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LITTLE MIRACLES

Using Communities of Practice to improve front line collaborative responses to multiple needs and exclusions



Little Miracles: Using Communities of Practice to improve front line collaborative responses to multiple needs and exclusions

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Revolving Doors Agency is a charity working across England to change systems and improve services for people with multiple problems, including poor mental health, who are in repeat contact with the criminal justice system.

The Social Care Workforce Research Unit (SCWRU) is an interdisciplinary national centre for original research into issues relating to the social care workforce. The Unit exists to develop research knowledge and to disseminate the findings to policymakers, service providers, employers and social care service user and carer groups.

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Introduction

Integration or better 'joint working' has been the 'holy grail' of social policy in the UK and internationally for over forty years. This report summarises the learning from a development programme which established six 'communities of practice' in different locations across England whose aim was to improve front line collaborative responses to people facing multiple needs and exclusions (e.g. drug and alcohol dependencies, mental health problems, experiences of homelessness, domestic violence, local authority care and the criminal justice system).

Communities of practice provide a vehicle for brokering knowledge and social relationships between different groups of practitioners thereby opening up the potential for interdisciplinary learning and more collaborative or collegiate ways of working. In setting up a community of practice the aim is to provide a safe venue for people to listen, reflect, receive feedback on processes of care, to tune their competencies collaboratively to new evidence and circumstances, and to try out small changes that encourage innovation. Communities of practice have been used in a wide range of independent and public sector settings and are a close relative of 'managed clinical networks' in the NHS.

The programme was funded by the Economic and Social Research Council (ESRC) to take forward promising findings from earlier recently completed research which had piloted a community of practice as a means of improving collaborative working in the context of multiple exclusion homelessness (Cornes et al., 2011). This study found that while there was much commitment to 'joint working' among front line practitioners, this was often limited to 'sign-posting' service users onwards. There was little evidence of working together in the context of sharing assessments and support plans with each 'problem' addressed largely in isolation of the others. The research observed that this led to problems of continuity, the so called 'revolving door' and a situation in which 'Everyone has got snippets of the individual but no one is collating it' (p2). In seeking to address these problems, communities of practice were proposed as a means of moving beyond 'sequential handovers' to more iterative interactions which go beyond co-ordination and co-operation.

While the original research was concerned primarily with 'homelessness', the focus of this follow-on project is on broader multiple needs and exclusions (Making Every Adult Matter, 2012). We felt it was important that, in order to achieve wide cross-disciplinary engagement in the programme, the focus should be on 'complexity',



How is a community of practice different from other kinds of multi-disciplinary meeting?

- Communities of practice use specially trained facilitators to promote more collegiate styles of working, for example, taking time to develop the social relations of the group and to promote things like 'active' listening skills
- The activity usually centres on 'case-based' learning and reflection
- They encompass 'knowledge brokerage' and opportunities for more evidence-informed practices.

understood as multiplicity or breadth of need rather than any single issue or problem. Anderson conceptualises the challenges as follows:

“Adults with multiple needs often brush contact with a wide range of services across health, welfare and criminal justice. Too often they will be 'famous faces' for all the wrong reasons. They will fail to engage, fail to make progress and be a source of considerable frustration for professionals. They will also be costly to the system, accessing expensive crisis services rather than structured support.” (2011, p28)

The programme ran between March 2012 and February 2013 and was led by the Social Care Workforce Research Unit at King's College London (who undertook the original study) and Revolving Doors Agency, a third sector organisation with an established record in delivering similar improvement programmes.

As part of the programme, a small scale (in-house) evaluation comprising a questionnaire survey and a focus group with each community of practice was carried out in December 2012. The survey response rate was 61% (n=33/54 members). The total number of members taking part in a focus group discussion was 34. In the evaluation, community of practice members were asked to reflect on the value of the initiative for the service users they worked with in terms of any outcomes linked to improved 'joint working' and also for themselves personally. An important secondary aim of the programme was to explore if communities of practice might also form part of the rubric of 'psychologically informed environments' (PIE's) by supporting workers in what is an emotionally challenging and stressful role where 'burn out' and staff retention problems are often reported (Scanlon and Adlam, 2012).

The overall aims of the programme were to explore if communities of practice might:

- Provide a vehicle for building networks and improving and sustaining relationships between different agencies and professions
- Lead to improvements in front line service responses through knowledge brokerage and opportunities for interdisciplinary education and learning (facilities for imagination)
- Provide shelter and space for reflective practice and interdisciplinary group supervision with opportunities for mutual (collegiate) support.

The programme

During the lifetime of the programme, communities of practice were established in Brighton (CP1), Halifax (CP2), Colchester (CP3), Stoke-on-Trent (CP4) and Tower Hamlets (CP5). With the exception of the community of practice in Workington (CP6), which was previously established by King's College London, the sites were all selected on the basis of a competitive tender. This invited applications from organisations interested in hosting and facilitating a community of practice (all the applicants were from the voluntary sector though this was not a stipulation). Each host was awarded a small budget (£6,950) for housekeeping (room hire, refreshments, etc.) and for payment of a facilitator who was to hold responsibility for the initial brokerage work needed to set up the community of practice and for its subsequent

running. Facilitators attended a two-day training programme at the start of the programme on advanced group work skills and part of the selection process was that they should have previous experience of setting-up and running groups. The facilitators met quarterly with the programme team and an advisory group.

In setting-up the community of practice, the facilitators were expected to recruit a group of between 6-10 front line practitioners from health, housing, criminal justice and social care who they considered to be representative of the various 'disciplines' involved in working with people with multiple needs and exclusions. The inclusion of an 'expert by experience' or person with experience of using multiple services was encouraged but this was only achieved in CP6. It was emphasised that a key objective of the programme was to 'open-up' new learning opportunities by bringing together those workers who do not usually collaborate together. There was no stipulation that members should be professionally qualified or non-professionally qualified. In keeping with communities of practice in general it was stated that the main criteria for membership were that the worker should be passionate about the topic and wanting to make a difference and not necessarily an 'organisational representative'.

Each community of practice was expected to hold a minimum of six meetings (most meetings were held monthly). At each meeting a member (or a group of members where there was joint involvement) was asked to present an anonymised case study for discussion. The case could be presented as a particularly challenging one or an example of innovative practice (what worked well). The discussions were structured by means of a template which included: presentation of case, next steps/suggestions for practical action, identification of any learning for improved practice, and identification of any potential issues for commissioners. At subsequent meetings, feedback was given on the progress of the case to see if the suggested actions/interventions had been helpful.

Two researchers (one from King's College London and one from Revolving Doors) took on the role of 'knowledge brokers' attending all the community of practice meetings in order to source any research evidence or policy documentation which was thought to be potentially valuable to the unfolding case study discussion. This information and an update on what was happening in each community of practice, was shared across the sites and further afield through a monthly newsletter.

The case studies themselves were subsequently written-up by the facilitators as ‘learning objects’ with a view to converting and codifying tacit knowledge to increase its fluidity across boundaries (Williams, 2012). These were deposited in an online forum and repository developed by Revolving Doors. A selection of the cases can be viewed at: www.revolving-doors.org.uk/partnerships--development/programmes/improving-frontline-responses/communities-of-practice/getting-started

This forms part of a tool kit for those interested in setting-up and running a community of practice.



Getting started

The six communities of practice evolved at different speeds and in different ways. The facilitators agreed that they had all underestimated just how much development work (brokerage) this would entail.

Despite best efforts CP2 failed to secure enough members to keep going beyond meeting three. The key learning here was that the facilitator, a relatively junior member of staff, needed much more senior management support when it came to approaching other agencies. Where the facilitators did not have personal contacts, gaining access to front line staff often involved persistence and negotiating many different management levels. Arranging to meet with managers in person was thought to be time-consuming but essential in securing the participation of front line staff.

In the early stages, CP3 also struggled to achieve a consistent membership and the facilitator commented that even though the same worker did not attend every meeting as was requested, the fact that agencies were sending someone was itself an achievement. Across most

of the sites, the perception was that ‘joint working’ had become increasingly difficult in the current economic climate with agencies withdrawing into their primary and statutory roles. It was noted that other kinds of meetings such as ‘provider forums’ were also struggling to secure interest and participation.

The final membership of each community of practice is shown in Figure 1 on page 6. Each community of practice had its own ‘weak ties’ or ‘problematic relationships’ to contend with and all were left with what was perceived to be a significant gap. The practitioners thought hardest to recruit (in no particular order) were social workers from local authority adult social care, NHS mental health practitioners and housing officers from the local council (district or unitary).

Benefits of participating in a community of practice

While a small number of people dropped out after the first meeting (which was designed as a ‘taster session’) the overall feedback from those that took-up membership in a community of practice was overwhelmingly positive. Having time out to reflect, a chance to meet with other practitioners, and to learn about different services and roles and ‘access to a wealth of expertise’ were all noted as important benefits of participation:

“ [On first hearing about the community of practice] I thought ‘Oh God no, it’s another meeting’... but I’ve been pleasantly surprised just how well everyone’s related and we do have a vast variety of skills and expertise here... and you’re hearing about how different people deal with different problems and it’s ‘Oh yeah I never thought about that, and now I’m sort of seeing things in a different perspective... ”
(Member CP5)

Members appreciated the structured approach to meetings with clear ground rules for confidentiality and information sharing. In terms of developing collegiate (more positive) relationships, the use of anonymised case studies worked particularly well in that it seemed to afford respite from the ‘turf wars’ which can damage day to day joint working relationships. One member commented that the case studies were ‘a lower pressure way to discuss issues.’ (CP3). Another commented:

FIGURE I: COMMUNITY OF PRACTICE MEMBERSHIP

COMMUNITY OF PRACTICE	CP1	CP2	CP3	CP4	CP5	CP6
Voluntary Sector						
Director, Substance Misuse Service	F					
Recovery Manager			F			
Link Worker Development Manager					F	
Housing Support Worker	Y	XXF	XY	X		F
Homelessness Outreach Worker					X	
Mental Health Worker, Reconnections Team (Social Work Qualified)					X	
Mental Health Link / Support Worker		Y	XY		X	Y
Housing Support Worker (offenders)		X				Y
Crime Reduction Initiative (drugs in criminal justice)				XX		X
Alcohol Outreach Worker	X					
Substance Misuse Worker (adults)	XXY				X	
Substance Misuse Worker (children/young people)		Y	XY			
A&E Support Worker (alcohol)				X		
Domestic Violence Worker	X					
Sexual Violence Worker	X					
Women's Support Worker/Manager	XXY			X F	X	
Family Support Worker		Y		X		
Local Parenting Support Service			XXY			
Young People's Education and Training Advisor						X
Citizen's Advice Bureau Worker				X		Y
Young Person's Sexual Health Worker			YY			
Local Authority (LA)						
Housing Options / LA Homelessness					X	Y
Manager – Homelessness Response Team [16-17 Year olds]			X			
Social Worker – Homelessness Response Team			XY			
Substance Misuse Senior Social Workers	X					
Children and Families Social Worker						X
Community Safety Manager			X			
Leaving Care Team		X				
Local Area Co-ordinator						Y
NHS						
Mental Health Worker						
Community Psychiatric Nurse				X		
Dual Diagnosis Nurse Consultant	X				X	
Drugs Worker						
Community Matron				X		
A&E (Alcohol Liaison Nurse)	X					
A&E Consultant	Y					
Criminal Justice & Police						
Probation Officer	X			X	X	Y
Youth Offending Team			Y			
Integrated Offender Management Manager		Y		X		
Police Sergeant	X					
Experts by Experience						XX
Total confirmed members, December 2012 (N=54 excluding Ys)	13	5	9	12	9	6

X = attended 2 or more meetings Y = dropped out/attended less than 2 meetings F = Facilitator

“ [A community of practice is] like a very informal MAPPA (multi-agency public protection arrangements) type process, a multi-agency thing but obviously less protocol in it... A bit more relaxed in a sort of friendly environment and probably a bit more constructive in some ways. ”

(Member CP4)

“ [The community of practice] helps us understand each other's frustrations... When someone says 'I can't do that' you think 'What a bag of bones, that's useless'. Whereas in the [community of practice] meeting, you understand why they can't do it. You come away thinking 'Ah it's not because they don't want to do it, it's because of their organisational bureaucracy'... So I think your working relationships are more informed. ”

(Member CP4)

The mix between professional and non-professional workers, and experienced and less experienced workers worked well. It was felt the non-hierarchical, friendly and supportive environment fostered within the community of practices was crucial in helping members overcome any nerves about 'discussing your practices in public'. Initially, some of the case studies presented would not have been out of place in an advertisement for a particular service, only once trust was established did more critical reflection on practices begin to emerge.

“ When I presented my case there was lots of questions 'Have you thought about...?' It's been done in a very constructive way. ”

(Member CPI)

In some of the communities of practice, there was concern about the inclusion of 'experts by experience' and whether this would be appropriate or feasible. CP6, the longest established community of practice, included two 'experts by experience' as part of its second development stage. Practitioners reported that they found this input helpful in a variety of ways. For example, one practitioner had become 'sick with worry' about how best to respond to one of her service users whose child had been taken into care. She subsequently found it very reassuring to hear from the 'expert by experience' who had first-hand experience of receiving support at such times, that she was, in her opinion, doing the 'right thing'.

Both 'experts by experience' reported that being a member of the community of practice had been a positive experience. One 'expert' who had been in the care of a local authority as a child, said that working with a social worker in the community of practice had allowed her to understand more about the work that social services do.



Key points for involving 'experts by experience'

- Involvement should commence from the outset
- Having two is better than having one because 'it takes the heat off you'
- Those who are being involved need to have 'reflected on themselves and moved on'. Being a community of practice member is probably not a suitable role for someone who is currently 'in trouble' and using services.

(Experts by Experience, CP6)

The input of the 'Knowledge Brokers' who provided policy and research evidence 'tailored' to the needs of the case being discussed was also something that was greatly appreciated by community of practice members. Indeed, the sheer breadth of research evidence and knowledge required to underpin the practice discussions surprised both of the knowledge brokers. Being there in person to give verbal feedback on the latest research/policy was thought to be important as members varied in their use of the written summaries that were also prepared by the knowledge brokers:

“ I'll be honest. I haven't read an awful lot of the research just because it's an awful lot and time just doesn't allow for that... What's nice is that we know it's there and it's something we can draw on if there's a case that we need a bit of guidance on. ”

(Member CP3)

The only concern to emerge in the feedback given by members, and a point we shall return to later, was that the benefits reported above were largely contained inside the community of practice membership and that impact may be fairly limited beyond this in terms of improving collaborative working across the wider system.

Outcomes for practitioners

In the survey of community of practice members over 90% of respondents agreed:

- My skills and competencies in working with people facing multiple needs and exclusions have improved through my membership in the community of practice
- My knowledge of the role and function of other agencies has increased through my membership in the community of practice
- I have increased my networks and contacts through my membership of the community of practice.

Integration and 'secret case loads'

Members of CP4 felt that prior to the programme starting, there had already been a considerable amount of work undertaken in the locality by commissioners to promote front line collaborative working around the multiple needs and exclusions 'agenda'. They felt that, in some respects, an informal community of practice already existed in that much joint working was already taking place with regard to certain individuals with complex needs. In the community of practice meetings most of the cases discussed were 'open' (being actively worked on) by many of those present. Because of this 'live' involvement in the cases, coupled with the temporary 'co-location' afforded by the community of practice meeting itself, integrated support planning often 'happened' whereby a goal or objective would be identified during the discussions with members subsequently co-ordinating their activities around this shared objective.

For example, in one case it was recognised that the service user was particularly vulnerable to crises at weekends when she did not see anyone, which often led to a visit to the Accident and Emergency department. In order to try to break this cycle, it was decided that because the agency providing the mainstay of support was unable to provide a worker at weekends, the police representative would ask a police community support officer to call on her. This also prompted discussion as regards whether there was scope for the support plans held by each of the different practitioners to be brought together in some way to reflect the interconnectivity between them.

In CP4 the format of the meetings perhaps came closest to that described by Soubhi et al. (2010) who have used

communities of practice to underpin interdisciplinary team working around multi-morbidity in Canadian primary care. In this model, interdisciplinary learning and reflection are integrated alongside more traditional case management/ case conferencing type activities. However, transferring this model across to the English system is not straightforward because of the potential for duplication. In the case mentioned above, for example, the service user was already receiving multi-disciplinary case management through the 'Care Programme Approach' (CPA) in mental health.

Members of CP4, one of whom had attended a recent CPA review, felt that one of the main problems with existing arrangements for multi-disciplinary case management (case conferences) was that they were sometimes hierarchical (with doctors taking charge) and time pressured meaning that there was often little scope for the kind of in-depth reflective review which was possible in a community of practice meeting. In the case outlined above, this process of in-depth review was recognised as having been critical in enabling the group to take a step-back from the management of the immediate or presenting crises and to rethink its whole approach, moving from a problem focussed to a preventative solution focussed one.

While it was recognised that it would not be feasible for every service user to have their case reviewed at a community of practice meeting (given that they met for two hours monthly) members felt that if cases were selected purposively with a view to generating transferable learning around a specific issue (e.g. 'dual diagnosis') then these meetings might work effectively to enhance (rather than duplicate) other existing arrangements for multi-disciplinary case management. In some of the other sites, it was recognised that people facing multiple needs and exclusions often found it difficult to access (statutory) case management, and that the communities of practice might in the future potentially fill a gap.

The 'flexibility' or blurring of agency boundaries described above whereby the police community support officer provides an element of 'social support' is something which is often aspired to in descriptions of integrated systems. However, interestingly among community of practice members these practices were often viewed as something which might potentially get them into trouble if their managers found out. Some argued that service contracts and job roles had become increasingly prescriptive in the current economic climate leaving much less scope for this kind of 'good will'. As in the case above, there is the danger that collaboration can try to substitute for a lack of practical community services.

Across all the sites, 'secret caseloads' were very much in evidence. These are circumstances where service users should be 'officially' discharged from time-limited services or not accepted into services at all, but are allowed access because workers are concerned that there are longer-term needs still to be addressed or that there is no other support available. Communities of practice played an important role in surfacing and enabling members to think about how capacity and demand impacted on their practice approaches.



Are communities of practice just a talking shop?

While collaborative or integrated working remains high in policy circles, some academics have drawn attention to the lack of evidence of the outcomes for service users (Petch, 2012). Greig and Poxton (2001) posed the question, 'Nice process, but did it change anyone's life?' The theory of collaborative advantage assumes that participation in communities of practice will lead to enhanced capability, coordination and new and innovative practice (Soubhi, 2010).

However, even after achieving some of these things, what most often emerged from the community of practice meetings in this programme was a sense of mutual frustration, sometimes despair, about the intractability of many of the issues being discussed whether that related to a lack of suitable accommodation for a homeless young person or a shortage of psychological support services for people with a diagnosis of personality disorder. Practitioners were also acutely aware of the pressure to achieve 'recovery' (change outcomes) in short spaces of time rather than maintenance and prevention outcomes over the longer term. This influenced members' understanding of the likely impact of community of practice participation on service user outcomes:

“ Having them stabilised for a period of time is an outcome but it's not one because they've not progressed but they've not got any worse and actually that's a bloody big achievement for some of the customers that we've been discussing... The value of this [community of practice] is not necessarily moving the customer on, it's keeping the staff engaged and motivated to continue to do what they're doing on a daily basis for the customer that's presenting with the same problem day in day out for three years. That can be quite draining on the staff but actually to sit and talk about it and get that collective support that we're all going through the same thing gives you a bit more energy and motivation to **carry on doing** whatever it is, for a longer period of time. ”

(Member CP4, emphasis in the original)

The concept of 'shelter' was a pervasive theme in many of the community of practice meetings. Many members were anticipating or undergoing service re-structures or cutbacks to staffing. They reported feeling beleaguered by targets which often did not reflect the intricacy of their holistic work with clients. Some were weary at the realities of doing more for less and of what it meant for those whom they are seeking to support. One member commented that she felt the climate was not right for communities of practice as this was seen by her as the antithesis of the current outcomes and target driven culture.

In terms of the broader rubric of psychologically informed environments, the 'shelter' provided by reflective practice and structured peer supervision, such as that provided through communities of practice, seems critical. Without it, professionals can be exposed to intolerable stresses and become incapacitated, unable to support those who desperately need their help. Very often it was simple suggestions offered by other community of practice members that seemed to make all the difference in helping a practitioner to feel that he or she could move forwards where they felt themselves to have become stuck or at an end point with a particular service user. It may be then that the main outcomes achieved for service users through this form of collaboration, is the prevention of further exclusions:

“ Our patient group that we work with is a very challenging group... When you're working alone and you're seeing patients one after another you think, 'is it just me seeing this problem' and clearly it's not just me and that reassures me. ”

(Member CP5)

“ There’s a lot of agencies [that] have clinical supervision and I still do... [The community of practice] feels outside of that. It’s very reviving to sit round with lots of people who are coming from different perspectives... ”

(Member CPI)

“ I remember thinking at the time that’s so simple, why didn’t I think about that... It was the simple thing of asking [the client] “What are the positive things in your life?” ”

(Member CPI)

“Communities of practice are just a talking shop”

100% of survey respondents **disagreed**

Intelligent commissioning and ‘ginger groups’

Given that communities of practice can also act as a forum for ‘the practitioner voice’, greater impact in terms of improved services and outcomes might also be achieved by making the connection with commissioning (e.g. processes such as Joint Strategic Needs Assessments). This might include commissioners receiving a copy of the case study write-up or attending a meeting occasionally. For the communities of practice themselves, knowing that managers and commissioners are tuned in to their ‘difficult conversations’ and recurrent blockages seems particularly important even if solutions are not easily found. Opening-up dialogue, for example around practices such as ‘secret caseloads’, seems particularly important in preventing inequities from seeping into the system.

It is maybe that further capacity cannot be found but at least decision-making as to who gets ‘special treatment’ should be made organisationally explicit. In one of the sites, the community of practice had already to some extent taken on the role of an activist or ‘ginger group’, asking questions of strategic commissioners as to why people with multiple needs were being excluded from a ‘dual diagnosis’ care pathway. It will be important that this ‘campaigning’ element is embraced by commissioners rather than shied away from. As Williams and Sullivan (2010 p10) point out, ‘too often people are attached to collaborative initiatives by virtue of their seniority and status and contribute as organisational representatives rather than ‘partners’ seeking to manufacture collaborative advantage’.



Managing endings and new beginnings

The communities of practice all had different ideas about how they would like to take things forward beyond the lifetime of the programme. The organisation hosting CP4 planned to train senior practitioners in each of its geographical divisions in community of practice facilitation and then to set-up communities of practice in these areas to work with ‘priority needs’ cases. The other communities of practice wanted to infuse more traditional training activities alongside reflective case discussions, such as inviting guest speakers to some of the meetings. CP6, the longest established community of practice which had run for nearly two years, decided it was time to draw things to a close.

Members felt that they had discussed a sufficient range of topics through case study reflection and that they had now exhausted the knowledge of the group. Due to re-tendering processes several members had also changed their jobs, many moving out of the locality where they previously worked. This left little scope for moving toward discussion of cases which might be ‘jointly worked’.

Importantly, Wenger (1998) always contended that what was important was not the life of any isolated community of practice but that they should ‘sprout’ almost naturalistically where a need arose. Here, the role of the manager or commissioner is to ensure that there are processes and structures in place across organisations and systems which support communities of practice to grow while honouring their roots in personal passion and engagement. With regard to collaboration more generally, Soubhi (2010) similarly describes the need for:

“ ...continuous nurturing, organisational support and leadership with a view to facilitating change, optimising the people who take part in collaborative care, their relationships and valued roles and their collective competence and capability. ” (p1)

Conclusion

In their article 'Despite all we know about collaborative working, why do we still get it wrong?' Williams and Sullivan (2010) caution that collaboration does not just happen in mainstream services but that, it requires dedicated resources for activities such as networking, brokerage and boundary spanning. This is particularly the case in times of austerity where agencies often retreat even further into their primary roles and statutory functions.

Through this development programme we have shown that, given a relatively small financial investment, considerable gains can be achieved through communities of practice in terms of building collaborative relationships, opening-up opportunities for interdisciplinary education and learning, and potentially improving certain kinds of outcomes. Most likely we see those outcomes as being linked to tackling exclusion by sustaining the workforce itself, that is in motivating workers to remain engaged and thinking positively in what is an emotionally challenging and stressful job role.

This is an important conclusion in that it may afford something of a 'reality check' on what is possible through integration. Very often integration appears in policy documents as the 'magic solution' if only it could be achieved in practice, something which may perpetuate what Scanlon and Adlam (2011) have identified as a societal refusal to face up to the complex reality of the problems facing people at the margins of society.

KEY POINTS

- Managers and commissioners need to nurture front line collaborative practice. It will not just happen on its own. For a small financial investment communities of practice can reap many benefits in terms of delivering on the integration agenda.
- In areas with a history of poor joint working, the amount of brokerage and development that may be needed to set-up a community of practice should not be underestimated.
- There is a need to be realistic about what outcomes can be achieved through collaborative and integrative practice such as that found within communities of practice. Maintenance and prevention outcomes linked to resilient and continuous practice over the longer term should be valued just as much as recovery (change) outcomes.
- Receiving case study write-ups and attending occasional community of practice meetings is a good way for commissioners and managers to show support and gain valuable intelligence about the complex realities of front line practice.

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