

Introducing the Learning Practice – II. Becoming a Learning Practice

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Abstract

Rationale, aims and objectives This paper is the second of three related papers exploring the ways in which the principles of Learning Organizations (LOs) could be applied in Primary Care settings at the point of service delivery. **Methods** Based on a theoretical and empirical review of available evidence, here we introduce the process by which a Practice can start to become a *Learning Practice* (LP). **Results and conclusions** Steps taken to enhance both individual and organizational learning begin the process of moving towards a learning culture. Attention is given to the routines that can be established within the practice to make learning systematically an integral part of what the practice does. This involves focusing on all three of single-, double- and triple-loop learning. Within the paper, a distinction is made between individual, collective and organizational learning. We argue that individual and collective learning may be easier to achieve than organizational learning as processes and systems already exist within the Health Service to facilitate personal learning and development with some opportunities for collective and integrated learning and working. However, although organizational learning needs to spread beyond the LP to the wider Health Service to inform future training courses, policy and decision-making, there currently seem to be few processes by which this might be achieved. This paper contributes to the wider quality improvement debate in three main ways. First, by reviewing existing theoretical and empirical material on LOs in health care settings it provides both an informed vision and a set of practical guidelines on the ways in which a Practice could start to effect its own regime of learning, innovation and change. Second, it highlights the paucity of opportunities individual general practitioner practices have to share their learning more widely. Thirdly, it adds to the evidence base on how to apply LO theory and activate learning cultures in health care settings.

Learning to change: allowing Primary Care staff to drive the changes

The reasons for change in the National Health Service (NHS) often originates *outside* the NHS and suggested innovations contained in the Government's white papers originate *outside* the NHS. Such frequent change can seem wasteful of human efforts and not give staff a chance to consolidate practice around new structures. Existing good practice can seem ignored, invisible, and unvalued whilst there is evidence to suggest that Primary Care (PC) within the NHS offers a very good service (and exceptional value for money) when compared to systems in other countries (Starfield 2001). However, staff become tired of constant change and disillusioned about the effectiveness of its impact. In short, reform fatigue develops (van Eyk *et al.* 2001).

Effective practice needs to be recognized and built upon and staff encouraged to be proactive and creative in responding to the changing context of PC (Argyris & Schon 1978; Sofarelli & Brown 1998; Smith 2001). However, sometimes even when staff are aware of the need to change they can find themselves constrained by existing practices and organizational rules that make new ways of working very difficult to implement (Smith *et al.* 2000). It has been said that:

There are too many cases in which organisations know less than their members. There are even cases where the organisation cannot seem to learn what every members knows. (Argyris & Schon 1978)

Health organizations need to be able to learn and develop for themselves and their patients (Birlleson 1998; Rushmer *et al.* 2004). It was to address these issues that this paper draws from a wide literature on collective learning to try and understand how PC Practices can become more like Learning Organizations (LOs). The first paper in this series (Rushmer *et al.* 2004) outlined the nature of a Learning Practice (LP) – its structural arrangements and cultural underpinnings. This paper explores how practices might think about and tackle the *processes* of change needed to move towards this vision.

The purpose of learning within the practice

Prioritizing learning does *not* represent a project or task for a practice, but a way of thinking and acting

that puts learning at the centre of what staff do (Timpson 1998). Most projects in general practice involve participating in a programme to reach certain standards, being able to complete a checklist. This can involve demonstrating certain achievements to others located outwith the practice. The requirements are usually set external to the practice, and are often geared to gain compliance and consistency in certain clinical or procedural matters. Usually these projects are not part of the immediate agenda of the practice, but are to some degree enforced.

Learning Organizations work beyond this level and proactively take control of the developments they make, by undertaking organizational learning (Dodgson 1993). LOs change the way staff normally work, regardless of the task being undertaken. So, when external events do impact on their working lives, together, they are better able to deal with them, because they are already able to learn together, share experiences, and help and support each other – as this is normal. Ways of behaving and working collectively (Bohmer & Edmondson 2001) are already in place, learning is part of what they do, and change is not feared. Changes are made for the benefit of the staff who work together and for patients by treating everyday events as opportunities to streamline, adjust and bring about easier and more effective ways of doing things. Here learning is not undertaken in order to 'please' others (or to jump their hurdles), but because things can be done better and the staff know how (Argyris & Schon 1978). As with all service delivery, there will be things that work well and things that could be improved. The challenge is to identify which is which, preserve the effective practice and change what needs changing (Gundlach 1994).

A Learning Practice

An LP is a collection of PC staff who deliver services together and who have decided to adopt some of the LO ideas to help them collectively develop their practice and service provision so as to make life better and easier for themselves and their patients alike. It is worth expanding upon what forms learning may take and how these might operate amongst members of a Practice.

Types of learning

Four types of learning have been identified (Pedlar & Aspinwall 1998):

- learning about things – knowledge;
- learning to do things – skills, abilities;
- learning to become ourselves – personal development, self-awareness, and
- learning to achieve things together – collective learning.

Within PC, service delivery depends upon the pooling of effort, expertise and skills. Without the combined efforts of many staff service provision or delivery would be much more difficult or not possible at all. In this way it is this last form of learning, learning to achieve things together, that could make a real difference if mastered within PC. Skills can be individually based, but pooled through sharing and collaboration, or they can be duplicated in many staff and truly collective.

Individual, collective and organizational learning in the Learning Practice

If a Practice wished to develop a collective learning capacity and become an LP, how could it proceed? The remainder of this paper attempts to address this practical issue. In order to do this, it is necessary to examine what facilitates individual, collective and organizational learning, then consider ways in which these could be achieved. It is prudent here, to clarify some of the terms being used.

Individual learning is, as the name suggests, learning, knowledge, expertise, skills and experience which is the personal mastery of the person concerned. It can be thought of as personal expertise.

Collective learning is learning, knowledge, expertise, skills and experience held collectively and in common by a number of people who work together around the achievement of certain tasks. This learning is not the same as the learning they hold *between them* (each an expert in their own area), but the things they know *in common*, the things all know. In this way collective learning is not a simple summation of all individual learning but a measure of the duplicated learning and redundancy held in the collective who work together in order to get things done. The more capable the greater number of staff are, the

more knowledgeable and ‘clever’ PC could be. In this instance collective learning can be thought of as team or practice learning.

Organizational learning is where collective learning has been dispersed and disseminated more widely to the organization or community of practitioners (beyond those who normally work together), in order to effect systemic learning that feeds back into training, systems, rules and procedures for a group of people beyond the original collective. This type of learning is preserved and systematically deployed beyond the setting in which it was first developed. In this instance it can be thought of as systems change and organization-wide evidence-based innovation.

Within a Practice (or any single part of a large complex organization), learning can take place at all of these different types of levels. Individuals develop their own skills and expertise. Groups, subgroups and teams who work together directly to achieve a set task can achieve collective learning (e.g. innovations in the nursing team). If this collective learning is passed on to others who were not directly part of this group or team, in another time or place (e.g. other members of the practice), then the learning is *becoming* organizationalized (e.g. into Practice routines). The further the learning spreads through the wider organization [beyond the Practice, or the PC Trust (PCT), or Local Health Care Co-operatives (LHCCs)], to regional and national parts of the Health Service then the wider organizational learning becomes. As this learning forms an evidence base informing future practice and development within the organization as a whole (and its relevant parts), then the closer full organizational learning becomes. These levels of learning serve as a *theoretical device* for understanding the importance of disseminating pockets of excellence in service provision so that this learning can benefit all within a Practice and then spread to the wider community of PC and health services.

The reasons for distinguishing between collective and organizational learning will become apparent as the paper progresses. In short here, it is possible to envisage collective learning within PC as Practice-based learning. As this learning is shared through the whole Practice, organizational learning develops at Practice level. Yet it remains much more difficult to see how any learning emerging from general practitioner (GP) practices as excellence in service

Table 1 Activities that help people to learn

Learning is encouraged and not judged
 Others are learning too
 Learners have had a chance to practise new behaviours
 There is not too much to learn at one time
 The learning is relevant and meaningful to the person

After Ribeux & Poppleton (1981); Case (1996).

provision could inform change in the wider delivery of PC. The spread of organizational learning to the wider Health Service seems sporadic and unlikely, as there appear to be few mechanisms to achieve this.

Becoming a Learning Practice

Helping people to learn

To become an LP, Table 1 illustrates the kinds of activities practice members could encourage. These are expanded in more detail below.

Learning is encouraged and not judged (Kim 1993)

Courage to try new things and learn is a big step, especially if a person's working life has been very routine and clear-cut. An atmosphere has to be created where it is OK to try, without being made to look silly or to be judged. Early successes build confidence and the motivation to try more.

Others are learning too (Mallory 1993; Argyris 1994)

A communal spirit of 'giving-it-a-go', and 'we-are-all-in-this-together' can develop. There is support and encouragement and a sense of anticipation and fun. It builds the belief that the changes are being taken seriously and that something will happen.

Learners have a chance to practise new behaviours (Revans 1971)

If learners were going to be perfect first time, there would be no need to learn. So real learning may involve getting it wrong at first. So, minor errors, misunderstandings, forgetfulness, reverting back to old ways at first, whilst learning is taking place, should be tolerated. Getting it wrong is OK, mistakes will happen, but people are encouraged to try again, next time will be easier, better.

Table 2 Activities that help organizations to learn

They strive to enhance the individual capabilities and skills of their staff
 They allow staff to learn together in teams
 They update and challenge assumptions they hold (mental models)
 They develop and share a cohesive vision
 They consider the bigger picture (open systems thinking)

After Senge (1990); Davies & Nutley (2000).

There is not too much to learn at one time

Everybody needs time to take in what they have learned so far, practise, get it right and then they are ready for the 'next-bit'. This is known as 'consolidation' – if learners move on too fast some of the new learning will knock out what they have learned so far and they will forget the early lessons. Different people will learn at different speeds, depending on how new the new experience is for them (e.g. learning a database package is easier if they already know how to use a word processing package – it is not something completely new, but builds upon existing knowledge).

The learning is relevant and meaningful to the person (Case 1996)

It also helps if learners can see what the point is. What it is all for. How it will be useful and help them to do their job better, or provide a better service or help them to work with others more easily. Nobody likes to feel that they are wasting their time.

Helping organizations to learn

Having explored what helps people to learn, attention is now given to what helps an organization to learn the lessons that its people know. How can an LP develop, get faster at learning lessons and recognizing opportunities to respond and change? What could a practice do to learn to use its staff effectively and support them well, so they can do a good job for themselves? How can sharing learning help this? Table 2 illustrates the five things that seem to help organizations to learn (Senge 1990; Davies & Nutley 2000). These are expanded in more details below.

They strive to enhance the individual capabilities and skills of their staff (Milstein 2001)

Collective learning starts with the skills of the individuals who work together. By helping these people be the best they can, everybody will benefit from what they bring to the task. Individuals need to be constantly encouraged to improve their own personal skills. Initiatives that begin by looking at problems in one particular area of service delivery in PC could work well, especially if the people providing that service lead these. However, these should also take place alongside team-based learning projects, because teams deliver PC based around GP practices.

They allow staff to learn together in teams (Mason 1993; Thompson 1994; Timpson 1998; Partis 2001)

Collect together all the skills present in the team and use them together. Encourage the team to harness the diversity of its people not to be afraid of it. Learning to work together, as a team, and cooperating is essential because most organizations achieve the tasks they do through teams. Activities, which concentrate on developing whole teams rather than separate professional groups, will be crucial. Membership of this team is defined by the nature of the patient's journey. All the members of staff that a patient talks to or meets as they contact, move through and receive PC (in all its forms) are members of the PC team. Team learning is about getting the whole GP practice (and beyond) to 'join-up' and work together in the interest of the patient. It is also about finding a way of working together, which is sustainable and acceptable to, all involved.

They update and challenge assumptions they hold (mental models) (Mallory 1993; Argyris 1994)

New learning requires some un-learning. Some ways of thinking about the world, about work or about other people may no longer be useful. These views have to be shared and changed if necessary. Skills need to be developed in open-mindedness and tolerance. Day-to-day behaviour is shaped, largely unconsciously, by our 'embedded mental models'. These models are made up of deeply held assumptions and beliefs. They form our opinions of

the world: what others are like (patients and staff); what actions are possible; and what the results are likely to be. It is easy to see how they strongly influence what actions we think are possible and what things we dismiss. If staff speak out and air these assumptions then these models can be examined to see if they are still useful or relevant. They may need to be updated. What lies behind this is a determination by staff to remain open-minded and 'wait-and-see'.

They develop and share a cohesive vision (Deutschman 2001)

PC practitioners may do things in different ways with different skills and backgrounds, but all the tasks done should tie together to foster patient care (Timpson 1998; Chin & McNichol 2000). Everyone pulls together. LOs constantly look for ways of removing the negative effects of 'pecking-orders' and other formalities that suffocate good suggestions about new ways of working. LOs try and view the input of all staff as equal. At the same time, everyone needs to be working towards the same basic goals. The LP would need a vision, of what is possible and desirable. This would include a clear sense of direction, and the values that would guide all members of staff (Deutschman 2001; van Eyk *et al.* 2001). Everybody in an LP would know and accept what the team is working towards and how this can be achieved. A well-devised Practice plan constructed with the input of all staff could help to achieve this.

They consider the bigger picture (open systems thinking) (Thompson 1994)

More important than anything else is the need to see the Practice as part of a wider system of health care. Too often people only see their little 'bit' of the world. We need to see the 'whole' (Adler & Docherty 1998). A GP practice is only one part of the wider world of Primary Health and Social Care. LOs learn from the richness of the whole outside world. Systems thinking is about seeing things as 'wholes' not 'parts', whole people not just illnesses, whole communities and their issues, whole systems of care serviced by many providers and agencies not just GP practices. This way of seeing things encourages staff to see the 'interconnectedness' of what they do and

what others do. This thinking goes beyond the walls of the practice to other parts of the NHS, to other agencies of health and social welfare and other aspects of community.

Learning routines

For learning to have an impact, behaviours need to change. People have to learn to do different things and to do things differently. Deliberate and specific steps can be taken to increase the likelihood that lessons learned by one or two staff are acted-upon, deployed, reviewed and retained within the practice. Learning in an LP takes place at three levels (Senge

1990) – these are known as learning routines. Learning routines take individual learning and create processes by which this learning can be shared and sustained throughout the practice. Any Practice is likely to be more successful in its efforts to become an LP if it deliberately adopts these learning routines and processes as opportunities to examine, monitor, reflect upon and enhance its service provision and delivery (after Senge 1990).

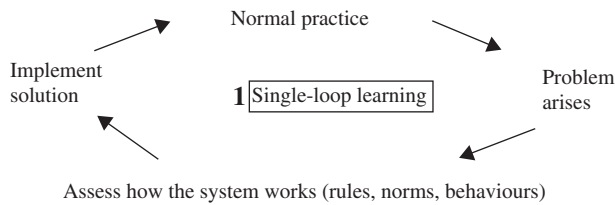


Figure 1 Illustration of single-loop learning.

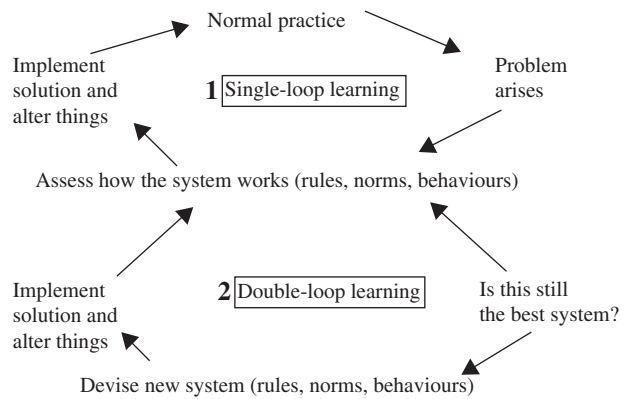


Figure 2 Illustration of double-loop learning.

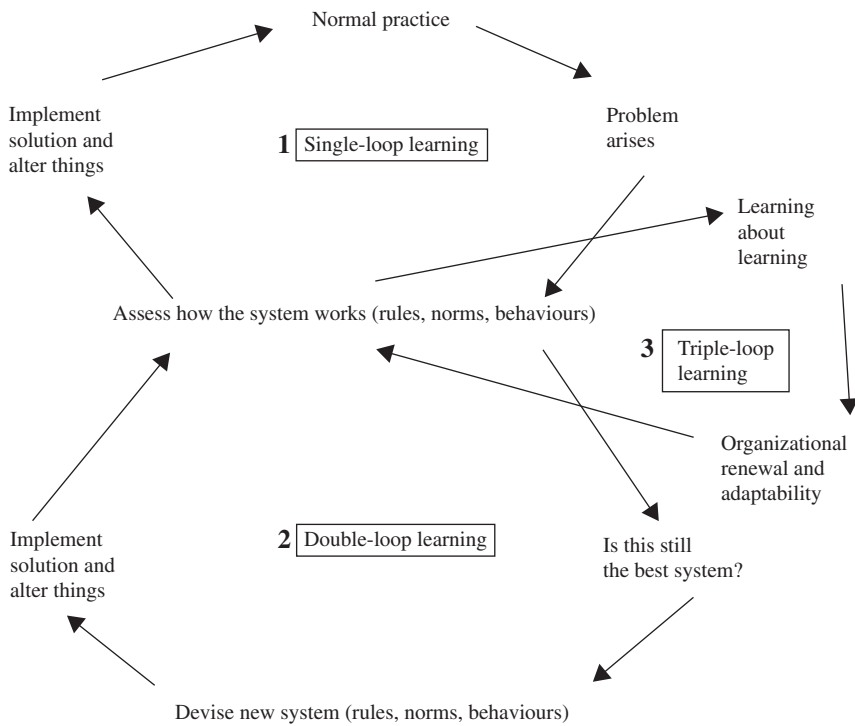


Figure 3 Illustration of triple-loop learning.

Single-loop learning (adaptive learning) (Argyris 1994; Clarke & Wilcockson 2001)

This is the simplest level at which learning can take place. It involves looking at the present way of doing things to see how smoothly it is working and then correcting any inefficiencies or problems. It supplies a feedback loop into the present system of working to allow for corrective action and restoration of 'normal service'.

This type of learning monitors and maintains the status-quo efficiently. It is suitable in stable environments where the aim is to do again today what was done yesterday (and will be done again tomorrow) ever more efficiently as time passes. In PC, Clinical Audit would be an example of this type of learning and corrective feedback loop.

Most everyday learning would take place like this as staff give feedback to each on the outcomes of their actions. Informal communication probably fits this best, a quick chat, an agreement to try a different approach next time, support and understanding when things could have gone better, or recognition and praise when things work out well.

Double-loop learning (generative learning) (Argyris 1994; Clarke & Wilcockson 2001)

When constant attempts to refine and 'mend' (single-loop), the present system fail to have a lasting effect, then the Practice and its members should be prepared to change 'normal practice' (double-loop). A face-to-face meeting with all staff would be appropriate. Alternative ideas need to be generated, and their impact and implications thought through and discussed. Individuals should be identified to take the changes forwards, with deadlines and methods for reporting back any outcomes. The actions will generate a period of transition, where practice is needed, adjustments need to be made and minor errors are tolerated before the new systems settles down and starts to become familiar.

Triple-loop learning (learning about learning – meta-learning) (Gavan 1996)

Double-loop learning is about re-designing systems rather than just correcting existing systems and putting them back on course. If staff have learnt to change

one system (one area of practice), then they might be able to apply the same principles elsewhere and change other systems. For example, if a practice now understands what helped the change to be successful (what were the blockages, resistance, managing patient expectations, etc.) – then these are valuable lessons about 'how to change' in general. These lessons may be generalizable and help in other situations. It would be possible to impose this loop of learning on single- and double-loop learning as in Fig. 3.

Meta-learning involves the three loops of learning (1, 2 and 3 on Figs 1–3). First, single- and double-loop learning takes place within the specific change you are attempting and then generalized lessons are drawn from it. In this way triple-loop learning or meta-learning contains two elements: specific learning about that particular change that may be useful somewhere else and more generalized learning that can apply to other learning situations in a more generic way.

Arguably this is the least formalized and most undeveloped of all learning routines in PC (Gavan 1996). Often this type of knowledge and learning exists only in the heads of the staff as their 'experience' and memory of 'what things worked in the past'. This type of learning is prone to 'decay' through forgetting, selective recall and lost altogether if staff move on. It is only this type of learning that allows the Practice to move on cumulatively. As a practice accumulates what it has learned about different situations and how to learn successfully, what helped and what hindered, so it can begin to build a repertoire of useful attitudes, behaviours and actions, without having to learn from scratch every time. Nobody should be blazé about the difficulty of learning at this level. Learning-to-learn is a skill in itself (Gibbs 2000). It is difficult to do and easy to lose the skills associated with doing it successfully (as often evidenced by older people attempting to return to formal education after a few years' gap).

Triple-loop learning can be helped to occur by taking time to record major changes. Recording factors such as antecedents, actions, outcomes, key issues and players, external and internal factors, and learning outcomes for each major change would seem to be the only way of preserving this information for all staff in times to come. Such a record could be periodically reviewed (almost as a reflective diary of

practice learning), and a statement of the current collective learning could serve as a reminder of achievements and progress made and mistakes not to be repeated. This could become the beginning of an evidence base for effective practice and decision-making (Hebert 2000).

Another behaviour that builds triple-loop learning is just by *doing it*, again evidenced by those returning to formal education, as they take time to get 'back-into-the-swing' of learning-to-learn again, and rediscover these skills. Learning-to-learn gets easier as we do it, we remember and recall what helps us to do things and what hinders our efforts. We bring these new learning skills to each new setting making it progressively easier to change and adapt.

A working example: learning routines and tackling DNAs

Table 3 illustrates what form the learning routines might take as an LP attempted to address the issue of DNAs (did-not-attend) in its practice. It illustrates the simplicity and speed of single-loop learning in quickly making adjustments where this is all that is needed. This could make timely changes to day-to-day service delivery, with immediate impact. It would build the confidence of staff to feel that they can make a difference. The impact would be immediate, potentially ease what may be constant and traditional friction points and smooth the way for bigger changes.

The table also considers the reasoning behind taking steps to address the cause of DNAs in double-loop learning and a re-orientation of the practice to meet its patients' needs. At the same time it acknowledges the effects that this level of change might have on the unseen workload of staff in the practice. Changing systems can indeed make things more turbulent initially (new routines, confusion, hassle, resistance, drop in efficiency). The gains are to be made longer term.

The table highlights the role of meta-loop learning in the systematic deployment of knowledge around the LP and the PC system. In this example triple-loop learning contains two factors. First, learning about 'access', lessons that may help with access-issues in other parts of the organization. These experiences become helpful in a very specific, focused way in similar change situations in the future. Second, experi-

ence has been gained in 'how to change in general' – learning about changing itself (perhaps involving and mobilizing people, informing all stakeholders, changing the accompanying paperwork and forms, etc.). These are generic lessons that may be helpful in many and varied change situations in the future. Table 3 also details the paucity of opportunities, routes and infrastructures that exist to pass on learning between practices and on to other parts of PC to PCTs or LHCCs, to Trust members, those on the Boards, or staff in other agencies, to help them share and learn these lessons.

Conclusion

The NHS as a service-driven organization relies upon the personal skills of its staff as the basic building block of its service provision. The notion of the LP offers health professionals the opportunity to take charge of their own personal and professional development (Timpson 1998). With the motivation and encouragement to be proactive in their approach to change, the whole of PC is upgraded, negating the need for constant externally imposed innovations. However, whilst individuals within a Practice can already take charge of these issues (training and development programmes, professional bodies and networks, etc.), the difference with LPs is that this empowerment can be *collective*. This can be achieved (beyond personal mastery of key skills) through collective and organizational learning and established through learning routines (Senge 1990; Argyris 1994). By duplicating the skills and learning from each other and between each other, collectively all sorts of actions become possible that could not be achieved unilaterally. Team- and Practice-based learning could transform life and service provision within practices to the benefits of all concerned as practitioners tackle issues together that they know could make a difference speedily and positively (Davies & Nutley 2000).

In reality, there may well be good reasons for supposing that individual learning will be easier to achieve than collective learning (Gavan 1996). First, the professional status of health care practitioners provides a strong motivation for personal mastery. Second, supporting systems for individual training and development are both well established, a requirement for registration, and valued through sta-

Table 3 Working example of levels of learning in a Learning Practice (learning routines) Problem: 50 DNAs ('did-not-attend') each week. Patients fail to turn up for appointments and do not cancel to allow appointment to be re-allocated. General practitioner (GP) time wasted and failure to meet the 'see patients within 48 hours' recommendation.

<i>Level of learning</i>	<i>Aim of the solution</i>	<i>Example solutions</i>	<i>Learning to learn Politics, resistance or conflict issues</i>
Adaptive (single-loop)	Take corrective action (address the immediate problem under the present system). Try to meet standards	Put a notice up in the waiting area, informing patients OR get reception staff to remind patients to cancel in good time OR send repeat 'offenders' letters asking for better appointment keeping	The safe option: not too different, risky or costly <ul style="list-style-type: none"> • Looks as if something is 'being-done' • Maintains status quo, may help a bit for a while
Generative (double-loop)	Consider new ways of understanding or addressing the issue of appointments and rethink the whole issue of patient contact. 'Why do we have appointments?' 'Making access fair?' 'Is there a better way to achieve this now?'	Cancel the appointment system and hold open sessions (perhaps with the support of a triage service upon arrival) OR change the referral pathway to allow multiple access routes into Primary Care services instead of using GPs as 'gate-keepers' to services OR introduce a triage system for appointments OR another solution that fits the particular Learning Practice	Innovative solution goes to the cause of the problem; however, it is more risky, unfamiliar and will need monitoring. Negative <ul style="list-style-type: none"> • Staff and patients will have to do things differently – can be uncomfortable, needs effort, due consideration and time to make the changes work well • Risk of initial loss of efficiency as the transition takes place • Staff may resent or dislike their new role or loss of their old role • Some GPs make welcome DNS as 'breathing-space' within crowded surgery schedules Positive <ul style="list-style-type: none"> • Problem and solution is owned by all involved • Long-term solution – likely to be effective when established
Meta-learning (triple-loop, learning to learn)	Transfer this learning to other Primary Care Services/other parts of National Health Service/ other Health and Social Care agencies	Identify other areas where this approach might ease access (e.g. direct free access to opticians without a green form) AND What approaches to change worked here – might they work somewhere else?	Builds transferable, cumulative, systematic learning based on what works But, currently, how does one Learning Practice <ul style="list-style-type: none"> • establish this as effective practice in the system beyond the Practice? • communicate their findings? • thereby effect systematic change? Needs a feedback loop to policy making (through Primary Care Groups (PCGs) or LHCCs?, etc.)

tus. Third, evidence suggests that present attitudes and ways of arranging work may represent a difficult starting place from which to begin to develop learning cultures. With evidence of restricted organizational roles, status and pecking orders (West 1995; West & Slater 1995), perhaps serving to make integrated working and collective learning difficult (Rushmer *et al.* 2004). However, as noted earlier in

paper one it is to these very issues that the LP would turn its attention first, so there is reason to remain optimistic, that practitioners will not stand in the way of their own collective development.

More pessimistically, the diverse and dispersed nature of PC has long left practitioners 'isolated' in terms of input to strategic decisions surrounding the development of PC as a whole. So, whilst individual,

collective and organizational learning can be envisaged at Practice level, if a Practice approaches these sensitively, it is more difficult to see how any one individual practice could inform change at systems level within PC in general. To some extent the introduction of PCTs and local health care cooperatives can provide voices to individuals, however, the potential of LPs to throw change wider is dramatic and clear. Learning and the impetus for change that emerges from excellence in service provision or innovation at Practice level could drive changes in PC Practice that is bottom-up, evidence-informed, owned and sustainable, but *only if* it can feed back into wider systems (Adler & Docherty 1998; Chin & McNichol 2000; Coghlan & Casey 2001).

The likelihood of gaining this feedback and impact probably rests upon two factors. First, an attitudinal factor, individuals or Practices would need to be *willing to try* to spread the good practice they have developed and make the lessons they have learned available to other practitioners. At the same time those other practitioners need to be receptive to these messages and be *willing to try* to learn from their fellow Practices in a collegiate way. Second, more significantly, the lack of feedback procedures with the wider system of PC beyond the GP Practice could prove to be a significant stumbling block. Even if a Practice became an LP and made notable leaps forward in service provision, how would it (could it) share this localized learning with PC regionally, and nationally? In effect how could learning in LPs become systemic and its benefits widespread? The present system of masterclasses, research bulletins and small-scale conferences seems insufficient, being ad hoc, piecemeal, irregular and not necessarily inputting systematically into the agenda of decision-makers and to the future of PC.

It has been argued that one way to change the future nature of PC is to make sure that the learning that goes on in practices feeds back into the education and training programmes of tomorrow's Health Service staff (Iphofen 2000). In this way training programmes are informed by active and up-to-day practice and are therefore more realistic (Henry *et al.* 1995), and more likely to be 'owned' by practitioners and students (Jowett & Wellens 2000). Alternative ways of achieving this feedback loop between up-to-date effective practice and future training pro-

grammes is to use academics to develop and offer in-house training programmes to PC, where theory and practice mix *in situ* (Partis 2001) or to get academics to act as development consultants, giving ongoing facilitation in personal and organizational development in PC (Barnes 1999). These are, however, very specific solutions, which will always involve a time delay and there is still a degree of vagueness about how (and if) these connections or feedback could be made to actually happen.

In effect, if there are solutions that exist to these blockages that prevent organizational learning spreading through PC they are not as yet well established, or clearly apparent. However, it is unlikely that such solutions could originate from anywhere other than practitioners themselves, as it seems doubtful that cooperation across practices could be forced. One can 'force' compliance but not conversion (Asch 1956). At the moment, the expectation seems to be that individual practices must begin to think, act and spread learning systemically themselves to other practitioners in other places, yet nowhere in the system is there the authority (or incentive?) to achieve this.

Arguably this is the real challenge facing PC. Good practice *is* already existent, presenting as pockets of individual and collective learning, hotspots of development and innovation. Any journal of health services research will provide testament to this. Yet, somehow PC as a whole fails to seize, preserve and deploy this learning across its entirety. It is to this challenge that policy-makers should turn their attention, but not through enforced structural change but by working with practitioners. In owning the problems, *with the will to succeed* and share good practice, the solutions need to be theirs.

Paper one in this trilogy reviewed the nature of the LP – what it could be like, its cultural and structural characteristics. This paper has explored the route upon which any practice might wish to embark in order to start to become an LP. What they could do, the systems and learning routines that could help and how and why they should strive to preserve and deploy this learning beyond their immediate setting. The third paper will look at the core contextual conditions that feature as pivotal factors in the likely success of this undertaking. It will examine research evidence that suggests that leadership, participation,

reflective practice and protected learning time play a key role in the LP's chances of success. Any of these factors can play out either as helping and facilitating forces or as hindering factors, blockages and pitfalls.

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