Releasing the grip of managerial domination: the role of communities of practice in tackling multiple exclusion homelessness

Releasing the Grip of Managerial Domination: The Role of Communities of Practice in Tackling Multiple Exclusion Homelessness

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Abstract

Purpose – This article discusses 'system transformation' in the context of different workforces and organisations seeking to support people experiencing Multiple Exclusion Homelessness (MEH). From a relational and integrated care perspective it identifies barriers to achieving more effective ways of working in the prevailing context of 'managerial domination'. Communities of practice (COPs) are evaluated to identify their potential to overcome some of these barriers.

Design/methodology/approach – The article presents a theoretical and conceptual discussion of a project in which a number of communities of practice were established and evaluated to ascertain their value in developing more relational ways of working in the context of MEH. Case studies of COPs operating in the context of MEH are explored and discussed.

Findings – It is concluded that communities of practice have the potential to deliver small-scale changes ('little miracles') which are characteristically more subversive than transformative. Nevertheless, we still see these small gains as significant when compared to the inertia that is often found in local systems of care where more traditional management techniques (such as 'payment by results') prevail. We also draw attention to the scope for much improved service quality which flows from moving beyond the 'tick box' and into the realms of what it really takes to tackle homelessness and multiple exclusion. In other words, although often requiring considerable amounts of 'craft and graft' to deliver seemingly very small amounts of change, these 'little miracles' may actually be more conducive in the long run to delivering the kind of tangible 'real' change that is often aspired to by both workers and service users and their carers.

Research limitations – The communities of practice project was limited in terms of time and scale and, hence, further research would be needed to, for example, ascertain their longer-term potential

Practical implications – There is merit in the theoretical perspectives discussed and, from these, of understanding how best to establish and operate communities of practice as a vehicle for achieving better outcomes through integrated or collaborative working.

Social implications – There is much scope for better integrated or more collaborative working in the context of MEH and this paper draws attention to how communities of practice could be one means of achieving better outcomes for people experiencing MEH.

Originality/value – This is the first paper to set out the theoretical analysis of communities of practice as a means of achieving better integrated or collaborative working.

Keywords managerial domination, integration, multiple exclusion homelessness, communities of practice, relational perspective

Paper type conceptual paper and project evaluation

Introduction

In a previous article published in this journal, Cornes (2011) argued that personalisation would be unlikely to deliver the positive tangible changes promised unless there was a radical departure in the way local managers and commissioners approached the task of policy implementation ('system transformation'). In particular, she drew attention to the pitfalls of encapsulating change in 'pilot projects' and delivering workforce development as 'brief encounters' (e.g. launch events and one-off training sessions). Lack of ownership of problems leading to poor service user and carer experiences was highlighted as a specific issue and one that was rarely mitigated through the actions of transitory project management boards or 'steering groups'.

This argument appears to be borne out in the emerging academic literature where personalisation is often characterised as having fallen into difficulties (Slasberg et al. 2013). West (2013) has further developed this thesis beyond ideas about management deficiencies at the point of implementation, arguing the case for 'management domination'. This is a process in which 'personalisation-transformation' *speak* is used to provide ideological cover for the most draconian of austerity measures. Illustrating how this worked in one local council she describes the process as follows:

> 'I do not deny the difficulties facing the council [in having to make large cuts to the adult social care budget]. What is of interest is the way in which the council sought to pass the 'new offer' off as part of a transformation programme, strongly connoted with personalisation as liberation and empowerment and signifying dignity and self-actualisation for social care users…The fact though is that the ['new offer'] potentially means tightening of individual budgets [and the restriction of eligibility criteria which] denies many the very possibility of even obtaining a personal budget in the first place.'(p643)

From the perspective of the institutional actors involved she sees them as being cast into the trauma of austerity and the whittling away of the welfare state, and seeking to make the best of an impossible situation in which they are required by national policy to bend the rules. In this psychic economy, 'Personalisation is part of the coping strategy. It signifies hope.' (p650)

In suggesting how 'system transformation' might be managed in such as a way as to re-humanise the experience of being cared for (and of doing caring), Cornes (2011) proposed

the idea of *working through* communities of practice. A community of practice is a vehicle for brokering knowledge and nurturing 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 (Soubhi et al., 2010). In effect, what was being proposed was the need for a more relational or psychologically informed way of working in which *authenticity* and *honesty* might release the grip of 'managerial domination'. The adjective 'managerial' in this context functions ideologically ~~Managerial is here an ideology~~ and helps convey as commonsense an associated set of practices proposing management and management techniques as the preeminent means of organising work, as we discuss in more detail below.

In this article, we revisit this earlier thesis by drawing on the findings of a small-scale research and development project that enabled us to test some of these ideas in practice. The project was funded by the Economic and Social Research Council (ESRC) and was carried out as part of the 'Multiple Exclusion Homelessness Research Programme'. It involved setting-up and evaluating six communities of practice situated in different locations across England. The overall aim of the project was to improve collaborative responses to some of the most extreme forms of homelessness and exclusion.

We begin the article by briefly introducing the concept of multiple exclusion homelessness (MEH) and how 'managerial domination' impacts in this area. We then discuss from a conceptual and theoretical perspective what is meant by more relational ways of working before exploring if the communities of practice were able to deliver this.

Multiple Exclusion Homelessness

Many people who are homeless experience several simultaneous interacting problems in addition to being homeless, such as drug or alcohol dependency, mental health problems, a history of poor quality care, and/or relationship problems. In the UK the term multiple exclusion homelessness is used by professionals and some policy makers to describe this complex situation (McDonagh 2011). In social policy terms this is a 'wicked issue', i.e. one that is a set of complex, interacting problems and experiences that are individually long-running and difficult to resolve, but even more so given their entwined nature. Indeed, complete resolution may not be possible and incremental improvements may be the most that can be hoped for with such issues.

In this situation people experiencing multiple exclusion homelessness have often found themselves receiving responses from services focused on a narrow aspect of their needs, and which in reality are insufficient to address their complex needs. Generally people experience sequential handovers between frontline staff and their organisations, rather than

the holistic, integrated care and support needed to address their circumstances (Cornes et al. 2011). For example, a client may experience help with accommodation, but only later receive support with mental health and/or substance dependency issues, and the delays and lack of integration in support may then endanger their tenancy. Yet, in public policy, practice integration and better coordinated, holistic care, are espoused goals (Department for Communities and Local Government (DCLG), 2012). Clearly, in multiple exclusion homelessness there is a policy implementation 'gap' between desired practices and rhetoric, on one hand, and the experience at the frontline of work and receiving care and support on the other.

Managerial domination

'Managerial domination' ~~marked by~~with increased funding accountability in the face of austerity has its roots in New Public Management (NPM). Clark, Denham-Vaughan and Chidiac (2014) note that NPM has been a powerful force shaping public sector leadership and management and is characterised by private sector management practices such as contracting, auditing and, more recently, 'Payment by Results' (PbR) to provide monetary incentives to change/improve practice. They note that, 'As much as relationships are considered in NPM, they are frequently seen as hierarchical and control orientated with an instrumental focus on achieving ends set at the top' (p5). They see these kinds of approaches as reducing complexity to simplistic statements that give the impression of 'tame problems' that can be easily managed. According to O'Neil,

> '[NPM] is widely experienced not just as changing but (I think) as distorting the proper aims of professional practice and indeed damaging professional pride and integrity. Much professional practice used to centre on interaction with those who professionals serve… now there is less time to do this because everyone has to record the details of what they do and compile the evidence to protect themselves' (quoted in Clark, Denham-Vaughan and Chidiac, 2014 p6).

Discussing practices such as Assertive Outreach in the fields of substance misuse (where MEH is strongly implicated), Roy and Buchanan (2015) make a very similar point about the constraints NPM has placed on the scope for authentic and meaningful practice with service users and carers. In particular they see managerialist approaches as having had a detrimental impact on the quality of the services provided:

> 'Unfortunately, top-down bureaucratic approaches to service delivery, part of the new managerialism have eroded professional autonomy, tending instead to prioritise exhaustive levels of documented client assessments of need… Managerialism has also been marked by the withdrawal from community engagement, fewer home visits and the centralisation of office locations, which has further isolated health and social welfare staff from the local communities they serve' (p4).

When it comes to addressing the needs of individuals with high problem severity and low recovery capital, Roy and Buchanan (2015) describe the strong international evidence base that underpins the argument for more rather than less Assertive Outreach. However, Hill, Wilkie-Jones and Leigh (2012) report that the government's favoured model has been the extension of PbR which they describe as a radical and visionary step-change in the delivery and commissioning of drug and alcohol treatment. In this model, funding is withheld (all or in part) until the service provider demonstrates that certain 'recovery' outcomes (such as reductions in symptoms, abstinence, achieving employment or reducing reoffending) have been achieved. Reminiscent of West's 'personalisation-transformation' *speak* it is reported that,

> 'The PbR system based on outcomes will drive the market and improve quality…Commissioners [in the pilot site] are keen to point out that this is not intended to be a money saving exercise - it is not about disinvesting in substance misuse, it is about having more effective services.' (2012 p35)

Beresford questions if ideas like 'recovery' can mean what we want them to, when the dominant use of them is so powerful, regressive and negative (quoted in Roy and Buchanan, 2015 p2).

In addition to the complexities from the client perspective for whom relationships with their service providers are hugely important (Fazel et al 2014), there also can be complex impacts on members of staff working in this area. Practice is characterised by uncertainty and risk with regard to what will happen when working in MEH, which develops anxiety for frontline workers and managers. This is associated with high levels of stress and burn out amongst practitioners working with people with complex needs (Scanlon and Adlam 2011; 2012). This needs to be managed within the organisations and the workers. Organisational responses have typically been to develop structures to do this – risk management tools and processes, for example – that have managerially become more dominant as the legitimate forms of addressing these challenges. There are concerns that as budgets have been reduced, there is less time for things like 'reflective practice' and individual and group/team supervision which is known to be protective of workers well-being (Cornes et al., 2015). Like West (2014), Scanlon and Adlam (2011; 2012) describe workers as being in an impossible situation stuck between the rock and a hard place of increasing demand and reducing resources. Overall, it is reported that:

> 'While some local areas are making progress on better-coordinated interventions, the present national policy environment (defined by funding, outcomes and accountability channels) does not encourage this, instead promoting a culture of silos working on specific issues within organisational boundaries. This is not sustainable' (The Calouste Gulbenkian Foundation (UK Branch) and Making Every Adult Matter (MEAM) 2015 p5).

Re-humanising the system

Amidst the complexities of defining and assessing integration in health, housing, social care and overlapping sectors of public services, no matter what the nature of the integration (e.g. vertical or horizontal) its success depends on relationships between people (Philp, 2015). Yet, this aspect seems too easily ignored in operational developments in integrated and collaborative working. There are questions how, amid the constraints described above, more relational ways of working can be achieved.

By relational we mean understanding the interplay of individuals, their interdependency, relationships and interactions within a social situation. ~~A number of perspectives can be used to examine this relational reality. For example, sociologically we might consider it from that of structuration (Giddens 1984), i.e. the interactions of agency and social structures.~~ Gestalt psychology (Yontef & Jacobs 2010) is similarly concerned with individuals and what is referred to as the 'field', the whole social context, and how this influences people. In the remainder of this section, we consider two aspects of practice most pertinent to MEH, namely i) the blocks to authentic relationships between workers, and ii) managing the need for emergent responses to needs. Addressing these could make providing and receiving care seem more humanised.

i) Authentic relationships between workers

In terms of achieving goals, clearly there is interdependence between workers and clients. Trying to achieve desired integrated, holistic support entails another dimension to this interdependence, namely that between the different workers involved. We need to understand this much more fully to assess the potential for integrated working and for the possibility of interventions such as Communities of practice to address the policy-reality fissure in the area of multiple exclusion homelessness described above.

A relational view entails understanding the individuals, their relations to each other, and the impact of the social context, or, as mentioned, in Gestalt psychological terms, the field. Relationships between workers are mediated in usual working arrangements by the field, e.g. role/professional and organisational boundaries, resources and processes. As such, workers often have little time to develop more authentic relationships, especially across organisations. By authentic we mean a deeper understanding of each other and a more honest relationship of understanding and exchange between individuals as people. When interactions between members of staff in different teams and organisations are sporadic and short in duration, and are mediated by fractured and fraught work conditions and boundaries, it is difficult to develop such relational authenticity. For example, people are expected to act professionally towards each other, which generally means conveying an unemotional relationship. This downplaying of an emotional interdependence as an aspect of integrated working is exacerbated in societies stressing individualism, and by notions of professional workers as individuals. If the working relationship is successful, it is a good professional one in which each party does his/her job. If it is not seen to be a successful relationship the emotions may be deflected in to something else and not addressed – e.g.

stating that the organisation they work for always does that, and so on. Worker A, for example, may expect worker B to do something without realising that the organisational environment he/she is in formally or informally inhibits this. The resulting frustration can further undermine good worker relationships and, hence, achieving integrated working with individual clients. Even in formal organisational integration programmes this is usually the case – workers are integrated through structural arrangements and processes, not necessarily through changes in their relationships. Organisationally recognising, allowing and addressing the emotional aspects of working in the context of homelessness are important (Scanlon and Adlam 2011; 2012). One approach advocated is to develop work environments that are Psychologically Informed Environments (PIEs) (DCLG et al., 2012).

Further, using managerial tools to manage situations ignores the fact that experiences of trust, honesty and belonging are important to successful work, especially of the kind we are discussing here, and that these result from the interaction of social and psychological phenomena. Trust and issues of risk management are inherently bound to contexts and are inter-relational, rather than imposed by organisational processes (Brown & Calnan 2012).

ii) emergent responses to needs

It is possible for existing knowledge structures, and professional and organisational arrangements to become too rigid and stifle emergent responses to people's needs and circumstances, which are often very fluid in the context of MEH. Workers are likely to face 'the imperative to match professional practice and knowledge with the situation at hand' (Fook, 2004, p.34), but may be hindered in doing so by, for example, prescribed responses and organisational boundaries setting limits to such responses. Balancing helpful work structures with an approach that can cope with the diversity and emergent nature of people's needs and how these change over time, and make use of opportunistic moments and spontaneous insights, is a challenge. The application of knowledge by professionals and other workers is contextual, working with and within a whole system and understanding how factors interplay to influence action and outcomes. This has implications for generating and working with knowledge (Fook 2004).

Professional and organizational factors frame structured knowledge, but success in supporting a person is also highly linked to developing knowledge. This may be socially constructed on the basis of emergent needs, various interactions, contextualised understandings, and decisions of the specific context. The more managerialist approaches of highly structured processes (such as risk management), very codified practice knowledge, and targets all limit scope for this emergent knowledge, the more they potentially hinder success by limiting the capacity for people to adapt to and work with each individual client.

Where managerialist principles have become a more dominant way of organising and holding workers to account they tend to work by providing further structure at the expense of emergent working. Codified forms of knowledge, such as targets around numbers of

contacts and caseloads, and protocols or work plans, allow for more managerial control of the work of frontline staff through holding them accountable and standardizing work (e.g. Fook 2004). However, these in turn hinder more flexible, emergent working. Such an approach to organising is not capable of coping with the diversity of the wicked issues we have discussed in relation to the client group experiencing MEH. Striking the right balance between structure and flexibility is difficult, and not something that can be always easily managed, especially at an organisational level. It may be something that is best enabled at the individual level, the relational reality of workers, which, for better integrated working, means across as well as within staff groups and organisations.

Approaches to achieving more relational ways of working

Finding ways that explicitly address these relational aspects of integrated working may help realise successful outcomes. Yet it is possible to establish something which ostensibly does this, but which in reality misses the point. Bate & Robert (2002 p648-9), for example, from their position of having researched Collaboratives in the NHS, similarly argue for the importance of understanding relational aspects of work, especially the socially constructed reality of knowledge: *'knowledge is not objective but exists subjectively and inter-subjectively through people's interactions, through working together, sharing knowledge, respect and trust'* (ibid). Hence, the organisational priority might be less one of a mechanistic view of knowledge and its management, and more towards a relational one. Management and leadership ought then to be seen as about creating the conditions for, and modelling the correct relationships between people to be able to generate the appropriate knowledge to best support each client in a holistic and emergent way (Clark et al 2014). A more mechanistic view might mean developing the resources to support turning tacit in to explicit knowledge and creating meetings expecting knowledge to flow between people/organisations. A relational view would contend that this is not sufficient and unlikely to be effective on its own. Knowledge transfer between different workers depends on the quality and strength of relationships between people, requiring strong personal connectedness and trust and cooperation (Bate & Robert 2002).

Bate & Robert (2002) argued that the underpinning scientific rationale behind Collaboratives in the culture of the NHS meant there was a focus on explicit knowledge (e.g. codifiable facts) being transferred between members of the collaborative, but little focus on, nor opportunity for, tacit knowledge (e.g. wisdom) to be aired and exchanged. There was a failure to recognise the relational needs. Bate and Robert argued that NHS Collaboratives were not truly Communities of practice and needed to move to a more interactive approach. Communities of practice cannot be so easily managed as they are more naturalistic, organic and voluntary than formal meetings, a feature which Bate and Robert (2002) suggested made them difficult for the NHS to come to terms with in its then prevailing 'project management' culture.

Communities of Practice

The traditional working definition of a COP is 'a group of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an on-going basis.' (Wenger 2002 p4). Communities of practice are grounded in situational learning theory that sees learning as emerging in social contexts, and understands relevant knowledge as provisional and socially constructed (Lave & Wenger 1991; Contu & Willmott 2003; Handley et al 2006; Roberts 2006). A strength of situational learning theory is the way it draws our attention 'directly upon learning as a pervasive, embodied activity involving the acquisition, maintenance, and transformation of knowledge through processes of social interaction' (Contu & Willmott 2003 p285). This is in contrast to theories mostly concerned with an individualist perspective on learning, and on views of knowledge that overly emphasise its disconnectedness from specific social contexts and as something that can be comprehensively packaged in guidelines or other procedures. Some knowledge is clearly able to be generalised across some contexts, and to be codified in guidelines, but its application is always in a specific context that will, to a greater or lesser extent, mediate its direct application. This requires judgement to be exercised by (groups of) practitioners.

Features of communities of practice to note here are:

- They are places of interaction;
- There is a socially constructed view of knowledge underpinning them;
- Participation is important for interaction and exchange;
- This requires members to have a sense of belonging, trust, loyalty and mutual participation;
- There needs to be an ethical commitment to the community of practice and participants;
- Identity and its social construction are important to the communities of practice and members.

From this description of communities of practice we would see them as fitting very neatly into the relational idea of improving integrated working with people with MEH that we have discussed above. There is a similar view on the socially constructed, emergent view of knowledge and on the importance of interconnectedness between actors, knowledge and social context.

If communities of practice were successful in the context of this project and our relational understanding we would expect to see more better relationships between participants, resulting in sharing of knowledge between them about each other's work, organisations and contributions to helping people experiencing MEH. Relationally, we would be concerned with how people in the communities of practice develop their notions of worker/professional roles and identities and interdependences within the group, and how this interacts with the social context beyond the group. We would explore, for example, the impact of managerialism as a means of shaping and controlling the context within

individuals in the communities of practice work. We would also need to consider issues of power within the communities of practice, and between the communities of practice and their wider environments.

In Gestalt terms there is a need to understand the field conditions within which people are located, think, feel and act. In terms of the communities of practice there is a Venn diagram of fields – the context of the community of practice itself, then the organisations individuals work in, plus the overall societal context. The interactions within, and between each of these fields need to be examined to develop an understanding of the impact and potential of communities of practice.

Evaluation of communities of practice

The evaluation this paper draws on explored whether establishing local communities of practice of people working across organisations in the homelessness sector could help workers to develop more authentic relationships and understanding of each other's work, engage in better social construction of knowledge, and, hence, improve communication and practice between them. The objectives were specifically to examine if communities of practice could:

- Provide a vehicle for building more collaborative 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 interprofessional education and learning.
- Provide shelter and space for reflective practice and interprofessional group supervision with opportunities for mutual (collegiate) support.

Between 2012-2013 six communities of practice were established across different locations across England by King's College London and Revolving Doors Agency. Each community of practice was managed by a local voluntary sector organisation who invited the participation of other relevant agencies and professionals (statutory and non-statutory) from across the spectrum of health, housing and social care services. The voluntary sector organisation, then, took the lead in defining the local community of practice following initial discussions with the evaluation team about what COPs are and how they operate. People were asked to identify 6-10 people to join the COP form the network of organisations they worked with and would like to improve joint working with to deliver better outcomes in MEH. They included colleagues from health care, housing, criminal justice organisations and social care. They were also encouraged to invite someone with direct lived experience of MEH to join the COP, but, for various reasons, this only happened in one COP. One of the COPs only managed 3 meetings as they were not able to develop enough commitment and membership, the learning form this being that the relatively junior member of staff trying to organise the COP did not have sufficient authority in the locality and needed more senior management support.

The communities of practice met monthly to discuss an anonymised case study, chosen by a member of the COP, that raised specific issues for local MEH practice. The discussion was aided by a structured template for each session, that included the stages of presentation of the case study, suggestions for practical action, and identifying learning for improved practice. At subsequent meetings previous cases were discussed to see what had been most helpful and to elaborate on learning points. A member of the project team linked with each COP to act as a knowledge broker to bring in to the discussions any key research or policy material that could be found (see also Anderson et al. (2013) and Cornes et al. (2013 a & b; 2014) on the how the COPs operated).

~~The working of the communities of practice in this project is described more fully in Anderson et al. (2013) and Cornes et al. (2013 a & b; 2014).~~ The evaluation took place at the end of the project and was carried out by the same team responsible for developing the programme. It comprised a questionnaire survey and a focus group with each community of practice carried out in December 2012. All members of each COP were invited to complete the questionnaire, and the response rate was 61% (n=33/54 members). 34 members of COPs took part in the focus groups. In the survey and focus groups, community of practice members were asked to consider the value of the COP initiative for the service users they worked with in terms of any outcomes achieved linked to improved 'joint working', and also the impact on them personally and their work. Data were analysed by the researchers and discussed with the project steering group~~a focus group with each community of practice and a survey of community practice participants (see Cornes et al., 2013)~~.

Cornes et al., 2013 provide a discussion of the evaluation and other aspects of the empirical data. Here we are primarily concerned with those findings from the data pertaining to the relational perspective on COPs. Within the communities of practice in this study, strong interpersonal bonds were built between ~~several~~ participants. Informality, for example, seemed important to them. Structures, such as ground rules and anonymised case studies for discussion, were useful in creating a shared, safe environment. The anonymised case studies presented a focus for discussion and also, as one COP participant phrased it, 'a lower pressure way to discuss issues'. ~~This~~ They allowed emergent, grounded issues to be discussed and knowledge to be shared, but did not appear to constrain discussion or stand in for developing authentic relationships between members. As Cornes et al. (2013) note, initially the case studies were somewhat sterile discussions of good practice, but once trust was established between members of COPs, more critical discussions of local practice and collaborative working became the norm. One COP participant commented that the case study they presented was discussed with lots of helpful 'have you thought about . . . ?' comments and was all done in 'a very constructive way'.~~.~~

~~As one~~Another participant in a COP ~~reported, the community of practice meeting was similar to~~drew comparison with a MAPPA (Multi-agency Public Protection Arrangements) meeting – a formal meeting to discuss arrangements by responsible authorities to manage people who pose particular risks to society, such as violence and sexual offences – but

continued that ~~it~~ the COP was less protocol driven and, consequently '*more relaxed in a sort of friendly environment and probably a bit more constructive in some ways'*. Others noted that existing multi-disciplinary meetings could often be limited in effect, compared to the community of practice in generating inter-disciplinary working and learning because of a lack of time for focused discussions and/or because of hierarchical barriers to open conversation. It seems important, then, to pay close attention to the details of the COP, i.e. the facets of the field (in Gestalt terms) within which it operates that members of the COP have most direct control over such as operating rules, support mechanisms like the (much appreciated) knowledge broker role, and the general ambiance of the meetings.

Out of these filed details come the immediate working relationships between members of the COP. As one member of a community of practice commented:

> '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'* [COP participant, quoted in Cornes et al 2013 p5]

Another COP participant commented:

> '[The COP] 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.'

Developing a fuller understanding of someone, their work ethic and the organisational constraints they work under, led to more appreciation of colleagues in other organisations once the formal organisational barriers and roles were reduced by the opportunity to develop more authentic relationships.

Sustained mutual support has been argued to be important to collaborative ventures such as communities of practice (Bate & Robert 2002). We might add that participants need to establish an ethical commitment to each other, the identity of the community of practice and their collaborative endeavours as part of the authenticity of their relationships and for the shared knowledge exchange and learning to happen. Trust was an important foundation in the successful working of the communities of practice (Cornes et al. 2013 a & b).

Having established such foundations, there was a positive response from participants of the communities of practice in terms of reporting i) their own knowledge and skills had developed, ii) their knowledge of the role of other agencies had increased, and iii) they had increased their networks and contacts (Cornes et al 2013 p8). What then happens to that learning and whether or not it is transferred to practice outside the community of practice brings in concerns about the field beyond the group.

It was noted in the communities of practice evaluation that whilst integrated working is often espoused and aspired to in national and local policies, in practice how organisations are managed can make this difficult. As observed above, one of the communities of practice participants found a means of supporting a particular client during weekends, when she was ~~particularly~~ especially isolated and vulnerable to experiencing crises, by blurring the role of a police community support officer.

However, others in communities of practice said that because of tighter definition and management of roles and service contracts, straying beyond these could get the person in to trouble with managers, and, so, reduced the scope for informality and flexibility in practice. Across most of the COPs the experience was of it becoming harder to work more collaboratively and flexibly to address wicked issues as organisations were feeling compelled to withdraw to more rigid working patterns set by contracts and performance management systems as the economic climate made organisations feel more vulnerable to cuts.

–The experience here, then, is of people within the communities of practice developing a shared legitimation of the need to work differently to be able to support each other and clients and of some successes in doing this, but, this far at least, not greatly challenging the wider field and what is seen there as legitimate knowledge, management imperatives, and routine ways of working.

As originally formulated, though not as always subsequently communicated, situated learning theory draws attention to the exercise of power in social situations and its implications for learning and knowledge and individuals (Contu & Willmott 2003). In the context of working with individuals experiencing MEH there are huge questions of power between workers and between them and clients (Scanlon & Adam 2012). In the communities of practice studied by Cornes et al (2013) questions of power surfaced, such as in trying to form the communities of practice and when participants in the communities of practice confronted limitations to what they could do differently. Experiences of power were different across each community of practice, relating to the specific contextual nature of each of them despite the fact they were all working on similar issues.

This experience of externally imposed managerial factors hindering relationship work was reported by members of the communities of practice in this study. They experienced external control over their roles, and pressure to meet targets that they felt did not always help to achieve the best means of working with clients. In response to this latter point, some workers reported keeping 'secret' or hidden caseloads as a means of dealing with emergent situations, maintaining relationships, and delivering the kind of flexible support they felt desirable but which organisational structures did not allow.

Where members of COPs had control over aspects of the field, most notably in how the COP operated, they were able to develop their knowledge and a more positive relational, collaborative ethos. In the survey of COP participants, over 90% of respondents agreed with the statements that as a result of participating in the COP 'my knowledge of the role

and function of other agencies has increased' and 'I have increased my networks and contacts'.

In some cases where individuals in the COP felt able to influence the wider field more so they were able to identify different practice to deliver better outcomes. In the case of one COP, for example, local commissioners of services had already done a great deal of work to promote more collaboration at the front end of care. As a result, many of the cases discussed in this COP were live cases involving several members of the COP and, as a result, integrated care planning happened in these cases.

However, the very real difficulties of the wicked issues and, in most of the COPs, the economic climate and management practices were able to exert powerful field constraints on much larger changes in practice. One example was when participants expressed frustration at being driven to achieve short-term outcomes for clients, but not able to focus on longer-term support, and by targets that did not reflect the complex nature of their work. What often emerged in the COPs was 'a sense of mutual frustration, sometimes despair, about the intractability of many of the issues being discussed' (Cornes et al 2013:9). There is merit in airing and sharing these frustrations, and recognising that they are not unique to individual members of the COPs as point clearly expressed by one respondent who felt reassured by establishing they were not the only one experiencing certain problems. Indeed, this process may, at least initially, add to the greater sense of authentic relationships between participants and be very supportive and motivating. As a participant noted:

> 'The value of this [COP] 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.'

Conclusion

In this paper, we set out to revisit Cornes' (2011) earlier thesis about the potential of communities of practice to deliver 'system change'. The communities of practice examined in this project in the context of working with people experiencing MEH need to be seen within the methodological limitations of the study in which the communities of practice were small in number and support for them was time-limited. 'Effect sizes' were small, but as 'little miracles' (Cornes et al 2013) they may be significant developments when considering practical aspects of the project, such as the short time scale and limited resources, and the realities of dealing with wicked issues. The communities of practice took

place in a challenging social backdrop, including managerialism in a context of financial austerity and the challenges of working with multiple needs and exclusion. Communities of practice provided opportunities for emergent knowledge and learning to help individual workers adapt better to the challenges of helping individuals. However, we saw that the managerialist structuring of work and knowledge potentially constrained the potential of the communities of practice and people within them to work even more flexibly and effectively to help individuals.

Nevertheless, the communities of practice in this evaluation did seem to be a more effective or worthwhile vehicle for nurturing change than the traditional 'steering groups' described in Cornes' (2011) earlier paper. As psychological developments the communities of practice produced or enhanced trusting and supportive relationships between different workforces and sectors. Through reflective practice using case studies to generate discussion the impact of 'managerial domination' was frequently surfaced and discussed in open and honest ways. Workers gave an insight into their organisational constraints rather than being defensive about them. Actions and small-scale innovations often flowed from meetings or were at least explored and considered. The communities of practice also seemed to come close to delivering the authentic collegiate working often aspired to where the goal is to meet the 'real' care and support needs of their clients. By 'real' we mean generating understanding around the complexity of the issues and problems facing people at the margins of society. In 'secret case loads' and 'unsanctioned' boundary spanning we saw small acts of defiance that temporarily released the grip of 'managerial domination'.

Indeed, the main impact of the communities of practice may have been in the emotions (frustrations, challenges and passions) they generated in the participants that were in stark contrast to the sleepy inertia so often seen in more traditional management meetings. Indeed, a very similar conclusion emerges from Whiteford's more recent evaluation of communities of practice in the field of alcohol and homelessness where one nurse reported feeling depressed after a community of practice meeting,

> 'It is important to recognise here that the community nurse was not referring to the constitution of the community of practice, but rather to the complexity and challenges involved in care management of high-impact users… Participants felt that their involvement conferred certain professional or psychological benefits namely engendering a process of sense making and providing access to an enabling environment' (2014 p7).

As noted by Bate and Robert (2002), the practical challenges of bringing people together, of sustaining engagement, delivering culture and service change, may mean that modest improvements are what we ought to realistically expect from

collaboratives and communities of practice. This is in keeping with Dickenson's (2015) view of 'system transformation' and integration in which she asserts there is no magic structural solution only 'craft and graft'. Somewhat ironically, Whiteford alerts us as to how in some areas communities of practice are being appropriated as the latest 'managerialist tool' (2014 p3) by large corporations where the earlier concern with creating and fostering new groups and good working relationships has been superseded by the language and importance of 'leaders, champions and facilitators' and their power and potential to 'drive strategy' and develop new 'business opportunities'. This raises the question as to how to communities of practice can be kept relationally focused, authentic and honest in the face of 'managerial domination'. One radical solution that has been put forward is to give up entirely on management techniques and solutions and instead to tell and listen to stories (Bevir and Rhodes quoted in Dickenson, 2015). Perhaps this can be an authentic means of (re-)humanizing the experiences of providing and receiving care through formal organisations.

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