagement in consultation and proposed change. Professional leadership appropriate to the NHS requires clinicians to maintain a clinical commitment as an essential pre-requisite (NAPC 2009:3). It is also suggested that the necessary engagement can only be achieved if professional leadership spans across the entire clinical workforce at operational and strategic

levels. This professional leadership must be enabled, empowered and effective to achieve the required level of clinical engagement. Professional leadership needs to be at all levels that impact on the commissioning process and across all health professionals engaged in the delivery of frontline services (NHS Alliance 2007:5). A brief survey undertaken with some of those who had a professional leadership role found that often those individuals wanted to be leaders, felt they had attributes (NAPC 2009:3) and that they should be supported to develop those broader leadership skills.

2.2.2 Defining theoretical qualities and styles of leadership

The history of the nature of leadership is that it developed through 5 main stages: the 'trait' approach; the 'behavioural' approach, out of which the concept of managerial and later leadership competencies emerged; the 'situation' or 'contingency' approach; the 'new paradigm' approach, with that focus on 'distant' transformational, often 'heroic' leadership; and finally, the emergence of 'nearby' transformational or 'engaging' leadership, and the associated concept of 'adapted' or 'distributed' leadership (Onyett et al 2009).

Trait theories (Marquis and Houston 2000) neglected the impact of others or the situation on leadership roles whilst contemporary opponents such as Senge (1990) argue that leadership skills can be developed and are not just inherited. Because leadership researchers and theorists do not agree on exactly what leadership is and whether the skills can be developed or are inherent it is possible to focus on either, roles inherent in leadership or skills, knowledge, traits and behaviours of leaders. Alternatively the NHS Leadership Qualities Framework (2003) created, through detailed research and tailored to the specific needs of the NHS, is applicable to all leadership roles arranged in three clusters – personal qualities, setting direction and delivering the service.

Therefore leadership is potentially complex but fundamentally about engaging others as partners in developing and achieving a shared vision particularly whilst enabling others to lead. Research often focuses on the individual person as well as their authority in an organisation. Alimo-

Metcalfe and Alban-Metcalfe (2000 page 26) noted:

‘the staggering complexity of leadership roles within the NHS and local authorities suggesting that leadership can be measured in terms of what it achieves for staff and services’

They showed that leader’s most important characteristics are concern for others and the ability to communicate with and inspire other people with awareness and sensitivity to the needs of stakeholders, both inside and outside of organisations and encourage ‘connectedness’ or joined up thinking among service providers. Daft (2002.1:5) deliniated the essential elements of the leadership process:

‘*Leadership is an influence relationship among leaders and followers who intend real changes and outcomes that reflect their shared purposes’.*

According to Adair (2009:9) leadership is more than possessing the qualities that are required and respected, although there are certain qualities that are the hallmarks of good leaders. Integrity or personal wholeness help to make for trusting and truthful relationships as well as conveying a sense of adherence to standards or values external to any individual. Being tough but fair in addition to other qualities such as enthusiasm and warmth become infectious as well as the need for calm reasoning and judgement. Adair (2009:22) describes alternative approaches in understanding leadership styles depending on the task in hand, the team constituents and any individual’s needs saying that success depends on the interelationship and interaction between those three elements depending on the following styles:

1) functional leadership around a particular area of expertise

2) situational leadership in determining the leader at any given time

3) motivational leadership in working with natural processes to progress

Adair (2009:16) suggests there is a wide range of styles that can be equally effective saying that decision making should be shared, not least because participation tends to produce commitment. Preferred leadership styles need to be adapted to match different situations. He emphasises that all practice comes from expertise, knowledge, experience and activity of the

leaders and a key function is the ability to guage the levels of competence and commitment of staff to accomplish their tasks alongside the desired outcomes. According to Hersey and Blanchard (1998) leaders need to evaluate the competence and commitment of their colleagues, and then adjust how they direct or support them using behaviours accordingly. Coulshed and Mullender (2001) also propose an alternative concept of leadership style which takes into account the variability of emphasis they place on different aspects of their roles.

Leaders tend to seek change through creativity and taking advantage of potential chaos. They do not always need the same structure as managers who seek order, control and closure through the very nature of the role suggest Marquis and Houston (2000) adding that management and leadership are not the same and can therefore come into conflict with one another. Leadership is about giving direction, building teams and inspiring others by example and work, with often having more freedom to act. A manager can be appointed but will not necessarily be a recognised leader without the associated personality, character, knowledge and skill being recognised and accepted by others involved (Adair 2009:59).

The ongoing debate about what makes a good leader continues to centre around three elements of skill and knowledge, vision and values and personal qualities. The fundamental focus for this research centred around clinical specialists in professional leadership roles using all of those elements to influence everyone working towards improving safety and quality of services within the trust.

2.2.3 Leadership influence for changing and improving services

Adair (2009:69) believes change can be described as endemic within the public sector just as much as in private industry and does need leading: this leadership includes the effective use of evidence and resources to produce a high performance team and desired outcomes. In addition the following characteristics have been suggested by Adair as being required within the whole team identifying that a result depends equally on the quality, training and morale of team members as much as how the skill of the leader is able to influence and mobilise the team through

- clear objectives and process planning

- a shared sense of purpose
- best use of resources
- an open atmosphere
- regular progress reviews
- experience and ability to ride the storm.

Previously leadership skills had been identified as key to influencing the overall delivery of good health and social care delivery, but it has not always been easy to define what that meant (Taylor 2007). Although early theories of leadership focused on the personal traits of leaders as though leadership was a characteristic, more recently there have been attempts to develop a potential for leadership in a range of people throughout organisations to achieve change. This implies that leaders are responsible for encouraging qualities of leadership in others, who can be described as followers as well as influencing relationships among leaders and followers who intend real changes and outcomes that reflect their shared purpose (Rost 1993 in Daft 2002). Moreover values that are deemed important and are commonly understood in healthcare services, such as honesty, openness, respect for individuals, mutual help, empowerment and a community of interest, are highlighted in transformational and visionary models of leadership.

Vision can hold teams together and when shared, can be compelling and can bring out collective courage to achieve the desired outcomes that people did not realise they had. The traditional idea of leaders being special, setting direction and energising staff is rooted in individualistic and non-systemic work views. But there is an alternative perception of leadership, which focuses on different goals, in which leaders are designers, stewards and teachers, responsible for building organisations in which people continually expand their knowledge and capabilities. Leaders can pursue their own vision but this might be part of a bigger picture and they become the steward, driver or catalyst of a vision that can become a calling (Taylor 2007). Alternatively although vision is a valuable leadership quality there is a need to see and understand where the organisation is going and see the journey as success rather than the destination. Support

from PCTs is required to allow that vision and to develop individuals in the dual roles of clinician and professional leader, where they are valued as both (NAPC 2009). Planning is also a leadership function, it's a continuing activity of selecting objectives, identifying alternative courses of action and choosing the right way forward within the policy framework laid down by the strategic direction or equivalent in any organisation. Common sense and the ability to listen cannot be ignored in identifying why some leaders produce better collective outcomes than others.

2.2.4 Leadership and responding to health and social care policy

Safety and quality, meaning excellence through achievable and measurable high standards as well as using evidence based practice to achieve the best outcomes for people receiving interventions and care (Darzi 2008), is high on the list of aspirations/aims in changing organisations and the desire to change culture within the circumstances of current health and social care policy. Leadership is seen as essential to achieving this, particularly the need to increase the visibility, expertise and authority of clinical leadership, and so it is important and necessary to understand what makes a leader or how leadership skills can be developed to contribute to current and future strategy and policy. High Quality Care for all (Darzi 2008) made quality the organising principle of the NHS as we strive significantly to improve health care services for patients.

The design of services during the previous Labour administration, was driven by policy with the underlying principles of standardisation, continuity of care and individualisation at the point of delivery. Making a Difference (DH 1999),The NHS Plan (DH 2000), various National Service Frameworks and the Introduction of the Expert Patient (DH 2001) meant a change in roles to meet patient/client/carer need as well as life long learning and continuing professional development. Furthermore quality was monitored and risk managed with the opportunity to learn from adverse events. With the emphasis on integrated care pathways, guidelines, protocols, procedures and policies it became even more important due to cultural differences and the need to deliver results, to have visionary leadership in place to ensure the safety and quality agenda was on track, being

monitored and evaluated.

Antrobus and Kitson (1999) found how important it was to note that professional leadership is greatly shaped by the impact of politics and policy but contemporary professional leadership has both an internal and external focus and these should effectively influence and shape the future of professional leadership itself. They suggested that policy is often formulated with little influence from clinicians, except at the grass roots level of implementation, so it is necessary to consider how an individual or group knowledge base and skill set can be generated, identified and managed to influence the context in which professional leaders are working and how that dynamic knowledge may help them in operating to increase their visibility and impact to promote social change and embed the learning into the socio-political context of the time. There is a paucity of literature to demonstrate such outcomes and this research study offers the opportunity to demonstrate how that may become a reality in line with policy recommendations .

The NHS Alliance (2007:5) report, representing 26 professional groups, said to achieve effective professional leadership PCTs needed to:

'Ensure strategic professional leadership from within the professions to influence the direction of travel and draw on the diversity of talents.'

'Empower frontline professionals to contribute both spontaneously and in response to specific engagement activities, making best use of all available clinical resources and thereby improving financial efficiency.'

'Support the development of professional leadership from across the professions, so the local health community becomes a dynamic system focused on patients (and their relatives).'

Health professionals needed to:

'Develop a better understanding of commissioning and be willing to contribute to identification of need and planning of services.'

'Develop professional leadership by - identifying, empowering and developing clinical leaders; and taking collective action in support of clinical leadership within their own and across professions for the delivery of patient care and health'.

Department of Health and the Strategic Health Authorities needed to:

'Promote and support multi-professional leadership and engagement within PCTs.'

'Help to develop further multi-professional leadership, by insisting that commissioning is multi-professional and challenging decision-making that fails to engage clinicians from across the professions.'

'SHAs need to ensure strategic leadership from within the professions at SHA level and within PCTs.'

During recent organisational changes and service development initiatives transformational and charismatic leadership have been identified by Khurana (2002) as 'the power to perform miracles' but there is also a belief that this activity has potential to deliberately destabilise organisations and more pragmatic leadership styles and behaviours are suggested (Binney et al 2009: 33). Their research showed transformations do not happen to order and the focus on 'whole system change' and huge 'cultural change' takes time to be effective. In addition the impact of leaders is not necessarily the one they expect or intend particularly in large organisations or in the public sector because the expectations are unrealistic and the pressures unreasonable meaning that followers can find vison and change impossible to comprehend.

2.2.5 Leadership for quality improvement

The case for leadership for quality improvement was put by the Department of Health in the NHS Operating Framework 2006/7:35:

'*Leadership across the NHS, and particularly in the new Primary Care Trusts (PCTs), remains the key to delivering improved services to patients*.'

It was reiterated the following year in the Operating Framework 2007/8:36:

'*It is the very nature of the reforms that improvements must be owned and delivered by clinicians, managers and other front-line staff on the ground…..It is the responsibility of the NHS community leadership… to engage fully with clinicians, staff, patients and the wider public to communicate and explain the need for change and the potential of the reforms locally to improve services and people's lives.'*

The case for professional leadership was also clearly stated again by Lord Darzi in his Our NHS our future: interim report: 37 (2007:3), saying the Department of Health will:

'*ensure that local decision-making processes are subject to greater public and clinical scrutiny including ensuring the local case for change is led by clinicians,..*'.

Leadership is to be found in areas for action and professional leadership highlighted:
'The essence of clinical leadership is to motivate, to inspire, to promote the values of the NHS and to create a consistent focus on the needs of patients being served. Leadership is necessary not just to maintain high standards of care but to transform services to achieve even higher levels of excellence.'

The discussion and examples presented in the NHS Alliance (2007) leadership report demonstrate a 'can do' approach, the value of multi-professional involvement in planning and commissioning of health care and implementation of service changes required to achieve the necessary improvements in safety and quality of health and social care services. Professional leadership is about individual leaders and multi-level leadership, translating concepts and ideas so that they have meaning for colleagues working with patients, designing services or considering patient needs. It is about building commitments and agreement to go forward together – addressing population and service needs, changing services and delivering services. Evidence from across the globe (DH 2009) around large scale change, shows that leadership looking out to customers and communities is more likely to work than looking up to bureaucracy and to the centre. Recognising that the NHS had not grasped the importance of leadership there was a need to systematically identify, nurture and promote talent and leadership. David Nicholson the NHS Chief Executive (DH 2009) also added that:

'it is imperative to align what is happening with leadership with what is needing to be achieved with quality. That is leadership with a purpose and we shall really struggle to deliver high quality locally driven services that are responsive to the needs of individual patients if our leadership is not representative of the communities we serve.'

Professional leadership was recognised as one of the four principles, the others being co production, subsidiarity (localisation where possible) and system alignment, to maintain the safety and quality agenda which had great potential to mobilise and empower clinicians and it was recognised that without this knowledge and ability progress would not be made.

2.2.6 Summary

Although there was a dearth of literature relating specifically to 'professional leadership', my thinking was informed by taking a more general historical and developmental approach to reading and critical analysis of leadership research and commentary. The review of leadership literature eventually highlighted the complexity of a definition but also the need for and importance of the required leadership skills in developing today's health and social care services. Political and national strategy awareness were also identified as necessary for leaders instrumental in change, innovation and influence on improving safety and quality of services. This research attempted to find out how some of that leadership knowledge, skill, style and behaviour is generated and used within an emerging Community of Practice.

2.3 Communities of Practice

2.3.1 What is a Community of Practice?

Communities of Practice have been promoted as vehicles for bringing together relevant stakeholders to achieve an agreed task whilst drawing on a range of resources and sources of knowledge.

'They represent one approach for inter-agency working in which several agencies can be involved in different types of care and can collaborate in both service design and delivery' (Lathlean and le May 2002:394).

Wenger et al (2002:4/5) described them as:

'Groups of people who share a concern, a set of problems, or a passion about a topic and who deepen their understanding and knowledge of the area by interacting on an ongoing basis……these people don't necessarily work together on a day to day basis, but they get together because they find value in their interactions. As they spend time together, they typically share information, insight and advice. They solve problems. They help each other. They discuss their situation, their aspirations, and their needs. They think about common issues. They explore ideas and act as sounding boards to each other. They may create tools, standards, generic designs, manuals and other documents, or they may just keep what they know as a tacit understanding of what they share…over time they develop a unique perspective on their topic as well as a body of common knowledge, practices and approaches. They also develop personal relationships and establish ways of interacting. They may even develop a common sense of identity. They become a Community of Practice.'

This description immediately suggests why Communities of Practice should be important for people who practice in health and social care settings.

'*They are increasingly forming, either naturally or through being deliberately created, as a mechanism for getting people together in order to develop best practice, implement new knowledge or shape old knowledge for new practice so that people might do their jobs better day to day'* (le May 2009 1:3)

Two conditions of a Community of Practice are crucial in helping people to understand them as normal: shared experience over time, and a commitment to shared understanding (Wenger et al 2002). A Community of Practice engages people in mutual sense-making – about whatever enterprise they're engaged in, about their respective forms of participation in the enterprise, about their orientation to other communities of practice and to the world around them more generally. Whether this mutual sense-making is consensual or conflicting, it is based on a commitment to mutual engagement, and to mutual understanding of that engagement (Wenger et al 2002).

Communities of Practice are about developing a fertile, supportive environment for creative thinking, and for challenging assumptions about how health and social care should be delivered. The process of how services integrate or 'join up' (Lathlean and le May 2002:394) across

organisational boundaries is significant as rarely do individuals make events occur in isolation. To explain the purpose of integration the underlying values and determining strategies of organisations need to be understood.In additon professional leaders as clinical specialists as well as advisors and operational managers can benefit from working together, understanding each other's roles in order to provide the best possible opportunity for integration to be achieved and improve the quality of service to the client or patient.

2.3.2 Origins of Communities of Practice

Although Wenger (1998) states that Communities of Practice have existed for centuries the term was first coined by Lave and Wenger (1991) almost simultaneously with Brown and Duguid (1991) when they first discussed the idea of a Community of Practice in relation to group learning, knowledge and the ways in which knowledge was used by a particular group to undertake an activity or solve a problem. Theoretically a Community of Practice relies on the existence and sharing, by the community or group, of a common goal with the existence and use of knowledge to achieve that goal. The nature and importance of relationships between the people in the community is very important as well as the relationship between the community and those outside it. Also vital is the relationship between the work of the community and the value of the activity. In addition a Community of Practice enables participants to focus their attention on the evolving, continuously renewing relationships between people, their individual actions and their world. This is typical of the theory of social practice suggesting how the whole person develops through the ongoing activity and development of human knowledge following the tradition of social sciences.

Originally Lave and Wenger (1991) proposed that communities emerge in situ, where learners are based in close proximity and are constantly interacting with one another. In contrast with traditional didactic learning, characterised by a hierarchical relationship between expert teacher and student in which the expert teacher imparts knowledge to a group of students, learners in a Community of Practice learn from their fellow community members through informal conversations about their practice or observation of one another's practice. It therefore suggests a more

egalitarian and dynamic set of relationships. Alongside the practices involved in getting the job done, Communities of Practice are contexts for the formation of professional identities among the community's membership. Communities of Practice and the identities that are developing within the communities, reproduce themselves through the practice being passed on to new members when they join a group – a feature explored in detail by Wenger (1998: 98).

Gobbi in le May (2009) suggests the Latin roots of the word community denotes: '*sameness*', '*common or shared by many', 'together' and 'performing services*'. These features certainly resonate with professional practitioners and leaders in person-based occupations, who perform services with and for people, espouse common values, practice and frequently operate in co located or virtual small groups, albeit now in more inter-professional and interdisciplinary ways of working. In these communities professionals share together their professional woes, experiences, hopes, aspirations, achievements and joys in the context of their interactions with each other, their clients, related co workers and the other persons who comprise the wider society. In order to achieve their espoused goal of professional recognition or status accorded by the relevant society, novices are required to enter and participate in these communities whilst achieving any personal goals associated with their intended aims. Also, as Lave and Wenger (1991) noted, what distinguishes some professionals from others is the nature of their relationship with clients. Learning for individuals within their communities may be at different rates which includes a moral dimension, but also depends on traits like courage, discourse and pragmatic knowledge. Developmental progress can be acquired through analysing experiences, individual ability and the interactions occurring within communities of practice.

2.3.3 Legitimate peripheral participation

Lave and Wenger (1991) explored deeper, developing the notion of '*legitimate peripheral participation'* originating from an ongoing reading group on activity theory in 1988. If we view learning like this it means that learning is not merely a condition of membership, but is in itself an evolving form of that membership. The concept of community underlying the notion of legitimate peripheral participation and hence 'knowledge' and its location in

the lived in world, is both crucial and subtle. I was aware that my own research might have the opportunity to pursue this notion because of the relationships between the expert members within the Community of Practice relating to others who might be called novices working across the organisation (Benner 1984). This is how we can describe learning viewed as situated activity, where learners inevitably participate in Communities of Practice and that the mastery of knowledge and skill requires newcomers to move toward full participation in the socio cultural practices of a community. It provides a way to speak about the relations between newcomers (apprentices) and old timers (experts) and about activities, identities, artefacts and communities of knowledge and practice. If we are to conceive identities as long term, living relations between people and their place and participation in Communities of Practice Lave and Wenger (1991) suggest identity, knowing and social membership embrace one another. So a key to success could be through cultivating Communities of Practice in strategic areas in a practical way to manage knowledge as an asset with an ability to influence the wider agenda, just as commercial and public companies manage other critical assets. This would need to include an understanding of how the members of an established Community of Practice relate to each other as well as recognising how newcomers are welcomed and helped to become part of the community. A Community of Practice is a set of relations among persons, activity and world, over time and in relation with other tangential and overlapping Communities of Practice.

2.3.4 Cultivating Communities of Practice

Wenger et al (2002) believed that Communities of Practice are a natural part of organisational life, they can develop and flourish, whether an organisation recognises them or not. Voluntary engagement and the emergence of internal leadership are important and for the process to be dynamic there needs to be an amount of autonomy and informality. Some may argue that Communities of Practice cannot be cultivated but Wenger et al (2002) disagree, suggesting that organisations need to systematically and actively cultivate Communities of Practice both for themselves as well as the individual members. Wenger believes that some Communities of Practice will grow spontaneously whilst others need careful seeding but if

the environment within an organisation values the learning, making time, resources and participation possible their full potential can be realised and contribution recognised as an integral part of organisational development (Wenger 1998). Having said that Wenger later suggested that organisations should not and cannot do anything to cultivate Communities of Practice apart from allow them to elicit participation from interest within. They cannot be managed unilaterally as in traditional organisational structures and need to be mediated by the community's own pursuit of its interest. Although in contrast Gabbay et al (2003) found that they were able to purposefully create and facilitate (albeit they did not follow the conventional model of practice) Communities of Practice within an organisational structure, working on improving specific aspects of health and social care analysing and processing applied knowledge throughout. Influenced by Wenger, Nickols (2003) described self organising and self governing models where group members pursue shared interests through voluntary and informal arrangements suggesting that these can be fragile yet extremely resilient. This can also be the same for sponsored Communities of Practice initiated, chartered and supported by management with an expectation to produce measurable results that benefit the organisation.

2.3.5 Stages of Community of Practice development

Communities of Practice just like any other living thing go through a natural cycle of birth, growth and death, Palloff and Pratt (1999) outline the five stages with respect to the life cycle of community development, forming, norming, storming, performing and adjourning. Storming referred to conflict that is an inherent and necessary part of all workgroup evolution. According to Wenger et al (2002:82) they evolve through five stages of community development: potential, coalescing, maturing, stewardship and transformation, the process is rarely smooth with painful discoveries and tensions. As the Community of Practice develops the key domain issues are defined and scoped alongside identifying people within the community and the key practice and knowledge issues. Again influenced by Wenger, Nickols (2003) also identifies and describes a distinct life cycle that I decided to follow for my own research, which might be long or short, but goes through the following stages of committing, starting up, operating,

winding down and shutting down.

2.3.6 Value and challenges in Communities of Practice

Value is gained by sharing knowledge and working together where members can get immediate help with problems, devise better solutions and make better decisions (Wenger et al 2002). It is possible to take more risks with the support of the community and work across organisational boundaries to address current problems and develop long term strategies for the organisation. Latest ideas and evidence can be used to prepare the way and respond to necessary developments. Some of the benefits are tangible such as confirming competencies and practice standards as well as improving knowledge and skills. Although these provide legitimacy it is also important to remember that there is value in the intangible outcomes such as relationship building, a sense of belonging and the spirit of enquiry generated as well as professional confidence and identity. Successful Communities of Practice deliver value to their members as well as the organisation and Wenger et al (2002:106) suggest that:

'if members do not benefit directly from participation the community will not survive because they will not invest themselves in it.'

Also if the organisation does not see the value of a Community of Practice it will be difficult to justify investing resources to legitimize its voice. The ability to combine the needs of organisations and community members is crucial in the knowledge economy, where companies succeed by fully engaging the creativity of their employees (Wenger 2002:107). The multiple and complex ways in which Communities of Practice deliver value to both members and organisations is the reason they are becoming a central part of the management and leadership agenda.

Challenges can occur when anyone in charge of knowledge resources do not know how to run a broad initiative, and they also need to understand in detail what it takes to start communities and support their leaders. Community coordinators or champions need to understand the developmental stages of communities and the specific actions they can take to help their communities evolve, but they also need to reflect on their work in the context of strategic objectives and organisational transformation (Wenger el al 2002). An understanding of the power dynamics is essential

to the development of a full understanding of knowledge creation and dissemination. Communities of Practice can include members of varying standing in terms of experience, expertise, age, personality and authority with an organisation (Lave and Wenger 1991). Later work (Wenger 1998, 2002, Contu and Willmott 2000) discuss and explore the implications of power and Marshall and Rollinson (2004) suggest negotiation of meaning can be misinterpreted as excessively 'quiescent and consensual' while in reality such activities are plagued by misunderstandings and disagreements. Also without trust there may be a reluctance to share knowledge and whilst this can be complex and problematic Lazaric and Lorenz (1998) argue that trust is identified by behaviour or action, referring to trust about behaviour and decision making as well as mutual understandings in complex situations

2.3.7 Structure of Communities of Practice

This can vary widely as Communities of Practice are as diverse as the people who get involved with them and the situations that bring them into existence (Wenger et al 2002). Therefore they can be big or small, long term or short term, co located or widely distributed, homogenous or heterogeneous, inside or across business or organisational boundaries, spontaneous or intentional and unrecognised to institutional. The various forms can also change over time and move from one end of the spectrum to another.

Despite the variety of forms that Communities of Practice take Wenger et al (2002) describes a basic structure with a unique combination of three fundamental elements:

A *domain* of knowledge, which defines a set of issues

A *community* of people who care about the domain and

A shared *practice* that they are developing to be effective in their domain

The *domain* creates common ground or topic and a sense of common identity. If it is well defined the members and other stakeholders will

legitimize its value and purpose. Understanding the domain will inspire members to contribute and participate as well as guiding their learning and giving meaning to their actions. Knowing the boundaries gives guidance to levels of activity, information sharing and presenting ideas. It also enables potential to be recognised from tentative ideas and realised through participation in the Community of Practice. The important thing is to maintain a shared sense of identity rooted in a shared understanding of the domain. Where there is concern with complex and long standing issues that require sustained learning Davenport and Prusak (1998) suggested that mapping domains and defining their content and scope is an art. When the goals and needs of the organisation link with the passions and aspirations of the participants this forms the basis for a thriving and successful Community of Practice and Wenger et al (2002) explain the importance of passion and personal investment in a domain to spur creativity and to engage the persistent effort that is required to develop expertise or create significant innovations. Wenger et al (2002) provide the following descriptions:

The *community* creates the social fabric of learning, with the opportunity to foster good relationships based on mutual respect and trust. It encourages a willingness to share ideas, learn from each other, ask difficult questions and listen carefully. To experience the mixture of openness and intimacy in a Community of Practice enables the intellectual process to involve the heart as well as the head. The community element is crucial to an effective knowledge structure and it is the group of people who interact, learn together, build relationships and develop a sense of belonging and mutual commitment. To bring the Community of Practice to life the members need to communicate regularly about important issues and there must be some continuity to build relationships, trust and respect over time and create their own identity. Communities can change in structure and characteristics as they grow and vary from being intimate to much larger. The progress of a Community of Practice depends on personal commitment for its effectiveness and although the membership may be self selected or assigned, the actual level of engagement is a personal matter and so could be considered to be voluntary. Internal leadership is important to the success of Community of Practice, although this may be distributed throughout the Community of Practice. Expertise and diversity help to

legitimise leadership and influence internally as well as building external credibility. An element of reciprocity creates a deeper understanding of mutual value that extends over time. An atmosphere of openness which can be unique to that Community of Practice can be used as a firm foundation for collective enquiry, enabling members to speak the truth and ask difficult questions (Wenger et al 2002).

The *practice* involves a set of frameworks, ideas, tools, information, styles, language, stories and documents that are shared by the community. This structure helps the specific knowledge to be developed, shared and maintained by the community (Wenger et al 2002). There is an expectation that members, after a specific time, understand the basics within their frame of reference and contribute to the resources available to enable the community to proceed efficiently within its domain. Practice includes the knowledge, concepts, symbols and analytical methods used by the community within their domain. It is important to share a baseline of common knowledge although this may include specialist knowledge and individual expertise. It can also be complemented by new and inspiring knowledge in the field so that shared practice contributes to innovation quickly and focuses attention on the immediate. Practice identifies a socially defined way of doing things in a specific domain with a set of common approaches and shared standards that enable action, communication, problem solving, performance and accountability. These communal resources include a variety of knowledge types, cases and stories, theories, rules, frameworks, models, principles, tools, experts, articles, lessons learned, best practice and heuristics. These are far reaching from tacit knowledge to less tangible displays of competence and include knowledge bases as well as acceptable behaviour that bind the Community of Practice together (Wenger et al 2002).

How well these elements function together is fundamental to how a Community of Practice assumes responsibility for developing and sharing knowledge. To be effective the collective Community of Practice evolves by organising knowledge in a way that is especially useful to practitioners, with each one having a specific way of making its practice visible through the way it develops and shares knowledge. Some use stories and others documents or articles depending on the best mode for communicating and capturing the knowledge. A Community of Practice must have a collective

understanding of what aspects of the domain are codified and agreeing on standards, frameworks and best practices inevitably involves debate to which all members should commit so that practice can be managed and issues put into perspective

2.3.8 Principles of Communities of Practice

In addition to these three elements Wenger et al (2002:51) highlighted seven design principles necessary for cultivating successful Communities of Practice. These encourage allowing the dynamic nature of the community to evolve by not over directing its evolution but allowing it to emerge by creating a vibrant environment through using both formalized events as well as informal chats and exchanges, to develop trust across its membership and stimulate ideas, which in turn go beyond the immediate boundaries through networking with others outside the organization. Through this various levels of participation can be encouraged through a dialogue between inside and outside perspectives. Alongside this public and private community spaces can develop, focusing on value, combining familiarity and excitement to create a rhythm for the community. Although not a recipe, together they embody how elements of design work together and reveal the thinking behind a design as well as being explicit making the outcome more flexible, improvisational and organic. These principles were taken into consideration during the research design and study.

Having embraced some early ideas and basic facts relating to Communities of Practice I believed there was merit in understanding how one might develop and flourish using storytelling and narrative as one method of collecting the data. By connecting practitioners in this way social capital has already been found in Communities of Practice leading to behavioural change and positively influencing organisational performance as well as the desired step change required in the safety and quality of health care in England and Wales. (Lesser and Storck 2001, Bate and Robert 2002:644).

2.3.9 Summary

The review of literature at first began with the descriptive concepts and ideas behind models of Communities of Practice and took me on a journey to the present day, confirming how the theories and research relating to them have been interpreted and mandated over the last twenty years in a variety of ways by academics, managers and practitioners. Secondly it

enabled my research proposal, developed through me becoming a champion, to focus on observing a group of professional people who shared a passion about a topic (safety and quality) and wanted to deepen their understanding and knowledge by interacting together.

2.4 Narrative and the use of storytelling

2.4.1 Using stories and narrative to re create events

Stories and narrative are the re-creation of events and actions in a symbolic structured way so that the motives of the actors and the morality of the situation can be understood by self and others (Hill 1997). A story describes a sequence of actions and experiences done or undergone by a certain number of people, whether real or imaginary. These people are presented either in situations, that change or as reacting to such change. In turn, these changes reveal hidden aspects of the situation and the people involved, and engender a new predicament which calls for thought, action, or both. This response to the new situation leads the story towards its conclusion (Hill 1997).

Although traditionally storytelling has been viewed as less reliable than narrative it is important in our lives because it performs a great many bridging functions, by connecting the teller to the listener (Seely Brown et al 2004:21). It fires the imagination and can be a creative form of communication between people particularly in large organisations. Although telling a story and listening to it or trying to repeat it can mean subtly different things as we all construct for ourselves a story about what we think we are hearing. According to Greenhalgh and Hurwitz (1998:3) all stories have a finite and longitudinal time sequence that is a beginning, middle and end. But any sequence of events may be told by one narrator to more than one listener and still be true although it may have different viewpoints and interpretation for each person. The analysis provides insight into how a person understands their experience. This element of storytelling was of particular interest to this research as participants would be sharing their stories and experiences from their own specialist roles within the emerging Community of Practice.

Over the last few years sharing stories between leaders and managers from different backgrounds within large organisations has become an extraordinarily valuable lens for understanding and managing large scale, strategic development and change (Seely Brown et al 2004). Seely Brown et al (2004) describe how researchers have found that when people tell stories about others, the motivations are reliability, trust and knowledge. Trust is very important in close working relationships, especially when the story or narrative is about the nature of specific work and how to do it differently or better. It is much easier to talk and understand someone than read a document, find out what the problems are and learn from each other. Storytelling builds trust and unlocks passion and feelings which encourage learning and candid dialogue according to Steve Denning on line (2005). He also writes that telling stories within a Community of Practice can be a safe place where people learn from each other and demonstrate through the experience of knowledge management adding that Communities of Practice only flourish when their members are passionately committed to a common purpose, whatever that might be. Storytelling is non hierarchical, an inherently collaborative way of communicating on equal terms and a useful technique in research for enabling an in depth understanding or what is happening in any given context.

2.4.2 What is added by telling stories?

By their very nature stories are subjective and contextual, connected to previous stories within an unbroken flow of experience over time. Johns (2000) says stories can also be emotional, reflecting intimacy, anguish and joy of human encounter. They can be complex and contradictory, reflecting the complex, indeterminate nature of clinical experience, and do not always have a logical flow, rationality or neat ending, but often raise more questions as various threads extend the stories into unpredictability. The beauty of the story is the way it illuminates the contextual meaning of complex theory in ways that others can sense and feel in the context of their own experience. Johns (2000:14) describes how storytelling:

- *Illuminates subtlety and complexity of caring and theory as a whole from a holistic perspective*
- *Makes visible the nuances and significance of caring within every day practice*

- *Tests the meaningfulness of extant theory within unfolding situations*
- *Invites the listener to relate to the story in terms of their own experience*

Stories provide evidence for any general points and personalise experiences, reinforcing evidence and tell us something about the person, what they feel and how they evaluate and experience the world (Johns 2000:18). The experience is put into a time frame and is chronological, making it much closer to our experience of the world, having a temporal coherence to it. It acts as evidence and gives respondents a voice, encouraging a certain seriousness to the way people construct and support their identity because through their stories people tell us what kind of person they think they are or would like us to think they are! Consequently stories can help to focus on people who are not usually represented or taken seriously. Stories have dramatic and rhetorical force and they are easier to hear, more convincing and persuasive then generalisation which makes them an ideal way of communicating work experiences to share knowledge and learn from each other (Seeley Brown et al 2004).

2.4.3 Sources and functions of stories and narrative

People can simply be encouraged to tell their story through naturally occurring conversations as well as through a variety of interview techniques so texts from a variety of sources can be given to narrative analysis. Gibbs (2009:59) suggests stories are very common and a natural way of conveying experience as well as providing insight into what are important features for people. There are many functions including using personal experience to convey news and information, to meet psychological needs, helping groups to define an issues or make a collective stance towards it, to persuade, to give credibility or a positive image, undertaking a social transmission of an experience and to structure our ideas, establishing and maintaining our identity.

Storytelling comprises an array of tools, each suitable for a different business purpose, as summarised in Table 2.4. Steve Denning on line (2005) says understanding the differences between these patterns is key to the effective use of storytelling, and to avoiding the most frequent mistakes that people in organisations make. It is helpful to be mindful of the various narrative patterns when analysing stories and this research set out to use

stories shared between professional leads to communicate with each other, share knowledge, transmit values, enable collaboration and influence change as identified by Steve Denning on line (2005).

Table 2.4 To show the eight different stories/narrative patterns associated with different purposes identified by Steve Denning (2005)

If your objective is: .	**You will need a story that:**	**In telling it, you will need to:**	**Your story will inspire such phrases as:**
Sparking action (springboard stories)	Describes how a successful change was implemented in the past, but allows listeners to imagine how it might work in their situation.	Avoid excessive detail that will take the audience's mind off its own challenge. .	"Just imagine…" "What if…"
Communicating who you are	Provides audience-engaging drama and reveals some strength or vulnerability from your past.	Provide meaningful details but also make sure the audience has the time and inclination to hear your story.	"I didn't know *that* about him!" "Now I see what she's driving at!"
Transmitting values	Feels familiar to the audience and will prompt discussion about the issues raised by the value being promoted.	Use believable (though perhaps hypothetical) characters and situations, and never forget that the story must be consistent with your own actions	"That's so right!" "Why don't we do that *all* the time!"
Communicating who the firm is - branding	Is usually told by the product or service itself, or by customer word-of-mouth or by a credible third	Be sure that the firm is actually	"Wow!" "I'm going to tell my friends

	party.	delivering on the brand promise.	about this!"
Fostering collaboration . .	Movingly recounts a situation that listeners have also experienced and that prompts them to share their own stories about the topic	Ensure that a set agenda doesn't squelch this swapping of stories—and that you have an action plan ready to tap the energy unleashed by this narrative chain reaction	"That reminds me of the time that I…" "Hey, I've got a story like that."
Taming the grapevine	Highlights, often through the use of gentle humour, some aspect of a rumour that reveals it to be untrue or unreasonable.	Avoid the temptation to be mean spirited— and be sure that the rumour is indeed false!	"No kidding!" "I'd never thought about it like *that* before!"
Sharing knowledge	Focuses on mistakes made and shows, in some detail, how they were corrected, with an explanation of why the solution worked.	Solicit alternative—and possibly better— solutions.	"There but for the grace of God…" "Gosh! We'd better watch out for that in future!"
Leading people into the future	Evokes the future you want to create without providing excessive detail that will only turn out to be wrong.	Be sure of your storytelling skills. (Otherwise, use a story in which the past can serve as a springboard to the future.)	"When do we start?" "Let's do it!"

2.4.4 *Leadership narratives that inspire and enable change*

Steve Denning on line (2005) believes one of the most difficult challenges that leaders face is getting everyone's buy-in to a fundamentally different way of doing things—a new business model, a change in culture, a critical strategic shift. An important part of a leader's job is preparing others for what lies ahead. A story can in principle take listeners from where they are now to where they need to be, by getting them familiar and comfortable with the future in their minds. The pitfall is how difficult it is to craft a credible story about the future when the future is not known. Schwartz (1996) suggests telling a compelling future story is inherently difficult and Denning (2000) agrees crafting the right story is only half the battle saying the most perfectly crafted story will be totally ineffective if it isn't performed convincingly. The non-verbal aspects of performance are critical – the tone of voice, the facial expression and the accompanying gestures. The way a story is told can radically change its emotional tone in the mind of the listener. Kahan (2004) says the first thing leaders need to realise is that their primary goal is to make change happen, not to be seen as a good storyteller. Harris and Barnes (2005) believe that "self-disclosure through storytelling is a powerful method of engaging and inspiring others. As a

respected and admired leader, a story disclosing a failure can have the paradoxical effect of building trust and encouraging openness, if a disclosure is told with humour and confidence dialogue can be stimulated about what you could have done differently and opens the way for others to share their stories. The potential benefit of using stories in a Community of Practice is captured by Seely Brown et al (2004:117) by the Brazilian proverb:

'*when we dream alone, it's just a dream but when we dream together it is the beginning of a new reality*.'

2.4.5 Summary

My reading and analysis identified that using stories to get our messages across is acknowledged as being extremely useful. The technique has been used by practitioners and researchers widely because it performs a great many bridging functions. Listening attentively to other's experiences offers the opportunity to reconstruct, interpret, reflect and analyse particular situations as well as clarifying misunderstandings. This became my chosen method for studying the professional leaders within a Community of Practice.

Chapter 3 The research design

3.1 Introduction

This chapter details the research design used in this study, following an appraisal of various ways of managing the research I decided to use a qualitative approach and techniques to data collection with a case study design. The chapter starts by considering the general context within which the research took place and situating the research within the Practitioner Research paradigm. It then moves on to describe the research approach taken, a qualitative case study, the methods used for data collection and analysis.

3.2 Context

The literature reviewed in the last chapter identified a number of factors that affect the roles and responsibilities of professional leaders and how they might be expected to work together. As explained previously I wanted to further my knowledge of how professional leadership influenced the safety and quality agenda and outcomes of the emerging integrated services of the Trust and Local Authority across which I worked. As described in the

NHS Leadership for Safety Guide (2008:4) organisational boards oversee mission, strategy, executive leadership, quality and safety and should especially guard quality of care; they are expected to fulfil an oversight role in quality assurance, and the continuous improvement of the care provided by the organisation. In the modern view, they bear direct responsibility for the organisational mission to provide the best possible care and avoid harm to patients or service users. This responsibility cannot be delegated to front line clinical staff and service leads but does require experienced collaborative professional leadership to advise and inform the Board ensuring safe and harm-free care to patients they serve. The guide goes onto explain one primary function of senior leaders in health and social care is to support their 'followers' in developing behaviours, skills, habits, processes, and technologies that lead reliably to dramatically improved performance. Once the vision and aims are established there are three key activities of leadership to achieve the vision NHS Leadership for Safety Guide (2008:5):

1. Build will *in the form of visible, constant, unrelenting, and well-explained commitment, starting with the organisation's leaders.*

2. Ensure access to ideas *about the clinical best practices and support processes and insights about how to introduce them, so that the organisation has readily available designs and concepts that are superior to the status quo.*

3. Attend relentlessly to execution. *Integrating improvement actions and review into the daily work of the organisation, and ensuring that better results are sustained, and spread throughout the organisation.*

Expert professional leadership is the catalyst to not only lead the clinical workforce through changes to improve safety and quality of services but should be used to inform and advise the Board (DH 2005).

Following re-organisation of local services, in response to the then government's policy "Commissioning a patient led NHS" (DH 2005), an opportunity arose for a group of professional leaders responsible for leading on the safety and quality agenda to work together. I was a member

of this group and at our first meeting raised the idea of developing a Community of Practice. The group was keen to do this and it was out of this encounter that the research study was born. The Community of Practice of professional leaders became the focus for the research and alongside reviewing the literature (see Chapter 2) I selected case study as the research design best able to answer the following research questions:

1. *How does the Community of Practice enable participants to influence change through professional leadership?*

2. *How do participants use a Community of Practice to share their knowledge and understanding of professional leadership?*

Yin (1993:10) states 'no issue is more important than defining the unit of analysis' but Stake (1995:2) does stress the importance of each case being 'an integrated system' and therefore the case under study in this research was the:

'Professional Leaders interacting within a Community of Practice.'

Later in the chapter I detail the methods used in this research study to explore professional leadership and the usefulness of a Community of Practice model, I discuss how I exposed professional leadership through the stories and case examples generated in and around the workings of the Community of Practice. Finally I wanted to describe the ways in which expertise was shared and knowledge exchanged through the Community of Practice in order to support shifts in services and understand better how the theoretical model of a Community of Practice enabled participants to sustain change in relation to professional leadership.

I systematically excluded other research methodologies in making the decision to use a real world case study design. I had previously used grounded theory and felt it was not appropriate for this research study as my intention was not to generate theory. It was not ethnographic with any intention to infiltrate and describe the people involved or culture in which they operated in detail. Nor was the intention to emphasise attitudes, beliefs or perceptions through a phenomenological approach.

Action research is associated with 'hands on', small scale research projects which impact on practice and so worthy of consideration. Following further thought and understanding I excluded it as although action research is recognised as an opportunity for enhancing knowledge the main focus of my research was not necessarily for the participants to demonstrate an improvement in their practice but instead to share and increase knowledge through participation as well as learning together. My intention was to observe as an insider how professional leaders interacted together whilst not necessarily addressing an acknowledged problem or improvements in practice.

I therefore chose to work in this study as both a professional lead participating in the Community of Practice and a researcher; in order to do this I was guided by the concept of Practitioner Research now commonly used in health care research (Robson 2002). I was aware that as a practitioner researcher I was holding down a full time post in my area of expertise as well as undertaking this enquiry which was relevant to that role.

3.3 Practitioner research

The general aim of practitioner research is to generate new knowledge from practice (Meyer et al. 2006) and involves a formal and systematic attempt by practitioners to develop new understanding in practice (McCormack 2007). Practitioner research originally evolved in education where it has been described as the '*questioning and testing of ideas by classroom research procedures*', and, '*systematic inquiry made public*' (Stenhouse 1975:144). It also includes:

- Critical reflection and systematic study of practice;
- Practitioner control and ownership of research

Noble (2009) suggests these principles can easily be transferred into health and social care research. Practitioner research is closely related to, and draws on, the methodologies of action research described by Kemmis and McTaggart (2005). It also draws on methods from a wider field than action research and allows the undertaking of small-scale research in case

studies, ethnographic studies and for the eclectic use of methods (Campbell et al. 2004). Practitioner research has previously been used to encompass a number of research-based activities undertaken in the fields of practice in health and social care and education. It implies that practitioners will learn from their research into practice, which is not always the case in other forms of research. Practitioner research is also concerned with improving rather than proving as an approach to research (Campbell 2007). It is argued by Groundwater-Smith and Mockler (2006) that in the field of practice-based research, those who carry out practitioner inquiry will ultimately engage with knowledge that is both 'theoretical' and 'practical' moving seamlessly between the two.

Defining practitioner research is not easy. Simply put, it can be described as research carried out by professionals in disciplines such as nursing and social work where the research is conducted on or with individuals who are either receiving care from or working with the investigator in his/her capacity as a service provider or leader (Fox et al. 2008). This aside, Rolfe (2003) makes the salient point that a major difficulty in attempting to understand practitioner research is that many writers cannot seem to concur on what it is or, more importantly, '*what it is for'* (Rolfe 2003: 132). Research is often conceptualised as a straightforward and linear process with a rational and logical plot, but practice-based disciplines such as clinical activity can be complex, context-dependant and not suited to cleanly cut research procedures where everything goes to plan. This study therefore had the following features:

- *It was research carried out by a practitioner in response to a concern.*
- *It aimed to bring about a direct improvement in the issue being researched.*
- *It aimed to contribute to personal knowledge and theory (Rolfe 2001).*

To achieve these aims I managed the research in a systematic manner ensuring that the data were gathered methodically and were organised in such a way as to enable analysis. As it took place, questions that arose during data collection and at analysis were discussed with my supervisor and informed the findings. These questions often arose from the practice activity and concern which sometimes could not be anticipated. Practice

activity therefore often drove the research. Alongside this, observation of the Community of Practice and the context within which the discussion took place, also informed the analysis. There are advantages and disadvantages to being a practitioner researcher (see Table 3.1)

Table 3:1 Advantages and disadvantages of being a practitioner researcher (Robson 2002:447)

Disadvantages	***Advantages***
Time: trying to do a systematic enquiry as well as my full time job	*Insider Opportunities: I had some pre existing knowledge and experience of the people and environment*
Lack of Experience: The design, method and analysis with the biggest challenge being 'not knowing what I didn't know!	*Practitioner Opportunities: Access and implementation was easier*
Lack of Confidence: Working with experienced professional colleagues and wanting the research to be robust	*Synergy: Insights as a practitioner researcher helped the design, implementation and analysis of the study*

Insider challenges: Awareness of any preconceptions, issues and solutions. Potential hierarchy difficulties.	

Accessing the formal training in research methodology as part of the Doctorate in Clinical Practice programme was essential as well as the supervision process which became an important element of my reflection and reflexivity. Alongside acknowledging my own position as practitioner researcher it has been helpful to identify issues relating to existing individual histories and organisational culture that contribute to the interpretation or understanding of developing and sharing knowledge as well as demonstrating the learning. Keeping a reflective diary and recognising the process of reflexivity was essential in order to understand and come to terms with my own frame of reference and pre judgements so that I could make sense of the knowledge generated

3.4 The Design

This research used a case study design underpinned by multiple methods of qualitative data collection techniques. In the research study I set out to observe and explain how people, in professional leadership roles worked and learnt from each other in an emerging Community of Practice and how they shared knowledge through professional leadership when working to the national and local safety and quality agenda. Case study was first advocated by Yin (1994:13) who said it could be a valuable strategy in this type of qualitative research because of the focus on a contemporary phenomenon within real life. Appleton (2002) commented that a review of case study literature indicated a lack of clarity about determining a case and this situation is exacerbated by the fact that 'case studies' have been used in several different ways (Lincoln and Guba 1985). For example Yin (1994) and Stake (1995) regard case study as a research strategy, Lincoln and Guba (1985) view it as a technique for reporting the findings of a naturalistic inquiry, while other researchers have described case studies as evaluation tools (Patton 1990; Yin 1993). Yin (1994:13) regards case study as 'an empirical inquiry that investigates a contemporary phenomena within its real life context, especially when the boundaries between phenomena and context are not clearly evident' and 'in which multiple sources of

evidence are used'. Robson (2002:5) defines the term similarly to Yin (1994) while Stake (1994:237) provides a less specific definition of case study stating that it 'is both the process of learning about the case and the product of our learning'. From these many definitions it can be determined that case study is an intensive analysis in which the inquirer attempts to examine and understand key variables which are important in determining the dynamics of a situation, in order to provide detailed insight into a specific phenomena of interest.

Appleton (2002) writes that faced with the confusing mass of literature and miscellaneous viewpoints two questions appear to be important when attempting to define the nature of a case. Firstly, is the definition of a case really important? Secondly, if it is, what is its purpose? The literature appears to suggest that in fact anything can be considered a case as long as the researcher depicts it clearly. Quite simply it is the phenomenon of interest and the context that constitutes the case, but faced with many complexities it becomes a complex issue. The important thing is to clarify how the case will inform data collection and lead to an understanding of the phenomena of interest.

A constructivist approach to inquiry was therefore adopted. Firstly, Lincoln and Guba (1985:39) suggest that constructivists believe 'realities are wholes which cannot be understood in isolation from their contexts' and therefore appropriate for examining the concept of professional leadership within the Community of Practice, including the potential influence of multiple interacting factors which may be operating. Secondly the belief that context is an important element in determining the applicability of research findings, thirdly the fact that values are an intrinsic part of contexts and can determine research findings and fourthly 'the belief in complex mutual shaping rather than linear causation, which suggest that the phenomenon must be studied in its full scale influence (force) field' (Lincoln and Guba 1985:39)

Further to the discussion about case study boundaries it was important to recognise that 'boundary' can either depict the actual nature and periphery of the case in 'how it might be constrained in terms of time, events and processes' (Creswell 1998:64) or alternatively the term can be used to describe the blurred edges between the phenomenon of interest and its

natural study context (Stake 1995). In contrast Yin (1994:13) uses the term 'boundaries' to describe the sometimes indistinguishable links between the object of interest and study context, rather than the limits of the case. The intensity of case study research is reflected in the need for the researcher to focus in depth on one issue 'on understanding the case itself' (Stake 1994:8). It is only through this immersion in the research setting, that a researcher is able to unearth the intricacies and subtleties of the case.

3.4.1 Type of case study

As there are two main protagonists of case study I found it useful to refer to different types of case study associated with the perspectives of Yin (1993,1994) and Stake (1994,1995) (Table 3.2). Yin (1993) defined case study research as descriptive, exploratory or explanatory while Stake (1994, 1995) describes three different types of case study design as intrinsic, instrumental or collective. For the purposes of this research in which I was attempting to capture some of the issues and complexities around the influence of professional leaders in 'real life' contexts, I regarded this case study as 'instrumental' in design because I was trying to further knowledge and understanding of how professional leaders worked together in the Community of Practice, rather than focusing on individuals themselves - therefore I adopted Stake's approach.

3.4.2 Defining the case study

As previously mentioned my initial ideas developed from the professional leaders working to the safety and quality agenda through which the 'case' to be studied was defined as –

Professional Leaders interacting within a Community of Practice.

The findings from preliminary research work and the general literature review indicated that professional leaders may be influenced by multiple interacting contextual factors which included:

- *National political policy*
- *the historic and present PCT environment*
- *NHS and Local Authority procedural directives*

- *the Strategic Health Authority*
- *authority, power and control*
- *professional leadership and practice*
- *operational management*
- *implementing evidence based practice*
- *individual attitudes and behaviour*
- *learning and knowledge management*.

These influencing factors were therefore taken into consideration during the research process.

3.4.3 Rationale for the method

The case study design was a useful technique when I knew little about the issue and I intended to undertake an intensive and detailed examination of a contemporary issue within a real life setting using multiple data sources to elicit greater understanding about the case. I could have adopted either Yin (1993, 1994) or Stake's (1995) method of case study as the preferred strategy for both emphasise the importance of studying phenomena in their natural and uncontrolled environments, where multiple data sources are used and the focus is of an indepth understanding of the whole. Yin (1994:1) outlined a number of factors that needed to be considered as well as the preferred approach when 'how' and 'why' questions are being considered, alongside fairly prescriptive guidance for any researcher embarking on a case study investigation but I needed to adopt an approach consistent with the constructivist assumptions of the research. Stake (1995) offered a more philosophical, less directional, qualitative approach to seeking out the complexities of a case with an opportunity to learn (Stake 1994:243). Stake's (1995:99) approach to case study is closely influenced by a constructivist epistemology believing that knowledge is constucted rather than discovered. Although this raised possible issues of external and internal validity due to the exclusivity of the research context I would argue that these quality criteria are not always a suitable measure in a constructivist inquiry. I decided that Stake's case study strategy best fitted this research because:

- *Of the need to adopt qualitative methods to establish meaning and portray multiple viewpoints*

- *Commitment to use data triangulation to gather more complete data about the case and clarify different meanings*
- *Recognising the skills and adaptibility of the researcher through intuitive processing to search for meaning*
- *Offering a framework for sampling cases to help structure the organisation and analysis of the data*

Stake (1995:77) says

'I seek to make sense of certain observations of the case by watching as closely as I can and thinking about it as deeply as I can. It is greatly subjective', and stresses the importance of the researcher needing to spend long periods of time in case study sites

'personally in contact with activities and operations of the case, reflecting and revising meanings of what is going on'

Table 3.2 Case Study: A comparison of the perspectives of Robert Yin and Robert Stake

Comparative elements of case study	**Yin**	**Stake**
Definition of a case	*A case is a contemporary single unity, phenomena or issue of study. An object of study, sometimes referred to as a unit of analysis (Yin 1993:10)*	*A case is an object of study. 'The case is a specific, a complex, functioning thing…each case 'is an integrated system' and 'has a boundary and working parts' (Stake 1995:2)*
Types of case study design	*The case study design can be single (either holistic or embedded) or multiple, as well as descriptive, exploratory or explanatory (Yin 1993)*	*Three types of case study design: intrinsic, instrumental or collective case study (Stake 1994, 1995)*

Rationale for the method	*Suitable for the study of:* *'How' and 'why' questions* *Focus is contemporary issue(s) or unit(s)* *In real life settings* *Where no researcher control* *Using multiple sources of data* *For qualitative and quantitative approaches*	*Suitable for the study of:* *Contemporary issue(s) or unit(s)* *In real life settings* *Where no researcher control* *Using multiple sources of data* *Focusing on qualitative data* *To construct an in depth understanding of a single case/issue or multiple cases*
Paradigmatic orientation	*Positivism and post positivism*	*Interpretivism -Constructivism*
Sampling approach	*Replication logic. Potential for literal replication or theoretical replication*	*Purposive sampling*
Use/location of theory	*Case study should ideally be guided by theoretical propositions* *Through the use of 'analytical generalisation' case study results may be generalised to an existing theory*	*Theory may emerge through the case study, but there is no insistence on theory development*
Time	*A great deal of time needed for the intensive and detailed study of the case*	*A great deal of time needed for the intensive and detailed study of the case*

(Summarised from; Yin 1993, 1994; Stake 1994,1995)

3.4.4 Constructing the Community of Practice

As previously stated this study began when a group of professional leaders working to lead the implementation and oversight of the safety and quality agenda within integrated community services, began initially to meet together every two weeks before this became every four weeks. This group of six emerged as the professional leadership structure formed within an integrating health and social care service provider directorate from within a geographically large and demographically varied primary care trust and local authority. Not everyone came with a recognised 'clinical' qualification but each came with a sound knowledge and background from within their own sphere of expertise which included experience in general practice,

mental health services, adult and children's acute and community services, professional bodies, strategic health authorities, private companies and national exposure. Some of the leaders had been recruited through a rigorous provider interview and assessment process, whilst others had transferred from the commissioning arm of the organisation. Another came from an acute hospital via a circuitous route. None of them knew each other to work with closely, only by reputation reflecting their style, personality, experience, skill and knowledge. The one common thread which united them and their teams was the need to work together focusing on the patient safety and quality agenda. I was one of these leaders and encouraged the group to consider forming a Community of Practice at our first meeting. They agreed, taking ownership of the concept and constructing themselves as a Community of Practice to identify priority tasks to focus on using their skill, knowledge and experience as professional leaders within safety and quality of the integrated services. Following my original reading of Lave and Wenger(1991) which informed Nickols' later interpretation I shared my understanding of Communities of Practice with colleagues, particularly demonstrating the life cycle as described by Nickols (2003).

I also developed the start up process (Table 3.3) with the professional leaders (Nickols 2003) what the expectation might be, so that everyone had an understanding of how the Community of Practice might develop.

Table 3.3 A view of a start up process

Preliminaries	***Start – Up***	***Behaviours & Activities***	***Shut Down***
Identify the champion and the sponsor *Pick a focal point e.g. problem, practice area, process* *Prepare a business*	*Set the agenda e.g. issues/interests, problems, goals/outcomes* *Devise modes of interaction e.g.*	*Share experiences and know how* *Discuss common issues and*	*A shut down decision may be made by the Community of Practice members or by sponsoring*

case *Present a proposal e.g. value/benefits, sponsorship/support, interactions, outcomes* *Select/enlist members* *Get organised*	*email, face to face, virtual, teleconferencing, video* *Confirm and secure support e.g. technology,, resources* *Get underway*	*interests* *Collaborate in solving problems* *Analyse causes and contributory factors* *Experiment with new ideas and novel approaches* *Capture/codify new know-how* *Learning*	*management if a sponsored Community of Practice*

Once agreed and constructed the workings of the Community of Practice were recorded as notes at every meeting by one of the participants who took on the role of note-taker. At the same time I observed and recorded in field notes as a practitioner researcher; as well as audio recording each meeting. Details of these methods of data collection are given in section 3.6. The data were then used in two ways; firstly, all the notes were used as a way through which I began to study the professional leads and the way they used the Community of Practice to expose what they did in their work influencing the quality and safety agenda and secondly how the Community of Practice operated and developed its workings. Techniques for analysis are found in section 3.7.The Community of Practice met seventeen (fifteen recordings) times between November 2009 and March 2011.

3.4.5 The professional leaders

The six professional leaders (Table 3.4) were initially asked to participate in the project by a letter and explanation of the research (Appendix 2) which was followed up by a formal consent procedure (Appendices 3 and 4). A participant information sheet (Appendix 5) was shared with each member during the construction of the Community of Practice. All six participants chose to take part at the beginning of the study.

Table 3.4 Individual roles in relation to professional leadership within the organisation

Community of Practice Member	***Role in relation to Professional Leadership***
SN1	*Senior Nurse 1(RN) – overall accountability and responsibility with board level responsibility*
SN2	*Senior Nurse 2 –(RN,RMN) deputy, adult and mental*

	health services
CS	*Childrens Services (Health Visitor) – multi agency, integrated children and young people services between health, social care and education 0-19 years*
OT	*Allied health professional Occupational Therapist – role of head of all community therapies*
SW	*Social Worker – integrated adult and mental health services*
CG	*Clinical Governance – with corporate responsibility for health care governance*

3.5 Ethics

Before any data collection took place I considered access and ethical issues. Access to the Community of Practice was through the Director of Health and Social Care and their consent obtained following local and central ethical approval before the project began. In preparation for ethical approval a research protocol was designed, participant information sheets prepared and consent forms agreed. In order to achieve individual consent I gained the co-operation of the professional team within the potential Community of Practice. The project was recognised as a genuine study and did not involve any covert observations. In view of this anonymity has been maintained and identities obscured because the material produced could have been seen to demonstrate various attitudes, comments or demeanour. Ethical approval was granted following a rather challenging process by a very medical ethics committee as well as the University of Southampton (Appendices 6 and 7). The professional practice leadership naturally became the participants as described earlier.

All data have been stored securely during the research in accordance with the Data Protection Act (2003). Confidentiality has been maintained by not divulging information to other personnel, but there has always been the possibility of inappropriate practice being identified during the research

process of observation and analysis. Any registered nurse or allied health professional is bound by their code of conduct through their professional organisations to disclose this and this has guided my own practise as a practitioner researcher. No such practices have occurred.

3.6 Methods of data collection

Several methods of data collection (audio-tape recording, using participant observation, analysing meeting notes, the documentation of fieldwork notes and a reflective diary and conducting semi-structured interviews) were used in this study. Seventeen, two-hour long, pre-arranged Community of Practice meetings were observed by me in the role of participant observer as well as notes of each meeting taken. My observations resulted in the

construction of fieldwork notes of the stories, dialogue and interactions occurring in the Community of Practice. Feedback on the experience was also collected after the Community of Practice had shut down; through informal discussion and semi-structured interviews between myself and the other group members. I anticipated that the feedback would give a better understanding of what the participants' experiences of working together as professional leaders were like. Using the semi-structured interviews with each participant allowed me to explore whether or not the participants believed that using the emerging Community of Practice contributed to their knowledge generation, learning and sharing within the field of professional leadership as well as safety and quality. Writing my reflections of the day-to-day research process in a diary allowed me to be reflexive and generate an audit trail of the data collection and analysis processes which will be described later in this chapter.

Each of the data collection methods is addressed in more details below.

Table 3.5 shows the sequencing of the meetings and data collection.

Table 3.5 Sequencing of the Community of Practice meetings and discursive interviews

Recording and observing the CoP meetings and story board	***Semi structured Interviews***
November 2009 – March 2011	*July 2011- August 2011*

3.6.1 Recording the Community of Practice meetings

Audio-tape recordings were made of the content of fifteen of the seventeen Community of Practice meetings. These were transcribed. A self-appointed (but different member each time) note-taker took notes of all the meetings and these were used to confirm/supplement the audio-taped data of the meetings. Additionally, I observed and recorded in fieldwork notes each of the meetings. I was present at all of the meetings acting as a practitioner,

participant observer.

3.6.1.1 Participant observation

Participant observation, although unstructured, provided another opportunity for data collection as I had ready access to the meetings that might otherwise have been inaccessible. The other distinctive benefit was that I was able to perceive reality from an insider's viewpoint as a Community of Practice member and professional lead and I believe this was invaluable in portraying an accurate picture of the case study phenomena because it adds to the ability of being an active investigator. Apart from the potential for bias (Becker 1991) the participant observer can be seen to be a supporter or advocate for the phenomena being studied. However, several disadvantages did arise in terms of accurate recording of detail as there was not sufficient time to take notes or raise questions from a different perspective as a non-participant observer might. Therefore the primary method of data collection is the use of audio-tape recording which provided a complete record of the Community of Practice meetings making participation easier and more accurate data generation.

Yin (2003) suggests that the main strength of participant observation is in its ability to capture reality and context and generate full insights into interpersonal behaviour and motives. Participant observation helped me to understand how knowledge was generated from within this group (Spradley 1980). Having an insider's view created a different species of knowledge from one of just looking in from the outside. This intangible understanding was of fundamental importance because we all use it constantly to generate behaviour and interpret our experiences. To inquire about the meaning of behaviour raises the research to another level and Spradley (1980) describes dimensions such as feelings and emotions in particular contexts, what 'actors' are attempting to accomplish, specific individual actions and how people physically position them selves on particular occasions to support the depth of potential interpretation.

3.6.1.2 The field notes and reflective diary

I maintained my research diary, containing field notes and personal reflections of each Community of Practice in which I recorded my observations and thoughts. These field notes helped me to reflect on what

occurred over the period of the research and assisted in structuring the data. The diary was used to inform my thinking and analysis of the data rather than being used as a source of evidence. It contained data obtained by observation and via conversations with colleagues. Within this diary I also maintained reflexive notes on my role as a practitioner researcher and participant observer. I also recorded notes on the research process documenting the decisions I made along the way. This was undertaken not only to collect research data but in an attempt to understand and resolve problems as they arose with the aim of systematically improving practice (Rolfe 2001). Entries in my diary were accompanied by the date of the event and contextual information such as the time, location, participants and anything which might be important to the research. This helped me to recall and write about experiences that occurred at a specific period of time for example after a particularly challenging meeting. Sometimes I wrote descriptive sequences containing accounts of specific activities, descriptions of events and portraits of individuals. At other times I wrote interpretations, feelings, speculations, hunches and explanations of events. The substantive field notes were the descriptive record of observed events and conversations.

3.6.1.3 The development and use of the story board

A story board was developed for the duration of the research where individuals added their thoughts, ideas, comments and anecdotes on a private secure drive (Seely Brown et al 2004). This was an adjunct to the Community of Practice and allowed participants to communicate between meetings.

3.6.2 Reflexivity

In the literature, reflexivity is used in different ways which typically draws attention to the complex relationship between the production of knowledge and the range of contexts of such processes as well as the involvement of the knowledge producer (Alvesson and Sköldberg 2000). Reflexivity involves paying attention to how one thinks about thinking. Alvesson and

Sköldberg (2000) suggest that serious attention be paid to the weaving of specific linguistic, social, political and theoretical elements in the process of knowledge development, during which time empirical material is constructed, interpreted and described. Reflexivity is linked with the researcher's self-awareness and how it impacts and transforms the research they undertake. Noble (2009) suggests that a way of ensuring a sustained 'critical gaze' throughout any research process is by maintaining reflexive field notes or a diary journal. This aids the construction, collection and interpretation of data. For this purpose, I kept reflexive field notes (Kingdon 2005) extracts of which are discussed within the findings of this research. My reflexive field notes impacted on the research as I continued to participate in the Community of Practice. Examples of this are both in the Community of Practice recordings as well as the individual discussion interviews afterwards. To begin with, as I audio recorded and then listened to the Community of Practice recordings, I quickly recognised with the help of my supervisor that my interactions within the Community of Practice were both reflecting my practitioner researcher role as well as my professional leadership role. Later the discussion interviews focused on my colleagues' views of how the experience of being in the Community of Practice had felt for them and how it had enabled them in their leadership roles to influence the quality and safety agenda. For example; an extract from my early field notes describes this: I talked with Andreé my supervisor after she had read one of the transcripts. She pointed out how interesting it was that we were focusing on the clinical detail of the story being discussed and how that was being managed. How the members of the Community of Practice had responded to a particularly sensitive situation and not benefitted from the opportunity to explore the reason for it. I hadn't noticed this myself. I read the transcript again and realised she was right. My aim then was to review the way the Community of Practice participants could gain a more measured view of how they interacted, knowledge was generated and learning shared through the professional leaders. Supervision for the study, aimed to identify how new knowledge gained from within the Community of Practice was generated through professional leaders. Regular discussions were used to sensitively but rigorously examine my progress through the research process and to acknowledge the possible impact that my personal experiences might have on the

direction of the research.

3.6.3 The semi-structured interviews

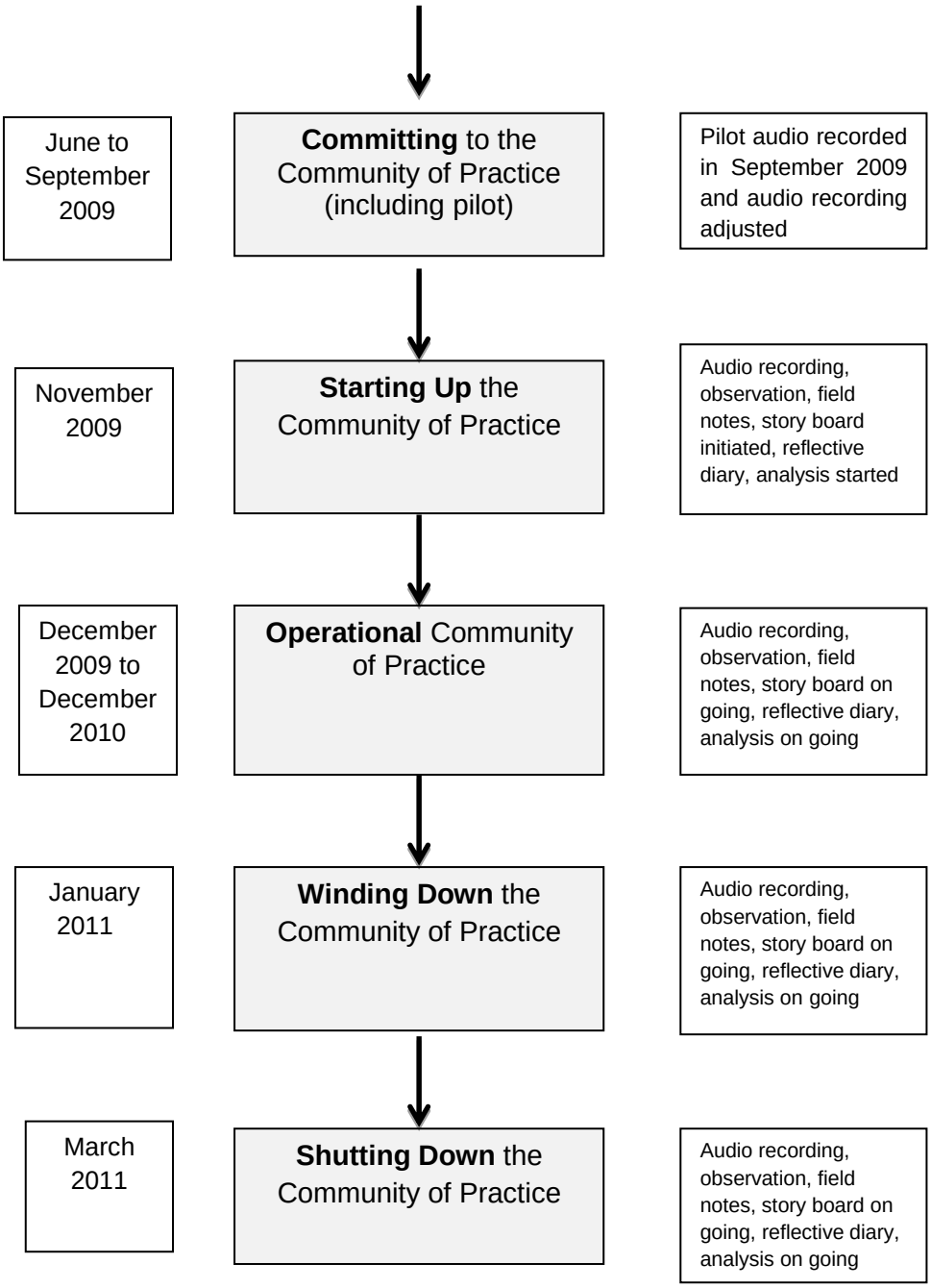
Each participant was asked to participate in a semi structured interview for between 20-40 minutes and asked to reflect on the Community of Practice meetings, their role within the group and the role of the other members. They were also invited to share any views about the benefits and challenges of the Community of Practice from their perspective, as well as explore issues such as knowledge brought to the group, how that knowledge and learning was incorporated into their own tasks and the types of knowledge valued and rejected by the participants. I used a simple guide for the discussion which was based on an opening question: How has being part of the 'Community of Practice' helped you to manage your leadership role, share knowledge and learn from each other?

3.6.4 Piloting the data collection methods

The data collection methods were piloted (September 2009) in order to try out and develop the process and my own skills. I audio recorded one of the first discussion meetings and transcribed it. Insights were to emerge following this preliminary work, transcription and analysis which influenced the future sampling selection for the main study when I decided to record each Community of Practice irrespective of everyone attending but eventually made a decision to only use the recordings of those meetings where a quorum of four members were present. The pilot work also served as a means to acknowledge and test the effect of the recording and myself as a practitioner researcher on participants within the emerging Community of Practice.

Diagram 3.1 To demonstrate the construction and process of the Community of Practice (CoP)

Dates	*Details*	*Data Collection & Analysis*
April to June 2009	Initial discussions, ethical and organisational approval	Diary notes



3.7 Methods of data analysis

The qualitative data were analysed to create a description of the emerging Community of Practice and its workings from the audio taped stories, the meeting notes, my field notes, the semi structured interview results.

The data were analysed with two things in mind:

1. Detail on the process and benefits of the emerging **Community of Practice** by collecting participant observations throughout the twelve meetings.
2. Descriptions of **professional leadership** activity, learning, development and sustainability

Following completion of the audio-tape recording of each Community of Practice meeting, the data were transcribed and analysed. Transcripts were read, re-read and notes made of each transcript. This took the form of interpreting meaning from the data in an attempt to identify common and developing features at a descriptive level and make some sense and meaning of the reality of each encounter (Gibbs 2009 : 42). It became clear at an early stage that the stories were being used within the Community of Practice to communicate as individuals, transmit values, collaborate by sharing and explaining experiences and knowledge to develop professional leadership and contribute towards leading and managing change.

Each stage of the analysis is described for convenience below although analysis of the audio recorded data was an iterative process (Silverman 2000).

Stage 1 Listening and coding

My first analytical step, before coding, involved listening to each meeting via the tape recording in order to check for clarity and to take in the sense of the whole meeting. Listening to the transcripts in their entirety helped to provide clear meaning and continuity of the stories and conversation during each meeting as a whole and in context. This offered a way of becoming familiarised with the data and served to develop insight and sensitivity into understanding what was going on (Miles and Huberman 1994).

I then transcribed the tape-recorded meetings in full and verbatim. Every transcript page was labelled with the code of the meeting and page numbers so that pages were easily identifiable (Miles and Huberman 1994) My intention was to become immersed in the data as I read and reread the transcripts (Silverman 2000). This gave me an opportunity to interact, in a relatively informal way with the data. The initial coding of transcripts involved assigning unique labels to stories and text passages which

referred to particular categories of information (Miles and Huberman 1994:.56). This helped with data reduction (Miles and Huberman 1994). The codes brought together selected data and help in the identification of emerging features. First-level coding is the process of naming and classifying data and results in a working set of codes but Miles and Huberman suggest they can also be interpretative. The codes (features) were developed from the initial research questions. Occasionally, multiple codes were developed for single stories, narratives, anecdotes and segments of text. A constant search for emerging features took place as coding was carried out and memos were documented along the way in my research diary. As the analysis was conducted, discrete incidents/events/ideas were noted in my diary. A process was undertaken to develop 'categories' 'or concepts' within the stories and narrative, which were initially provisional but with the aim of moving from coding to interpretation, as discussed by Coffey and Atkinson (1986:69):

'*The move from coding to interpretation is a crucial one…Interpretation involves the transcendence of factual data and cautious analysis of what is to be made of them.'*

Stage 2 Comparing; corroborating and categorising

The next stage of my analysis was to compare the information recorded by the note taker at each of the Communities of Practice with the transcripts and my own brief field notes. The field notes contained observations, methodological and theoretical ideas as well as personal reflections. I have already acknowledged my role as a participant observer and this involvement was inevitably recognised in my analysis and interpretation. This stage involved recoding passages of text that really told a story through identifying and noting those sections that exemplified and corroborated the same thing (Gibbs 2009 : 50). This second-level or pattern-categorising was a meta categorising process (Miles and Huberman 1994) where explanatory or inferential categories identified an emerging feature or explanation. A field note written during this second-level categorising stage offered an example of how this took place. After initial coding of several meetings I had various categories identified e.g. learning, partnership, accountability.

Stage 3 Selecting stories

Storytelling is one of the ways that people organise their understanding of the world by making sense to themselves of their past experience as they share that experience with others (Seely Brown et al 2004). So the careful analysis of topics, content, style, context and the telling of the story revealed an individual's understanding of the meanings of key events or experiences in their life or communities and the cultural context in which they engaged and worked. By analysing stories we can examine the rhetorical devices, otherwise understood as eliciting meaning from the narrative, that people use and the way they represent and contextualise their experience and personal knowledge.

Stage 4 Reflecting, interpreting and reporting

As the analysis took place I recorded in my diary the steps in the analysis process and thoughts about the relationships and features in the data. These were also influenced by what I had observed and noted through field notes. Every stage of this process of data analysis required careful judgement and decision-making on my part but it was my interpretation of the data that made it possible to describe the emerging Community of Practice. This included the workings, reporting how the features of professional leadership were exposed as the participants collaborated and learnt together, engaging in the safety and quality agenda and assurance mechanisms. Others immersed in similar data might have decided on different interpretations, descriptions and findings, depending on decisions they made during the data analysis, but this would not make these findings any less valuable. After the Community of Practice had shut down, I was able to review and revise my interpretations by analysing the discussions during the semi structured interviews.

3.8 Establishing trustworthiness

In order to enhance the trustworthiness of this research study, a number of practices were adhered to starting with a detailed description given in this design chapter of the type of case study used to construct and create the Community of Practice. I also identified how participants have been fairly managed within an ethical framework to ensure that they were not

endangered in any way. Alongside detailing the multiple methods of data collection described in detail the impact I may have had on the research (Miles and Huberman 1994). There was an opportunity to share and check out my ‘interpretation’ of some of the stories with members of the Community of Practice throughout the time of the research.

The analysis has enabled me to create a description of the Community of Practice and its workings from the audio recordings, my field notes, the meeting records and the discursive interviews which is described in the following chapter.

3.9 Summary

Chapter 3 has set the context for the research as well as describing my decision making for the case study design and methodology. I have explained why I used practitioner research in addition to participant observation within the case study design. Finally I have described the method and process of data analysis.

Chapter 4: A description of the Community of Practice

4.1 Introduction and creating the Community of Practice

Communities of Practice come into being in many ways such as spontaneous, mandated or facilitated. This Community of Practice was constructed by participants as equal partners with myself as champion, the activity was self generated under the auspices of safety and quality assurance. The professional leaders chose not to have a leader and be self

governing raising issues as they developed and used a combination of informality, passion and structure. Discussions were varied over the period of the Community of Practice focusing on generating new knowledge and learning. They focused on relevant and significant issues at the time which were identified through agenda setting at the beginning of each Community of Practice meeting. They included incident reporting and learning from incidents, operational decision making, opportunities for innovation and change, the role of and relationship between professional leaders, policy interpretation and workforce development.

Chapter 4 shows the creation, construction and progress of the Community of Practice through the pragmatic stages described by Nickols (2003):

- Committing
- Starting up
- Operating
- Winding down
- Shutting down

4.2 Committing to the Community of Practice (June to September 2009)

The Community of Practice was constructed and came into being at the same time as unprecedented major organisational redesign occurred. This redesign placed a national emphasis and focus on safety and quality assurance through statutory duties of commissioning organisations to monitor clinical quality outcomes through contracts (DH 2005). Therefore professional leaders were in the spotlight, pressured and with responsibility placed upon them through the need to evidence clinical quality of care identified within three domains in Lord Darzi's (2009) High Quality Care for all. These domains were Safety- 'will I be OK?' Effectiveness - 'will it do me any good?' and Experience - 'will I be cared for?'

The professional leaders for each service had not worked closely together before and came from a variety of different professional backgrounds and career experiences, but found themselves in a relatively small pod of an

open plan office sharing hot desks and being honest and aware enough to express their feelings of being overwhelmed with the task ahead. The two most senior and influential members for adult services included an executive nurse with acute orthopaedic hospital and executive board level experience (SN1), and another senior nurse with a background in adult mental health, adult community services and previous experience with the Royal College of Nursing (SN2). They were joined by an allied health professional lead for adult services, from an occupational therapy professional background who had worked mainly for the local authority (OT), myself as a nurse, midwife, health visitor professionally leading children's services (CS), a social worker in a leadership role from adult community care (SW) and a previous general practice manager employed in a senior health care governance and compliance role (CG). We had all mainly been appointed by the Community Services Executive Board following a robust interview and selection process or been redeployed from commissioning or other organisations.

As we began working together identifying our individual practice areas and associated problems discussing the importance of communicating and shared learning, it became apparent that many of the issues we encountered were relevant to each other and could be applied across all services. I was interested in the espoused benefits of and further researching Communities of Practice in a local setting, and began to discuss the principles and philosophy behind Communities of Practice and the opportunities available if we were to develop as a Community of Practice. There was a general consensus that this was an opportunity and I became the champion when a proposal to form a Community of Practice was agreed and presented to the Senior Management Team who were initially sceptical. The presentation demonstrated the potential value and benefits of collective expertise working in this way, how the methodology could be sponsored and supported as well as how the participants needed to interact with each other also acknowledging the possible positive outcomes for the organisation. The Senior Management Team underwrote their approval. The model was shared and explained by me at the same time as the application for organisational and ethical approval was made to research the process, followed by requesting participant involvement and consent. As the champion I particularly wanted to use a Community of

Practice model as a different way of working together, to encourage and enable everyone to feel empowered, innovative, dynamic, creative and equal. Following initial explanations and preparations the participants agreed readily to the research process alongside the everyday practical approach to the Community of Practice.

I undertook a pilot during September 2009, by audio recording and taking observation field notes from one meeting. This provided the opportunity to review the audio recording technique as well as the observations and make them less intrusive without losing the quality of the data.

4.3 Starting up the Community of Practice (November 2009)

The Community of Practice was constructed with my self continuing as champion, the activity was self generated under the auspices of safety and quality assurance but the participants chose to be self governing and used a combination of informality, passion and structure. This was the opportunity to develop ways of solving problems, as previously stated, recognising and following the theory of Communities of Practice espoused by Wenger et al (2002) and using the process life cycle based on Nickols (2003). Communities of Practice have always been promoted as vehicles for bringing together interest, expertise through relevant stakeholders to achieve an agreed task whilst drawing on a range of resources and sources of knowledge. It was acknowledged that Communities of Practice are only one approach for single or inter-agency working in which several professionals can be involved in different types of care but can collaborate in service design, delivery and change recognising the challenges along the way (see Chapter 2 page 38). Following ethical and organisational approval the individual participants discussed how a Community of Practice worked and individually consented to identify their own roles and be part of the research. Alongside this, practical arrangements were made to meet monthly, early on Friday mornings for two hours, a regular room booking made and breakfast treats organised. This newly created group of experienced professional leaders working across integrated health and social care soon developed a spontaneous and genuine learning environment. They realised the need to meet and work together identifying the benefits of a Community of Practice model (see Chapter 2 page 38) supported and encouraged by myself. An identity was created around a

common safety and quality assurance agenda as well as an area of learning with the opportunity to develop and demonstrate innovative ideas and evidence based practice within an overarching domain of integrated corporate and clinical governance. Corporate governance was defined and understood as the requirement and accountability for assuring and maintaining the organisational reputation whilst clinical governance was described in terms of practitioners using evidence based knowledge to deliver safe, effective best practice and provide high quality care for all service users in line with the expectation of the Darzi (2009) features. This overarching safety and quality agenda was wide ranging and included productivity, efficiency, safety and quality within the integrated health and social care provider services through the professional leadership structure. In the first instance the participants discussed the importance of meeting regularly to share experiences and information to help them develop their roles in the most proactive and evidence based way possible.

4.4 Operating the Community of Practice (December 2009 to December 2010)

The participants developed a definition at the beginning of their journey, through discussion and reflection of what professional leadership meant to them in their current role. This was underpinned by a feeling of sameness and association as well as a sense of trust and commitment built on their understanding of individual and collective vision and values, skills and knowledge as well as personal qualities and relationships. This definition focused on the following components:

- *Professional means maintaining levels of practice that reflect the quality of professional expertise and high standards of service outcomes.*
- *Effective leadership is a key ingredient in modernising today's services and is essential to focus and motivate a group/team, by co-ordinating and influencing quality health care activity to enable them to achieve their aims.*
- *Professional leadership is accountable and responsible for clinical activity outcomes for a group/team as a whole, and provides*

continuity and momentum in developing, implementing and sustaining high quality clinical services.

- *Professional leadership is flexible in allowing change of direction within the confines of overall objectives, ensuring staff engagement in consultation and proposed change.*
- *Professional leadership offers strong and effective leadership, collaborating with operational managers in the delivery of high quality, evidence based and safe clinical services, promoting and meeting the set standards of professional practice.*

This definition was used initially as a basis to think about the impact and influence of professional leaders and as you will see discussions were ongoing (see section 4.4.2 page 84), particularly in relation to the safety and quality agenda. We also discussed how the emerging Community of Practice could enable us to bring collective expertise together, sharing knowledge, solving problems, building skills and improving practice and learning through building relationships and acknowledging expertise within health and social care. The intention was always for this expertise and shared learning to be taken forward and implemented into front line safety and quality practice. In the event the Community of Practice became known as PPAG (professional practice and governance) reflecting its core emphasis on safety and quality. The title became acknowledged and accepted by clinical staff as well as operational and strategic managers who became aware and supportive of the activity.

The findings of the research show how the Community of Practice enabled National Health Service and Local Authority employees (clinicians, managers and allied health and social care professionals) to develop together, achieving more integrated approaches to work with the opportunity to understand how different professions lead and undertake their individual roles, and how this was hindered by the cultural differences between professionals within the organisation (See Box 4.1 as an example).

Box 4.1 An example illustrating how NHS and Local Authority Community of Practice members used the Community of Practice to explore cultural differences.

SN1 said

I went to work in an organisation once where they didn't have their basic induction or ongoing training sorted at all through workforce. There is certain statutory and mandatory training that NHS employees must attend such as risk health and safety, information governance, infection prevention control etc. We must make a decision on how we're going to take this forward so that everyone has to attend.

SW replied:

I just don't see how you can do that when Local Authority employees do not have to attend stat/mandatory training, we can't make them attend but it would be good if we could encourage the staff do undertake some joint training.

This example demonstrates one of the first cultural differences in the way new staff were not only inducted into services but also how basic training was implemented, delivered, monitored and evaluated. The outcome of this discussion led to the development of a statutory and mandatory training matrix and implemented across integrated services.

The findings also illustrate ways the participant professional leaders shared their individual knowledge and experiences through storytelling, anecdotes and narrative within the Community of Practice. They also show the context of the stories, narrative and anecdotes relating to everyday situations brought to the Community of Practice, during the duration of the research, and demonstrate the variety and complexity of services being delivered in partnership with other organisations.

The following section describes how members of the Community of Practice shared knowledge and solved problems through a variety of techniques:

- Storytelling, sharing anecdotes and narrative
- Debating the influence of professional leadership
- Creating and sharing a meaning for professional leadership
- Generating professional capital
- Sharing experiential knowledge
- Creating a forum for learning

Exploring issues of corporate governance

Serious untoward incidents (SUI) requiring investigation

Extended team functioning

Maintaining individual standards and reputation of the organisation

Continuing health care

Leadership accountability and responsibility

Reflections on decision making to change strategies

Interpersonal relationships through membership

- Developing skills and confidence
- Being instrumental in transforming services
- Using a story board

4.4.1. Storytelling, sharing anecdotes and narrative

The findings identified how individual participants used stories and narrative to demonstrate very practical and realistic examples of everyday clinical activity and practice through the emerging Community of Practice to share their knowledge, experience and understanding of professional leadership and how the collective Community of Practice enabled participants to encourage and achieve changes through the influence of their individual professional leadership roles. The stories, anecdotes and narrative shared during the time of the Community of Practice, provided real life situations from the front line of health and social care delivery, demonstrating the activity taking place to evidence those experiences and show how various elements of professional leadership can influence change and improve services. Knowledge was brought in from other organisations and previous experience as well as sharing experiential learning through the stories (see Chapter 5).

4.4.2 Debating the influence of professional leadership

The Community of Practice spent time thinking about their individual roles at the beginning and had reflective discussions about what being in a

professional leadership role meant to them (see page 81). As the research progressed the meaning of professional leadership developed and eventually focused on a single theoretical definition that delineates the essential elements of the leadership process: '**Leadership is an influencing relationship among leaders and followers who intend real changes and outcomes that reflect their shared purposes (Daft 2002: 5)'.**

The context and key elements of how this worked included:

- **Influence** – a reciprocal process between superiors/leaders and followers
- **Change** – creating change and influencing people to bring about change toward a desired future
- **Shared purpose** – an outcome that both leader and followers are motivated through energy and enthusiasm to be effective
- **Personal responsibility and intention** - committed to something outside their own self interest either as a leader or follower (Daft 2002: 6)

These responsibilities and elements of leadership were fundamental to many of the discussions and interpretation of stories, anecdotes and narrative**.** Individual leadership styles, alongside the agreed definition and principles, also had a great influence on the climate and outcome of the group working together, but this was acknowledged and understood at the beginning of the research that it was unlikely most of the professional leaders would fit into one consistent leadership style or behaviour and recent theories would support this by suggesting that leaders move dynamically along a continuum in response to each new situation (Hersey and Blanchard 1998:26). This was evidenced in the findings, recognised and accepted as adaptive behaviour in response to the need for situational leadership.

SN 2 admitted:

I stayed right out of it as I felt this situation was being managed in a more directive way and just said to the Operational Manager, who is a social worker of course 'the

patient safety team are here if there are patient safety concerns but we will leave the operational stuff to you'. I would have been more supportive I suppose

Leadership roles within the Community of Practice changed and evolved during the course of the research, reflecting national and local policy and practice, demonstrating dynamic, responsive and evidence based activity. This benefitted from the sharing of stories and the leadership discussions that took place as a result of individual experiences and narratives. It was this dialogue in the Community of Practice that enabled the leaders, who were individuals shaped through their various backgrounds, to share their vision and create a culture to advance and shape local services. In order to achieve change they needed authority, which was based on their credibility, sphere of influence and ability to make an impact through sound professional practice decisions. As authority generally requires a managerial position many discussions took place relating to how professional leaders were able to manage themselves, lead teams of clinicians as well as influence and change practice. In reality this did not all happen simultaneously as each leader made significant contributions at different times depending on the national initiatives and local priorities at the time which were reflected in the content of the stories.

Never the less the Community of Practice focused on detail from the NHS Operating Frameworks (2007 -11) and the six identified challenges to respond to including higher patient expectations, an ageing society, the dawn of the information age, the changing nature of disease, advances in treatment and a changing integrated workforce. Services were expected to be preventative, people centred and productive as they should be and integrated teams were required to take the lead, look to their own practice and in many cases make the changes if necessary. Professional leaders were expected to work with operational managers to influence and make sure the changes were fully in line with current best practice, to shape care along whole pathways, not just within the immediate organisation but diverting resources into areas that were seen as a higher priority at any given time. Roles changed as models of care changed.

4.4.3 Creating and sharing a meaning for professional leadership

Attention was drawn to the supportive and explanatory components of social learning and capital – meaning, practice, community and identity all

of which underpinned and were integrated through the Community of Practice. Having a structure at the beginning proved helpful in the identification and discussion of the building blocks in social learning as well as the wider contribution to health and social care through also acknowledging the generation of social, human, organisational, professional and service user capital. CG said

> *I don't think I could do my job anywhere near as well if I didn't have this as a sounding board, by thinking things through and being able to talk them through with all of you I feel that I have really grown in confidence and what we do as professional leaders is made much more meaningful through our association.*

The theory of social learning was described as the connections among individuals - social networks and the norms of reciprocity and trustworthiness that arise seem akin to participants in, as well as, between Communities of Practice as they allow people to work together and pursue shared objectives effectively Putnam (2000:19). Social capital was defined as the sum of the actual and potential resources embedded within or derived through the network of relationships possessed within the Community of Practice (Wenger 1998:3). Following discussions about how we were benefitting from working together within the Community of Practice I have interpreted it as follows from the conversations within and after the Community of Practice had effectively ended.

Meaning: a way of talking about our ability - individually and collectively – to experience our life and the world as meaningful with 'learning as experience'. SN1 said:

> *The social component involved our sharing, personal contact and increased social interaction and developed our social wellbeing and sense of belonging which made us more committed and engaged in the process.*

Practice: a way of talking about shared historical and social resources, frameworks and perspectives that can sustain mutual engagement in action with 'learning as doing' SC said:

> *By sharing knowledge from our day to day jobs, performing tasks* and *interacting together meant that new knowledge was created in action.*

Community: a way of talking about the social configurations in which our

enterprises are defined as worth pursuing and our participation is recognised as competence with 'learning as belonging' CS said:

> *Our enterprise was informal and self organised in the beginning with some fluidity around membership but as the Community of Practice progressed and a variety of expertise was brought in to participate it did become a more formal and organised community*

Identity: a way of talking about how learning changes who we are and creates personal histories of becoming in the context of the communities with 'learning as becoming'. SN 2 said

> *We felt the compelling need to associate with each other, to learn and grow as we faced similar issues and challenges relating to patient safety and quality of health and social care services*

I found these descriptions helpful to immediately understand why the Community of Practice was so important for the people practising in various health and social care settings and how the professional leaders worked together to influence change (le May 2009). They developed through participation, negotiation, interaction and reification giving form to meaning alongside mutual engagement and joint enterprise which resulted in the creation of shared histories, repertoires and identity. In line with this understanding, trust was soon established and benefits realised and verbalised, between leaders in this Community of Practice which was a non-traditional situation recognising the importance of change across organisational and disciplinary boundaries. In addition the connections among the individuals including reciprocity and trustworthiness that arose allowed the Community of Practice members to act together in order to pursue shared objectives through social capital. SN 1 enthused:

> *I really look forward to our meetings and I know I am always late because I am packing up the house to go home for the weekend but I know you will all carry on without me and I can trust you to do the best for the safety of services. We are honest with each other and that makes working and learning together so much easier if we are able to speak genuinely without having to worry who you are going to upset…..not that I care about that because I'm known for being fairly blunt*

4.4.4 Generating professional capital

The Community of Practice enabled collective learning by bringing the participants together, with their knowledge from outside the organisation, to learn through their mutual engagement in all the storytelling and associated listening, reflecting and generating new knowledge. It was understood as a joint enterprise by all who participated and the capability it produced. The professional leads had individual skills and knowledge for their own activities but through developing relationships, a shared repertoire of ideas, commitments as well as the sense of identity they were able to function at a higher level and with more confidence through the Community of Practice. Their professional capital as described by Lave and Wenger (1991) meant that they could find a voice to act on behalf of professional leadership and be valued through recognition by other professionals and understanding of the contributions as professionals that they were able to make. This included trust, appreciation and the ability to grow as part of the process but also involved using and developing various resources such as routines, practices, tools and documents to demonstrate the practical ways of doing and approaching their shared and significant activities. The Safety and Quality Manager attended saying:

> *I know you have recently revised the incident reporting policy and the reporting process through the Community of Practice in line with national guidance. I am planning the implementation of the new evidence based documents and guidance. Can you advise me and make some suggestions for the best way to achieve this through your leadership meetings so that we can spread this new work as quickly and broadly as possible*

This was one example of what Wenger claims as 'reification' of accepted and acknowledged practice. Through their interaction the participants negotiated new shared meanings and a way forward for developing concrete artefacts from the group conversations.

Awareness of the challenges to align safety and quality outcome processes across all functions, making sure that the intelligence was available to understand the safety and quality of commissioned services and how that affects patient experience was made possible through the Community of Practice. Whilst high level risks were being monitored and overseen by a Quality Board, the activity in the Community of Practice was an important part of establishing those informal and formal networks that were able to share intelligence and knowing, as part of the process for developing risk

based escalation of concerns with clear accountability and agreed plans to mitigate risk. The benefits realised meant more responsive and effective services to localities with clear identification and management of quality of care concerns. Following one incident CG advised:

> *That is exactly what should be logged as an incident because if it hasn't been logged it is our internal mechanism for flagging up those things and learning from it. I haven't logged it as a SUI (serious untoward incident) but we need to progress this to an investigation and then disseminate the learning across the organisation.*

However the acquisition of professional capital in safety and quality of services was identified as a complex entity throughout, because although each member had their own knowledge and skills characterising an individual professional portfolio, sometimes this was shared between particular professional leads. This had the potential for linking individuals together and was evidenced by mentoring and coaching during the time of the Community of Practice but also caused friction and challenge depending on the previous and professional backgrounds and individual experiences. For example although the collective professional capital was extensive it had been developed and harnessed in a variety of ways and at different levels. This included educational, research and professional differences as well as perceived status, authority and power within the immediate group and the organisation which led to distrust at times rather than collaboration between individuals and this led to some undermining of potential professional capital. There were also differences in socio cultural practices between professional groups in health and social care which along with experience had to be taken into consideration so as not to undermine the full participation of any individual.

In addition, alongside the Community of Practice individuals had their own formal or informal specialist role related networks which they used to guide and develop their own practice. Sometimes really checking out the best way of undertaking an activity individuals often took a short cut and accessed external sources that they trusted through their own professional networks. Although these helped to problem solve they also continued to have an impact on individual professionals and their behaviour and practice. Sometimes the specialist activity was able to contribute to the overall professional capital of the Community of Practice under scrutiny but

alternatively this could be random or even work to the detriment of the overall and longer term learning. SN2 said:

> *I am going to access the Nursing and Midwifery Council help line to make sure I have the latest and best advice. I have listened to what you have all said but for nursing it may be different from therapies and social workers and I must make sure I am making the right decision in this case.*

SW found the differences between professions and organisational culture most challenging and suggested this was why they were not as committed to the Community of Practice as health colleagues (as demonstrated by their attendance and comments). SW said:

> *I don't think we would act in the same way in the Local Authority, first of all our supervision structure is completely different so I don't think we would be in such a compromised position because the caseload, operational, professional and restorative supervision are all combined. I can't understand why they appear to be so fragmented in health.*

Having acknowledged the differences, on the whole the group dynamics were productive with everyone listening to each other's experiences and knowledge. Referring to my field notes on several occasions sometimes I noted that the dialogue was relaxed and cheerful with jokes being made and at other times more serious and contentious. By acknowledging the tension, trusting each other and showing mutual recognition the topics were dealt with constructively even if there were differing and conflicting views eventually practical solutions were suggested in order to move on. At times the more experienced were dominant as they were able to contribute with more in depth knowledge, demonstrating legitimate peripheral participation from the other participants, but this fluctuated depending on the topic and where each individual was in their own domain at any one time.

4.4.5 Sharing experiential knowledge

The knowledge exchanged was often experiential and learning was fostered by discussion of the experiences of being part of the integrated health and social care infrastructure in which the Community of Practice operated and by individual and collective engagement and contribution to the practices within the Community of Practice. Social capital was realised by interacting regularly, undertaking complex activities through co operating

and trusting each other. By sharing the outputs and concepts with various parts of the organisation the members made some progress on brokering elements of practice through meetings, conversations and presentations and facilitated learning with an effective flow of knowledge across the services. CS reported

> *I attended the root cause analysis (RCA) meeting last week, which was chaired (not very well) by the commissioning safety and quality facilitator and it became very clear that we should have undertaken a professional investigation into the perinatal death rather than a joint professional/operational process. I felt at the time the manager was skimming over some of the detail both about the practitioner as well as the hospital. I felt very vulnerable at the RCA and thought the midwives were placing an element of blame not only on the midwife and hospital but on the investigation process. Since then we have had a 'wash up' and acknowledged where things could have been done differently and better. For me this would have been an independent investigation with much improved admin support or a digital recorder to capture the interviewees statements*

This and other instances in turn enabled increased learning through this knowledge to benefit the organisation in going some way to reaching goals and developing whilst the Community of Practice remained active and the catalyst for ongoing debate and learning.

The Community of Practice discussion and process frequently revolved around putting into practice a variety of national guidance and documentation which were initially used to benchmark the organisation's status as well as being used to underpin the assurance process and inform the required action planning. Alongside them in search of evidence based practice on which to base service development and delivery it became obvious that leaders used a far greater variety of skills, knowledge and experience acquired from many sources to help them make decisions. The stories and anecdotes demonstrated practical examples of hands on knowledge showing how the collective discussions helped to deal with particular problems at any given time. SN2 said:

> *I have been contacted by the SHA about mixed sex accommodation and our need to demonstrate compliance. This is a national initiative to do with privacy and dignity and it is important we don't breach. I spoke to PMc to ask him if any of our in patient facilities had mixed sex wards even when we have pressure points and he couldn't tell me! I was horrified and have taken the plunge (initiative) to set up a*

survey of all the community hospitals and clarify if there is a possibility of any breaches. I am sure we have a problem with mixed sex toilets and bathrooms so this is going to need a capital spend so he'd better look out and flag it to estates

Potentially conflicting roles within professional leadership were represented and resulted in challenges that had to be acknowledged. These were overcome by sharing information, developing evolving ideas for improving practice, once a level of trust had been established both between the participants and from within the resources being used.

The value was of sharing experiential knowledge from situated learning focused on cognition, meaning and concepts of identity without placing too much weight on the effects of others, individual development or morality. OT admitted

I was on a ward the other day observing a practitioner doing an assessment before an elderly gentleman could be discharge and all of a sudden I heard voices behind an adjacent curtain. I don't think they realised who I was or even if I was there but they (two health care assistants) were clearly having a private conversation and laughing whilst they were seeing to an elderly lady. I was absolutely stunned when I realised so I couldn't stop myself referring them to the dignity policy when they came out from behind the curtain. They were full of remorse but it was too late by then. I just had to ask the matron on my way out of she could facilitate a learning set for the whole ward so that everyone from the cleaner to herself would remember that just because people are elderly, frail and demented they must be treated with dignity

In addition professional learning relied on factors influencing decision making, judgements, actions and discretionary practices because the broader community of professional leaders operated in a context of the 'immediate' and responded to the needs of clients. It was evident that the learning was stimulated, enabled, structured, archived, recognised and retrieved within the Community of Practice which benefited not only clients and practitioners but the professional leads as well.

4.4.6 Creating a forum for learning

The creation of a shared learning agenda motivated the participants to contribute their insights into particular problems. By defining and understanding what could be important to everyone and appreciating the

cutting edge of the safety and quality domain relevant contributions were communicated and presented in useful ways for example the need to balance corporate risk alongside experience and compliance with evidence based guidance such as monitoring hospital acquired infections or the use of mixed sex accommodation.

4.4.6.1 Exploring issues of corporate governance

During the first few meetings the content and attendance at corporate induction as well as mandatory training became a hot but essential topic relating to quality and safety as well as providing assurance both internally to the Board and externally to the Strategic Health Authority and County Council. CG was able to share a story from another private organisation:

> *My previous experience of this is that I was called into an organisation that had effectively been closed down and refused trading because of their poor standard of training. They didn't seem to realise that there were statutory requirements for them to provide a certain level of training to all staff. This was around risk, health and safety which included sessions on fire safety, information governance, equality and human rights. This was before you even start on the mandatory requirements such as adult and child protection, infection control, moving and handling as well as basic life support. There lack of understanding was shocking and I had a really tough time trying to persuade them of the need to up their game!*

This provided the impetus for levels of training to be debated, decided and confirmed within the Community of Practice for both clinical, administrative and multi agency managerial staff. The members later acknowledged this important and visible decision making had given the necessary challenge to carry on, develop and confirm the organisational model for mandatory and statutory training as one that could be acknowledged externally to improve services and contribute to cultural change through helping all staff to understand that they must attend statutory and mandatory training to benefit and protect themselves as well as the organisation.

4.4.6.2 Serious untoward incidents (SUI) requiring investigation

Following the unexpected intra partum death of an undiagnosed breech baby, an internal investigation and recommendations were made.

SN 1:

> *Yet again we are working around a difficult situation and trying to make the best of something when we were being held to account for a tragic situation. It was registered as a community provider serious untoward incident and it is important to manage the process efficiently before reporting to the commissioner*.

Although each member brought their own expertise and resources to any subject under discussion, in this case only one member of the Community of Practice had the midwifery experience required to actively engage in discussion around evidence based practice and decision making saying.

> *In order to obtain expert and up to date information and evidence it was necessary to invite external midwives and supervisors to provide the detail and evidence about what happened and how it might have been different.*

Some members of the Community of Practice admitted to feeling vulnerable and exposed but were able to draw from the expert knowledge about textbook breech deliveries plus associated policies and procedures that could have been followed alongside using professional judgement in order to amend their previous understanding.

This situation demonstrates the developing but sometimes complex and sensitive relationships between the commissioner and provider structures in public sector services. How experienced professionals can feel threatened and exposed by being held to account by authority. This is a new experience for some in a rapidly changing public sector world as it develops into a more business and productive model of care with a need to demonstrate high levels of performance through recordable and measurable quality outcomes and outputs. Assertiveness skills are sometimes required as part of this leadership development.

4.4.6.3 Extended team functioning

Inevitably in a fast paced changing, complex world anxieties will be expressed periodically and it was important to respond to them as happened following a particularly sensitive deputation from the business support services. As in many public services it is often the ‘backroom’

business support staff who are not seen to be valued or are depleted during service re design. Following this deputation from the administrators the Community of Practice debated the issues that had been raised.

SN 2:

That has not made me feel angry, what it has created in me is that I am quite proud of them, and they are solution focused. They have been honest...the highest member of the team is Band 4 and that is how and why they have written it but they have really tried to find solutions and they have suggested some very helpful ones especially around managing the reception area more efficiently. For some reason I am not angry, but it is right anyone should have your own personal assistant as an Assistant Director just like the others at your senior level. There just is not any equity across the organisation. Perhaps we should look at some of the other administrators at headquarters and identify if they could share or take on extra responsibilities, although those doing either the Director's business support or corporate activity will never change what they are doing.

SN 1 sounding annoyed said**:**

This is about competence of all the business support in the office and the level they are all employed at as well as how they are working. None of them are trained in shorthand and they don't like doing minutes or sending emails etc. I think some of these issues and suggestions are a touch out of order and it feels like the tail wagging the dog. If we all did 'Productive Leader' (Institute of Innovation and improvement) it is not unreasonable to work to the principles and standards set by that programme. What a personal assistant does is take a lot of work from you to make you more productive. What is the office manager doing to support this and help them to work more efficiently? I think moving their desks and giving reception properly to one person would sort this out, their desks need screening off and the receptionist needs a mobile head set so she can move about and answer the phone whilst she is photocopying as that would be a very simple solution. We have been to the office manager several times in the last few weeks for help and she is hopeless and doesn't do anything, it is a pointless exercise.

CG replied:

A public facing business should never have a reception unoccupied, you could have an answer phone but it reflects on our organisational reputation and the Director needs to know about it. The number of times we have all approached people in reception to try and help them when they walk through the front door as

reception isn't working; another option would be to have a cover rotation. We have already proposed it and now it needs to happen.

SC added**:**

They also need to print papers ready for meetings, manage messages, meetings, and manage diaries. The local authority business support operates in a very different way to the NHS. It is more of a team spirit because that is the way they are recruited in the first place. I know we all work in different ways but there are some basic things you would expect any administrator to do. Does everyone have someone to manage their diary? The frequency of meetings is high at the moment, so we either reduce meetings or resource them better. Some of them hate doing meetings and the trouble is we are doing catch up because we are so behind with the content and progress of the meetings. Their hand writing is so bad that they then have to spend half a day writing them up. Another option is for us to do notes ourselves and then send them for alignment and formatting. Some of them have been support to Chief Executives in previous organisations so I would expect them to be able to achieve what they are asked to do. We need a time and motion study, tell them to stop talking and be more productive as they are so easily distracted

SN 2 intervened**:**

Let's clear the decks here they need a requisite skill set and the office manager needs to make sure they are competent because there are huge governance issues about all of this. We are getting an apprentice to work with them and they should be able to take some of the paperwork of them. They can all move so that they are not distracted by the reception window, but some just are not pulling their weight!

Everyone in the Community of Practice had their own thoughts and individual views on this subject but there appeared to be an ongoing fundamental problem here about relationships, competence, performance, leadership, team functioning and dynamics. Following this fairly heated debate a decision was made to meet with the business support team monthly and identify particular issues, regarding their work volume and capacity to undertake certain tasks, as well as help them to prioritise various activities which were essential to the safe running of the overall directorate. This resulted in them being more engaged in the business side of the service and also feeling listened to and an important part of the overall activity.

4.4.6.4 Maintaining individual standards and corporate reputation

The Nursing and Midwifery Council (NMC) exists to safeguard the health and well being of the public and set the standards for education, training and conduct that nurses and midwives need to deliver high quality healthcare consistently throughout their careers. This includes assurance of keeping skills and knowledge up to date and upholding the standards of their professional code of conduct. Some sources of knowledge were not used appropriately and neglected or even rejected if not valued or trusted by some members who were not seen as experts in a particular field in the Community of Practice e.g. a non nursing colleague was ignored when they suggested that some empathy might be helpful during the incident relating to a registrant forgetting to register with the NMC. Social workers, although needing to re register every three years do not currently have the same continuous practice developments or constraints put on their practice as nurses and therapists do. The Community of Practice demonstrated the opportunity to discuss quite different attitudes between disciplines relating to quality, capability and disciplinary processes as the following story from SN 2 shows:

We had an appeal hearing which was chaired by the local authority manager with a social care background and I was on the panel as the professional advisor. He really didn't have a clue about the regulations and standards required for registrants and admitted that social care practice was not performance managed in such a rigid way. The appeal was for the nurse who had been dismissed for capability not disciplinary, following an investigation relating to one drug error when administering antibiotics as they did not follow the drug administration policy. They then made another error, by giving night sedation for a second time when it had been given previously and then falsified the records to try and cover up the error. The patient went into respiratory arrest after they were given the sedation overdose. Another nurse came in pretending to look at off duty and changed the records. That nurse wasn't dismissed for records falsification and this has become a process issue as alongside this we have an issue on how, now the registrant has been demoted to a healthcare assistant role and will need to be supervised in a southern hospital. We have a letter from Human Resources saying this person has given 26 years of service with 15 years on nights. They have to now come onto days, not return to the same hospital and be supervised through the health care assistant competencies. If this is not managed by the book we shall have a tribunal otherwise on our hands. We are picking someone up where there has been a long

time of slowly not achieving.

The outcome that ensued was a frank and open discussion of how the member of staff in question could be supported to achieve the necessary competencies in the demoted role alongside a further development programme to enable them to be re instated as a registrant. It was also acknowledged and confirmed that any registrant who had been dismissed for capability or disciplinary must be referred to the NMC for further decision making. This was seen by some members to be a draconian measure and a certain amount of scepticism was voiced in relation to the final outcome demonstrating how difficult decisions are sometimes made through majority rather than complete consensus. This certainly highlights the cultural differences between professions and the complexity of working in integrated services

4.4.6.5 Continuing Health Care[1]

Analysis of the data showed that new knowledge and learning were demonstrated through the emerging Community of Practice. Different sources and types of knowledge were used depending on the particular issue being debated and developed, often reliant on experiential sources but also complemented by personal, managerial, specialist, factual, empirical and professional knowledge exposed in storytelling. This is evidenced by many discussions and stories for example a senior nurse with extensive experience of working with care provision of older people, particularly with mental health problems and the legislation surrounding systems.

One particular discussion around decision making within Continuing Health Care (CHC) included the following descriptive dialogue:

Most of CHC sits within commissioning and they are dealing with the financial side of distributing CHC, and all the appeals and reviews. Our feedback from the Strategic Health Authority around CHC was not favourable. In provider we have a clinical lead and someone dealing with the retrospective issues. We have nurses

[1] *NHS Continuing Health Care is a package of continuing care provided outside hospital, arranged and funded solely by the NHS for people with ongoing health needs*

out in the community in the CHC's. Because of past experiences within CHC a lot of individuals have been bringing solicitors, as representatives to the meetings in order to deal with their cases. Also when they do their assessments of continuing need the solicitors have been looking at patient records and sitting there so the clinical group brought this up as in appropriate. One particular nurse had to sit through several hours of barraging from the relative and the solicitor. Any way our solicitor came yesterday to hear the appeal and I have suggested that they start to use our un acceptable behaviour policy because regardless of who is behaving unprofessionally to them they still have the right to stop what is happening so this is not helpful to any party, remove themselves, write to those people and try and re establish the meeting in a better way with setting boundaries around behaviours. The solicitor has gone off to do a process map and set some standards around behaviours.

This example around professional behaviour begins to demonstrate through personal responsibility, how professional leadership style, knowledge and skill and the ability to influence change were shared through discussion at the Community of Practice. It enabled the transformation of continuing health care through the implementation of appropriate policies as well as the development of standards to support the delivery of the desired behaviour change and sustainability. This story also gave an example of how members of the public, relatives, parents and carers sometimes behave towards health and social care professionals when they are anxious about the care their relatives receive. However it is a worrying trend for professionals in regard to their own safety when relatives of the young and elderly use threatening behaviour particularly in a lone working situation. Following this incident a period of support and training was put in place for front line practitioners around conflict resolution and managing difficult situations particularly as a lone worker in the community.

This demonstrated through sharing stories how information and knowledge were able to be interpreted and translated into a wider and broader contribution to other more strategic areas of the organisation. This developed some of the skills and knowledge required of professional leaders to operate successfully in a variety of contexts as well as develop the requisite level and content of knowledge to access the power sources and language required to operate alongside operational managers as equal partners. This is one example of identifying knowledge derived from stories

in practice of an integral component of the repertoire of skills required to be a professional leader but the knowledge held by individuals was broadened through the Community of Practice and interpreted and translated between the participants to improve practice in various spheres of the organisation. Professional leaders were seen to be practical doers and one of the outcomes of the Community of Practice encouraged them to be seen in a much broader strategic role with the ability to influence the wider agenda of transforming services through their tacit knowledge which gave them the confidence to operate at a more strategic level.

4.4.6.6 Leadership accountability and responsibility

Each leader showed consistently that they had the ability to use knowledge and skills associated with different areas within their sphere of speciality and influence but also learn from each other. The domain of professional leadership within the clinical practice of safety and quality was supported by individual priorities and responsibilities and was also influenced by how those individuals operated between practitioners because that resulted in a wider impact on other areas rather than just their primary focus.

Services constantly worked with complex and competing priorities, sometimes demonstrating that extra activity had to be undertaken in times of greatest need. The workload and priorities varied throughout the period of research which included some strategic engagement and directional decision making particularly during the height of the swine flu epidemic, when media attention focused on death rates and vulnerable people so that pressure and responsibility was placed on SN 1 who required support:

We have to be represented at all swine flu meetings, we need to keep this tight with best practice and follow up operational decisions. The practical decisions include things like the treatment phase, limited swabbing, managing prescriptions, using FP10s. I don't know what the protocol will be because if they have FP10s they will have to be dispensed by a pharmacist. I just heard that in passing and the pharmacist will have to arrange that. Swine flu vaccination programme; this will be a mass programme and we need to understand what the differences are about immunisation and vaccination? There will be a first and second cohort, two doses three weeks apart. If we move to the second cohort phase we shall need to decide how we deliver that. 2 doses have to be from the same manufacturer and there are two of those producing the vaccine. The first cohort will be all children and the

second are NHS staff. Process is partly through a national help line to answer questions and this can be done on line as well. I don't know yet when the programme is starting but we have to increase the uptake very fast particularly for staff uptake of vaccine. We have to be leaders in getting people to have this vaccine particularly as apparently the under 50s are the most vulnerable? There is a belief that the over 65s flu vaccination programme has given the oldies some sort of immunity. What we have to do is encourage as many people as possible, providing them with the evidence and facts of the illness and side effects of the vaccine. And did you know 63% of people who are affected are obese which in interesting and I suppose is connected to poor diet and lifestyle. What are their social networks because we need to get to those? We have to pull 50 staff together and train them for anaphylaxis. I said to the senior managers why have we got to use all provider staff? Isn't there something here about using practice staff? Operational bases open at the moment are being picked up by cluster managers and DR, I am not sure if current staffing has been taken care of but that is an operational issue; if they come to you to access children's staff because that service is already on the provider risk register due to staff shortages and Ofsted registration will be put at risk, and I think we need to think about that. The pharmacist has been looking at what has to be done, what we have agreed is that the swine flu meeting keeps tight and I will go. I will try and represent children's services as M (social worker) wouldn't think of the clinical needs of the service or staff.

This illustrated a dissonance on several counts between what clinical staff were being asked to do in relation to their own beliefs. Many professionals did not wish to have the vaccine themselves, were not convinced that there was sufficient evidence to acknowledge it's benefits or that the 'epidemic' was as wide spread as the media information was suggesting and yet were being asked to encourage others to receive the vaccine. In hindsight this turned out to be the case nationally following further investigation. The atmosphere in the Community of Practice reached a very low point due to the individual differences and the need to respond to corporate directives.

SN 2 said*:*

A headmaster came through to the switchboard saying he has two cases but he should have gone through education and the local authority and not through his personal contacts here. We all have a responsibility to enable colleagues to follow the guidelines that have been put into place for this important programme.

SN 1 replied*:*

He is the worst person to be organising this as he is a real flapper. We have exhausted all staff availability locally and so operations will need to manage it there but that is where the organisation of all of this should sit anyway. We are here to give professional advice to operational managers to keep these clinical services safe and that is where our responsibility should end. Recent sickness made the Walk in Centre vulnerable and our professional advice was to put the operation elsewhere to keep it out of the wards but the Matron negated that. There is also a new keen Band 7 who is very agitated about sick people with swine flu symptoms coming into any of the hospitals. We need to be quite clear here what is operational management and what is professional practice and how the two need to meet in the middle in order to keep the whole process and final outcome safe.

This demonstrated experiences about responsibility and accountability, leadership by one group and passing it on to another who could be trusted to get it right. It is an example of someone thinking through where responsibility and where leadership and accountability should really lie - their struggle. This group were seen as the fixers – which meant leadership could be dodged at another place because the fixers were taking some responsibility.

Another example of this was when the Community of Practice reviewed clarity about who was technically accountable and responsible for providing assurance on safety and quality through the necessary processes and channels within the organisation. At the time the format for assurance was provided through Standards for Better Health (2006) performance framework declaration which was replaced by the Care Quality Commission registration and response through the essential standards self assessment.

CG said:

I think this is a classic example and I think it is the nature of the directorate. It is the same in commissioning and it is the same all over and it is for those people who lead in relation to some of the unavoidable assurance relating to standards and assessment of services; there are massive risks about safety of services, quality and human rights is in there but largely through the leadership from within the corporate risk, health and safety directorate. This then comes my way and they

think we in professional practice must put it right so instead of putting it right in the team that should have been doing it they pass it to our team because they think they will stand a better chance of getting it right. I think that is often a reaction that we get. I think we take things on to put things right rather than putting right what the team should be doing for them selves. This is what we as a group must try and do, enable the teams to take responsibility for evidencing their activity and outcomes. Does that make sense? What you have said previously is right. We cannot close the door because there is no door on patient safety and quality, it is an open ended corridor so I think we are in danger of keeping on putting things right ourselves and perhaps we should be saying 'look this should be allowed to fail' and then things put right strategically or corporately. That is my observation and I think we have lots of examples of that, where we take things on where things have to be put right and we are the best people to do it but purely because we haven't got time to fix other things that are wrong.

4.4.6.7 Reflections on decision making to change strategies

As the Community of Practice developed the participants were more able to challenge each other's professional judgements although this did result in some uneasy and tense moments when the group felt a senior nurse had acted too hastily, without thinking the process through. The story related to a nurse who had been on long term sick leave had forgotten to renew her registration with the Nursing and Midwifery Council.

SN 2 took responsibility for managing the situation**:**

The registration had lapsed whilst the nurse had been off sick, with difficulties in concentrating and they had forgotten to renew their registration. I had to apply the policy of the organisation and revert to a health care assistant post and salary. That was the correct process for the situation and I am sure it would have been the same if I had taken HR advice. If they want to maintain a pension they need to retain their registration.

CS challenged:

Well at the moment they want to resign, today they are attending a workshop and I thought it was good opportunity to reflect on our actions, reasonableness and context. I personally thought you were too hasty and that you did not show much sympathy for the situation. They could take out a grievance in relation to what might be perceived as bullying behaviour, poor communication skills and lack of a

soft skills approach to a delicate situation.

SN 2 replied**:**

If nurses want to retire at 55, they do need to be registered and they did let us know the registration had lapsed

CS challenged*:*

Well I do think a bit of flexibility and humanity wouldn't go amiss and to see how much we can compromise. They will be signed off so why did it have to be yesterday? If they were on a ward it would have been different. We could have applied the policy in a different way, if we had prepared ourselves it would have been better. Is it from yesterday or from last May? There are other extenuating factors and they are frightened of driving in the dark, they are very fragile and this was a catalyst.

SN 1 agreed**:**

(tearfully) I needed to slow down as it was so busy with all the meetings and interviews last week. I do care about people and perhaps I should have applied the policy more leniently. I always try and care for a person when they are not well and they are much more fragile than we realised. They are actually still and need lots of support from everyone. I work really hard on my people skills and I could have done better.

CS said:

Are we able to challenge unrealistic expectations sometimes and do we need to show more compassion? Also when we are asked to pick things up occasionally we need to say no. Please don't beat yourself up about it because to conclude it is really healthy to have this conversation, for us to acknowledge we have too much on, so in touch, up to our eyeballs in complex activity and know that we don't have to absorb everything. To do this job we need to have personal resilience and it is good that we have this level of humanity in the team. We all have people skills as part of our leadership skills and we are lucky to be able to work together like this.

On reflection the group considered if situations needed to be dealt with

immediately, with some acknowledged learning on how this situation had been dealt with. A follow up with actions resulted in the Senior Nurse speaking to the nurse with advice and assistance from human resources. They then identified that the sanction is usually applied from the day the lapse of registration is known and it is not back dated. The line manager swiftly took responsibility for the situation and supported the registrant through the process of re registering and getting back to work. This shows that although policies and procedures need to be followed it is necessary to reflect on individual delivery styles as well as using emotional intelligence and awareness on the impact individuals have on others.

4.4.6.8 Interpersonal relationships through membership of the CoP

It is important to understand how the ways in which all of the professionals in the Community of Practice influenced ongoing service development and cultural change when acknowledging their differences. The purpose of the Community of Practice was to progress the safety and quality agenda alongside expected productivity. The knowledge being explicitly and implicitly shared had different connotations depending on whom and where it came from. This sometimes led to difficult discussions between various professionals about what constituted best practice. SN 2 said

> *It's alright nurses becoming graduates but where are we with that basic thoughtful human interaction that makes a difference. I think we also need to consider how our support members of staff have been trained to the sort of standard required to support those nurses who are working as graduates. But the fundamental thing here is that she didn't get the trained nurse. I don't expect them to know what to do but I expect them to come and get me.*

Membership and affiliation to the proposed integrated purpose of the group became very significant because of the need to be more than just a network but to actively participate and learn as well as through identity being able to relate to the rest of the organisation.

4.4.7 Developing skills and confidence

Individual benefits spanned many topic areas including improved reputation, a better understanding of what others were doing in the

organisation and increased levels of trust. The familiar and supportive environment encouraged member interaction and ongoing professional development and learning about new tools, methods and procedures. The participants expressed the benefits of increased access to wider subject matter experts and valuable information resources. Together these benefits allowed members to develop professionally, remain at the fore front of their discipline and gain confidence in their own expertise. One member (and the others agreed) said:

> *If I have a question about a quality issue I am trying to unravel, for example....I might not be able to find that immediately. But by bringing it to the group I can get help and not only find the answer to my concern but often get other leads such as policies, documentation, other's experience, pointers that go much further than what I was thinking in the first place so it really expands my knowledge, gives me more contacts and the further opportunity to get even more information.*

SN 2 shared

> *I have been asked to lead a piece of work around the Liverpool Care Pathway and so I asked JM to take some protected time to research where we are with it and set up a group to sort the process. We have got to get this right because it is so sensitive and important to relatives that they are consulted and feel that their loved ones are looked after in the best way to help them die with dignity. Do any of you have previous experience of this as it really needs flagging as quickly as possible because it is currently a risk to the organisation.*

4.4.8 Being instrumental through transformation of services

Transforming Community Services (DH 2009) and information regarding timescales and processes for making decisions about future organisations came from the Department of Health and the Strategic Health Authority during the timing of this research. High level meetings were held between the commissioner, providers including General Practitioners and the County Council as well as union representatives. A range of options were written up, tested and fully evaluated before decisions could be made by the Board but the activity caused much anxiety amongst all staff who were concerned for their future employment as well as the general desire for services to be evidence based, high quality, safe, meet individual needs and be in the

best interests of local people. This was a very unsettling time despite reassurance that the provision of valued services was of paramount importance and assurance that the transformation process was intended to improve the way services were managed and organised. Whilst efforts were made to harmonise policies, procedures and processes as well as undertake change management activities alongside budgetary restraints, in preparation for a new world, inevitably some staff decided to see if the grass was greener elsewhere. In addition this was a time of shifting allegiances between existing members and external contacts that perhaps in the wider world were seen to be more powerful or knowledgeable.

One Senior Nurse was able to share serious concerns and her own anxieties and frustrations at a very early stage*:*

> *But we are going to lose people if they are not listened to and responded to, good people and I had a colleague come to me yesterday, who has asked me to keep her confidence, but she has come to me to say she has applied for another job and if she is successful I am sure I will be told we cannot fill her post. She is incredibly important to my team and that is not my decision.*

The participants continued to explore through stories and case examples how National Health Service and Local Authority employees (clinicians, managers and allied health and social care professionals) professionally lead, worked and learned together.

This was acknowledged as the end of an era but with the knowledge that working in the Community of Practice had been a positive experience for the professional leaders and one that had been beneficial to all in preparation for the next phase of their career.

4.5. Ways in which expertise was shared and knowledge exchanged through using a story board

Although the story board was not used as intended with shared practice examples, it did prove useful for general communication between each Community of Practice meeting. It was used for introducing new ideas and for general reflection, intuitive responses, thinking in practice and comments that followed the face to face meetings. SN 2 wrote:

> *The fragmented relationships between operational management and professional*

leadership are seen as detrimental to the quality and safety of services and I think children's services are closer to getting the delicate issues squared in relation to the interface with operational management. I think we should do what they do and improve the professional practice leads communication through the senior management meetings so that they can share strands of work they are doing.

CS responded:

Children's professional leads come in on a quarterly basis and they come to the SMT (senior management team) which meets every 2 weeks, they discuss before they attend to identify the highlights and hot spots and how they are going to present their information so that they are productive and get the best out of the opportunity which has to be short, sharp, dynamic and to the point. They all have that on their work plan because I meet with each one of them on a monthly basis to keep them on track and then I sit in with the SMT to find out what they are doing and that is the structure we have put in place. It works quite well but of course there is always room for review and improvement if necessary.

The story board became a medium for regular reflective practice and focused primarily on the previous experience to help individuals understand the significance of the dialogue in the Community of Practice. Therefore whilst comments were grounded in meaning for individual professional leads, the story board comments sought to facilitate clarity and acceptability across the Community of Practice. It supported them in taking responsibility for their actions and facilitating growth the story board was the opportunity and template to 'think aloud' and reflect on the validity of their existing philosophy and practice. It became the opportunity to revise their current thinking (Appendix 8). Information and assumptions identified between meetings were worked on each time and resources developed to reflect the value and potential impact of collective decision making. There was no one source of information and the participants began to take ownership of the tasks and group activities as well as decision making.

4.6 Winding Down the Community of Practice (January 2011)

As the services moved towards new hosting arrangements, due diligence processes began and the professional leaders worked with great interest and altruism towards supporting the staff, patients as well as looking after

themselves in taking services forward into the transitional arrangements and different organisations. Such fundamental structural change to provider services created individual and collective anxiety and raised tensions. Self efficacy through resilience, self belief and marketing were elements considered in the discussion and progression towards new business models with a summary of key messages for members to remain alert to despite the closing of the Community of Practice, placed on the story board by one member.

Dear Fellow Meercats

Keep the connections and clinical networks

Making the invisible visible 'building blocks to support my current performance and practice – remember back stage staff and services

Service development through the front door NOT the back door so they can be governed

If you don't know ask!

Keep focused on the job in hand

At this time some structural support was withdrawn and a few professional colleagues, external to the Community of Practice, came to the end of fixed term contracts and were no longer available to support professionals in practice. This had an impact on the members of the Community of Practice. Preparing for change meetings were organised and reporting back from them became a standing item on the Community of Practice agenda. Policies and protocols began to be reviewed and extended alongside the changing operational management structure and meetings.

The activity used to support winding down the Community of Practice focused on completing outstanding pieces of work and achievements. This included the use of formalising the organisational response to Quality Accounts, operating a dignity day, auditing and refocusing managerial, professional and child protection supervision, acknowledging any future workforce reductions across the Strategic Health Authority and using the Operating Framework to underpin activity.

The Community of Practice came to a natural but formal end as Transforming Community Services began to highlight the requirement for

increased productivity alongside reduced resources. These final meetings focused on maintaining authenticity whilst remaining corporate and opportunities were identified for building confidence. Some professional leads were naturally anxious about their future in new organisations and this impacted on productivity in the Community of Practice. At times there were challenges to be managed between operational managers and support required from within the Community of Practice to deliver on the requirements of the challenge as well as the necessary collaboration with colleagues. Alongside this investigations and disciplinary processes continued as well as development of clear partnership arrangements with the local authority particularly around the mental health of older people agenda and transfers of services from other organisations. New posts with fixed term contracts were appointed to for patient experience, manual handling and productive community services.

The findings and comments in Table 4.1 came from a collective group discussion during the winding down phase and tell us how the Community of Practice illustrates success:

Table 4.1 - Illustrating potential success factors for the professional leaders collaborating in the Community of Practice (adapted from le May 2009)

Membership	*This was initially prescribed to a certain extent through roles and responsibilities, with minimal opportunity to include or exclude other members of the professional leadership group who could legitimately be involved because of their role and associated skill, knowledge, expertise and ability as leaders in their field and the organisation. This became more flexible as other skills were required at various stages.*
Commitment	*This came readily from individuals as well as within the service and the requirement to achieve the desired goals relating to governance in quality and safety through professional leadership and practice. Individuals voted with their feet with majority attending regularly and contributing effectively.*
Relevance	*This had been explained to individuals for their own professional development and support to do the job as well as more generally with the need for service development and change in leading the quality and safety agenda. But the informality of networking and creativity demonstrated the benefits of the time spent in the Community of Practice.*
Enthusiasm	*This was evidenced through personal, professional and service engagement in the development and working of the Community of Practice, but involved negotiating individual positions and interests as well as leadership and particular but changing roles and responsibilities.*
Infra-structure	*There was no formal process for accessing knowledge or evidence through library or IT support and this did affect efficiency. In response each member took some responsibility for finding information about their current service or speciality from various networks or through sourcing latest documents, directives or data.*
Skills	*Limited secretarial support was available where actions could be taken forward, progress recorded, reports and business plans developed from the dialogue. Any individual IT skills were utilised to present information to wider audiences in addition to undertaking the maintenance of the story board, external surveys and user feedback through a secure drive.*

Resources	*External resources, in addition to the research study, were not available to pump prime a pilot and strategically formalise the desired outcomes for change or for evaluating the effects of change. This proved to be a shortcoming and disappointing in relation to the ongoing professional leadership influence and sustainability of the Community of Practice.*

4.7 Shutting down the Community of Practice (March 2011)

By the time the research ended the Community of Practice members realised the value of what they had created by experience and took ownership of the benefits recognising an innovative product and how it might impact positively on future services. They acknowledged the productive tension between aspirations and everyday narratives and were committed to replicating the model in their new organisations, but whilst it was also considered a possibility to retain the current members the Community of Practice naturally dissolved through the transforming community services process when individuals left. Within the integrated health and social care organisation there was a change of attitude towards the concept of Communities of Practice and the original scepticism turned to enthusiasm. It was acknowledged as an enriching experience by the participants who described the benefits including:

- *Professional networking*
- *Leading the mobilisation of members to face and solve problems alongside maintaining and improving espoused standards of both the Community of Practice and the broader community of professionals alongside operational managers*
- *Exposing the salient features of professional leadership for the safety and quality agenda*

The Community of Practice shut down and the research activity effectively came to an end as services transformed. The decision was taken to formally close the Community of Practice due to the organisational

restructuring and the impact that had on changing allegiances. Once this had been acknowledged by all the participants there was a feeling of loss and a period of bereavement recognised by several of the members, it became the end of an era and the Community of Practice went through a formal sign off. Everyone expressed the desire to keep in touch with a feeling of sadness as well as acknowledging how helpful the activity had been agreeing to meet socially and for mutual support in a less formal arrangement. In hindsight, there has been regret, as this would have been an opportunity to sustain the professional support with the Community of Practice into a new world.

4.8 Summary

The findings in this research have enabled a much deeper insight into the practical process and workings of a Communiy of Practice, formed to undeprin activity and development towards safety and quality of health and social care services through the professional leadership activity and structure. The experience identified issues related to using the Community of Practice methodology and will be discussed alongside more recent literature in Chapter 6.

Alongside the Community of Practice discussion the features identified focused on the meaning and influence of professional leaders, how the Community of Practice allowed professional capital to be generated through the creation of a forum for learning where experiential knowledge was shared and the opportunity was provided for partcipants to develop their own skills and confidence. These will also be discussed in Chapter 6 in relation to more recent studies and ideas associated with the meaning of leadership particularly in developing contemporary health and social care services.

Chapter 5 Professional Leadership in Safety and Quality

Chapter 5 describes in more detail how the professional leaders articulated, influenced and impacted upon safety and quality activity, enabling change through working together in the Community of Practice. Expertise was demonstrated and knowledge exchanged in the stories, anecdotes and narrative shared through the activity within the Community of Practice allowing shifts in services, but identifying shortcomings and recognising the challenges that had to be addressed and overcome. This chapter exposes the salient features of professional leadership with the safety and quality agenda

5.1 Exposing features of professional leadership.

The salient features of professional leadership were exposed through day to day activities in the Community of Practice and the stories and narrative in this chapter highlight the variety and complexity of some of the situations and ‘wicked problems’ (Beinecke 2009) shared and developed through the Community of Practice. These features can be grouped under three headings in bold below and were exposed through debates around the implementation of productive community services, managing sensitive situations through cross working arrangements with other organisations, implementation of new service initiatives, non compliance with policies and procedures, reacting to poor performance and capability concerns, peripheral participation and demonstrating leadership ability.

The professional leaders articulated, influenced, impacted upon the safety and quality agenda and enabled change through the Community of Practice by dramatising practical experiences, learning together to create an entrepreneurial identity before using their skills and knowledge to work alongside managers dealing with never events to lead clinicians through:

Constructing and sharing a meaning for professional leadership through dealing with safety and quality events and dramatised representations of their day to day activities by:

- Partnership working and forming professional networks
- Fostering cross organisational learning to improve safety and quality with examples related to:

  -Reviewing and changing discharge procedures

  -Improving communication and developing links between services

  -Safeguarding vulnerable adults

  -Sharing statutory information and learning

Creating an entrepreneurial identity through contextualising new knowledge and learning. These included:

- The creation of an entrepreneurial identity
- Creating shared conceptual frameworks for example

  -managing conflict

  -leadership influencing expertise

  -constructing quality and safety

  -developing clinical pathways

  -understanding different cultures

  -changing systems, processes and practice from experiential learning

- Contextualising new knowledge and learning

Developing skills and confidence to be instrumental in progressing the safety and quality agenda through transformation of services.

Each of these features will be focused on below.

5.2 Constructing and sharing a meaning for professional leadership through dealing with safety and quality events and dramatised

representations of their day to day activities.

5.2.1 Partnership working and forming professional networks

There were always lots of things happening in either the text or setting, not only was the content of what was being said rich and diverse – the participants were doing things that could be understood in several different ways at the same time through the social fabric of the organisation - but the participants also indicated things about themselves and their world by their actions and the way they expressed themselves. The interpersonal relationships that either contributed to or diminished the explicit and implicit knowledge and meaning communicated through sometimes difficult discussions cannot be ignored as they were a vital contribution to the final outcome in practice. It was not possible to capture all the knowing looks, facial expressions and changes of behaviour seen between the professional leaders during this research but they could all be used to identify deeper and different meaning alongside the language or silence through thoughts left unsaid on the audio tapes.

Throughout the time of the Community of Practice definitive tasks had to be undertaken even during the committing stage which helped the group to form and become more cohesive during the early stages and make progress. These related to the focus on professional practice and leadership in health and social care with the added definition:

> **Professional:** being the very best in high quality, safe, effective, productivity and efficiency.
>
> **Practice:** being every day activity, incidents within and about the service
>
> **Leadership:** being about the influence between leaders and followers through shared values and purpose, personal qualities and responsibility, knowledge and skills alongside a desire for change

This definition, alongside their own (Chapter 4 page 81) was discussed and confirmed by the professional leaders and demonstrates the fundamental truth and good reason why active co-participation was critical to reflect the learning that took place in practice as well as the formation of health and social care professionals continued education. The professional leadership,

practice and knowledge in both health and social care became interrelated and constantly crossed boundaries to discuss and make partnership decisions about many professional practices and leadership issues both inside the organisation and through other external networks such as:

- *Clinical Pathways*
- *Training, workforce and personal development*
- *Cultural similarities and differences*
- *Incident reporting and learning from the outcome of investigations*
- *Supervision evidence and the results seen in changing practice*
- *Leadership skills, team development, functioning and dynamics*
- *Staff wellbeing and empowering front line clinicians*
- *Organisational procedures and disciplinary processes*
- *Adherence to policy and standards alongside experiential learning*
- *Safeguarding adults and children*

This was complemented by legitimate peripheral participation (Lave and Wenger 1991) when various professionals were invited into the Community of Practice throughout the time of the research, including the safety and quality manager (see chapter 4 page 88), the non medical prescribing lead, the infection prevention and control consultant nurse, the customer services facilitator, the equality and diversity lead, the medical director and the safety and quality facilitator. They were temporary attendees to the Community of Practice but came willingly, with specific and essential knowledge to contribute which encouraged a reciprocal dialogue, initially able to participate from the periphery and having the distinct benefit of bringing essential information. The Community of Practice participants drew cleverly on their networks to harness knowledge and views, positioning themselves between the thoughts of individual practitioners and the organisational hierarchy. Unfortunately for some even this peripheral participation was denied at times SN 2 said:

…. is desperate to come into the meetings, but I don't think that is right. She thinks she is missing something but I think it is better to keep her in her place and I will

tell her in supervision if there are things she needs to know. She is so needy that I am sure she would disrupt the flow…..

At other times the core group only used others to obtain information and rather than facilitating legitimate peripheral learning actually prevented them from being part of developing new knowledge and benefitting from it as they never became core members.

In addition similar problems arose, implicitly, when adversarial relations between hierarchical positions came into play. At times this made participation constrained under certain circumstances and prevented optimum partnership working by the Community of Practice participants as well as external partners during the final stages of the Community of Practice.

During the Community of Practice operational phase through the participants working in partnership together the benefits accrued when the professional leaders were problem solving and engaging in collective reflection on decision making. These included increased idea creation, increased quality of knowledge and advice, problem solving and creating a common context. The community provided a forum for free expression of creativity and new ideas, providing members the opportunity to share ideas and think outside the box. SN 2 confided:

I have been struggling with the best way to do this and I need advice on how to get started, some suggestions would be helpful. We have decided to introduce 'Productive Community Services' into my services and because it comes from health the modules and material, although they are very clear to me, have the potential to alienate some of the social care staff. We can't just deliver as is so it would be helpful if we could think about it differently

This admission sparked a debate about integrated working and the need to acknowledge different cultures when introducing innovation and changes to practice which helped with the project planning and implementation.

5.2.2 Fostering cross organisational learning to improve safety and quality

The Community of Practice participants were able to set up direct lines of communication through face to face task and finish groups to develop systems including recognised care pathways to improve safety and quality

within our own organisation as well as across the associated stakeholder secondary care hospitals, saving time, increasing productivity and learning alongside innovation. CG said:

> *We don't have to reinvent the wheel with this project as I remember something similar I have done previously. I will look it out and see if that can be used to kick start the process, we may have to develop it but the project implementation template will at least get us started and should save some time*

Once a document had been created, reviewed or re written within the Community of Practice it was retained by our integrated health and social care organisation to not only demonstrate corporate memories, but be translated into future best practice as well as be used in any relevant situation as a focus for innovation. CG said:

> *A local trust, who are working towards foundation status has seen our policies on the website and has been in touch with to ask if they can use them…I don't have a problem with that so long as they acknowledge us on their documents do you?*

CS replied:

> *That's funny because they have also been in contact with the Children in Care nurses to ask if they can use their protocols. I was of the same opinion as you because I am confident they have been through a robust process, by being evidence based or at least based on NICE guidance and working towards compliance so I said exactly the same as you.*

This constant cross organisational learning and sharing was evidenced through the collective expertise in creating policies and procedures that were reviewed as part of due diligence and taken into transforming organisations with the following examples:

5.2.2.1 Reviewing and changing discharge procedures

In all health and social care provider organisations as winter approaches safety response levels are raised relating to demand and capacity of staff, equipment and resources. Enhanced communication between stakeholder acute hospitals and the community hospitals became normal practice. Being responsible for working with operational managers to monitor the community bed state one SN 1 said**:**

Winter pressures are looming with only twenty two beds in the community and the acute hospitals on red alert. At closure of DMT (Delivery Management Team) there was a flurry of excitement and four extra beds were opened at the Acute. Other issues were staff going from community to acute to man the beds and beds from community being transferred physically to the Acute. The Chief Executive saying the Acute was virtually in meltdown and they would physically have to close the doors. There were fifty or so patients waiting to come into our community hospitals and there is a build up because of the funding and community assessment issues so they can't physically get them out into the community. They have a slow down policy at the moment because of their financial situation and therefore that has an impact. There is also an issue around the needs of the elderly with mental health problems impacting on our beds which I have now evidenced. This happens every single year and it is like a domino effect. People get hyped about it.

Understanding the complexity of the situation the OT suggested*:*

This also has an impact on occupational therapy because it takes ages to do a home assessment and then there is panic. We have lots of examples of people waiting in the Acute for 10-12 days just to get to community and then when they get there they have to start all over again but potentially they could have started ten days before so that all was organised for when they get to community.

SC agreed:

This also puts so much pressure on social care at this time of year and I think this is where integration falls down in practice because we end up arguing about who is responsible for funding these cases if they aren't able to go back to their own home. I think this is where we begin to show cracks in our personal, professional and organisational relationships. Obviously I have my own professional opinion about this and need to work with colleagues

This demonstrates the complexity of health and social care activity with the need to balance various political, financial, professional and organisational components to achieve optimum safe and high quality service delivery. Following this dialogue the Community of Practice took the opportunity to review relevant guidance as the issues of timely and appropriate discharge from acute settings to the community was reflected in the DH Operating Framework for Primary Care Trusts (2009/10) and interpreted into local business plans and contracting with commissioners. Building on the original investment, whilst acknowledging the turnaround achieved in integrating health and social care there was a need to set a new ambition hence the

DH publication the NHS 2010-2015: from good to great, preventative, people-centred, productive (DH 2010). The Community of Practice participants acknowledged the need for professional leaders to be politically aware and acknowledge the impact of the change of administration and associated jargon. This strategic document continued to underpin the approach to having health and social care services in the right place at the right time, working in partnership with other providers to create a seamless service as well as giving patient's choice, convenience and control in relation to their care.

The professional leaders within the Community of Practice had individual and specialist lead roles and responsibilities but the benefit of collective working resulted in a more creative approach and broader knowledge base contributing to final outcomes. The reality of implementing the vision, usually through front line staff and accelerating safety and quality improvement for all was challenging, especially during particular periods of financial constraint. In addition the NHS Constitution (2009) locked in the improvements already made ensuring that the NHS did not slip back to some of the unacceptable standards experienced in the past. It set out the roles and responsibilities of the NHS and partner agencies through describing patients' rights as well as those of staff and organisations in order to deliver the vision. The Community of Practice context and structure enabled them to craft a collective entrepreneurial identity that helped to maintain the internal structures as well as the external concepts and relationships within the wider services. This was demonstrated by the shared identity, common values, and acknowledged roles or professional leaders being understood by the membership as well as those outside. The professional leaders were able to be innovative but aware of the need to work across organisations within a political and resource limited framework. The Community of Practice structure provided the opportunity to test out theories and examples alongside the assurance that evidence based practice was identified as the basis for service developments.

5.2.2.2 Improving communication and developing links between services.

Coincidentally from conflict resolution training an anecdotal story came to the Community of Practice. Two members of staff on the training from children's services were talking about a young person with a learning

disability who, when receiving dental treatment with his mother, had allegedly hit a member of staff before being locked in a room. This incident had happened several weeks previously and did not come to light until the conflict resolution training some time later. The outcome was that three members of staff were in tears at the training and the whole scenario was flagged up to the safety and quality team by the trainer afterwards. The service lead had received a message from the trainer suggesting there was an issue around confidentiality and incident reporting as well as confusion relating to whether this story was about a child or adult. Previous performance concerns had been raised about the particular service not wanting to take responsibility for patients with a learning disability which had compounded the current concern. There had already been a risk assessment undertaken previously for managing the service safely. It was decided to investigate the truth of the story and allegations in the first instance as the incident had reportedly taken place several months before. If the young person had been locked in the professional leaders discussed equality, diversity and dignity principles within the Community of Practice and were quite clear this would need to be reviewed as a disciplinary matter and staff would need to be held to account but it appeared they were lacking in written evidence through the routine reporting systems. The service lead was already reviewing this through an investigation process, but the outcome of this story was to connect with the children's learning disability lead around the pathway of how they do or don't manage the young people in the future which consequently resulted in routine risk assessments, development of standards and potential to change practice.

The Community of Practice acknowledged the young person was a sixteen year old autistic boy who might well have been frightened, but there was also concern about the lack of appropriate incident reporting. CG agreed that:

> *We are so entirely dependent on people who are part of the incident to report it, it is the very worst type of incident that we don't know about that leaves us with no option but to hold people responsible. We need the person who is responsible to complete it and it is difficult to know how to break that really.*

The participants agreed that progress was being made by responding proactively to individual incidents and the need to try and get it right each

time realising that we needed to believe people are good unless proved otherwise. Interestingly the lack of continuity of effect was acknowledged because of previous incidents on the same site with the same set of people and the CG reminded us:

One of those had been where a tourniquet had been left on a toe following surgery which meant that the written protocol, which includes a check list of actions to be completed and signed off, had not been followed.

A discursive debate ensued about staff being tuned into the reporting of clinical incidents. SN 2 said

If I was the person that was assaulted I would be reporting it in case anything happened as a subsequence of that. I would have a legal standing. There is something about recording things that are not clinical. But of course we don't know the facts yet, he may have been rude or pulled his hand away or just...or not...it depends on their tolerance as a team to accept that sort of behaviour. If they have already labelled these people as.., and decided they don't want to work with them which is a strong flavour of what came through to the professional council you don't know the facts of the matter. The other thing is that if they did lock him in the room that may have been the safest thing they had available to them at the time. I am not saying it is appropriate but what else might have been available. Also is there security, was the parent there, there are all sorts of things that could be done. If there was no parent there and this guy was absolutely causing mayhem, absolutely causing mayhem screaming etc what can you do? We need to know the facts, it is a big hospital and there are staff upstairs and male staff and porters in MIU etc. There are lots of ways you could have sort help. I would like to have thought that was the very last resort, most of us can deescalate can't we and that is what conflict resolution training is all about. It is any lasting damage that might have been done to that young man from being locked in a room. How is that going to affect his future treatment? You would like to think that was the absolute last resort. I really hope it hasn't and I can't see that it will have and it would be a last resort but if people were in danger. We don't know the details and what their decision making processes were.

The professional leaders used these examples as a way of communicating across their specialist groups to demonstrate how important it was to have

and follow policies and procedures, based on best evidence and experience in organisations contributing towards safe and high quality services. This was not to the exclusion of individual registered professionals being accountable for their own actions and acknowledging where performance management might be required. Also the professional leaders used a period of collective reflection to clarify and confirm the facts in order to contribute to the most satisfactory and safe outcome. As the participants continued working together it seemed increasingly that ideas and decisions were shared and developed, by checking things out through interacting with each other and relationships evolved with building trust and respect for each other. Responsibility and accountability are documented on all public service job descriptions and can be identified alongside those situations where systems are seen to be responsible for service failures.

SN 2 said

> *We just need to have much better ways of individuals communicating across the whole system. We must all take responsibility for this because we can all be accused of working in silos! If we take responsibility for our own actions as professionals that also involves looking outwards to see what other stakeholders there are around us and how we and they impact on each other*

Usually both areas need to be considered and the benefits of using a whole systems approach were realised in this case to identify the root causes.

5.2.2.3 Safeguarding vulnerable adults.

Safeguarding children and vulnerable adults is of paramount importance to all health and social care services where daily conversations happen supported by Working Together to Safeguard Children (2010) and the Mental Capacity Act and Deprivation of Liberty (2009). The Community of Practice members had extensive specialist knowledge of safeguarding both adults and children carrying much of their tacit knowledge, collected over many years training and experience, in their heads as this provided them with guidance at their fingertips when faced with difficult and complex situations. With specialist trustworthy networks to support experience and instinct, sometimes it was necessary to amend previous thoughts and share an understanding of practical knowledge that fitted with current circumstances as in the case of an elderly couple who had been very

protective of their privacy and refused to allow services into their home.

SN 1 shared:

> *A case was reported by the ambulance crew following the unexpected death of an elderly gentleman in his own home. Health and social care organisations have a memorandum of agreement with the police and following a chronology of the notes – a problem was identified in the use of assessment tools and timeliness of recording. The team looking after the case lacked robust leadership with the senior nurse being supervised by a social care manager who is currently being performance managed due to lack of leadership skills. We can't talk to each member of staff because it breaches the memo of understanding with the police. The initial findings were that the care was OK, that we weren't negligent and that there were lots of problems with the gentleman and his wife refusing access to the house, admission to hospital, heavy drinkers and not looking after themselves. After he died his wife went AWOL and we couldn't find the notes for a long time. Time line and chronology have been done but we couldn't follow an internal investigation because we were waiting for the safeguarding meeting. We do need to think on the surface of the matter, but the way the ambulance staff have described things, expressing themselves and escalating matters in ' we had to peel his skin off the chair' indicating the state of his bottom (safeguarding). The chair of the strategy meeting appeared biased and the situation was compromised.*

This demonstrated how multi-agency services work together in complex situations, despite a different remit being able to use professional skill competencies and knowledge to make an individual clinical decision and professional judgement with the evidence available. The various sources of knowledge needed to be shared and amalgamated to develop an understanding that fits with particular organisational circumstances and roles.

SN1 provided leadership and support to the community nursing team involved in this case and following discussion at the Community of Practice was able to confidently review the multi agency investigation process, identify learning and develop a process protocol for future incidents.

5.2.2.4 Sharing statutory information and learning

Community services were responsible for providing health and social care

to several prisons within the county and SN 1 explained:

> *Following the death of a prisoner in the main prison, even though it was an expected death they were technically in our care, this caused much debate and fact finding about individual and corporate roles and responsibilities*.

The SC added:

> *Eventually it was realised that it is a statutory requirement if a prisoner dies in the care of prison officers, irrespective of the cause there has to be an investigation and so it automatically becomes a serious incident requiring investigation, a SUI. This included the content of Coroner's report which can sometimes take a long time to be received*.

This isolated example illustrates how working together provided the opportunity to share statutory information and learning. As this is a relatively unusual situation that may rarely happen in a professional career it was important to undertake some fact finding and learn from the experience for all of us.

5.3 Creating an entrepreneurial identity through contextualising new knowledge and learning.

5.3.1 The creation of an entrepreneurial identity

Already with a wealth of experience each professional leader was provided with a platform to participate in the Community of Practice and explore the connections between practice, leadership and learning through gaining new knowledge. To get the most out of the community it was important to identify the kind of knowledge the participants needed to share; how the community was going to bond; and how useful it was going to be for our everyday work. This was done by overcoming previous isolation and acknowledging learning together about safety and quality issues. The heart of the community developed from concepts associated with interpersonal relationships, the initial purpose, relating to the role of the professional leader in developing and sustaining changes in practice and culture to ensure improvements in the safety and quality agenda. Also including the way new knowledge was generated and communicated alongside how that learning was embedded in practice. An element of this research focused on characteristics of professional leaders and what influence that had on the

community as well as how professional capital was generated, acquired and maintained as a result of the community influencing community services. The driver for this learning and action was the need to make a decision about patients in their best interests and professional judgements were often easier to make with the benefit of group discussion, consultation, decision making and reflection. The findings show that the learning was embedded within experience through observation, role modelling and advice from others. Often the professional leaders needed to think creatively with an entrepreneurial spirit (Adair 2009:133) to introduce new ways of working and opportunities to do things differently. One example of this was when CS shared:

> *I have looked at other areas nationally and the evidence behind introducing volunteer community mothers into the community. I originally saw this idea in my professional journal but I think this is an opportunity to build community capacity alongside the children's centres to provide more support for parenting groups and working with individual families. It really builds on the peer supporters we have working to help women extend the time they breast feed but I am sure this would work if we have the right governance and monitoring arrangements in place.*

This idea was first muted within the Community of Practice which collectively gave the confidence to take the idea further and develop it into a project plan with the associated implementation, monitoring and governance arrangements in place. The Community of Practice exerted power over individuals within, through the way they learnt together and each became responsible for contributing to the whole quite distinctive epistemology which became an important aspect of their collective professional capital. On the whole there was great communion between members who demonstrated practical examples of fellowship towards each other through their dialogue, discussion, reflexivity and influence creating an impact that would not otherwise have been possible. Usually they were comfortable and authentic with each other in the way they acted and worked together. The common purpose was to influence the patient safety and quality agenda and an important aspect of their professional capital but it was evident at times that individual professions and backgrounds threatened to compromise the activity and potential out puts which were identified on several occasions. Although further exploration afterwards

revealed less specific identification of knowledge with the evidence of transferable skills and ability to interpret and translate for the benefit of influencing the wider agenda.

5.3.2 Creating shared conceptual frameworks

Participants in the Community of Practice brought stories and anecdotes to share relating to specific experiences and expertise from their own sphere of practice including executive leadership, adult and children's services, health or social care governance and allied health professionals to the discussions. These included

- *managing conflict*
- *leadership influencing expertise*
- *constructing safety and quality*
- *developing clinical pathways*
- *understanding different cultures*
- *changing systems, processes and practice from experiential learning*

The opportunity for knowledge generation and the impact of leadership influence therefore needed to be generically re conceptualized realising that skills, knowledge, ability and experience could be transferred to a variety of settings and situations where professional leadership influence was required. It became noticeable that one of the benefits of the Community of Practice enabled participants to operate between their own specific domains as they learnt to be aware of and use their knowledge with a wider impact. The knowledge and influence of the most senior executive professional lead was also considered throughout, due to their broader strategic management domain needing to be taken into consideration and an awareness of the potential conflict between operational management and professional leadership.

5.3.2.1Managing conflict

All of the participants brought their own personal histories to the Community of Practice, including workplace, social and family experiences

similarities and differences. Although these often complemented each other the huge variation brought conflict at times and had to be reconciled and negotiated throughout the research. Both for the individuals and the transfer of knowledge it was important for everyone to actively participate in a meaningful way as well as develop positive relationships and be instrumental in constructing the identity of the community. This brought mutual recognition although collaboration and respect were sometimes lacking as evidenced by observing individual practices. SN1 said:

> *I feel quite angry about things like 'doing own emails' I often do lots of emails in the middle of meetings and this is not about how to manage their work it is how they can prevent themselves from doing any work when we are all trying to be as productive as possible*

When conflict arose there was generally an effort to rebuild confidence and trust in the process but this did affect relationships which began to break down towards the end of the research and although a salvage effort was made by some members, this undoubtedly had an impact on the ability to function as a community. Never the less activity involved actions towards common altruistic goals with a strong sense of mission and vision that the learning would add value to the overall aims of the organisation. There was a noticeable difference between the professional practice of nursing with the authority and accountability held by individual professionals within the community which impacted on the flow of activity at times. The duties, responsibilities and obligations placed on nurses sometimes came into conflict with others when at one level accountability was assigned as a broad responsibility for events and at another demonstrated individual accountability for practice. SN 2 said:

> *I could not support the nurse on this occasion when it became clear at the hearing that she had returned to the ward on the pretext of checking her off duty when in fact she had gone into the office, had accessed the patient records and altered them after the event to make it look as though the incident had never happened. It is just not acceptable and we have processes in place to escalate this not only within the organisation but to the Nursing and Midwifery Council where I believe it will need investigating further.*

Learning in the Community of Practice often involved dissecting individual appraisal against idiosyncratic beliefs, values and standards. It provided the

opportunity for personal reflection and to examine moral and social responsibility alongside clearly deciding and articulating the community dimension. Because of the opportunity to fully express important relationships between the participants, sometimes the professional leaders oscillated between self and community and this had an impact on overall learning and development of individuals as well as the community itself.

5.3.2.2 Leadership influencing expertise

In analysing the characteristics of professional leaders in the context of the Community of Practice, using and achieving the espoused goal of influencing the safety and quality agenda through professional recognition, I have been challenged to consider what made the difference and how that is demonstrated in the findings. By dedicated personal commitment, forming relationships, being able to constructively challenge in a non threatening way, sharing hopes and fears, achievements as well as failures the participants used all their skills of intuition, linguistics, reflection and thinking in practice to enable expertise and change to emerge through interaction with each other. The professional vision was constructed and became the basis for verbalising and understanding how each leader worked with learning from that tacit knowledge and evidence based practice through conversations brought about by the stories. Sometimes the stories revealed completely new ways (e.g. using leadership to introduce skill mix into teams, delivering individualised episodes of care and care packages, using volunteer community mothers to support parenting programmes, creating clinical champions within teams to embed ideas in front line practice, implementing productive community services) of seeing and doing things which in hindsight were sometimes acknowledged as common sense after they were shared by the community through an event, circumstance or experience. Also thoughts and looks left unsaid identified connections between participants because of their shared perspectives on a particular issue and this did become difficult to manage at times.

Demonstrating how the professional leaders collectively managed to integrate and generate professional capital the findings show how individual members related to each other, learning between themselves both formally and informally through generating and transmitting their expertise and experience to develop new knowledge. This involved retaining their ethical

beliefs and legitimate codes of practice as well as acknowledging historical and formal practices. But they were motivated to articulate their learning and challenge with a possibility of influencing and impacting on practice and culture. This was either visible or invisible but based on evidence, learning, communication, action and reaction through which professional capital was generated. In most cases as professionals the stories came from interaction with patients and clients in response to their needs.

5.3.2.3 Constructing safety and quality

The Community of Practice activity revolved around constructing the theoretical conceptual framework behind the safety and quality of services which was laid down through the commissioning arrangements with provider services. The expectation was to deliver services in accordance with the law, good clinical practice derived from evidence based research, involving patient choice through integrated health and social care activity, albeit unless an alternative agreement had been made with a co-ordinating commissioner. All staff were required to deliver care consistently within core national initiatives and comply with evidence based standards and recommendations issued by the Care Quality Commission, Monitor or any other regulator. The professional leaders oversaw responses to recommendations arising from audit, serious untoward incident reports or patient safety incident reports and to comply with the recommendations from time to time issued by any other competent body in addition to introducing new services.

SN 1 said:

> *We now have a project manager in place to look at E Rostering. This is a new idea that should make planning for staffing and managing all of our community services much easier.*

E Rostering was introduced to adult community services

In addition it was necessary to interpret, facilitate and apply evidence based practice as well as the standards and recommendations issued by any relevant professional body and agreed in writing between the co-ordinating commissioner and provider. SN 2 said:

> *We have looked at the options for extending twilight nursing services into twenty*

four hour care and the impact this might have on reducing out of hours medical services. It is a big task but it has been done in other areas similar to ours.

External scrutiny was also applied through compliance with recommendations in technology appraisals and guidance issued by the National Institute for Health and Clinical Excellence (NICE). Compliance was required with the 18 week referral- to-treatment target where it applied to any particular service and associated with that agreed quality and performance indicators were set out in each of the functional service specifications. A final quality indicator involved reducing the number of hospital acquired infections and strict targets needed to be met relating to the transmission of any infections in hospitals.

There was also a statutory duty to improve the quality of care and clinical services for service users through the integrated governance arrangements set out in national standards and this was to be achieved through following Department of Health guidance on clinical governance. Service user and carer experience surveys were carried out regularly in relation to all of the services at reasonable intervals in accordance with the law and as providers there was an expectation to co-operate with any surveys that commissioners undertook. The reporting arrangements were agreed to be in the form, frequency and reporting in accordance with the requirements of the service specifications or as otherwise agreed between the commissioner and provider. Professional leaders made themselves responsible for collaborating with operational managers to co deliver the necessary standards of care and achieve the desired outcomes for service users, by sharing the tools, concepts, structures and frameworks developed within the Community of Practice as significant elements of the National safety and quality strategic intention.

SN1 said:

We have no choice but to comply with Quality Accounts and National patient safety agenda and I know these aren't as rigid or comprehensive for community trusts as for the acutes but it is our responsibility as professional leaders to makes sure we do everything within our power to get this right.

National political and evidence based guidance was used constantly to support the discussions within the leadership discussions within the

Community of Practice.

5.3.2.4 Developing clinical pathways

OT and SN 1 had attended an NHS Clinical Pathways seminar in the early days and presented information on ambitions for acute care, children and young people, end of life care, learning disability and long term conditions. This provided a focus on organisational requirements as the ambitions were quite specific and included a methodology for developing prescribed action plans in order to achieve the necessary targets and feedback the priorities in a timely way. The work was underpinned by the Queen's Nursing Institute Transformational Guide Assessment matrices (2009) and by meeting regularly to share progress and challenges in specialist areas the professional leaders supported each other in making decisions and identifying achievable priorities as well as developing appropriate business plans. The findings demonstrate how everyone agreed the format though the following service benchmarks:

Getting the basics right - every time: through

- *Access and availability*
- *Care planning and case management*
- *Effective health and care partnerships*
- *New services and approaches*
- *Information and technology*
- *Education and training*

Making everywhere as good as the best: through

- *Local health needs and service planning*
- *Effective health and social care partnerships*
- *New service approaches*
- *Access and availability*
- *Care planning and case management*
- *Information and technology*

- *Education and training*

These principles were used as the basis for discussion by the professional leaders and how each one could be developed to influence change.

CS informed:

> *We have the opportunity to create a single point of access for all children into the integrated children's services. This would create a pathway from before birth, through the universal public health nursing service onto more targeted services for children with emotional and physical needs. We would link with social care, children's centres, other voluntary agencies and education as the child and family needed them. This could be streamlined and save families repeating their stories and preventing duplication. It is really exciting and I am working with the ops managers around reviewing the evidence base and monitoring the governance arrangements such as information sharing protocols etc*

SW on another occasion thought:

> *There is nothing to stop us developing integrated training and education, such as safeguarding adults and children training for example domestic violence and substance misuse. This would encourage more of a link between children and adult services and hopefully make the services more seem less.*

Integrated safeguarding training was made available as well as training for undertaking investigations, but this created difficulties because of the dissonance between cultural and historic supervision arrangements as well as policies and protocols relating to performance management and disciplinary processes between health and social care.

5.3.2.5 Understanding different cultures

The participants acknowledged the many difficulties and frustrations when trying to work with the concept of culture in integrated services and how it is sometimes difficult to be open and get to the bottom of things. Very early on in the emerging Community of Practice one senior health care nurse expressed her despair when trying to explain to social care manager colleagues the importance of incident reporting. Both could be seen as opinion leaders in their own right and there was a need for them to understand each other's position and reasoning within the organisation. The need to use the identified organisational system, underpinned by

policies and procedures, to report and monitor patient safety and quality issues prior to decision making and potential ongoing investigations as well as individual and organisational learning. SN 2 said:

> *I am trying to say is that governance, patient safety and quality are of paramount importance and the door to that can never close. You cannot shut down certain pieces of work and I don't know if there is always a complete appreciation in that for this team and from the outside managers. There is completely no understanding of what this team has done in terms of what it actually takes to put these systems in place and enable them to work properly, you know and that is just considered for all of us...from designing a policy to implementing that policy to setting up a Datix (incident recording) system to putting in a password..no one understands any of that and partly that is our fault because we just get on and we deliver it, and I wouldn't want us to work in any other way to be honest….it is because they (managers) will never understand because they don't see the need to but.....*

This led to an intense conversation about the relationships and differences between operational managers and professional leaders as well as between health and social care which became the topic of conversation on many occasions. A further debate relating to the breakdown in communication between operational managers as facilitators and decision makers and professional leaders as technical experts demonstrated the frustration felt about poor relationships at middle management level. By being able to verbalise the cultural differences and potential gulf between employees trying to work in an integrated way, but from totally different cultural backgrounds, it enabled the senior nurse to identify and work out a way forward to improve communication and build relationships for the future. Opportunities for shadowing each other became available. She said:

> *There was a comment yesterday by....., and I don't know really, in DMT (Delivery Management Team) that it was said about the relationship between the professional practice and senior management interface. At a very senior level it was seen to be working very well together. At a lower level like the lead nurse and therapists it is working well, but there was a comment about the cluster managers (social care/local authority employees) and I said 'I have no forum with the cluster managers'. I never go out to the regional areas and our teams are not included in anything. I have no relationship with them other than when I seek them out individually. It is not my natural group to get in contact with. I will get in touch with the matron (NHS employee) and that is quite natural. We really do need to build*

bridges across these groups if we are going to make progress and real change and so we have agreed that I shall attend on a quarterly basis with a quality and safety agenda to try and develop those relationships.

This story implies a breakdown in leadership through a lack of natural communication channels with the cluster manager, but by being able to communicate those frustrations within the Community of Practice the senior nurse was able to share a possible solution with colleagues as well as identify a way forward to work on communicating with and improving those cultural differences and responsibilities.

5.3.2.6 Changing systems, process and practice from experiential learning

An investigation was triggered when an unexpected death occurred, with an opportunity to provide a chronology of events and identify if anything could have been done differently, being open in responding when needed and take time and effort for organisational learning to improve services. A story was brought to the Community of Practice when SN2 shared**:**

A 30 year old died unexpectedly and a member of staff from the local hospital came to the Matron and said a friend of mine came to MIU the evening of her death and was not able to be seen. The Matron and Cluster Manager started to look into it and nothing had been recorded in the records so I suggested they do a Miss Marples and look at the CCTV to see if anyone had just driven into the car park and seen that the MIU (Minor Injuries Unit) closed at 10pm and just driven off again. What they saw was a woman coming up to the door having a conversation through the intercom and driving off again. They then investigated and realised the healthcare assistant had spoken to the woman who said she had a lot of pain and was told if it was really bad she needed to drive to the acute hospital and if it is not too bad she can see the GP in the morning. The lady got very cross and said well thanks for nothing. She drove home and died an hour and a half later from quite a big event. She is in her 30s with 2 young children. The whole thing was an absolute disaster from all points of view. It happened last week and the Cluster Manager and Matron are very aware of it all. They are doing an incident report and they are following all processes but because we didn't actually see her in our premises and because there are no records and no formal complaint and we are just following a mention from a member of staff I haven't escalated it in any other way yet but I think we need to learn from it.

CG**:**

That is exactly what should be done as an incident because if it hasn't been logged as a complaint it is our internal mechanism for flagging up those things and learning from it. I haven't logged it as a SUI (serious untoward incident) because she wasn't seen. There are lots of things/issues here to improve and learn from. They should have had an eye on the patient, they should have gone physically out of the building and gone and seen that lady, they should have logged the incident

SN1:

What is the expectation of the healthcare assistant? They should not have done that and they should have fetched the registered nurse. The registered nurse should have set her eye on the patient as the health care assistant was not in a position to triage or do anything she actually did. The registered nurse.....what is the protocol for when someone goes to the MIU when it is closed? I don't know if there is a protocol! This is like the child a few months ago...what happens when the MIU is closed. The principle needs to be when 'to check out their well being' This lady could have walked back to her car, collapsed by her car or driving. They didn't even look outside the building. The whole thing is a nightmare. Apparently the registered nurse was on their break, they heard the bell go and thought if they want me they will come and get me. Well everyone is entitled to a break and it is how these things work locally and there should be a rule that an un qualified member of staff doesn't make decisions like that. When someone gets cross when you are not meeting their needs you know there is something wrong. This is the worst reputational thing we could have turning a 30 year old away who later died. I think it needs a deeper in depth RCA (root cause analysis) and I think we need to seriously consider what went wrong here. But although some may say we are employed to look after people in beds, our staff should be thinking more about people and we don't have to have a protocol for everything. We need to share the story so that we don't have the same thing happening again. What will they do in the future? The Consultant Nurse for emergency care needs to go and do an RCA so that we and the organisation learn from this.

SN2:

What supervision are they getting and what will be the outcome of this event as I understand the new matron is working wonders

CS**:**

I must also find out if children's services are offering support to the family as this is not the sort of thing that happens very often. The staff who need to move up hill are

the staff on nights because they like the hours, money level of work etc It is hard to up skill them, they need to come and do a refresher, come onto days and however you want to work it out and the days can go onto nights and they can all experience each other's ways of working. As an organisation could we work towards an HR regime that allowed it? This could be a lever

This shows how necessary it is for everyone involved to be part of making sure all controls are put in place to try and prevent this sort of practical situation happening again because it was described as a never event. The positive outcome of an in depth review resulted in changes being made to protocols in Minor Injury Units and rotational shift patterns being addressed in order to up skill night staff and make them aware through training and competency reviews of their responsibility in taking action to make services safer. A code of practice was also developed for healthcare assistants.

Individual and interpersonal awareness helped us to identify each others' concerns and position our own ideas to address them and we did this by listening to each other but there were times when concerns were not vocalised, particularly when we had not developed a degree of trust in our internal relationships. We were all very different characters with a vast array of knowledge and experience and it took a leap of faith for someone who had a concern to raise their hand and mention it and this was often achieved outside of the research arena through one-on-one communication rather than in the group. This was often a more powerful way of contexualising advice and interpreting it for their particular situation. The atmosphere within the Community of Practice at times did become tense and we experienced periods of poor productivity through illness, animosity and pressure from other agendas.

Sometimes bargaining was used amongst participants, colleagues and clinicians to gain support to move things on by negotiating a mutually satisfactory outcome to a decision that had to be made or a piece of work that had to be progressed. Most of us responded to this approach which was quite straightforward, especially when there was an element of reciprocity but on occasions it caused resentment when members felt they got the short straw, particularly through the power base within the Community of Practice. CG confided:

I don't know why I am always left to pick up the policy writing when other people

could do some of it! We should be doing these together and I've only just finished the policy on policies and so now I've got to update the incident reporting policy, nice guidance implementation process and investigating guidelines……..

The participants chorused:

But you know how good you are at it! Of course we'll all help you to get them done!

5.3.3 Contextualising knowledge and understanding

For all the professional leaders collecting examples and focusing time for sharing stories and anecdotes to put them into context and generate new knowledge was recognised as essential to their professional roles as well as individual learning and personal well being. In addition this was the method used to highlight contemporary service issues where there was potential to inhibit safety, quality, productivity, efficiency or service development and achieve a refocused outcome from the sharing process that promoted the intended change. Interpretation of the data revealed not only important factors about the internal business of the organisation but the impact that external forces had on the nature of the stories and discussion in the Community of Practice and in turn the explication of new knowledge.

5.4 Developing skills and confidence to be instrumental in progressing the safety and quality agenda through transformation of services.

The professional leaders were able to become more visible with the generation of new knowledge, confidence and the ability to acquire and affect power, authority and influence whilst still retaining individual values of best practice. Some common features were identified in relation to the skills, knowledge, experience and personal traits found in individual and collective professional leaders enabling them to influence service developments and cultural change, being demonstrated through the stories and the interview data including:

The ability to influence and empower practitioners to change

Strategically facilitate learning processes

Generate new knowledge to translate into practice

Acknowledge values, purpose and meaning through reflexivity

Communicate and problem solve through complex situations

Coaching, shadowing and mentoring

Finding a voice for professional leaders

5.5 Summary

This chapter described how professional leaders worked together in the Community of Practice exposing and demonstrating the features of professional leadership by recreating and dramatising experiences through the stories and anecdotes they told about working towards the safety and quality agenda.

The participants used the Community of Practice to create a framework for **constructing and sharing a meaning for professional leadership through dealing with safety and quality events and dramatised representations of their day to day activities.** Additionally they formed professional partnerships both within their own services as well as across organisations and these were instrumental in making changes to a variety of safety and quality situations. These professional leaders were also able to **create an entrepreneurial identity through contextualising new knowledge and learning** and creating shared conceptual frameworks. At the same time they **developed skills and confidence to be instrumental in progressing the safety and quality agenda through transformation of services** by facilitating learning, communicating and problem solving through observation, reflexivity, coaching and mentoring which helped them find a voice in improving safety and quality**.** By developing an entrepreneurial identity, sharing their professional leadership values and purpose, through demonstrating personal qualities and responsibility and influencing professional practice safety and quality changes were made.

Chapter 6 will develop the analysis and discussion of professional

leadership within health and social care services with the possibility to inform others working in similar roles

Chapter 6 A discussion of the features of professional leadership exposed through the benefits of working in a Community of Practice influencing safety and quality

6.1 Introduction

This penultimate chapter comprises three parts. The first part discusses the professional leadership features exposed during the research, the second part focuses on the methodology of using a Community of Practice and the third part highlights the benefits, learning and challenges of professional leaders working in this way. During the discussion I draw on previous research studies identified in Chapter 2 and more recent and comprehensive literature relating specifically to the features of professional leadership that have emerged during the research. The discussion will be structured around the content of Table 6.1 and will include a reflection on the 'influence' of professional leadership and the 'impact' of professional leaders on effective safety and quality improvements and productivity. This chapter closes by considering the limitations of using a Community of Practice approach.

Table 6.1A summary of the central findings emerging during the Community of Practice

Part 1 Features of Professional Leadership
Constructing and sharing a meaning for professional leadership through partnership working and forming professional networks to foster cross organisational learning
Creating an entrepreneurial identity through contextualising new knowledge and skills
Developing skills and confidence to be instrumental in progressing the safety and quality agenda and transformation of services
Part 2 How the Community of Practice enabled the process
Using storytelling, sharing anecdotes and dramatising experiences to encourage debate and create shared meanings within the Community of Practice
Part 3 Influencing the safety and quality agenda
The Community of Practice creating a forum for learning through generating professional capital by sharing experiential knowledge

Part 1 Features of Professional Leadership

6.2 Constructing and sharing a meaning for professional leadership through partnership working and forming professional networks to foster cross organisational learning

I have already alluded to the lack of literature pertaining purely to professional leadership and will therefore discuss and reflect on the ongoing debate between 'leaders' (DH 2009) and 'leadership' (NHS Confederation 2009) …and 'leaderism' (O'Reilly and Reed 2010).

A meaning for professional leadership was constructed through the shared stories and dramatised experiences linking them together in integrated health and social care services by collaboration, partnership and networking. This research observed both individual leaders and collective leadership but focused primarily on how professional leadership could be enhanced through collaborative working. Iles and Preece (2006) pointed to fundamental differences between 'leader' and 'leadership' when they noted that, leader development refers to developing individual-level intrapersonal competencies and human capital (cognitive, emotional, and self-awareness skills for example), while leadership development refers to the development of collective leadership processes and social capital (through the

Community of Practice) in the organisation and beyond. This involves relationships, networking, trust, and commitments, as well as appreciation of the social and political context and its implications for leadership styles and actions. They wrote:

'*leadership development involves the development of leadership processes in addition to the development of individual leaders*' (Iles & Preece 2006: 323).

By observing professional leaders working together in the Community of Practice the research illustrated how the communication through stories and anecdotes enabled leaders to share meaning for their work and develop partnerships within their own services as well as across other organisations. This feature is supported by Day (2000) who found that leadership development, predicated on a 'distributed' model of leadership, is about enabling individuals and groups to work together in meaningful ways. This has, as its goal, the building of social relationships involving all members of the community in order to respond proactively and effectively to changing circumstances, and thereby achieve organisational and societal goals. This in turn may raise questions about the role of the leader in facilitating change alongside implementing evidence based practice as well as patient choice and how the skills and attributes required are high on a continuum of success (Harvey et al 2002). Never-the-less an engaging style of leadership as described by Conger et al (1988) is helpful in achieving success but the implication of this includes questioning whether leadership development programmes that rely exclusively on developing managerial/leadership competency can be regarded as fully 'fit-for-purpose.' and suggestions have been made for other methods of leadership development such as peer review, coaching and mentoring (see page 89) used during the time of this Community of Practice (NAPC 2007).

Alban -Mectalfe et al (2009) provide a resume of formal academic research into the nature of leaders and leadership describing development through 5 main stages: the 'trait' or 'Great Man' approach; the 'behavioural' approach, out of which the concept of managerial and later leadership competencies emerged; the 'situation' or 'contingency' approach; the 'new paradigm' approach, with its focus on 'distant' transformational, often 'heroic' leadership; and finally, the emergence of 'nearby' transformational or 'engaging; leadership, and the associated concept of 'distributed'

leadership. In recent research they suggest that it is valuable to distinguish two aspects of leadership – 'what' a leader does, and 'how' they do it.

This research identified initial professional leadership was isolated and vulnerable with acknowledged anxiety being recognised and an awareness of the need to engage in collaborative opportunities to enable the participants to 'do the job'. This concern is supported by a number of current issues and problems that affect the ability of professional leaders to influence and identified in more recent literature (NAPC 2009). These are a lack of formal training (Goldman 2008), limited career progression and rewards (NHS Alliance 2006), division between clinicians and managers (Edwards, 2005), quality of relationships between staff, lack of clear leadership from above (NHS Confederation 2007), weakness in middle management (NHS Confederation 2007), NHS culture of insularity (Dickinson and Ham 2008), short-term thinking, risk averseness and hierarchy; work load and balance (Fradd 2004), under-representation of particular groups working in the NHS (NHS Confederation 2009), complex lines of accountability and cooperation within primary care and tension between evidence-based practice and flexibility, innovation and local responses to integration. But findings from the literature also support my own findings and the notion that professional leadership is important and effective in encouraging partnerships between professionals and managers and initiating professional integration (NAPC 2009).

Gilmartin and D'Aunno (2007:408) suggest:

'*leadership is positively and significantly associated with individual and group meaning, satisfaction, retention and performance*'.

This draws attention to 'powerful professionals' dominating healthcare delivery (2007:408). These ideas are echoed in the way health care professionals are asked to aspire to safe and high quality services. The influential National Centre for Healthcare Leadership (NCHL) declared that it :

'works to assure the high quality, relevant and accountable leadership is available to meet the challenges of delivering quality patient healthcare in the 21st century'.

The professional leaders spent time at the beginning of the Community of Practice thinking about what the meaning of their role and responsibilities meant to them personally and professionally; also what being a professional leader meant to other clinicians, managers and various stakeholders and how their roles might be projected across the trust and externally. This idea is supported by the early development of role theory which was characterised by the assumption that the acquisition of role is a formal, sequential, staged process of socialization into an occupational or societal position (Simpson and Caroll 2008). The notion of 'role' has been dismissed by scholars on one hand as an old fashioned cliché (Mangham 1996) and on the other hand as something that is so deeply embedded in our ways of knowing that it has ceased to be a matter of debate (Joas1993). At the same time though, role and the meaning understood by it, continues to be used quite naturally and spontaneously by organisational members in descriptions of their practice and experience. This research demonstrated the importance of the meaning of professional leadership roles and the responsibility associated with that meaning.

There are at least two distinct theoretical threads in this development, resulting in a confusingly ambiguous and disputed array of terminologies. Firstly, from a constructionist perspective, roles perform a crucial function in the establishment of all institutional conduct (Berger and Luckmann1966). In particular, symbolic interaction (Blumer1969) elaborates this understanding of role and meaning as an ongoing process of social construction that depends upon the interplay between a fairly predictable, static social order, and the creative actions of actors. Roles are conceptualized here as different social 'masks' that actors may choose to adopt in their ongoing constructions of both self and society (Strauss 1969). Secondly, from an open systems perspective Katz and Kahn (1966) viewed individual behaviour as a series of role systems located within an organisational context. A role episode is a continuous cycle of sending, receiving and responding to behavioural expectations. Drawing on typical system categories (input, throughput and output), Katz and Kahn (1966) defined role in terms of role expectations, sent role, received role and role behaviour. This perspective on role had perhaps faded in this particular health and social care setting as in many others who have moved towards job descriptions that are less rigid, static and demarcated but it

demonstrates the need to create a meaning for professional leadership roles and a professional identity which for the professional leaders was not explicit at the outset.

By working in partnership, mentoring each other at times and adjusting roles, depending on the levels of expertise within any of the individual spheres of professional practice, the leaders developed confidence and improved productivity with the required outputs for safety and quality such as improved practice by staff (followers) and using shared standards, policies and procedures. More recent research has focused attention on the meaning of leadership and the relationship between leaders and followers, which has again come to be seen as the study of leadership behaviour, rather than just leader behaviour. Action centred leadership (Adair 2009) has focused on three core responsibilities which depend on a combination of the characteristics and roles already discussed; achieving the task, managing/leading the team or group and managing individuals. This requires looking inward and outward to see what is available through either networking locally with other professional leaders or as Wenger et al (2002:58) suggest looking for both public (meetings) and private (individual) community spaces to work in partnership with others. Pearce and Conger (2003) suggest many critical issues cannot be addressed by individual leaders and require collaboration rather than competition as well as breaking down ‘silo thinking’ and adopting across organisational processes. The new leadership model is differentiated from more traditionally individualistic models of leadership (Senge and Kaufer 2001, Fletcher and Kaufer 2003; Fletcher 2004). Rather than the focus on personal characteristics and attributes, new constructions of leadership continue to acknowledge the value of partnership and networks.

The building of partnerships within this research, spread not only across the trust but outwards to adjoining health and social care teams as joint learning reflected the wider impact of the safety and quality activity for the benefit of the whole population e.g. continuing health care, care within prisons and safeguarding vulnerable adults. It is therefore important to understand the nature of professional leadership in the 21st century, as well as the provenance of any model of leadership, to be able to critically appraise the value of the concept of leadership and how it can validly be

assessed in relation to impact and influence not only within the organisation but through external stakeholders. Professional leadership has been seen to have poor status compared to leadership in operational, political or academic domains (Antrobus and Kitson 1999) but these findings demonstrate that individual and collective professional leadership were enhanced and strengthened through this research paradigm. This Community of Practice research played a significant role in facilitating leadership confidence and enabled the creativity and innovation required to achieve some of the necessary service developments across the trust and adjoining organisations. This was particularly necessary through integrated working with the local authority when adaptive leadership was required to rethink assumptions and practices. Heifetz and Laurie (1997) and Heifetz (2009) describe the capabilities of adaptive leaders that go beyond technical/professional problems such as creating organisational learning processes, regulating systemic distress, keeping above the detail to see patterns of problems. By working in this way leaders have the opportunity to be innovative, creative and experimental which may be disruptive to the status quo but creates conditions for change.

6.3 Creating an entrepreneurial identity through contextualising new knowledge and skills

Through working with teams in a variety of settings, as well as acting as brokers between front line clinicians and operational managers, the professional leaders used their creative thinking and entrepreneurial spirit to give confidence through using new knowledge and skill in context and give credence to new innovative ways of evidence based working (see Chapter 5 pages 128-129). The role of professional leaders was sometime seen to be limited by several factors, such as lack of business sense, with the most significant being that anyone from a caring/intervention background was often recognised to be only concerned with '*getting the job done'* through front line activity with only the need for strategic managers to inform them of important decisions relating to the business once they have been taken which was supported by findings from the NAPC (2009). There was not always the recognition that professional leaders have important skills, knowledge and experience to offer on a wider operational and strategic level to not only support the final decision but be instrumental in leading, directing and learning through decision making rather than just the

implementation phase. This is corroborated by the need for an organisation to accept entrepreneurial behaviour and allow the trigger for change to come from entrepreneurs who have the need to do a good job as well as a need for recognition (Huczynski and Buchanan 1991:531). Changing the leadership concept is not easy as Turnbull James et al (2007) found that changes from top-down leadership created new organisational dynamics to be handled and this was demonstrated through conversations between professional leaders, strategic and operational managers. However learning together included how to manage emotional challenges, dismantling established assumptions and relationships as well as dealing with anxiety and vulnerability and losing protection through hierarchy. Huffington et al (2004) reiterated this in their research on distributed leadership and the need for leader's mindset changes. Turnbull James and Denyer (2008) describe the learning from changing a traditional and competitive approach into a collaborative enterprise to not only support leadership learning but understand and generate the hallmarks of collaborative and shared leadership.

Entrepreneurial leadership identity was developed and strengthened by working together and O'Reilly and Reed (2010) support this paradigm documenting 'leaderism' in public services, further to the evolution of entrepreneurial and cultural ideologies and practices focusing the user as co producer (Clarke et al 2007; Needham 2007). Alternatively they suggest that 'leaderism' is sometimes likened to 'racism' due to the way leaders can sometimes be marginalised in favour of managerialism. The negotiation of a common identity was a central requirement but often unspoken and relied on negotiation and experience from the participants with translation into meaning. The participants translated experiences which were secured by competencies, giving the entrepreneurial flair and willingness to take the initiative for change supported by the literature (NHS Confederation 2009). It came about through referring to ourselves as 'we' and understanding how important that was because it signified the collective in addressing some of the 'wicked problems' referred to by (Rittell and Webber 1973). Tame (or technical) problems might have individual solutions in the sense that an individual is likely to know how to deal with them, but since wicked problems (complex) are partly defined by the absence of an answer on the part of the leader/s then it behoves the individual to ask the right kind of

questions to engage the collective in an attempt to come to terms with the problem. In other words, wicked problems require the transfer of authority from individual to collective because only collective engagement can hope to address the problem. The uncertainty involved in wicked problems implies that leadership, as defined by Grint (2008), is not a science but the art of engaging a community in facing up to complex collective problems, learning together and developing new knowledge along the way.

One stereotype is that leaders are somehow different (Adair 2009), that they are above others; certainly this research identified professional leaders had self belief, personal integrity, courage and conviction, self awareness, emotional intelligence and were able to manage their own emotions most of the time as well as showing resilient commitment to their roles. However, in reality, the qualities required for effective leadership are the same as those needed to be an effective follower and may be the same person playing different roles at different times, with at its best leadership being shared among leaders and followers, with everyone fully engaged and accepting higher levels of responsibility as they move from cherishing stability and control to valuing change and empowerment. The move to empowerment also ties directly into new ways of working that emphasize collaboration and team work over competition and conflict. This then reflects the innovative concept of knowledge generation and management through nurturing positive relationships which relies on a culture of sharing rather than hoarding information. The dilemma and associated challenges arise when we try to transfer this understanding to an organisation built on assumptions of uniformity, separation and specialisation with people who think and act alike. The participants collectively agreed that the most meaningful and dynamic leaders in any organisation – private or public sector – make deliberate choices about how to tackle different situations and people in an entrepreneurial way.

The research found that the primary recipients of value in the community were the participants themselves, both individually and collectively. If they did not get value, they would not have participated and the community would have fallen apart. This outcome is reiterated by Wenger et al (2002) but they described other stakeholders whose perspectives on value creation are relevant to consider. These include the organisations in which

members operate, sponsors who have invested energy in enabling it, or the people who receive a service, such as clients, patients, or students. In this research the collective benefits for the participants was palpable but the wider benefits for the organisation not necessarily realised.

These findings are also similar to those of Lesser and Storck (2001) who describe how organisations benefit from Communities of Practice by improving performance through the sharing of knowledge, bypassing structural barriers and operating outside formal structures including their contribution to organisational memory. Undoubtedly as described by Lave and Wenger (1991:36) metaphorical apprentices and masters were amongst the co participants and although this wasn't explicitly acknowledged at the outset it soon became very clear as the various stories and narratives unfolded how the two worked together through both educational and culturally specific realities. The Community of Practice was able to clarify and demonstrate the distinction between the conventional 'learning in situ' and 'peripheral participation' (Lave and Wenger 1991:36).

By using conceptual frameworks within the research to influence the wider agenda, participants shared skills and developed confidence. According to Wenger (1998) and Wenger and Trayner (2011) the purpose of using a conceptual framework in any situation is to provide a foundation that can be useful across a range of endeavours, including research and practice but they insist the framework needs to be both robust and flexible. It is a tool that has to be rigorous enough to support the research: grounded in theory to ensure relevance and data-oriented to provide scientific validity and reliability. At the same time the process of assessment was useful for the participants in the Community of Practice and external networks as well as the organisational stakeholders. Wenger and Trayner (2011) view communities and networks as integral aspects of the social fabric of learning. The **network** aspect refers to the set of relationships, personal interactions, and connections among participants who have personal reasons to connect. The **community** aspect refers to the development of a shared identity and influence around a topic or set of challenges. It represents a collective intention – however tacit and distributed – to steward a domain of knowledge and to sustain learning about it.

6.4 Developing skills and confidence to be instrumental in progressing the safety and quality agenda through transformation of services

Working as a Community of Practice made it much easier to prepare for the journey through such a substantial transition. It allowed practitioners and leaders to develop and use their skills e.g. building an identity and finding a voice, even though it was a struggle to cope with the disintegration of one professional structure before being able to build a different version. Even so the rapid pace and lack of time for adjustment as described by Birchall and Hallet (1995) impacted on the collective productivity of the participants. This research found that using the skills and knowledge of evidence, engagement, logical persuasion and reason, expertise or data to challenge, convince and persuade others was effective, but also found this was limited and only in specific contexts such as systematic comparison between teams and formal business proposals. But people are human and even the best argument in the world could not overcome some of the backroom tactics (both between operational managers and professional leaders) that prevailed through historical and protective networks as individual anxieties came to the fore which had a tendency to blur some of the necessary and essential final decision making.

Moreover, many of the problems that integrated services deal with – care of the elderly, safeguarding children and adults, obesity, drug abuse, violence, poverty – are not simply problems of health, they are often deeply complex social problems that sit across and between different government departments and institutions. Conventionally, we associate leadership with the ability to solve problems, act decisively and to know what to do, but complex problems often embody the inverse of this – we cannot always solve them, and we need to be very wary of acting decisively as we would with a simple issue. The need for integrated professional leadership through combining scarce resources becomes even more important if we are to be clinically and cost effective in making a difference with complex health and social care problems.

Part 2 How the Community of Practice enabled the process

6.5 Using storytelling, sharing anecdotes and dramatising experiences to encourage debate and create shared meanings within

the Community of Practice

Storytelling was used predominantly in this research to dramatise experiences, share skills and generate organisational change but it can be used in other contexts and for other purposes, such as transferring knowledge, nurturing communities, stimulating innovation, crafting communities, in education and training and in preserving values (Seeley Brown et al 2004). Snyder (1996:37) also found sharing tacit knowledge required interaction and informal learning processes such as storytelling, conversation, coaching and apprenticeship of the kind that Communities of Practice provide. Sharing stories within the commitment of a shared domain (safety and quality issues) created a sense of association with a body of knowledge and therefore to the development of practice as described by Wenger et al (2002). This research was underpinned by the existing body of knowledge available around safety and quality as well as looking at leadership discourse through major official NHS policy documents produced by the Department of Health from the NHS Plan (1997) to the completion of the research in 2011. This period saw a number of wider changes in NHS policy that influenced the construction of professional leadership in relation to delivering the safety and quality agenda. Through this practice, which was denoted by defined approaches and standards to create a basis for action, communication, problem solving, performance and accountability through cases, stories, examples and anecdotes within the specific domain of safety and quality, we were able to share both tacit and explicit knowledge as described by Wenger et al (2002:38).

Stories by their very nature are subjective and contextual (Johns 2000) connected to previous stories with experience over time. The conceptual frameworks (see pages 128 -136) identified through the stories in this Community of Practice included managing conflict, leadership influencing expertise, constructing safety and quality, developing clinical pathways, understanding different cultures, changing systems, processes and practice from experiential learning. They varied from emotional and anxious to intimate and joyful but often complex sometimes without logic. Johns (1998) described the beauty of story as illuminating the contextual meaning of complex theory so that the listener can sense and feel it in the context of their own experience.

Analytical thinkers making sharp distinctions and crisp decisions may see storytelling as ephemeral, subjective, personal, unscientific and indirect but the caring professions tend to be made up of a scientific and artistic mix and the richness that brings only manages to enhance the experience and the journey of discovery throughout storytelling within a Community of Practice. Wenger et al (2002:56) sees this sort of participation as an active and connected process and describes the social involvement in the Community of Practice or similar saying it is a complex process that combines doing, talking, thinking, feeling and belonging involving the whole person, including bodies, minds, emotions and social relations. When we listen to stories or engage in conversation we somehow recognise in each other something of ourselves which relates to how we negotiate meaning. Storytelling in this research became an essential part of working together, sharing and developing knowledge and integrating (Seely Brown et al 2004) particularly in the chat between meetings. They were very powerful and one particular anecdote that helped encourage clinicians to become more engaged in audit for example was the story of Florence Nightingale who reduced infection rates at Scutari from several thousand to single numbers purely by auditing nursing practice. This was in addition to knowing that as a teacher and reformer Nightingale (1860) instinctively knew that concrete events are an excellent way to make people take note.

I found that the process of empathising with a story sometimes had the effect of altering the final analysis of the original narrative, especially when it was being linked to individual listener's concerns. By using the stories to further our own thinking the participants will have interpreted them in different ways which supports the psychological studies undertaken by Schank and Abelson (1995: 26) suggesting that internalised narratives are triggered through this process by a listener. In summary, anecdotes and stories are natural currency of a great deal of informal talk. Conversations are crucial, particularly in health care to adapt and evolve (Jordan et al 2009) also because stories often contain elements of metaphor, analogy and expressive imagery they are effective in conveying tacit knowledge that is otherwise difficult to convey (Nonaka 1994:20)

The seminal literature on Communities of Practice as defined by Lave and Wenger (1991) suggests they cannot be deliberately designed by managers and that an organisation can only establish a team which may

later emerge as a Community of Practice. My own research was created out of a group of self motivated professional leaders who recognised that collaborative working and learning together could be instrumental in progressing safety and quality. Wenger and Snyder (2000) also suggested that managers cannot mandate Communities of Practice because of the organic, spontaneous and informal nature of communities makes them resistant to supervision and interference, although they argue that some may benefit from cultivation by managers. Genuine multi-professional Communities of Practice remain rare even though the approach has been demonstrated to enhance inter professional clinical practice, facilitate quality improvement, promote knowledge transfer and contribute to the development of services spanning the interests of different stakeholders. The key factors that influence the development, functioning and maintenance of multi-professional communities remain as membership selection, goal commitment, local and service relevance, genuine infrastructure, critical appraisal skills and resources (Lathlean and le May 2002).

6.6 The Community of Practice created a forum for learning through generating professional capital by sharing experiential knowledge

By dramatising their experiences the participants were able to relive and analyse clinical situations and incidents, learn through debate with their professional colleagues and take the new knowledge and learning back into the workplace. In Wenger's (1998) model new knowledge is created in Communities of Practice by the complementary processes of participation (interactions and shared experiences) and reification (analysing knowledge and rules or artefacts). This research showed that the multi-professional Community of Practice had cultural differences which potentially collided as the boundaries around specialties were gradually broken down. This was demonstrated by the social work colleague effectively withdrawing from the Community of Practice. We sometimes found it difficult to use common language to make knowledge accessible. This is similar to Robinson and Cottrell (2005) who drew on Engestrom's (1999) activity theory model in the context of knowledge creation and exchange proposing that conflict is inevitable within changing organisations. To create new knowledge and practice there is a need to work through processes of openly articulating differences, exploring alternatives, modelling solutions, examining an

agreed model and implementing activities (Engestrom 2001). The challenge of integrating cultural differences and disseminate that learning was acknowledged during the discursive interviews as something that the Community of Practice could have developed over a longer period of time to achieve benefits for all participants.

McDermott (1999) describes the need to accelerate and disseminate learning by building a Community of Practice on key technical topics (i.e. safety and quality) with the need to 'nurture' the three dimensions of Communities of Practice. These dimensions are described through 1) kinds of explicit or tacit knowledge 2) the level of individual and community identity and interaction and 3) how closely the knowledge and work could be shared and integrated. McDermott (1999) suggests these dimensions (none of which are mutually exclusive) are particularly useful to understand and determine what kind of community to develop where cross functional teams are the basic structure of an organisation saying that success depends on knitting together and knowledge sharing with technical peers while maintaining the focus on cross functional teams.

Through this contextual and situated learning, originally proposed by Lave and Wenger (1991) where professional learning occurs through participation in practice and interaction with colleagues, came the opportunity to explore understanding and communication, taking as a focus the relationship between learning and social situations in which they occurred. Lave and Wenger (1991) described situated learning in certain forms as social co-participation, rather than asking what kinds of cognitive processes and conceptual structures were involved, instead asked what kinds of social engagements provide the proper context for learning to take place. This implies a highly interactive and productive role for the skills that are acquired through the learning process; rather than the individual learner gaining a discrete body of abstract knowledge to transport and re apply in a later context, they acquire the skill to perform by actually engaging in the process through legitimate, peripheral participation. Time was identified and purposefully set aside during the time of the Community of Practice for relationship building and joint activities to establish shared goals, values and learning (Robinson and Cottrell 2005) and develop effective communication (Salmon 2004). The Community of Practice participants were challenged to rethink what it meant to learn, indeed to rethink what it

meant to understand each other in relation to their broader leadership roles and any particular action and context rather than being self contained. This shift altered the locus of learning to something deeper, taking place in a participation framework rather than an individual's mind, meaning that it could be mediated and distributed by the different perspectives among the participants in the community. There was a process of negotiated meaning for each unique discourse within whichever context it was presented and delivered, also shaped by other elements including interpretation of the stories and associated actions. This provided the potential for all participants to be affected in different ways but this constantly provided a continual process of renewed energy and negotiation.

Lave and Wenger (1991) introduced the concept of Communities of Practice in the context of the way participants learn and develop their knowledge in practice together, adapting to changes and having to negotiate the terms of what Wenger (1998) called their 'shared enterprise'. The Community of Practice demonstrated many resources that could be called their 'professional capital' such as knowledge and skills, individual expertise or mindlines (le May et al 2009), shared values and ethos, professional behaviour, practice and ways of communicating. This was certainly demonstrated within the formal and informal networks of colleagues showing respect and status built within their own networks and therefore able to bring that professional capital in a variety of forms to the Community of Practice. Wenger (1998) used the term social activity where mutual engagement and sharing clear understanding of any enterprise, even with the multiple conflicting complexities allowed the participants to share repertoires through the stories. Gobbi in le May (2009) suggests professional judgements can be between or concerning isolated individuals or groups of people but either way professional capital is a dimension of human capital and refers to the skills and knowledge, including tacit and embodied knowledge necessary for growth and development. In this context specialist knowledge (Leahy 2006) and evidence based practice (Goldenberg 2005) are ensured to be used effectively and efficiently through professional capital.

A systematic review undertaken by Li et al (2009) demonstrated that Community of Practice research in the health sector focused mainly on the

exploration of how people shared information, created knowledge, and built a professional identity in a social setting but a limitation of that review was that only publications between 1991 and 2005 were included realising that important new findings could have been missed. After the initial agreement, activity taking place within this Community of Practice developed spontaneously and crafted naturally without conscious recognition from elsewhere in the organisation. Although operational and strategic managers had been informed and agreed with the model at the outset they did not demonstrate awareness of the context or purpose of the activity. This was a short coming on the part of the participants as although more formal opportunities were available to present the outcomes of some of the activity and work of the Community of Practice this was not shared and advertised as an operational entity and possibly one of the reasons why it did not survive in the longer term. By integrating further with operational management (although one member of the Community of Practice in hierarchical terms had that opportunity) professional leaders could have had more of a voice in decision making and legitimacy to influence operational and strategic direction of travel through managing the value created alongside the knowledge generated within the Community of Practice.

The community's sense of identity depends on the level of participation and the boundaries that hold it together. McDermott (1999) identified the factors that impact on the strength of that identity in Table 6.2.

Table 6.2 To show the degree of Community Identity supporting success as informed by (adapted from McDermott 1999)

Weak Identity		**Strong Identity**
User/Interest Group	***Network***	***Community of Practice***
• *Need the same information* • *Use 'standard' sources* • *Learn from central source* • *Example: on line*	• *Share insights, experiences and thinking on a topic* • *Learn from each other* • *Network* • *Example: support*	• *Similar work* • *Mutually engaged in endeavour* • *Learn from each other* • *Network,*

training, HR policies	*group, multi discipline*	*interact* • *Develop common work practices* • *Common identity* • *Example: discipline, skill group*

Communities of Practice are therefore first and foremost natural networks of colleagues, with an acknowledged affinity. In hindsight the cultural and political differences, principles and practice between health and social care were seen to be quite diverse, so much so that this had such an impact on the joined up learning which affected the possibility to develop long term trust and rapport needed to share ideas and learn together.

This research did demonstrate that political ideology and policy implementation through necessity shaped the day to day activity of professional leaders alongside the need to facilitate front line practice to use evidence based practice. Improving productivity alongside adding value by delivering effective high quality care within an economically constrained environment was also the order of the day and supported by Ranmuthugala et al (2011). Their systematic review of research into Communities of Practice in health between 1990 -2009 found studies mainly focused on improving or changing practice through sharing knowledge. The strategy for promoting this has been through fostering Communities of Practice to share experiential knowledge and although they have gained recognition policies have often been formed and imposed with minimal intervention from professional expertise. This leaves a huge void for the facilitation and implementation of evidence based practice, along side patient choice and the experience of knowing what works for patient care. With opportunities through collective knowledge generation, learning and sharing to develop innovation and creativity alongside the policy gurus, wider publicity leading to increased credibility can be acknowledged in future.

One of Li et al.'s (2009) main findings was that Communities of Practice in the health sector tended to:

'*focus mainly on fostering social interactions at the workplace or during task oriented activities (e.g. journal clubs)*' (Li et al. 2009).

They also highlighted the fact that in common with Communities of Practice from the business sector, Communities of Practice in the health sector demonstrated (to a varying degree) a role in knowledge creation and sharing and building professional identity. However, when it came to examining the effectiveness of Communities of Practice in the health sector, they stated that:
"...there was a lack of empirical research that examined if Communities of Practice groups indeed improved the uptake of best practices in the health sector." (Li et al., 2009).

Ranmuthugala et al (2011) identified a significant increase in publications in the Communities of Practice healthcare sector since 2005. They suggested that despite this, there remains no conclusive evidence demonstrating the impact of Communities of Practice on improving the effectiveness or efficiency of healthcare. The published research continues to consist predominantly of qualitative research presenting case studies. Studies that examine effectiveness do so by presenting the findings from ethnographic observations, interviews and survey of members (Norman and Huerta 2006; Wilson and Pirrie 1999), and by content analysis of emails, discussion forums and reports. My own qualitative, case study research reflects the finding of this systematic review of Community of Practice literature.

Part 3 Influencing the safety and quality agenda

6.7 Debating the influence of professional leadership working within the Community of Practice and impact on the safety and quality agenda

Influence is described as:
'*having the capacity to have an effect on the character or behaviour of someone or something or the power arising out of status, contacts, or wealth'* (Oxford English Dictionary 1999).

Whilst in addition:

'*Impact is the action of one thing coming into contact with another, resulting in a marked effect or influence'* (Oxford English Dictionary 1999).

By sharing their influence through the Community of Practice the professional leaders 'created' and 'shared' a meaning of professional leadership which in turn had an impact on improving safety and quality. The Community of Practice provided a safe environment to discuss and debate the ongoing theory of leadership skills and leadership practice. The formal study of leadership, dates back to the first half of the 20th century, and developed through five identifiable stages. During the first three of these, leadership was seen as a process that (a) involved influencing others, (b) occurred within a group context, and (c) resulting in impact and goal attainment (Northouse 2004). More recently, however, definitions of leadership have emphasised the need for leaders to enable the organisation to adapt to a constantly changing and increasingly complex environment, and the role of leader as 'defining organisational reality' (Bryman 1996). In all cases, the emphasis has been on identifying those factors that make certain individuals particularly effective in influencing the behaviour of other individuals or groups and in making things happen that would not otherwise occur or preventing undesired outcomes. They can be seen to culminate in the concept of 'shared' or 'distributed' leadership which is an activity that is shared or distributed among members of a group or team that underpins a way of working. Shared leadership can be defined as a dynamic, interactive, influencing process among individuals in groups for which the objective is to lead one another to the achievement of group or organisational goals or both (Pearce and Conger, 2003: 1-3). However an important (but now possibly outdated) review of the literature by Stodgill (1963) was widely interpreted as concluding that there were, in fact, no consistent findings in relation to personality influencing characteristics that differentiated leaders from non-leaders, or more effective from less effective leaders. The findings of this research support the idea of shared leadership, involving others and the need to constantly adapt to changing situations.

This Community of Practice was identified as playing an important role in the promotion of learning and innovation in change by the participants but this was not necessarily recognised by operational or strategic managers.

Whilst innovation may be facilitated within communities this requires emerging community behaviour and support in the form of collaborative techniques, as well as facilitation and adequate scaffolding with radical innovations frequently occurring at the interstices across communities (Swan et al 2004). To date, there is no consistency in the way in which outcomes of Communities of Practice are defined or measured (Ramuthugala et al 2011) but for the purpose of this research, an outcome was defined by the impact of professional leadership on changes in behaviour or work practice that occurred, influenced by participating in Community of Practice activity or through accessing resources provided by the Community of Practice which in turn improved the safety and quality of services. The change may be through a process (such as adoption of a new system or process, or reduced time to achieve a goal that is related to improved care as was seen in changing the way people worked in community hospitals) an innovation (such as development of a new product or technology that will improve the delivery of healthcare as seen in E-rostering); or change in level of customer (patient) satisfaction (Rhodes and Lok 2008).

The participants spent time reviewing policy documents and identifying their relevance and impact on their own services. Martin and Learmonth (2012) also described their process of reviewing policy documents especially in relation to improving safety and quality and transforming services, how moving from administrators to managers and finally to leaders impacted on the interpretation of those policies. Talk of leadership distributed across the workforce and beyond might represent a rhetorical device that seeks to engage leaders in the reforms required but that is not to say that clinicians credulously take up these discourses. Martin and Learmonth (2012) also argue that over the last 10-15 years leadership has been taken for granted and that this recent popularisation of leadership represents a particularly important change for clinicians in marked contrast to past resistance to managerial responsibilities (Kitchener 2000). Their leadership debate shares a similarity to this research, arguing the power of leadership with the construct of professional leaders driving change, particularly relating to health and social care policy and future plans but the experience and reality of this research was that the imbalance of power, culture and authority between professional leaders and operational managers throughout health

and social care services caused conflict particularly during transformation.

Judi Sandrock (2010) (although working through virtual Communities of Practice) described immediate value through activities and interactions, potential value through knowledge capital, applied value through changes in practice, realised value through demonstrating performance improvement, reframing value through redefining success, perspectives through short and long-term value as communities and networks themselves also gain value over time as learning resources. But face to face communities where participants get to know and trust each other more quickly than in virtual communities are found to be more sustainable. The challenge of integrating Communities of Practice in an organisation could be described by as an exercise in paradox. How does an organisation engage with them without attempting to control them?

In the healthcare sector, Communities of Practice have been argued to play a role in the generation of social, human, organisational, professional and patient capital, thus being potentially useful for enhancing care, providing learning opportunities, analysing practice, problem solving, sharing knowledge and generating ideas (le May 2009). As this research has shown this does not mean automatic collaboration as participation involves all sorts of relationships, conflicting as well as harmonious, intimate as well as political, co operative as well as competitive but the activity itself in a social community shapes our experience and shapes those communities so that the transformative potential works both ways. In fact our ability or inability to shape the practice of our communities is an important aspect of our experience of participation in any particular context. The effects of the experience become part of who participants are in the wider world, going beyond direct engagement with specific people and places the negotiation of meaning in the context of various forms of membership in other communities and becomes part of our individual identities. It represents a sense of accountability to the professional standards of a particular specialty.

Currently Communities of Practice are used both as a theoretical approach to analyse mainly healthcare organisations as well as a practical tool to enable collaborative learning and knowledge mobilisation. But Bate and Robert (2002) also suggest collaborative approaches aimed at closing the

gap between potential and actual performance by testing and implementing changes quickly across organisations for quality improvement are likely to remain time limited projects, unable to achieve sustainable organisational change unless linked and active Communities of Practice are formed within them. In order to achieve that Kislov et al (2011) suggest that this idea should follow the three features of knowledge sharing within and across organisations, those being proper formation, manageability and building an identity. Iveson and McFee (2008) also suggest knowing is an enacted, communicated process that is difficult to observe or manage in organisations. They argue that although mutual engagement, joint enterprise and shared repertoire can be used to determine the existence of Communities of Practice, distinguishing between different ones and evaluating communicative processes in them is difficult without examining the combination of participation, observation and reflection to explore Community of Practice theory as a dynamic system for examining and evaluating organisational knowledge. This research has replicated this because although there was mutual engagement and participation from within the Community of Practice did not achieve the necessary outward facing, high profile identity required for long term sustainability.

6.8 Limitations of the Community of Practice

Some crucial questions remain unanswered about the formation of multi-professional Communities of Practice because it is still not clear what organisational, group or individual factors enhance the transition from a team to a community (Kislov et al 2011). The challenge in this research was to engage both health and social care professional leaders, who were expected to work together without necessarily being co located, not only because of their different understanding of role and function but the cultural and historical differences in the way health and social care ‘goes about its business’. The Community of Practice was set up through collaboration between the two cultures purporting to be working towards an integrated agenda. In reality the multi-professional and multi agency nature of the Community of Practice operating in a traditionally demarcated organisational landscape of both the NHS and Local Authority presented formidable obstacles to knowledge sharing between some of the professional groups and the longer term sustainability of a collaborative, cross organisational identity. This was evidenced by the social worker’s non

engagement and not responding to communications. In order to cross virtual/real boundaries between professional and organisational communities to enable a flow of knowledge requires recognition of the need for brokering knowledge as well as addressing issues relating to professional and organisational identification. The literature on deliberately formed multi-professional communities is often not clear on whether they are being confused with project teams or Communities of Practice in terms of achieving mutual engagement, joint enterprise and shared repertoire (Li et al 2009). The label may well represent a rhetorical device rather than organic communities characterised by shared practice and a sense of belonging. It remains difficult to know whether and how horizontal, informal, egalitarian multi-professional communities can emerge and function in a context where they have to co exist within the vertical, formal, command and control structures of public services given the evidence suggesting that the excessive legitimisation and formalisation or 'organic' communities can disrupt, rather than support, their knowledge sharing capacity.

It became clear that authority and control in individuals alongside wider organisational behaviour threatened and proved too powerful to achieve the complete altruistic vision held by the Community or Practice activities at the outset. There is also little empirical evidence in the literature that managers play a critical role in constructing, aligning or supporting Communities of Practice and it can be argued that managers are incapable of using them for developing policy and control. In spite of collaboration, the knowledge transfer in the Community of Practice did not always necessarily follow a model of evidence- based practice and was shaped strongly by the personal, political and professional agendas of not only the participants but by external influences which is supported by Gabbay et al's (2003) findings.

A suggestion might be that deliberate cultivation of multi-professional communities might help to solve problems of knowledge sharing but the extent to which they can be constructed and directed remains unclear.

The cultural barriers (even between different health services) became a cause of significant non engagement and eventual withdrawal from the Community of Practice particularly by one participant and although the literature supports Communities of Practice emerging within a situated theory of learning that views practice as the way knowledge dynamics

unfold in a socially situated view of learning, individuals continuously combine and modify knowledge through their everyday operations and interactions with each other (Wenger and Snyder 2000). Apart from explicit, codifiable, know how knowledge, collective practice does generate a great deal of tacit, know how knowledge which is embodied in the individual member's practical skills and expertise (Brown and Duguid 2001). Therefore homogenous and well established Communities of Practice can create cultures where they know how they know what they know but Duguid (2005) points out that knowledge can flow relatively easily within such cultures, where as it can become sticky at the boundaries between them (Kislov et al 2011). These boundaries can be classified as syntactic, semantic or pragmatic with the biggest problem being the difference in practice between cultures to overcome.

The theories relating to social learning and issues of cultural boundaries, as well as the findings from this research, have implications for the success of Communities of Practice trying to bring together members of different, well established cultures with clearly demarcated boundaries, distinct and partially incompatible epistemic backgrounds. The problems of interaction and knowledge sharing can potentially occur at multiple points with the inevitable tensions between the worlds of health and social care when they have difficulties communicating with each other given the differences between their epistemic cultures (Hall 2005). These two worlds are not homogenous and are represented by different professional and occupational priorities and therefore tensions should be expected because of the customs and characteristics of multiple professional groups with social care having the role of corporate parent and health being seen as the healer. Kislov et al (2011) suggest that even if communities are formed across organisations they are likely to retain their own disciplinary boundaries. In addition there is a huge boundary between clinical practice and operational management with profound differences in cultures, perceptions and decision making processes.

Although the professional leaders acted as simple brokers attempting to cross cultural boundaries in reality this required the use of various links such as knowledge brokerage with the need for membership to several types of communities seeking to facilitate interaction and co ordinate practice between them (Fitzgerald and Ferlie 2000). Some of the

professional leaders had managerial responsibilities within their own disciplines and although it may be possible for individuals with hybrid professional roles to broker knowledge by spanning the boundaries between professional and managerial roles, if this is in a multi-professional setting boundary objects such as language, meaning and practice have to be interpreted to transfer knowledge across various artefacts and discourses (Kislov et al 2011).

Protocols and guidelines can be used as an opportunity to allow this way forward but interacting across boundaries by people from different communities through meetings, visits and conferences alongside historical connections and previous experiences can also be utilised as links (Wenger 1998). Cross disciplinary communities expose practitioners to specific activities that go beyond their normal practice and encourage individuals to negotiate their own competence with that of others. Multi disciplinary activity may be a way it can also develop its own boundaries which prevents it from functioning as a knowledge broker between wider communities it had been intended to link. In addition by having allegiances to one community it may prevent brokerage and full participation to another.

Summary

By constructing and observing the Community of Practice through qualitative techniques and a case study design this research identified features in relation to professional leadership identity and the benefits as well as the challenges of using a Community of Practice. This chapter has enabled me to position my work within the wider body of existing knowledge. Being part of the Community of Practice enabled the professional leads to expose what they did in their day-to-day work and the analysis of this has created a framework of professional leadership within the safety and quality arena which could be used to guide others working in similar roles.

Several crucial questions about the formation of multi-professional Communities of Practice remain unanswered. These will be addressed in the Chapter 7 alongside the ongoing notion of professional leadership identity, limitations of the research and learning points. Recommendations

for future research and practice will also be identified with final conclusions.

Chapter 7 Reflections, limitations, recommendations and conclusion

7.1Introduction

This chapter confirms the findings of the research as well as the limitations. It also provides some reflections on the process before presenting final recommendations and a conclusion. At the outset of this chapter it is

important to return to the two research questions in order to determine the extent to which the findings have answered them:

- *How does the Community of Practice enable participants to influence change through professional leadership?*
- *How do participants use a Community of Practice to share their knowledge and understanding of professional leadership?*

This research has shown, despite some complexities, how the Community of Practice methodology was used to observe and explore professional leaders working in partnership to construct and share a meaning for their role. The Community of Practice supported them in dealing with safety and quality events and identifying ways of changing practice by providing the platform for professional knowledge to be generated through the creation of a forum for learning where experiential knowledge was shared through storytelling. In turn new knowledge was contextualised and an entrepreneurial identity created. The Community of Practice provided the opportunity for participants to develop their own leadership skills and confidence to challenge, collaborate and coerce thereby making changes towards the improved safety and quality of health and social care services.

By observing the emerging Community of Practice through recording participant stories and experiences the research helped to expose the features and debate the meaning of professional leadership as well as consider processes through which it could be developed. Communities of Practice have the potential to release the creativity of professionals and allow the sponsoring organisation to harvest and disseminate the knowledge they produce. Although more recent literature reveals some criticism of Wenger's approach to community development, suggesting that a Community of Practice is in reality a simplistic and unrealistic answer to a complex issue. Central to this is the concept of the development of professional identity which in some cases will emerge and be nurtured at an earlier stage. Small elements of cultural change were realised within integrated services and small but significant wins along the way, decreasing potential individual isolation, with an ability to share successes and concerns to overcome everyday challenges.

Common features of professional leadership were identified and shared in relation to the skills, knowledge, experience and personal traits found in individual and collective professional leaders enabling them to influence service developments and cultural change. These were revealed through the stories and included sharing values and purpose, through demonstrating personal qualities and responsibility, the ability to influence and empower change in professional practice, strategically facilitating learning processes, generating new knowledge to translate into practice, acknowledging values, purpose and meaning through reflexivity, communicating and problem solving through complex situations, coaching, shadowing and mentoring and finding a voice for professional leaders to act.

7.2 Reflections

Storytelling is now used widely as a communication technique in health care. The research observed, explored and exposed through storytelling, how health and social care professionals lead, work and make decisions responding to the safety and quality requirements of an integrated health and social care organisation. It proved to be useful, informal, non threatening and a natural way to collect data. At times the stories developed into a more formal reporting structure but through focusing on the analysis of stories and narrative the findings were able to be interpreted and contributed to the final conclusions. The debate regarding the existing professional leadership structure and discourse currently in operation was widened and questioned the necessity to review and reshape the context in which professional leaders act and are able to influence the wider agenda. Professional leaders were able to interpret issues of concern between front line practice, operational and strategic managers supporting safe and high quality services. It was important in recognising the strength of being able to do this through sharing stories and narrative in a Community of Practice to translating the detail and generating broader knowledge into a language that can be used in various environments.

On reflection the activity and learning that took place within the Community of Practice demonstrated positive impact on improving the care delivered in

integrated community settings. There was also increased individual job satisfaction and improved working relationships e.g. up-skilling night staff, developing operating procedures for community hospitals, supporting clinicians working in continuing health care. The opportunity for problem solving and joint decision making for all the participants was identified as well as generating new knowledge within professional leadership. Integration was created but not sustained for the duration of the research. Through using new knowledge individual strengths were evidenced and new roles welcomed. A further demonstrable positive outcome was the cohesiveness of the participants with each one having the ultimate goal of improving outcomes for service users in their specialist area, working individually and collectively together to achieve this goal. Another was the uniqueness of a close knit sharing of knowledge within the group as well as sharing knowledge outside.

Reflexivity occupied a central place both within the activity of the Community of Practice as well as the process of the research itself. It was useful to help individuals clarify their own purpose as well as their position (Noble 2009) as it is associated with self critique and personal quest for critical discussion with a potential outcome of sustaining objectivity. The individual stories and experiences were shared in good faith with the opportunity at times for rigorous challenge to question particular values. The research took place at a time of rapid change within the organisation when there was a possibility of representing alternative meaning to the individual narratives due to their personal circumstances. It was important for the members of the Community of Practice to understand themselves as individuals within the fast changing wider environment without losing sight of their own vision and values. Gaps in knowledge introduced challenges in terms of altering team dynamics and shifting allegiances. There was the potential for the development of significant power as a group however, this was not utilised at the time and only acknowledged with hindsight. Group dynamics, characterised by trust and mutual recognition did however, help the participants to deal constructively with differing or even conflicting views, which also exposed problems and deficiencies, in order to agree practical solutions and review them.

Currently there is increasing pressure to augment qualitative results with

more formal measurement of the financial benefits and costs of Communities of Practice. Measures of value are instrumental for communities to gain visibility and influence as well as to educate and guide their own development. Financial measurements in terms of tangible resources and time to support the community are relatively easy to identify but measuring and demonstrating the value of Communities of Practice is more difficult as these intangible assets are hard to quantify. Roberts et al in le May (2009:109) suggest that in order to know if an intervention is cost effective we need to know if it is effective - in other words does it 'work'? Policy makers, practitioners and service users want to know 'what works'? This study by bringing research and practitioners closer together, has been meaningful in identifying what did work and what didn't, particularly around cultural and organisational challenges.

The benefits realised by this Community of Practice were evidenced by improved practice and safer services which in turn reflect on the reputation and kudos of the organisation as providing 'good care' with the capacity to bestow not only personal value for the professionals but encourage the public to use those services. Professional capital was acquired through learning, reflection and thinking in practice. There was also evidence that collective learning took place and judgements were made as a result of that through leadership, personal commitment and individuals being co located with the ability to share their embodied practice.

7.3 Limitations

It would have been impossible to be wholly objective and although the tape recordings were discreet, I must acknowledge my own influence on the research process and outcome. Self awareness and supervision helped me to confront and celebrate any impact whilst attempting to be deliberately careful not to allow that to alter the natural proceedings for data collection.

I have been challenged to consider what made a difference? Whether the findings do demonstrate the existence of a Community of Practice or if the professional leads were just a group of professionals getting together to share knowledge and make decisions? It is encouraging to return to Wenger et al's (2002:4) original description of Communities of Practice as

‘*groups of people who share a concern, a set of problems, or a passion about a topic and who deepen their knowledge and expertise in this area by interacting on an ongoing basis*.' knowing that this study made a difference. This was evidenced through the enthusiasm, participation and passion of each professional leader. Their desire to improve safety and quality of health and social care services resulted in changes in practice, creating and contributing to individual and collective knowledge and exposing features of professional leadership through learning and identity. We debated and all agreed this was a Community of Practice as visualised by Wenger.

The research was unable to reduce the lack of understanding by operational and strategic managers of the need for professional leaders to be part of the day to day decision making. Communities of Practice need management and organisational support to be sustained, with evidence of impact on individual performance, team effectiveness, overall productivity and cost effectiveness but this research was unable to overcome some of the resistance from within the organisational culture and climate (particularly social care) and this potentially limited the effectiveness of the Community of Practice.

7.4 Contribution to knowledge and practice

Changes in practice and services were made through the influence of this research leading to the closure of the practice theory gap. Professional leadership issues were identified, discussed and debated which in turn created an entrepreneurial working environment, identity and atmosphere which was recognised by other stakeholders for the period of the Community of Practice. The study also showed that Communities of Practice may be interpreted in many different ways but by acknowledging what we did as one model of working as a Community of Practice it is possible to demonstrate that this type of study contributes to overall research knowledge. In addition professional leaders were able to empower people and help practitioners to improve the safety and quality of services.
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7.5 Recommendations

Despite the acknowledged limitations of this study the following

recommendations can be made

The Community of Practice methodology should be further acknowledged and established as an opportunity to generate collective knowledge to influence change in organisations.

Sharing stories and narrative is a nonthreatening, innovative way of sharing specific knowledge in order to reflect, contextualise and provide the language required to influence not only clinical practice but the wider organisational strategic direction. A recognised programme of further research into using storytelling in Communities of Practice to generate and share knowledge through professional leadership should be considered.

The opportunity to work in a Community of Practice to generate and share knowledge demonstrates the possibility of dynamic and meaningful outputs that give strength to a collective voice on important issues. More opportunities for working in this way need to be explored within the NHS and across it's boundaries with other organisations.

Communities of Practice generate qualitative data about their activities but further opportunities should be made available to look at quantifiable evidence to identify if they are efficient and cost effective. It is therefore necessary for any framework to support the inclusion and triangulation of multiple sources and types of data. For instance, some data can be collected easily through meeting attendance records, website logs, and download records for documents alongside data such as performance indicators and outcomes.

Other opportunities for future research might include more subtle indicators such as the levels of trust, the quality of relationships, clear focus on tasks and topics, productivity measures and leadership roles and responsibilities

7.6 Conclusion

The analysis of Wenger's seminal works shows that the concept and theory of Communities of Practice is still evolving as this research has demonstrated. Originally seen as an analytical tool of the theory of social learning embracing community, identity, meaning and practice, it has latterly been seen as a technique deliberately used by managers to improve knowledge transfer and organisational performance. Bringing a

diverse group of people together to establish a new community was a daunting undertaking particularly when the learning needs were not perceived as legitimate for all participants. The challenge lay in recognising the opportunities to move the existing disparate group closer to work within a Community of Practice perspective. By constructing and sharing a meaning for professional leadership to operate effectively in the pursuance of both safe and high quality practice and cultural change, the collective ability to share and contextualise new knowledge and learning from each other was found to be most positive. Using the Community of Practice to share experiential knowledge through storytelling created a forum for learning as well as developing a social infrastructure to generate professional capital. Practice, skills and knowledge were the central influencing components in mainstream discussions and decision making about individual cases. The professional leaders were able to work in partnership to shape changes in policy and practice, demonstrating how power, position and personality play an important part in individuals being listened to and their instructions or comments being acted upon.

During organisational change using the evidence created from Communities of Practice is helpful if not vital. Proposed and real reorganisations have dominated health and social care systems in the United Kingdom for the past 15 years, and too often the shape of the new organisation has been through a mix of turf wars, tradition and expediency. We must try to do what we can in the future to make sure strategic decisions and design are based on solid research evidence and reliable experience, showing the best model for the most effective care. This study has shown that using the Community of Practice methodology where knowledge and expertise are brought together and developed is one way of achieving that.

The professional leaders in this Community of Practice aspired to create an exciting and inspiring vision of involving front line practitioners in decision making and using clinical expertise to improve safety and quality. The professional leaders tried to pass that excitement through the clinical staff to make a connection between their function and the greater cause, and although this methodology was innovative the venture became reality as the participants connected through their vision and values. **Constructing the Community of Practice and exposing the features of professional**

leadership enabled learning and knowledge to evolve through the social process of like minded people. Nurturing this essence is likely to keep the concept of Communities of Practice healthy well into the future.

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Appendix 1

List of references for Professional Leadership

References	Description	Methodology	Comment
1. *NAPC 2009*	*Primary Care leadership paper in preparation for clinical commissioning*	*Opinion paper*	*Literature review useful with opinions on leadership potential in primary care and recommendations for the future*
2. *NHS Confederation (2009)*	*The Future of leadership in the NHS*	*Opinion paper*	*Planning for leadership opportunities and requirements during change*
3. *Lewin (2005)*	*Research into leadership styles*	*Book chapter*	*Historical development of leadership*
6. *Hersey, B and Blanchard, K.H. (1990)*	*Tri dimensional leadership effectiveness model predicts appropriate leadership style depending on followers maturity*	*Book chapter*	*Moderating behaviour depending on competencies of those around*
4. *Onyett et al (2009)*	*Study of the meanings and perceptions of relationships between 'leadership' and 'patient care' and how leadership is transmitted across team to impact upon service delivery, improved team working.*	*Research Paper*	*Traditional conceptions of heroic leadership alongside distributed leadership is the sharing of leadership between several individuals, who jointly generate commitment, cohesion and wisdom*
5. *Kouzes and Posner (2007)*	*Occupational and Leadership theory models*	*Book Chapter*	*Skills and vision for organisational change*
6. *Crisp, N. (2005)*	*Evidence based research to support leadership improvement and development*	*Quote in Leaders guide*	*NHS Modernisation Agency guide to leading improvement*
7. *Malby (1998)*	*Professional leadership in the delivery of clinical care*	*Clinical Paper*	*Practical advice on balancing leadership skills alongside to flexibility*
8. *NHS Alliance (2007)*	*Exploring how allied health and other health professionals lead change through and beyond commissioning for a patient*	*Opinion paper*	*A multi-professional paper examining the way forward for leaders during*

	led NHS		*organisational change*
9. Marquis and Houston (2000)	*Academic theory and application of leadership roles to enhance business management and finance opportunities in healthcare settings*	*Book chapter*	*Complexity and measurement of leadership roles*
10. Senge (1990)	*Leadership in learning organisations*	*Book chapter*	*Leadership theory development*
11. NHS Leadership Qualities Framework (2003)	*Research based guidance for specific NHS leadership development*	*Policy directive*	*Roles include personal qualities, setting direction and service delivery*
12. Alimo-Metcalfe, B. and Alban-Metcalfe. R. (2000)	*Difficulties in describing leadership roles, particularly in public services*	*Commentary in Journal*	*Complexity and measurement of leadership roles*
13. Daft, R. (2002)	*Comprehensive student textbook of historical theories of leadership with reviews of recent leadership research*	*Book chapter*	*Elements of leadership roles*
12. Adair, J., (2009)	*Embracing leadership in Management roles through better communication*	*Commentary*	*Styles and qualities of good leaders*
14. Coulshed, V. and Mullender, A. (2001)	*Research developments in social work practice*	*Book chapter*	*Emphasis on different aspects of leadership roles.*
15. Taylor, V. (2007).	*Nursing research papers studying implementing change and service development*	*Research papers*	*Defining the influence of leadership to high quality health and social care delivery*
16. Darzi (2008)	*High quality care for all*	*DH Policy*	*Importance of clinical leadership in improving quality and safety of health care*
18. Antrobus and Kitson (1999)	*Professional leadership is shaped dramatically by the impact of politics and policy*	*Research Paper*	*The importance of using clinical leadership to inform policy*
19. Khurana (2002)	*Perspective during the last ten years that transformational leadership from a distance was the way to implement organisational change*	*Book Chapter*	*Transformational and charismatic leadership*
20. Binney et al (2009)	*Practical ways of creating change through leadership in organisations*	*Book Chapter*	*Destabilising organisations through in appropriate leadership*

List of references for Communities of Practice

Reference	Description	Methodology	Comment
1. Lathlean and le May (2002)	*Using a Community of Practice to support interagency practice*	*Research paper*	*Evidence on the outcome of a multi agency Community of Practice*
2. Wenger et al (2002)	*Cultivating Communities of Practice*	*Book chapter*	*Seminal work*
3. le May (2009)	*Communities of Practice in Health and Social Care*	*Book chapter*	*Varied contributions and opinions chapters on using Communities of Practice*
4. Wenger (1998)	*Introduction to learning, meaning and identity within Communities of Practice*	*Book chapter*	*Practical examples of social learning and benefits*
5. Lave and Wenger (1991)	*Learning and understanding through co-participation and communication*	*Book chapter*	*Helpful descriptions of peripheral participation*
6.Brown and Duguid (1991)	*Problem solving through group learning*	*Book chapter*	*Particularly relating to business learning*
7. Gobbi in le May (2009)	*Workplace learning for nurses in developing professional capital*	*Book chapter*	*Identified developing professional capital in other ways*
8. Benner (1984)	*From Novice to Expert*	*Book chapter*	*Seminal text for developing nursing expertise*
9. Gabbay et al (2003)	*A case study of knowledge management in multi agency consumer informed 'Communities of Practice'; implications for evidence-based policy development in health and social services*	*Research paper*	*Creating a Community of Practice*
10. Nickols 2000	*Creating Communities of Practices*	*On line*	*A start up kit for Communities of Practice*
11. Pallof and Pratt (1999)	*Developing stages of Communities of Practice*	*Research paper*	*Another description of stages of development*
12. Contu and Willmott 2002, 2003	*Comment on Wenger's research*	*Opinion paper*	*Challenge and difficulties of power relationships in Communities of Practice*

13. Marshall and Rollinson (2004)	*The politics of collective sense making*	*Opinion paper*	*Challenge and difficulties of interpreting meanings in Communities of Practice*
14. Lazaric and Lorenz (1998)	*Issues and concerns of learning together*	*Opinion paper*	*Trust and decision making in complex situations*
15. Davenport and Prusak (1998)	*Aligning the needs of the organisation with the methodology of learning*	*Research paper*	*Examples of when thjngs can go wrong*
16. Lesser and Stork (2001)	*Benefits of Communities of Practice in improving organisational performance*	*Research paper*	*Outcome evidence of improving performance by using Communities of Practice*
17. Bate and Robert (2002)	*Knowledge management in Communities of Practice*	*Research paper*	*Good example of the private sector*

Appendix 2

Date

Introductory Letter

Dear……

Re: A 'Community of Practice'

I am writing to seek your help with my research.

In the first instance I am asking if you would are prepared to be involved in this project by becoming a participant in an emerging 'Community of Practice'. The research is being supervised by Professor Andrée le May at the University of Southampton.

The research project aims to record the emerging process of developing and sustaining a group of professional leaders, through sharing expertise and knowledge to change culture and service provision.

Wenger et al (2002) described a 'Community of Practice' as '*groups of people who share a concern, a set of problems, or a passion about a topic and who deepen their knowledge and expertise in this area by interacting on an ongoing basis.'* Their research identified the benefits of this way of working and the project is an opportunity to replicate the results which suggested that:

For the people involved it may:

- *Help with the challenges encountered and individual personal development*
- *Give confidence and help to build their reputation*
- *Make the work more meaningful*
- *Give access to expertise and professional identity*
- *Enable them to work together as colleagues*

For the service it may:

- *Help with problem solving and the strategic fit*
- *Save time and keep the process going*
- *Enable innovation through sharing knowledge*
- *Retain talent and create synergy*
- *Develop strategies through reconfiguring resources*

I have obtained ethical approval to observe and audio record meetings and activities with a view to writing up how the experience, learning and knowledge helped to underpin the developmental process of change.

If you would like to take part please will you return the attached before I proceed in order for me to be assured of formal consent?

Yours sincerely

Alison Lewis-Smith

Wenger. E., McDermott. R. and Snyder. W., (2002) Cultivating Communities of Practice. Harvard Business School. Boston. Massachusetts.

Expression of Interest Reply Form

A 'Community of Practice'

A project using storytelling to observe an emerging 'community of practice' which shares knowledge and ways of knowing, understanding and learning as a contribution to the development of professional leadership, cultural change and improved services.

I write to express an interest in being a participant in the research project to observe the emerging 'Community of Practice', which shares knowledge and ways of knowing, understanding and learning. This is in the wider context of developing professional leadership, cultural change and improved service provision for a population living within the South West of England using commissioned services through a Primary Care Trust.

I understand I will have an opportunity to meet with the researcher before the project begins to sign an informed consent form

Signed……..

Print Name……...

Job Role……...

Date……..

Appendix 3

Study Reference Number: PCT 0664

Patient Identification Number for study: 01 (Sample)

CONSENT FORM

Title of Project: A 'Community of Practice'

Name of Researcher: Alison Lewis-Smith

Please initial box

1	I confirm that I have read and understand the information sheet dated (Version 3 Jan 09) for the above study and have had the opportunity to ask questions
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.
3	I agree to take part in the above study.
4	I understand the observations and interview will be audio taped and that the tapes will be destroyed as soon as transcribed and only non-identifiable information will be used in the transcription.
5	*I understand that relevant sections of data collected during the study may be looked at by individuals from the University of Southampton, from regulatory authorities or from the trust, where it is relevant to taking part in this research. I give permission for these individuals to have access to my records*

Name of Participant	Date	Signature
Alison Lewis-Smith Researcher	Date	Signature

1 for participant; 1 for researcher; 1 to be kept in notes

Appendix 4

Study Reference Number: PCT 0664

Patient Identification Number for study: 01 (Sample)

CONSENT FORM

Title of Project: A 'Community of Practice'

Name of Researcher: Alison Lewis-Smith

Please initial box

1	I confirm that I have read and understand the information sheet dated (Version 3 Jan 09) for the above study and have had the opportunity to ask questions.
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.
3	*I do not agree to take part in the above study but do not object to being a participant in the 'Community of Practice' as it is being audio recorded. All dialogue relating to me will be excluded from the analysis and not included when the project is written up.*
4	I understand the observations and interview will be audio taped and that the tapes will be destroyed as soon as transcribed and only non-identifiable information will be used in the transcription.

Name of Participant	Date	Signature
Alison Lewis-Smith Researcher	Date	Signature

1 for participant; 1 for researcher; 1 to be kept in notes

Appendix 5

Participant Information Sheet

A 'Community of Practice'

1. Invitation

2. **You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research in being done and what it will involve. Please take time to read the following information carefully and discuss it with friends and family. If there is anything that you are not clear about or would like more information, please do not hesitate to contact the researcher. Take time to decide whether or not you wish to take part. Thank you for reading this.**

3. What is the purpose of the study?

The study is a qualitative piece of work being undertaken as the final project towards a Doctorate in Clinical Practice through the University of Southampton. The purpose of this study is to investigate how a 'Community of Practice' might emerge and evolve to enhance professional leadership and sustain change during service improvement within the organisation.

4. Background Information

'Communities of Practice' are based on the work of Etienne Wenger (1991) who described them as 'groups of people who share a passion for something that they know how to do and who interact regularly to learn how to do it better.' In reality they are a familiar experience but by becoming involved in one we can learn how they fit in with our work, understand how they are able to support and assist us with our need to develop and sustain new services through change. By starting this as soon as possible, with the identified core group or project team, it would give us the opportunity to learn together. In doing the work, participating together and taking increasing responsibility for sharing our knowledge it is anticipated that it will enable us to see the value of working as a community within the organisation.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep, a more detailed explanatory letter and be asked to sign an informed consent form. You will also be given a copy of the consent form to keep. If you decide to take part you are still free to withdraw at any time and without giving reason. If you wish not to take part you will not be disadvantaged in any way.

What will happen to me if I take part?

If you do decide to take part in this study, you will be observed by the

researcher who is also a participant during the regular professional leadership meetings as part of an emerging 'Community of Practice' with a qualitative case study as the proposed research method. Only participants who have agreed to take part through the informed consent process will be observed and constitute part of the case study. The aim of the study is to develop an in-depth understanding of what factors affect the knowledge and understanding of individuals working together. When the recording of group meeting has been completed and transcribed, you will be asked to talk about your experiences using a semi-structured interview storytelling process, with narrative as a method of data collection. Your stories will be audio recorded and then transcribed in an anonymous format so that your participation will not be able to be identified by any other party. For those that have agreed to participate the observation will be undertaken during regular fortnightly meetings of approximately two hours and the opportunities for storytelling will take another hour.

5. What will happen to the results of the research study?

6. **The results of this study will be submitted as part of the researcher's thesis for a Doctorate in Clinical Practice degree to the University of Southampton. A research report will be fed back to all the participants as part of the process of cultivating knowledge and the learning from the stories may then be used to develop 'Communities of Practice' in a more formal application across the organisation.**

7. Who has reviewed the study?

8. **Professor Andrée le May of the University of Southampton who has extensive research experience is supervising the study and has undertaken Department of Health funded research projects herself looking at how 'Communities of Practice' can develop within teams to understand how knowledge is shared and understood. The study has been peer reviewed as part of the University of Southampton research governance process, and by xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx**

How will confidentiality be maintained and data protected?

Any information collected during the course of the study will be handled confidentially and stored securely within locked NHS premises. All data collected will be anonymised so that the data cannot be traced back to individual participants. All audio recordings will be transcribed as soon as possible and the tapes will be destroyed. Anonymised data will be analysed using a password protected xxxxx computer. xxxxxxxxxxxxxx polices relating to confidentiality and data protection will be adhered to which are in line with the Data Protection Act (1998).

9. What do I have to do?

10. **If you are interested in participating in the study, please contact Alison Lewis-Smith for further information.**

Contact for information about the research:

Alison Lewis-Smith

11. Tel:

12. **Email:**

What if there is a problem or I have a complaint?

If you have a problem or a complaint you should contact your line manager in the first instance and follow the xxxxxxxxx Complaints policy.

Alternatively you can contact:

Dr Martina Prude,

mad4@soton.ac.uk;

Head of Research Governance

Building 37

Highfield Campus

University of Southampton

S017 1BJ

Or for a local contact:

Ms Pam de Clive-Lowe

R&D Manager

Tel:

Thank you for reading this information.

Please do not hesitate to contact the researcher if you require any further information.

Appendix 6

NHS
National Research Ethics Service

24 June 2009

Mrs Alison Lewis-Smith

Devon & Torbay REC
Royal Devon & Exeter Hospital (Heavitree)
Gladstone Road
EXETER
EX1 2ED

Tel: 01392 405271
Fax: 01392 405270

Dear Mrs Lewis-Smith

Study Title: **A project using story telling to observe an emerging 'Community of Practice' which shares knowledge and develops ways of knowing, understanding and learning as a contribution to the development of professional leadership, cultural change and improved services in health and social care.**
REC reference number: **09/H0202/5**
Protocol number: **6**

Thank you for your letter of 08 June 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk. *Where the only involvement of the NHS organisation is as a Participant Identification*

Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Insurance Certificate		01 August 2008
Participant Information Sheet	6	11 January 2009
Peer Review		23 June 2008
Letter from Sponsor		16 January 2009
Protocol	6	11 January 2009
Investigator CV		
Expression of Interest Reply Form	6	11 January 2009
Interview Schedules/Topic Guides	6	11 January 2009
Participant Consent Form: Refusal to consent	2	01 May 2009
Participant Consent Form	3	01 May 2009
Letter of invitation to participant	4	01 May 2009
Application	2	27 March 2009
Response to Request for Further Information		08 June 2009

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H0202/5	Please quote this number on all correspondence

Yours sincerely

Miss Kate Caldwell OBE
Chair

Email: Lesley.Holman@rdeft.nhs.uk

Enclosures: "After ethical review – guidance for researchers" *SL- AR2 for other studies]*

Copy to: *Dr Martina Prude, University of Southampton*
Ms Pam de Clive Lowe, R&D Manager, Devon PCT

Appendix 7

UNIVERSITY OF Southampton

Mrs Alison Lewis-Smith

[redacted]

16 January 2009

Dear Mrs Lewis-Smith

RGO Ref: 6251 REC No: 09/H0202/5

Project Title A 'Community of Practice'.

I am writing to confirm that the University of Southampton is prepared to act as sponsor for this study under the terms of the Department of Health Research Governance Framework for Health and Social Care (2nd edition 2005).

The University of Southampton fulfils the role of Research Sponsor in ensuring management, monitoring and reporting arrangements for research. I understand that you will be acting as the Principal Investigator responsible for the daily management for this study, and that you will be providing regular reports on the progress of the study to the Research Governance Office on this basis.

I would like to take this opportunity to remind you of your responsibilities under the terms of the Research Governance Framework, and the EU Clinical Trials Directive (Medicines for Human Use Act) if conducting a clinical trial. We encourage you to become fully conversant with the terms of the Research Governance Framework by referring to the Department of Health document which can be accessed at:

http://www.dh.gov.uk/assetRoot/04/12/24/27/041224

In this regard if your project involves NHS patients or resources please send us a copy of your NHS REC and Trust approval letters when available.

Please do not hesitate to contact me should you require any additional information or support. May I also take this opportunity to wish you every success with your research.

Yours sincerely

[redacted]

Dr Martina Prude
Head of Research Governance
Tel: 023 8059 5058
email: rgoinfo@soton.ac.uk

Corporate Services, University of Southampton, Highfield Campus, Southampton SO17 1BJ United Kingdom
Tel: +44 (0) 23 8059 4684 Fax: +44 (0) 23 8059 5781 www.southampton.ac.uk

Appendix 8

Community of Practice Story Board from December 2009-December 2011

I have just received a copy of the Patient Safety First 'How to Guide' for Leadership for Safety www.patientsafetyfirst.nhs.uk and I would like us to have a look at this at the next CoP. It came out last year but I think it would give us a good starting point. What do you think?

I've seen that in the past and I agree with you, it gives some really good ideas that I would like to use

Could we consider using WEBEX or at least a teleconference facility between meetings as there are things I want to discuss quite urgently and I don't want to wait until our next meeting

I'm on Annual Leave for the next meeting and I think x is too. We really need a formula for arranging annual leave and to sort out our housekeeping arrangements.

Hello everyone I'm back from leave and I have had some very good reports about how the Professional Practice group have been working together.

I just wanted to share how vulnerable I felt after our last meeting when we were talking about 'challenge and collaboration' and I want to ask you all how you think we might be more co productive. We could look at having a coaching session or doing some work on 'Appreciate Inquiry' (I have a contact) How can we have an in depth discussion, challenge and keep on track so that we feel more positive at the end o of it. Would it help to look at each other's styles and preferred ways of working so that we can build relationships with others outside of the CoP? The other thing for me is how we prepare ourselves for the change that is coming as I think in the back of our minds and perhaps making us all feel anxious.

The fragmented relationships between operational management and professional leadership are seen as detrimental to the quality and safety of services and I think children's services are closer to getting the delicate issues squared in relation to the interface with operational management. I think we should do what they do and improve the professional practice leads communication through the senior management meetings so that they can share strands of work they are doing.

Children's professional leads come in on a quarterly basis and they come to the SMT which meets every 2 weeks, they discuss before they attend to identify the highlights and hot spots and how they are going to present their information so that they are productive and get the best

out of the opportunity which has to be short, sharp, dynamic and to the point. They all have that on their work plan because I meet with each one of them on a monthly basis to keep them on track and then I sit in with the SMT to find out what they are doing and that is the structure we have put in place. It works quite well but of course there is always room for review and improvement if necessary

Appendix 9 Detail of the Community of Practice

A time-plan showing the discussion and content of meetings and attendance at the Community of Practice

Date	***Attendance***	***Content***
November 2009 **Starting Up**	*SN1* *SN2* *CS* *CG* *OT* *SW*	*Finally got together to discuss Patient Safety and Quality issues and responsibilities of professional leaders* *Business plan* *Vision and values for professional leadership* *Develop safety walk rounds* *Presentation to Board* *Innovation and change template introduced* *Influencing strategies exercise shared* *Supervision –reviewing policy, delivering training and audit* *Patient Safety and Quality workshop, 'Elephants in the Room'* *Use of 'Appreciative Inquiry' model of working together in a solution focused way with a define, discover, dream, design and deliver model* *Wicked Issues and Clumsy Solutions* *Vaccination programme and Winter pressures* *National Institute for Clinical Excellence guidance and benchmarking assignments* *National Patient Safety Agency* *Policy on policies* *Unexpected adult death discussed with STEIS and follow up* *Standing Agenda Items agreed – Hot Issues, What's working well, Feedback from meetings*
December 2009	*SN1* *SN2*	*Statutory and Mandatory Training content and compliance. General discussion along side the need to 'make quality everyone's business' at*

Operational	*CS* *CG* *OT* *SW*	*induction.* *NHS Ambitions for Acute Care closer to home, Children and Young people, End of Life Care, Learning Disability and Long term Conditions* *Transformational Guides with Quick Assessment Matrices* *NHS 2010-2015: from good to great. Preventative, people centred. Productive* *Feedback from 'Managing successful programmes' shared* *Developing and dressing's formulary* *Preceptorship* *Discussion and clarification re Capability and Disciplinary policies relating to different policies for NHS and LA following recent appeal hearing*
January 2010 **(not recorded)**	*CS* *CG* *OT*	*Role of Nurse Consultants* *Care Quality Commission self assessments* *Transforming Community Services changes* *Information Governance expertise* *Implementing Productive Community Services* *Winter Pressures and Swine Flu* *Silver Alert following Fire at warehouse (CS senior on call)13 households evacuated to local community centre*
February 2010 **Fully Operational**	*SN2* *CS* *CG* *OT*	*Serious incidents under investigation (SUIs,)* *Root cause analysis investigations – podiatry case notes missing, undiagnosed breach, unexpected child death, toe tourniquet retained, shoulder dystocia, arthroscopy, tension pneumothorax, whole care home investigations, Ambulance report, missing specimens,* *Infection prevention control reports* *Investigating incidents and developing Investigating officer guidelines* *Legal claims report*

		Patient and Public Involvement task and finish group with Non Executive Director involvement. Patient experience post to be considered *Satisfaction survey and use of tablets through a set of questions for patients and clients to respond* *Current AHP pressures discussed* *Role of the Secretariat* *Dignity pledges and patient stories* *Tribunals update and sign off* *Did not attend audit required* *Response to Mid Staffs required by SHA* *Healthcare communication handbooks in different languages to be piloted in community hospitals*
March 2010	*SN1* *SN2* *CS* *CG* *OT*	*Specialist roles in diabetes, epilepsy, stroke, end of life care* *Business case for a community records system* *Transfer of surgical activity from Community Hospitals to Acute providers* *Summary of efficiency plans presented previously at Operational Management Team meeting (OMT)* *Unexpected intra partum death of a baby death in transit between community and regional unit. Discussion re leadership and culture in unit where incident happened.* *CQUIN- Commissioning Quality and Innovation with a budget retained for completion of targets. Need to link to performance lead to design tools and metrics that will evidence outcomes* *Speech and Language Therapy review in progress* *Recent flooding incident and incident response report due to lack of access to community hospital. Media interest.* *Grade 4 pressure sore incident – nursing care home- continuing health care*
April 2010	*SN1*	*Discussion re role of and relationship with Cluster Managers and review of Cluster Manager Forum*

	SN2 *CS* *CG* *OT* *SW*	*Terms of Reference* *Dental theatre issues re managing young people with Learning Disability* *NMC- summit of referral with request for profile on current HR investigation outcomes* *Development of a skills passport to standardise mandatory training, learning and development and e learning* *Risk register update required as some entries are out of date*
May 2010	*SN1* *SN2* *CS* *CG* *OT(part)*	*Operational plan, contract and programme management in 2010-2011* *Relationship issues between Commissioner and Provider structure within the organisation* *Corporate governance discussed and issues re Corporate Manslaughter. Invite Risk health and safety Manager to CoP but works consolidated hours to incorporate child care on Fridays! Membership of CoP discussed and decision taken to invite specialist advice as required* *Implementing Productive Community Services through dedicated leadership* *Acknowledged no Patient Quality and Safety strategy – seen as a weakness* *24 hour nursing care and Community records system*
June 2010	*SN1* *SN2* *CS* *CG* *OT*	*Consent- reviewing policy, delivering training and audit. Big differences between adult and community services but merit in rolling out joint training.* *NICE implementation policy to be revised* *Delivering same sex accommodation- breaching of standards and report required for SHA* *Out of date policies to be reviewed and extended into the new provider organisations* *Transformation Programme with seven work streams:*

		Complex care teams, 24/7 Nursing, Virtual wards, Winter pressures and Hospital discharges with a full briefing required at the next Health and Social Care Managers meeting
July 2010	*SN1* *SN2* *CS* *CG* *OT*	*Appraisals, Objectives and Personal development plans* *Low confidence in delivery of Learning and Development* *Patient Safety Congress highlights include embedding the practice, increase actions and response to falls to include reducing falls in rehabilitation units and waiting time targets.* *Transfer of Specialist Children's Assessment Centre from Acute to Community* *Emergency Board Meeting feedback – reduce management costs, confirm and close all HR processes before TUPE transfer, authorisation to appoint to current vacancies has revised process for priority to existing staff* *End of Life register underway and collaboration of out of hours medics*
August 2010(Not recorded)	*SN1* *SN2*	*NICE, Alerts and NPSA process and closures* *Feedback from the Independent living centre*
September 2010	*SN1* *SN2* *CS* *CG* *OT*	*Quality benchmarking and patient safety walk rounds* *Responding to service user complaints re staff attitudes and behaviour* *SN1 attended a Quality and Safety Improvement event particularly for Community Hospital Planning with the aim of 'identifying interventions that would have the most impact on patient safety in community hospitals' alongside current initiatives e.g. Productive Ward and Productive Community Hospitals and how to implement a programme alongside a collaborative learning approach* *Older person with dementia struck out at staff – requires a Root Cause Analysis* *Restructuring clinical leadership discussion and*

		opportunity *Neonatal Hearing Screening part transfer to Acute*
October 2010	*SN1* *SN2* *CS* *CG* *OT* *SW*	*Child Death Overview Process defined and documented* *Theatre and Maternity Services transfer to acute* *Out of Hours Nursing development* *E Rostering project* *Southern issues between Social Care Cluster Managers and Professionals Leads- personality and culture. Operational management versus Professional leadership. Governance arrangements between health and social care discussed and issues highlighted* *Health and Social Care cost shunting in adult services, not joined up. Relates to deep cleansing (closing wards to reduce costs) and monitoring bed state and distribution* *Integration continues under difficulty circumstances with a charm offensive in progress, alarming* *Reputation versus Financial versus Clinical risks* *Agency staff only to be agreed at Director level* *Nursing and residential care initially for 2 weeks respite become two years plus!* *Older people's mental health and pressures highlighted* *Safeguarding adults as well as Dying in prison*
November 2010	*SN1* *SN2* *CS* *CG* *OT*	*Update on SIRIs by Quality and Safety Manager* *Monthly performance reporting and use of a 'Health and Social Care' dashboard with detailed performance indicators.* *Preceptorship Day at the SHA* *PEAT visit planning* *Nurse exec feedback focusing on Acute* *Readiness for all Graduate Status* *Connecting for Health, technology to enable*

		practise and need for IT skills in Job Descriptions *Professional Practice shared drive has been updated* *Child and Adolescent Mental Health services in the spotlight due to lack of clear referral criteria and long waiting lists. GPs really vocal. National support team to investigate and make recommendations*
December 2010	*SN1* *SN2* *CS* *CG* *OT*	*Due diligence process underway* *Care Quality Commission un announced visit- actions include remove all damaged commodes, look at discharge procedures, staff attitudes and behaviour, review incidents and complaints and patient/carer feedback.* *Collate learning and distribute regularly* *Stolen hard drive Information Governance risks excluded* *Vaccine fridge failure with large financial loss of contents* *Finance and performance report* *Medicine Management Action Plan*
January 2011 **Winding down**	*SN1* *SN2* *CS* *CG* *OT* *SW*	*Mutually agreed retirement scheme agreed* *Non medical prescribing risks relating to transfer* *NICE guidance and summaries to be progressed* *Quality reports to be separated* *Recent staff survey doesn't appear to have touched the wider world* *Information Governance tool kit requirement and Asset owner with all advised to access 'Introductory module'* *Planning for change acknowledged* *Away day included: Celebration of achievements, Peacocks and Penguins - resilience and change, team vision and values, colleague values)*

February 2011	*SN1* *SN2* *CS* *CG* *OT*	*Due diligence SN1 and CS involved* *Observation of CoP model to be offered externally as a model of collective working practices* *Clinical Audit and Effectiveness report, action plan and recommendations* *Pressure sore policy – seek Tissue Viability specialist advice* *Professional Accountability workshops delivered* *Care Quality Commission Essential Standards – general discussion re approach* *Current work pressures acknowledged* *Emerging conversation re future hosting of Children's Services through Local Authority* *Winter Noro virus toolkit with National Guidance* *Research Scholarships available from Florence Nightingale Fellowship* *Burdett Partnership Leadership Scholarship for National/Research/Travel/International Leadership study (unsuccessful application made)*
March 2011 **Shutting Down**	*SN1* *SN2* *CS* *CG* *OT*	*Apprenticeships with funding to be progressed* *Operating Framework – Public Health Nursing workforce, Family Nurse Partnership programme* *Managing emails and following Productive management* *Refresh role and contribution of professional Leadership* *Quality Accounts compliance* *Final Risk Register and due diligence detail shared* *Keeping going with everyone trying to be positive and cheerful but noticeable sadness today* *(Organisational Party next month so focused on outfits and arrangements)*