Part 1

INTRODUCING COMMUNITIES OF PRACTICE

The first part of this book introduces you to the concept of Communities of Practice and their relevance to health and social care.
Chapter 1
INTRODUCING COMMUNITIES OF PRACTICE

Andrée le May

Defining Communities of Practice

What are Communities of Practice (CoPs)? It would be difficult to improve upon Wenger et al.’s (2001: 4/5) description of 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 this 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, 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 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 established ways of interacting. They may even develop a common sense of identity. They become a community of practice.

This description immediately suggests why CoPs should be important for people who practice in health and social care settings. And indeed CoPs 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 practices so that people might do their jobs better day to day. CoPs are ideal mechanisms through which people can discuss the best ways to implement knowledge to suit the needs and context of their area of practice or particular patients and therefore improve the quality of care that they give. CoPs can function either as real face-to-face communities or virtually via interactive learning environments or electronic discussion groups. To be effective, CoPs need to pay attention to the following (adapted from Lathlean & le May, 2002; Gabbay et al., 2003):
Communities of Practice in Health and Social Care

- **Membership** in terms of choosing who is to be involved initially and throughout the life of the CoP, the extent (active or passive) and legitimacy of their involvement, their knowledge base and expertise, and the importance of their involvement to achieving the goal of the group and the alterations planned to care/services.
- **Commitment** from within the community to the desired goals and from outside the community in order to support any required service/practice alterations.
- **Relevance** to local communities and the existing services/professional groups/groups of patients to enable acceptance of the change.
- **Enthusiasm** that could be personal, professional or service related for the area being considered by the CoP.
- **Infrastructure** to support the work of the CoP in terms of ease of access to knowledge or evidence (e.g. availability of library resources and information technology, particular experts or opinion leaders) and resources which are available in order to find information about current services (e.g. networks, statistics and documents).
- **Skills** in relation to accessing and appraising a variety of sources of knowledge together with those needed in bringing evidence together into a coherent plan for action by the CoP. The latter, for instance, might involve writing action plans, reports or business plans.
- **Resources** for achieving the desired change that go beyond the time needed to meet, seek information or canvas support. These could include pump-priming money for pilot work in relation to the desired service change or funds for evaluating the effects of change on the quality of care provided by the new service.

Communities of Practice are beneficial not only for the people who form them, but also for the organisations within which, or across which, they function since they can be very powerful ways for sharing and applying knowledge whilst motivating participants to improve care. They therefore have the potential to positively impact on the:

- standard of care delivered to patients/clients;
- working environments and job satisfaction of the participants in the community;
- speed with which problems are solved;
- speed with which knowledge and innovation move into practice;
- creation of a unified team which may be uni- or multi-professional; and
- ownership and sustainability of changes to practice.

Furthermore, they can increase social, human, organisational, professional and patient capital – we will return to each of these as the chapter progresses.

Where did the idea of CoPs come from?

Although CoPs have existed for centuries, the term itself was coined only by Lave and Wenger in 1991 as a result of their analysis of apprenticeship learning in
'communities of practitioners' (Lave & Wenger, 1991: 29). Lave and Wenger’s observations of apprentices showed learning to be a situated, social process dependent on, and developed through, interactions with others in their apprenticeship communities rather than the isolated, ‘in the heads of individuals’ (Hanks, 1991: 13) learning often assumed to exist in the classroom. The social learning experienced through the master–apprentice relationship, in which master and apprentice learned from and through each other, and the apprentices’ interactions with each other and their wider community enabled successful learners to move from the edge (or ‘periphery’) of the community to full participation in its socio-cultural practices. This in turn resulted in apprentices forming an identity with the community and then becoming new masters, or old-timers within the community, working with newcomers or their own apprentices, thereby rejuvenating the original CoP.

The essence, then, of a CoP seemed in this early work to be its potential for enabling learning to occur and knowledge to evolve through the social process of interacting with like-minded people – within and across CoPs – where the purpose of the interaction was directed by common activities/practice and knowledge exchange. Successful learning was characterised in a CoP not only by mastering skills and gaining knowledge but by becoming part of the community and as a result of that gaining a greater sense of identity as a participant in the community (Lave & Wenger, 1991: 111) and, one assumes, within the ‘professional’ group that the community reflected.

Wenger (1998) used this early work, together with his later observations of insurance claims workers, to formulate a conceptual framework – what he calls a social theory of learning – to explain how learning occurred in CoPs and as a result of this the purpose and functioning of CoPs. The theory of social learning, as described by Wenger (1998: 3), placed ‘learning in the context of our lived experience of participation in the world’, suggesting that it is ‘a fundamentally social phenomenon' underpinned by four central premises:

1) We are social beings. . .
2) Knowledge is a matter of competence with respect to valued enterprises . .
3) Knowing is a matter of participating in the pursuit of such enterprises, that is, of active engagement in the world. . .
4) Meaning – our ability to experience the world and our engagement with it as meaningful – is ultimately what learning is to produce. (p. 4)

In addition, he set out an initial inventory of the components of the social theory of learning – meaning, practice, community and identity, all of which are integrated through the concept of the CoP. He defined each of these components as follows (Wenger, 1998: 5):

‘Meaning: a way of talking about our (changing) ability – individually and collectively – to experience our life and the world as meaningful’ (in terms of learning he refers to this as ‘learning as experience’).
Communities of Practice in Health and Social Care

‘Practice: a way of talking about shared historical and social resources, frameworks, and perspectives that can sustain mutual engagement in action’ (in terms of learning he refers to this as ‘learning as doing’).

‘Community: a way of talking about the social configurations in which our enterprises are defined as worth pursuing and our participation is recognisable as competence’ (in terms of learning he refers to this as ‘learning as belonging’).

‘Identity: a way of talking about how learning changes who we are and creates personal histories of becoming in the context of our communities’ (in terms of learning he refers to this as ‘learning as becoming’).

Meaning in CoPs is established, Wenger suggests, through an active process of participation, negotiation through continual interaction and the creation of artefacts (reification) that give form to this meaning (for instance, documents, guidelines for practice, protocols and directives as well as written descriptions of the workings of the CoP and its practice). This mutual engagement in the joint enterprise of the CoP also results in the creation of shared histories and identity stemming from a shared repertoire of practice, which in turn becomes a source of coherence for the community through which identity is created (and transformed) for both individuals and the community. A CoP is characterised by its collective pursuit of an enterprise/practice over a period of time in order to share significant learning and in some instances create new knowledge – ‘learning is the engine of practice and practice is the history of that learning’ (Wenger, 1998: 96).

So it seems safe to say that CoPs provide social infrastructures that foster learning. In order to achieve this, individuals, communities and organisations need to fulfil specific responsibilities towards learning – these include individuals engaging in, and contributing to, the practices of their communities and communities refining practice and regenerating their membership. Organisations hosting CoPs need to learn how to sustain these communities and enable links to develop between CoPs either within or outwith the organisation. Wenger (1998) suggests that this will occur through passing artefacts/documents/concepts (boundary objects) from one CoP to another, using the members themselves to broker elements of practice from one community into another often through conversations and meetings with, and making visits, to other CoPs (boundary encounters). These links will facilitate learning and the effective flow of knowledge across CoPs, and as a result organisations may better meet their goals and prosper whilst the CoPs remain hubs of learning.

These ideas are at the heart of Wenger’s (1998) social theory of learning. He situates this theory at the centre of several polarised intellectual traditions reflecting theories of social structure and theories of situated experience, theories of practice and theories of identity, theories of collectivity and theories of subjectivity, as well as theories of power and theories of meaning. The complexity of this proposition, although never fully explained by Wenger, is reflected in Figure 1.1.

In the chapters that follow, it may be useful to use this framework to consider what the social structures of the CoPs are, how they direct (or not) the behaviour
Introducing Communities of Practice

Figure 1.1 The conceptual underpinnings of Wenger’s (1998) theory of social learning in Communities of Practice.

of the CoP’s members, how power is played out in the CoPs, what meaning the CoP creates and what the CoP’s collective function is. You might also consider how individuals, groups and organisations associated with the CoP benefit from its existence.

**Designing for learning in CoPs**

From what we know so far then it seems sensible to suggest that CoPs are useful structures through which learning, knowledge transfer, knowledge generation, problem solving, meaning and identity develop. If we accept their inherent and explicit value as a learning community, one of the questions that still remains to be answered is how – if learning, as suggested by Wenger (1998: 229) cannot be designed for, only facilitated or frustrated – can CoPs be designed in order to create favourable learning contexts? In other words, how can CoPs best be designed for learning?
In order to answer this, we need to work from the premise that the existence of a CoP alone does not make learning happen, just as the existence of a curriculum or classes or textbooks does not guarantee learning. CoPs are simply structures, albeit rather complex ones, that when at their most effective facilitate learning and when ineffective are likely to frustrate rather than effect learning. Wenger (1998: 229) describes CoPs as being about content:

– about learning as a living experience of negotiating meaning – not about form. In this sense, they cannot be legislated into existence or defined by decree. They can be recognized, supported, encouraged and nurtured, but they are not reified, designable units. Practice itself is not amenable to design. In other words, one can articulate patterns or define procedures, but neither the patterns nor the procedures produce the practice as it unfolds. One can design systems of accountability and policies for Communities of Practice to live by, but one cannot design the practices that will emerge in response to such institutional systems. One can design roles, but one cannot design the identities that will be constructed through these roles.

There are certain things that can be done to encourage CoPs to develop – these have been detailed by Wenger et al. (2001) in their book Cultivating Communities of Practice and are further elaborated in the following chapters of this book. Whilst Wenger et al.’s proposals provide us with some design rules for the development and sustenance of CoPs, they also reflect the realisation that the CoP has the potential to ‘steward knowledge inside organizations’ (p. 220) and to extend knowledge systems ‘beyond the boundaries of the firm’ (p. 221), thus extending the impact of the CoP from one of learning and identity creation to one of enhancing organisational effectiveness and competitiveness and thereby increasing organisational capital.

In the first instance, a well-functioning CoP needs to develop and sustain three fundamental structural elements: domain, community and practice (Wenger et al., 2001: 27–40). Without them it cannot function. The domain is the topic the community focuses on – it gives the members of the community a common ground to work with and provides a sense of identity thereby giving purpose to and generating value for the CoP’s members and stakeholders. Having a clear domain also enables the CoP to interact with the organisation within which it is situated as well as other CoPs – they each have something to share, to develop, and to learn and to increase knowledge about. The community creates the ‘social fabric of learning’ (p. 28) within which the participants in the CoP are entwined. Working with the domain enables the community to determine and progress its common goals, which in turn generate trust and relationships between participants – these ensure that the CoP develops and is sustained. The practice is a set of frameworks, ideas, tools, language, stories and documents that the members of the community share – these represent the specific knowledge that the community develops, shares and maintains. This practice organises knowledge, tacit and explicit, codifiable and non-codifiable, in such a way that it represents the members’ perspectives and allows knowledge to be transferred. However, these ‘Communities of practice do not reduce knowledge
Introducing Communities of Practice

■

9
to an object. They make it an integral part of their activities and interactions, and they serve as a living repository for that knowledge’ (p. 9).

In addition to these three elements, Wenger et al. (2001: 51) highlighted seven design principles necessary for cultivating successful CoPs. These largely tell us not to stifle the evolving and dynamic nature of the CoP by over-directing its evolution but to create a vibrant environment through using both formal organised events or meetings and informal chats and exchanges to develop trust across its membership and stimulate ideas, which in turn are seeded beyond its boundaries through networking with others outside the CoP.

All CoPs go through a journey of development – this book tells the story of several CoPs in health and social care settings, each at a different stage of development and maturity. Even the most cursory reading of the stories conveys the key features of CoPs – domain, community and practice, as well as the learning that has occurred within them, or as a result of them, or still has the potential to occur. The case studies used in this book – which we hope will be capable of being translated into the reader’s practice – show how CoPs develop social, human, organisational, professional and patient capital and as a result better patient/client care.

Communities of Practice – more than the social fabric of learning

Wenger’s identification and discussion of the building blocks of social learning in CoPs provides us with a new vocabulary. Some might call it jargon! But it does give us the means to detail and explore the workings of CoPs – how they naturally develop, are sustained or closed; how we could manufacture or create such entities; how they impact on learning, on organisational effectiveness, on practice, on professional development and the development of professions; how and why they are used to transfer knowledge between people, communities and organisations. Briefly exploring these building blocks has allowed us, so far, to gain an understanding of how CoPs function as the ‘social fabric of learning’ (Wenger, 1996). We now need to move beyond this in order to expose their wider contribution to health and social care through the generation of social, human, organisational, professional and patient capital.

Using CoPs to generate social capital

For almost a century, scholars have been debating the ways in which concepts similar to social capital can be defined, used and measured, but the term, first used in the 1960s, has only more recently come into general use. Probably the best known and possibly the most contentious work in this field is Putnam’s (2000) investigation of social change in North America and his resultant theory of ‘social capital’. This theory defines social capital as ‘the connections among
individuals – social networks and the norms of reciprocity and trustworthiness that arise from them’ (p. 19): these connections seem akin to those fostered between participants in CoPs and also between CoPs as they allow people to act together in order to effectively pursue shared objectives.

Putnam describes social capital as having both individual and collective elements which benefit individuals, groups, organisations and society through encouraging citizens to resolve collective problems more easily, allowing communities to advance smoothly and extending awareness of the range of ways in which situations can be interpreted and dealt with. It is therefore not surprising that several writers (e.g. Lesser & Prusak, 1999; Daniel et al., 2003) have linked CoPs with the creation of social capital, which in turn may be associated with organisational success. Organisations use CoPs’ social capital to stimulate better knowledge management by, for example, enabling the quicker identification of experts or the more rapid brokering of agreements, thereby allowing knowledge to be found and used more efficiently and effectively by individuals, CoPs and organisations (Lesser & Prusak, 1999).

To gain the most from social capital, both the individual and the society (or the organisation) within which they function need to be well connected; this is true also for the CoP. For instance, when we think about social capital, Putnam (2000: 20) reminds us that ‘A well-connected individual in a poorly connected society is not as productive as a well-connected individual in a well-connected society. And even a poorly connected individual may derive some of the spillover benefits from living in a well-connected community’. The same may be true for participants in a well or poorly connected Community of Practice. Putnam gives as an example of this the success of the IT industry in Silicon Valley in California when compared to a less successful IT community near Boston. The reason for the difference he suggests was nothing to do with expertise or resources; it was more strikingly to do with connections – personal relationships and networks in Putnam’s terms – boundary working and the development of trust between (and within) CoPs in ours. The Boston community was deficient in these, whereas the Californian community was rich in them and prospered because of the free flows of information, mutual learning and reciprocity that occurred.

Thinking about the success of the Silicon Valley ‘Communities of Practice’ illustrates the relationship between, what Nahapiet and Ghoshal (1998) call, the three dimensions of social capital – structural, relational and cognitive – and CoPs. Successful CoPs provide participants with structural opportunities for networking within the CoP, between CoPs, from CoPs to the outside world and vice versa. In addition to these networking opportunities, successful CoPs act as a reference point for assessing members’ knowledge without them having to go outside the CoP’s boundaries; they also enable the initial assessment of new knowledge permeating the CoP to take place. Trust and respect are fostered by the CoPs ensuring that the relational aspect of social capital is maximised as too is the cognitive dimension not only through the knowledge generating and sharing nature of the CoP but also through the CoP’s ability to create artefacts that can then be passed on and studied.

Generating social capital would appear to be one of the positive spin-offs of successful CoPs, and this in turn contributes to their ongoing success. However, it is
not the generation of social capital alone that gives CoPs value in health and social care, it is also their capacity to merge social and human capital through learning that is important and in so doing generates organisational, professional and patient (or client) capital – all of which impact health and social care and the value that CoPs have in this arena.

**Communities of Practice can generate human capital**

Human capital is best described as the outcome of investment in people. This investment may take the form of, for instance, health or social care or, perhaps more conventionally and appropriately for us, the provision of education and/or training. Sharing knowledge and expertise in this way results not only in the possession of particular skills, dexterity (physical, intellectual, psychological, etc.) and judgement for the individual, but also in the facility to create outputs which may themselves be invested (Becker, 1964) in, for example, other people or organisations, thereby increasing ‘capital’ in some way.

Given this, it does not require too great a leap to recognise that the learning that occurs in a CoP generates human capital. For instance, in a CoP where newcomers learn from old-timers, the human capital of, for instance, the master (old-timer/expert) is invested in the development of the human capital of the apprentice (newcomer/novice); this knowledge sharing does not diminish the human capital of the master, it may even enhance it, but it does increase the human capital of the apprentice – and in doing so increases the collective human capital of the CoP. So participants in the CoPs learn from one another, CoPs learn from one another and in turn CoPs help to develop learning within organisations generating not only human capital but organisational capital too. There is a close relationship between human capital and organisational capital since the development and growth of organisations depends largely on the learning that occurs within them and the resultant return that they get from their investment in the people working in or involved with them.

**Communities of Practice can generate organisational capital**

Increasingly, CoPs are seen as mechanisms for transforming organisations through their contribution to the growth of organisational capital – ‘the knowledge used to combine human skills and physical capital into systems for producing and delivering want-satisfying products’ (Evenson & Westphal, 1995: 2237). Three broad components of organisational capital – workforce training, employee voice and work design (Black & Lynch, 2005) – would seem to be influenced by CoPs. CoPs enable effective knowledge transfer and learning, thereby affecting workforce training. Through participation they provide a voice for employees and influence workforce design by exposing knowledge, acting as a conduit for sharing it, solving problems and implementing change.
van Winkelen (2003) suggests that ‘the driver for organizations to invest in developing CoPs is deeply rooted in their value as ways of transferring knowledge between people’ and because of this they ‘offer a form of social structure that can take responsibility for fostering learning, developing competencies and managing knowledge’. CoPs may therefore provide the vehicle through which knowledge and human skills are combined and in so doing create advantage for the organisation; their importance may revolve around their potential for forming and holding corporate memories, transferring best practices and acting as a focus for innovation (Alani et al., 2002). A good example of this is the transformation of the World Bank, a Washington, DC-based organisation centred on reducing poverty in some of the world’s poorest countries, from a simple lending organisation to a knowledge-sharing organisation. This was primarily achieved through the introduction of CoPs and storytelling as ways of sharing knowledge both within the organisation and outside it (Denning, 2005b).

Significant organisational capital makes organisations more effective and efficient, which in turn has the potential to make them better places to work. Given this potential, it is hardly surprising that CoPs are being rapidly embraced by organisations and the business community; attention has extended beyond the early explorations of CoPs as communities of learning (Lave & Wenger, 1991) to focus on their value as a mechanism for effectively managing organisational knowledge (Cox, 2005) and thereby influencing organisational capital.

Communities of Practice can generate professional capital

Let us move back now to Lave and Wenger’s (1991) early ideas. In their book *Situated Learning*, they hypothesise that ‘learners inevitably participate in communities of practitioners and that the mastery of knowledge and skills requires newcomers to move toward full participation in the sociocultural practices of a community’ (p. 29). These communities, where there is a professional remit, are vast repositories of professional knowledge and skills – what I shall call ‘professional capital’. Members endow their knowledge and skills to others who may be newcomers or old-timers within the community; this in turn bolsters the community’s knowledge assets and leads to further growth in the community’s professional capital.

Professional capital is a complex entity comprising several interlinking parts. These include the following:

- The knowledge and skills that characterise the professional group. At first glance this seems straightforward enough; however, ownership of this portfolio is often unclear since, as in health and social care, it is frequently shared across professional groups.
- The sociocultural practices of the professional group.
- The formal and informal networks used to guide and develop practice.
- The written and unwritten rules that guide professional practice.
Professional capital is developed and amassed at several different levels of any profession; for instance, professional capital can reside in individuals, in educational and/or research establishments, in the literature, in CoPs (one person may belong to many) or in the profession’s governing/guiding bodies (for instance, Royal colleges, professional and statutory bodies, professional associations/societies). Professional capital may be variously viewed across and between professions. For instance, subgroups within a profession may distinguish between different groups’ professional capital by assigning greater or lesser respect to it – this may also happen between professions (Chau, 2005) and in turn lead to competition or distrust rather than collaboration between groups and professions with a resultant undermining of professional capital.

It is relatively easy to extrapolate Lave and Wenger’s (1991) observations of learning in CoPs to the health and social care arena and the acquisition and growth of professional capital. New students start their studies on the edge of a community of knowledgeable and skilled practitioners moving, as they master essentials of the repository of professional capital, closer to full participation. Mary Gobbi describes this process for nurses in Chapter 6. Having passed through their ‘apprenticeship’ to full participation, or from being a novice to an expert practitioner, they continue to contribute to the wealth of that community whilst belonging to other specialist/role-related CoPs. Whilst these specialist/role-related CoPs work towards fine-tuning practices and solving problems, they continue to shape the sociocultural practices of the profession. Sometimes the professional capital generated by these CoPs is reified and made explicit for reinvestment – sometimes reinvestment occurs more randomly, experientially through role modelling, listening and watching as practice unfolds. Chapter 5 written by John Gabbay and me gives a sense of the way in which Communities of Practice can contribute to and influence the continuous development of professional capital for doctors working in primary health care.

**Communities of Practice can generate patient capital**

Just as CoPs can generate professional capital, they can generate what I shall call patient (or client) capital. In fact within the broad landscape of health and social care, one cannot exist without the other – professional capital and patient capital are interdependent and mutually constituted. Wenger (1998: 6/7) reminds us that CoPs ‘are everywhere’, that they are ‘an integral part of daily lives’ and as such have for centuries provided a ‘non-professional’ social fabric for learning. Why then not take this one step further and think about how CoPs populated by patients or their representatives might generate patient capital?

Patient capital, whilst encompassing human capital, is the product of a distinct learning experience – one focused on health and social care through the lens of the recipient. This type of capital accumulates by learning from, for instance, the way people view their health and social situation, their satisfaction with health and/or social care services, their expectations of care and their plans for being
involved in, or changing, that experience. Generating and exposing this capital in CoPs builds a store that can then be used not only by others with similar experiences but also by professional caregivers, so also contributing to the stocks of professional capital. This process arguably has the potential to transform problems experienced individually into public issues (Gibson, 2006).

The potential to generate patient capital through CoPs is manifested in two ways. The first is through the involvement of patients or people who represent their views in multi-agency, multi-professional CoPs (Gabbay et al., 2003). In order for this to be a success, patients need to use strategies that make this type of capital explicit and communicate it effectively so that rather than sinking without trace in an assertive articulation of professional capital, it contributes to and advances it. I explore this a little more in Chapter 8 by considering how storytelling has been used in such CoPs to articulate the patient/client/lay voice and thus generate patient capital, which in turn advances care (not least by helping to improve professional capital). Secondly, patients can establish CoPs in order to explore a domain of health and social care perhaps originally through support groups or patient/client representative groups. The patient capital generated by these CoPs does not immediately have to compete with professional capital – rather this is done once the CoP exposes its work to others. Although it is not dealt with in this book, there may be merit in considering the role of patient organisations as a vehicle for enhancing patient capital through CoPs.

Whilst you are reading the case studies in the following chapters and thinking about the different sorts of capital that they may generate, it might be useful to think about what belonging to a CoP does for individuals, for the CoP collectively, for the organisation in which the CoP is situated and also for the professional or patient/client group that the CoP is situated in.

What can go wrong?

So far CoPs have been portrayed in a positive light, offering benefits for individuals, teams, organisations and professional or patient communities as the CoP’s knowledge is moved into the wider community within which, for us, care is provided. However, Wenger et al. (2001) warn that CoPs can also have their dark side, which rather than enabling learning stifles it.

There are a variety of ways in which the CoP can go wrong – some develop from within the CoP, others have their origins outside the CoP. Things tend to go wrong within the CoP either at a structural level or at an individual level. At the structural level failings might occur, perhaps as a result of the CoP being unable to fulfil all the criteria for successful working detailed above or not having a consistent membership; at the individual level, problems might occur as a result of some members becoming, for instance, too possessive of knowledge, believing the CoP to have a monopoly on that knowledge and ultimately resisting its transfer beyond the boundaries of the CoP (Brown & Duguid, 2001). Individuals may also form cliques within the CoP which hinder learning and knowledge transfer within it and
smother participation. Or it might be that the CoP fails to link up with others or cannot find new members; its members become mistrustful of each other or it is unsupported or overly controlled (Thompson, 2005) by its organisation because of internal politics or irrational fears of the CoP becoming too strong to contain – all of these will cause the CoP to perish.

Ardichvili et al. (2003) found knowledge hoarding in virtual Communities of Practice to be a problem. However, this was not knowledge hoarding for selfish reasons associated with power or status, it was knowledge being hoarded primarily because people were afraid to share it – either because of their fear of providing the wrong information, being criticised or having their knowledge belittled by others, or because they were uncertain as to whether or not their position in the organisation was high enough for their knowledge to be of any use. To counter this problem, they advocate face-to-face communities where participants get to know and trust each other more quickly than in virtual communities and also remind readers of the need to have supportive organisational structures which encourage and nurture CoPs rather than manage and stifle them leaving little room for creativity and learning.

Why are CoPs important?

As I have already suggested, Communities of Practice are different from other groups usually found in organisations providing health and social care in that they are first and foremost learning communities and as such we should be able to tell them apart from others. As a learning community their purpose is to develop members’ capabilities by building and exchanging knowledge (van Winkelen, 2003) within the CoP and the organisation, rather than achieving a task or delivering a product/service as is the case with working or project groups. The learning that accompanies this process requires the CoP to be adaptable and open to change, which in turn enhances the CoPs usefulness to the organisation by making it better able to adapt organisational processes to suit client needs. This is particularly important in organisations providing health and social care since the dynamic and flexible nature of the CoP suits the dynamic and flexible needs of the varied groups that either use or work in these organisations. In turn, health and social care organisations benefit from CoPs’ potential to integrate learning into practice and to generate learning from the discussion of practice experiences. Chapter 5 describes how this happens in primary health care, whereas in Chapter 7, Alex le May describes how CoPs can be used more widely to develop health care across global boundaries.

Communities of Practice are often described as places for developing new practices, new services and new products (Coakes & Smith, 2006). Nina Stipich, Jane Coutts and Mireille Brosseau in Chapter 2 write about the experiences of the first ‘graduates’ from the EXTRA (Executive Training for Research Application) programme in Canada as they sought to improve health and social care by promoting research-informed management in Canadian health care organisations. They have supported each other in this endeavour by forming a Community of Practice. In addition to this, Linda Sawchenko in Chapter 3 tells the story of how
Communities of Practice in Health and Social Care

Figure 1.2 The potential of Communities of Practice in health and social care.

a CoP developed in British Columbia to support Nurse Practitioners and how they not only enhanced their own knowledge and confidence through the CoP but also transferred this knowledge to their practice and improved patient care. Judith Lathlean and Michelle Myall in Chapter 4 describe how one ‘constructed’ Community of Practice developed learning around dermatology practices and transferred their learning to the wider health and social care world through an interactive database.

In an increasingly time-pressured and competitive world, CoPs provide opportunities for enhancing the effectiveness and efficiency of our practice as well as generating social, human, organisational, professional and patient capital. Their dynamic nature affords them multiple opportunities for creating learning and developing care through analysis, creative thinking and the sharing of ideas (see Figure 1.2).

But as we have seen, there are limitations and potential problems. We therefore need to know how effective they are in health and social care – later in this book (Chapter 9) Helen Roberts, Alan Shiell and Madeleine Stevens provide us with some ways for looking at this. Part of maximising the potential of CoPs to enhance services is to learn from, and evaluate, the experience of using them. It is hoped that the case studies presented here will allow us to begin that process.