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Introducing the Learning Practice – I. The characteristics of Learning Organizations in Primary Care

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Abstract

Rationale, aims and objectives This paper is the first 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. Here we introduce the notion of the *Learning Practice* (LP) and outline the characteristics and nature of an LP, exploring cultural and structural factors in detail. **Methods** Drawing upon both theoretical concepts and empirical research into LOs in health care settings, the format, focus and feasibility of an LP is explored. **Results and conclusions** Characteristics of LPs include flatter team-based structures that prioritize learning and empowered change, involve staff and are open to suggestions and innovation. Potential benefits include: timely changes in service provision that are realistic, acceptable, sustainable, and owned at practitioner level; smoother interprofessional working; and fast flowing informal communication backed up by records of key decisions to facilitate permanent learning. Critical comment on potential pitfalls and practical difficulties highlights features of the present system that hinder development: tightly defined roles; political behaviours and individual-oriented support systems; plus the ongoing difficulties involved in tolerating errors (whilst people learn). This paper contributes to the wider quality improvement debate in the area in three main ways. First, by locating Government's desires to create health systems capable of learning within the theoretical and empirical evidence on LOs. Second, it suggests what an LP could be like and how its culture and structures might benefit both staff and patients in addition to meeting externally driven reforms and health priorities. Third, it extends the application of LO concepts to the health care sector locating the principles in bottom-up change.

The need for ongoing change in health care systems

Arguably, the ubiquitous problem facing health care services around the world is to provide consistent quality care through organizational arrangements that span professional disciplines, employers and employment conditions, within a constrained budget and across varying geographical contexts. A logical assumption is that there are ways of organizing health resources (people and money, etc.) that will optimally address the needs of the patient population they serve. Believing this starts a quest to identify what these organizing and facilitating systems and structures might look like and how they might operate to address current priorities and maximize quality of health outcomes. This is the role of those that set policy, as well as those who seek to operationalize this and has formed the thrust behind recent health care reforms.

However, whatever the specific recommendations of present reforms one thing seems unavoidable: any solutions will be *time-limited*. Changing demographics, political agendas and financial issues constantly provide new challenges to be met. What becomes pivotal is the way that the system *adapts* and responds to changing circumstances and to patient needs. What works now almost certainly will not work forever.

Traditionally, organizing health care services along specialist functional areas (e.g. coronary care) and different professions [e.g. general practitioner (GP), nurse] allowed practitioners to develop deep skills, enhancing quality of care. Policy makers and managers were able to deploy resources around tightly defined clinical needs. Yet, the cost of order was rigidity and strict demarcation with tribalism (Smith *et al*. 2000) between staff and ranks resulting (Hunter 1996), status and pecking orders guarded jealously (McClure 1984) and departmental silos (Stewart 2000). Where tightly defined organizational roles once gave clarity, they soon began to impede flexibility and innovation (NHS Plan 2001). Attempts to address these issues through legislation (Scottish Office Department of Health 1998a,b, 1999a,b,c, and sister papers in England) has, ironically, not led to change but to 'reform fatigue' and a demoralized workforce (van Eyk *et al*. 2001), with problematic recruitment and retention of skilled staff (NHS Plan 2001, URL http://www.nhs.uk/nhsplan/). Service provision seems unable or unwilling to join up (Hogg 2000). The 'secret' might be to create a system that allows busy practitioners to identify and effect changes that would make a real difference to their daily practice, creating learning and change that is owned, rises from the ranks and makes an immediate difference. This paper will examine what such a system within Primary Care (PC) might look like.

Within such a system practitioners would need to tag and track their own actions and outcomes, learn, and modify future behaviour (Senge 1990) altering service provision to match patient needs closely (Deutschman 2001). Systematic reviews, flexibility, and pulling all staff together in order to learn would all be inherent qualities. Such a system would serve its staff, by creating order, but not fossilize service delivery or stifle capacity to respond rapidly, with flexibility and innovation to changing demands.

What makes learning and adaptation difficult in Primary Care?

There is no simple answer to this question. It is probably a combination of factors occurring together that makes learning less likely. These factors might include:

- Resources of all kinds (money, time, human skills) are often being used to full capacity and clinical time rather than organization development time is prioritized.
- The opportunities to learn and change that occur everyday in tiny ways are not shared, 'how-things-are-done' isn't changed, and practice remains stuck in unhelpful routines. Frustrations build and apathy grows, service delivery becomes stuck-in-a-rut. There is no effective way of sharing chances to learn and change – often there is no feedback loop within the GP practice or between different practices.
- Conflicting messages (and demands) over time and from different parts of the organization make it difficult to decide on the best way to proceed or what lessons to learn.
- Primary Care, as an organization, is a loose amalgamation of health care providers, geographically dispersed and locally differentiated from each other.

- Working patterns, different professional interests and time pressures mean that staff find it difficult to get together and just 'chat' and learn from each other's experiences.
- Knowledge often comes through experience and is seldom written down. So when staff leave or retire their knowledge leaves with them.
- Professional boundaries and unhelpful hierarchies sometimes inhibit innovative practice and the sharing of ideas (West 1995; West & Slater 1995).

The impact of poor adaptation

The outcome is one where knowledge and experience often exist somewhere in PC [or within the wider National Health Service (NHS)], but in a loose way. Experience is not deployed systematically or used effectively. The same blockages occur and the organization fails in its attempts to learn the lesson. In PC often things are done in a certain way because they have always been done that way. Staff are too busy working hard to work smarter. In the worst cases it takes a crisis in care delivery to force change through tragedy. Ironically then, policy is built upon avoiding 'bad' practice and not aiming to follow examples of excellent service delivery (Deutschman 2001).

Learning Organizations in Primary Care

A way of addressing the issues outlined above is through the theoretical framework of the Learning Organization (LO) (Senge 1990):

> . . . the intentional use of learning processes at the individual, group and system level to continuously transform the organisation in a direction that is increasingly satisfying to its stakeholders. (Dixon 1994, p. 4)

Taking such a view professional discretion is prioritized – those who do the job are considered best placed to know how to adapt it to changing circumstances and are charged to effect the changes needed (Deutschman 2001). Thus, the new ways of behaving are 'owned', 'empowering', motivating, create commitment and job-satisfaction (Hackman & Oldham 1980); and build individual capacity, confidence (Mintzberg *et al*. 1998). Organizational issues such as low morale and retention problems are potentially addressed simultaneously. However, LOs are not simply about individually skilling staff, it is more about learning collectively – 'what-we-all-know', knowledge, skills and know-how that is shared and held in common with others (Pedlar & Aspinwall 1998). What fundamentally underpins a clever health care system would be *over-capacity* and *duplication of skills*. This idea seems to run counter to ideas of efficiency, however, this is not so. Giving staff multiple skills allows them to be more productive, in a greater number of places and increases the flow of patients through the system as 'blockages' (waiting on the availability of key practitioners) are reduced as other staff can carry out their duties if needed.

From an operational perspective this builds flexibility (Atkinson 1984) and multiple levels of responsiveness, reducing dependency on key staff, and opening systems to further change and adaptability. In these systems staff tackle the changes they identify as needing to be addressed (Senge 1990), do it for themselves and without the strong push of external requirements or scrutiny – they have developed the capacity to learn for themselves (Argyris & Schon 1978) and take on the responsibility to do so. Practice is not 'stuck-in-a-rut' because of outdated traditions. In theory, change is ongoing, up-to-date and based on what works. For policy makers and managers this might signify a reduction in the need for strong policy and managerial interventions to drive professional practice towards quality outcomes. By getting 'buy-in' from practitioners themselves, in theory the *success* and *sustainability* of policy and operational changes should be increased and stress levels amongst staff decrease (Kanter 1983).

The Learning Practice

The question then is how can these ideas be articulated and operationalized in different service settings? Based upon an extensive literature review into the ideas of LOs, and their use in health care settings, this paper is informed by an extensive conceptual and empirical evidence base. Here we explore the application of LO ideas in PC. We define the Learning Practice (LP) as:

> A GP (or similar) unit where individual, collective and organisational learning and develop-

Table 1 Cultural values of a Learning Practice

Celebration of success
Absence of complacency
Tolerance of mistakes
Belief in human potential
Recognition of tacit knowledge
Prioritizing the immeasurable
Openness
Trust
Outward looking

After Schein (1996); Mintzberg *et al.* (1998); Davies & Nutley (2000).

ment is systematically pursued according to Learning Organisation principles, in order to enhance service provision in a way that is increasingly satisfying to its patients, staff and other stakeholders.

The LP moves the debate from a theoretical consideration of LO ideas in PC to consider the nature, characteristics and possibilities associated with PC staff who have sought, collectively, to adopt LO principles to inform their practice and service provision at the point of service delivery, within PC Practices. We can consider the nature of LPs in two distinct areas: their cultural underpinnings; and the structural arrangements that support such learning cultures.

The cultural characteristics of a Learning Practice (after Mintzberg *et al.* 1998; Davies & Nutley 2000)

Adopting a learning culture is mostly about changing attitudes and expectations (of un-learning prior-conceptions and stereotypes). Notions of what is possible and what is not, about what people are like and are capable of, may need revising. From a created basis of shared trust and tolerance, innovative behaviours might emerge that impact positively on practice life and service provision (Mallory 1993; Argyris 1994). Table 1 summarizes the cultural values of an LP, which are then expanded below.

Celebration of success

Fear of failure often stops people even taking the smallest of risks in making changes. LPs avoid this by ensuring that success is celebrated and valued. LPs take time to find out about each other's success and share it. Success is a time to feel good for all the team. The moment is savoured. When staff share a celebration this signifies recognition by colleagues, it is a personal testament of success and builds confidence and hope.

Absence of complacency (Gundlach 1994)

In an LP the old saying 'if it ain't broken don't fix it' is *firmly rejected*. Learning is not just about fixing problems, but about making things even better before they become a problem. LPs actively look for all those little day-to-day chances to find better ways of doing things that make life easier, simpler and more rewarding for staff and patients alike.

Tolerance of mistakes (Mallory 1993; Argyris 1994)

As LPs try out new things, innovate, encourage new ways, and learn to take measured risks – mistakes will happen. All humans err. However, an LP ensures its systems (mentoring, work shadowing, support, training, allocation of tasks) are strong enough – so that nobody is placed in such an exposed situation that a simple mistake becomes a disaster. In LPs, this may well create a tension as a tolerance of honest mistakes may be thought to run counter to the imperative of patient safety. However, if a blame culture develops, or witch-hunts follow mistakes, then creativity, innovation, and change will stop. People will hide problems and only follow safe instructions. To maximize learning and minimize the impact of mistakes, it is important that changes and risk levels are identified carefully enough to make tolerance possible. This can be ensured through prudent developments, supported by training, clinical supervision and mentoring. Examination and learning from errors must be handled sensitively, made personally acceptable and not traumatic or humiliating.

Belief in human potential (Timpson 1998; Barnes 1999; Chin & McNichol 2000)

Learning Practices believe people can make a real difference and given the right conditions they will. LPs try their best to create those conditions for each other. Without its staff – there would be no NHS, no LO. People are the greatest asset of the Service. It is people who innovate, develop and produce the results. LPs encourage respect for all its members, value their well-being and personal and professional development.

Recognition of tacit knowledge

Learning Practices recognize that those who actually do the job and carry out the tasks will have the best knowledge of them, the strengths and flaws of the job. Learning is more than formal qualifications. Much of the most important knowledge in service delivery is 'tacit-knowledge' that is gained by experience, often presenting itself as no more then intuition. LPs value this and take it seriously. As far as possible within LPs, the responsibility, discretion and skill of staff should be enhanced to help them develop their role and the role of their job to benefit the whole practice

Prioritizing the immeasurable

A system that is driven solely by 'what counts is what can be measured' has allowed itself to be constrained by the tyranny of numbers. LPs are guided by the formal need to collect official facts and figures, but they also find time to collect the qualitative information about service provision based around quality, humanity, decency, and integrity. Within an LP, adherence to official requests for information gathering can be questioned as well as complied with. LPs could gather their own information on their developments in order to make informed choices in the future about the effective and efficient deployment of staff and resources in accordance with their patients needs.

Openness

An open sharing of knowledge is crucial if everyone is to have the opportunity to learn from events. Reports and formal communications may not be effective in this. Better ways of sharing knowledge seems to be informally through multiprofessional teams, staff rotations, and learning-by-doing (Carkhuff 1996; Gavan 1996). This feedback allows practice to be assessed and changed if necessary. LPs learn to be open, constructive and helpful in their comments to each other, there is no place to 'gossip-about' others, and issues are raised with the person concerned directly. Work shadowing can enhance the holistic understanding of the total delivery of PC services and the particular needs of certain staff and client groups. In time this could be extended beyond the practice to other areas of Health and Social Care.

Trust

Without trust learning is a faltering process (Gambetta 1988). Staff must be confident that managers and leaders will not punish them for making mistakes as new things happen and managers and leaders need to know that staff will use time, space and resources given to them to facilitate learning wisely. Openness and working together helps LPs to start to rely on each other. Good experiences build confidence to try again and trust develops. Once established, little knocks are repaired, as staff know that nothing malicious was meant. In LPs the close-knit and professional nature of the work make the abuse of trust unlikely. However, tolerance of 'mistakes' requires to be considered carefully.

Outward looking (Thompson 1994)

Learning Practices do not become 'black holes' of learning where nothing escapes. They actively seek up-to-date information from outwith the practice. They also actively seek to pass on their experiences and learning back to the outside world, to their patients, and to others operating in areas of health care. Valuable lessons can be learned by the transfer of learning between agencies and across sectors (Argyris 1994). This will require LPs to be proactive in seeking out and forging networks with other organizations in the interests of joined-up care provision.

Cultures facilitative to learning such as those described also need to be supported and reinforced by specific structural arrangements.

The structural characteristics of a Learning Practice

It would be inaccurate to associate the LP with a cultural shift alone. Behind the 'softer' cultural factors lie some hard structural factors (expanded in Table 2) that make the appearance of the softer aspects of the culture (as described in Table 1) more likely. Alongside the changes in attitudes and behaviours need to be changes to systems and organizational arrangements that will facilitate and create changed service provision. Structural factors can be seen as almost a first step in the road to 'managing a learning culture'. Five structural elements would seem to help (Dodgson 1993; Maybey *et al*. 1998).

Table 2 Structural characteristics of a Learning Practice

Flatter hierarchies
Team work structures
Incentives and rewards for learning
Information and communication networks
Research and development budgets and programmes

After Dodgson (1993); Maybey *et al.* (1998).

Flatter hierarchies

Learning Practices will flourish best where hierarchies are kept to a minimum as this increases empowerment and discretion amongst ordinary members of staff and hierarchical niceties and negotiations can be reduced to a minimum. Strong autocratic hierarchies and 'pecking-orders' inhibit information flow, trust and participation (Argyris 1994). Clearly, GPs have ultimate clinical and financial responsibility for the practice, but skilful use of delegation and the release of autonomy to show initiative does not need to expose the practice to undue risk. In terms of learning and being a learner all should be equal. Those who currently enjoy high status positions may find it initially uncomfortable to undergo such a levelling experience (Miller 1997).

Team work structures

Team working works best if the *task requires* professionals to work together to achieve the outcome. Within GP practices, care is delivered by teams. Care delivery that crosses professional boundaries will, over time: break down demarcation barriers; raise skills; build trust; introduce an element of flexibility in the use of staff; get staff talking and information flowing; and build understanding of the whole of the practice and its various roles (Partis 2001). In LPs this may be one marker of early success. The more often and in the greater number of combinations that LP staff work together, the stronger communication links and trusting behaviours will be.

Incentives and rewards for learning

Often rewards are taken as a signal for what the organization really values (Harris 1999). Most commonly, people are rewarded individually, however, if collective learning is to flourish, staff should also be rewarded for working collaboratively and cooperatively and for helping other staff members. In PC where financial resources are constrained and pay awards set, it would be difficult (although not impossible) to make rewards in LPs, monetary. However, recognition, praise, autonomy, and a successful outcome are powerful rewards in themselves. LPs may involve staff in deciding (within given constraints) what would serve as a reward for them, thinking creatively about Practice resources.

Information and communication networks

Learning and sharing requires the transmission of information. Informal flow (talk) is quick, personable, and is the key to fast learning, however, for learning to be permanent *records* are required. Information technology (IT) systems that 'talk-to' each other can facilitate recording and save time on data entry (Sullivan 1997) and help practitioners cope with information overload (Skelton-Green 1995). Joined-up IT systems could also facilitate communication between professionals who work at a distance outwith the practice buildings, to become part of ongoing discussions and learning and reach distanced patients (Kovacich *et al*. 1998). Key skills held and reasons for decisions can be recorded so that important lessons are not lost as staff retire or move on. In short an evidence base for practice can be built (Herbert 2000).

Research and development budgets and programmes

Personal development is the very fabric from which shared learning is constructed. One of the ways in which the LP can exercise 'control' over the formal learning that will enter the practice is in the range of skills possessed by new recruits. Learning should be systematic, follow the needs of the practice and its patients (Thompson 1994), and keep up to date. This needs to be planned and supported. Financial resources for staff development are likely to remain constrained. However, in an LP, creative use can be made of existing staff skills and coaching. Reciprocity in teaching and receiving skills (Partis 2001) throughout the group should reduce the feelings of some staff that their personal expertise is being dissipated (as they acquire new skills themselves).

What might be gained by becoming a Learning Practice?

This pulls the debate back to the 'big-picture' – above are details of what an LP could look and feel like, and how it could be organized but what would it all be for? In fact, the move towards LOs can be *all about* many things.

A way of working:

- that helps practitioners cope with information overload (Skelton-Green 1995);
- that surfaces otherwise indiscernible data regarding barriers to change (Beer & Eisenstat 1996);
- that is supported, valued and makes a difference within the collective efforts of the whole practice (Timpson 1998; Chin & McNichol 2000; Deutschman 2001);
- that is sustainable long-term, despite increasing demands; working smarter not harder (Cowley 1995; Chin & McNichol 2000);
- that allows individuals to grow and develop and to share these experiences with colleagues (Beer & Eisenstat 1996; Deutschman 2001; Milstein 2001);
- that could be flexible and focused on patients and staff (Timpson 1998);
- that *may help* (Beer & Eisenstat 1996) practitioners evaluate their own practice and ability to learn (Milstein 2001), and
- that builds an enduring capacity to change (Cowley 1995; Skelton-Green 1995; Chin & McNichol 2000), although this may prove to be more difficult (Beer & Eisenstat 1996; Coghlan & Casey 2001).

Can Learning Organizations work in Primary Care?

The locus as the Learning Practice

One of the 'givens' (although not an unquestioned one) behind this paper is to locate the nexus of organizational learning at *GP Practice level*. Equally the focal point for organizational learning could have been placed at PC group level (or in Scotland – local health care cooperative level) or perhaps even at trust or board level. The reasons for focusing the change at grass-roots level emerge from the literature itself and the recent history of change in the NHS.

LOs call for changes that are owned, bottom-up and make a difference to ongoing practice – it seems only apt to place grass-roots staff in control of this initiative for themselves; indeed this is a pervasive theme that runs through most of the literature. Specifically, LOs are claimed to be most effective when they involve those who operate at the point of care delivery (Miller 1997; Eisenberg 2000). It may be that this is because they foster collective responsibility for care (Bellack 1999), or simply that they offer health professionals greater autonomy, participation, and discretion within their work (Cohen & Austin 1997).

Almost all recent reforms in the NHS have been 'top-down', externally imposed and driven hard by legislative change, offering little autonomy and thwarting discretion. The nature of the LO material is that change should be done *by* the staff not done *to* them. To locate the heart of the change within the NHS at a 'higher' level in PC than the GP practice would be to give the initiative a top-down, imposed feel and corrupt its very raison d'être.

Potential pitfalls

Simply because practitioners lead these changes it does not automatically make the undertaking easy. From the literature, and research in health care settings that have adopted LO principles, five potential stumbling blocks are identified, together with comments as to how these pitfalls might be addressed.

Politics and control

Many measurable subcultures exist within PC, usually clustered around the differing professional groups (Smith *et al*. 2000) – some of these have been labelled 'tribalist' (Hunter 1996). This may lead to suspicion and a reluctance to cooperate at least initially. Additionally, it is said that defensiveness can fuel unwillingness to take part in new initiatives (Bain 1998). It has been argued that LOs depict an ideal and Utopian view of organizations, bringing hope and inspiration (Garret 1994). However, at the same time it could be claimed that LOs ignore the politics of learning and elements of 'control' in the process (Coopey 1996). Some of the professional groups in PC have greater professional influence and 'clout'. As

independent contractors and employers GPs can wield both direct and indirect influence over many of the other professional groups (Labour Research Department 1999) and arguably limit the ability of others to participate fully and for learning to be diffused throughout the wider organization. There is also unequal access to training budgets, protected time, etc. Perceptions of inequity will harm notions of 'we are all in this together' and 'we are all willing to become learners' (Mallory 1993; Argyris 1994).

As with any changes, some people and groups will gain and some will lose out (e.g. status, preferred tasks, power) (Kanter 1983; Bartkus 1997). It is better to acknowledge this and the political realities of life it brings. Each person is respected for their views and allowed to take part in development as and when they feel able. Thus the team works within the conflicts rather than allowing minor disputes to stop progress altogether (Kushell & Ruh 1996).

Controlled empowerment

On a different level, the wider organization (the NHS) may have good reason for wanting to exercise overall control on the process of learning and its outcomes. With a remit of equity in provision and inclusion, it may be difficult for the NHS to sanction different Practices 'heading off in different directions' as their development interests take them (Rushmer *et al*. 2002). Parameters and direction will need to be in place to stop the coherence and consistency of service delivery across practices and areas further diverging. This may be as simple as an 'orientation road-map' (Bumgarner & Biggerstaff 2000). Practices will be free to develop, but perhaps only in line with national guidelines in accordance with clinical priorities, or within financial resources. A shift towards a culture of LPs in PC cannot be a carte-blanche (Harrison 2000; Rushmer *et al*. 2002).

Conflicts within current systems

Formal human resource systems are presently geared towards individuals whereas learning will take place in teams. At present training, appraisal, supervision and rewards focus on the individual and not their ability to contribute to the team or to collective learning. There are no monetary levers to encourage participation. Flexible training (Hartley 2000) that is multiprofessional (Miller 1997; Partis 2001) and reward systems (awarding recognition, status and acceptance) should be considered as alternative to formal systems (Rushmer & Dowling 2001).

Developments take time. Multiprofessional training is time-consuming (Partis 2001), and needs to be relevant to all professional groups present (Chin & McNichol 2000). Shared training may be an ideal, but can be difficult to operate in practice with time constraints, different working patterns, shifts and practitioners struggling to cover normal workloads (West 1995; West & Slater 1995).

Changing the practice unit and changing the system

The wider system is difficult to change. It will be easier to change things within the practice than to get the wider system to change (Beer & Eisenstat 1996; Adler & Docherty 1998; Coghlan & Casey 2001). One reason for this is the unconnected nature of GP units. It is still difficult for them to learn from one another and to find sufficient voice to influence policy-making bodies – perhaps as PC Trusts (PCTs) and Local Health Care Co-operatives (LHCCs) develop, this will change. However, it will take longer for the system to change (Gavan 1996) and new processes that report back to policy-making bodies and strategic groups will have to be put in place as feedback loops (Harrison 2000). There may be contradictions between the different levels of learning that can take place. For example, a nurse may want to change her behaviour within the LP to enable her to spend more time with the patient (quality of care) whilst the organization and system drives may encourage her to see more patients (increased productivity in care). One way to address these issues is to concentrate on the things that these units have *in common* and focus priorities around shared purpose and excellent patient care (Chin & McNichol 2000) or service need (Timpson 1998).

Coping with mistakes

Learning Organizations call for a tolerance of mistakes, in order for people to practise, learn and grow in skills and confidence (Schein 1996; Mintzberg *et al*. 1998). Some writers argue that LOs can potentially learn more from its failures than from its successes (Mintzberg *et al*. 1998). Can PC tolerate failures and mistakes? Delegation and learning must be located and managed in a way that staff are not put in a posi-

tion that places themselves and patients at risk. Risk can be minimized by prudent delegation, supervision, training, work shadowing, mentoring, so that a mistake does not equal a disaster. In effect, it means maintaining present safeguards and standards with the gradual expanding of roles.

All members of the team (the whole practice) must be willing to become learners and show vulnerability and be willing to err. There is doubt as to whether all professionals may be able to take this step (Mallory 1993; Argyris 1994). In particular, will GPs and other senior members of the practice be able to admit that they have things to learn from other members of the team?

Concluding remarks

From the above it becomes clear that *how* something is done is as important as *what* is done within an LP, making planning and managing the process that encourages LPs to develop crucial to its success. It is important to learn from the research and to prepare for the potential pitfalls in order to minimize their impact. Additionally, the characteristics that an LP may possess or adopt cannot be considered in isolation from the context in which it exists. Such diversity and richness of contexts and approaches to assessing them is well acknowledged within theory (Easterby-Smith 1997) and practice (Jennings *et al*. 1999). The exact nature of an LP will be different as those involved make the ideas work for them, in their local setting, facing their local concerns. However, this does perhaps leave an unsatisfactory 'looseness' (Harrison 2000) in the ideas and guidelines on 'how to proceed'. What would support the transition and smooth the developments are clear expectations, parameters and steer from a central body (Milstein 2001). External (to the Practice) and independent facilitation providing support could help practitioners map their journey, recognize progress and identify achievements. This aid to effective implementation can assist with clarifying the exact definition of *their notion of the LP* for a particular unit, practical operational advice and tools for measurement and assessment of progress (Garvin 1993).

Exactly what each practice would *do* with the ideas that LOs and LPs present should be considered in light of where they are starting from. Each GP practice is different, in terms of its history, skills make-up, personalities, geographical layout (Porter 1993) and location, client mix, how it uses its staff, degree of present integration of provision, etc. These make the exact prescription of what an LP *should* look like very difficult (and ill-advised), as people learn in different ways (Honey & Mumford 1982) so will different LPs (Hayes & Allinson 1998). However, if the ideas above have spoken for themselves readers should understand that a precise template is not necessary because an LP will be all about possibilities and what *could* be. For LO ideas to work and impact on development within a practice it must be sensitive to the configuration and needs of that practice. Participants will make it *fit* what their practice needs and opportunities. The authors of the LO literature describe the LO principles as '*guiding stars*' (Pedlar *et al*. 1997) – a way of being and doing, not a particular destination to strive to reach.

The shift to an LP culture must grow from within, supported by all involved and proceed in a way that is in keeping with the history and nature of that Practice. What may sound like vague and nebulous suggestions could, with facilitation initially, be resolved in real settings as practitioners make the ideas work for themselves. It will be manifest as hard and gritty changes to work practices and service provision that will raise hopes that things can be made better. It will also be marked by changes in attitudes and behaviours, and as courage to say 'I don't know' or 'Show me' and 'I'd like to try that' and 'Thanks.' This takes time. Given that each practice will be starting from a different place, may adopt a different route and faces varying issues along that route, it will always be a personal journey for the practice concerned.

Two following papers will explore additional factors involved in LOs as applied in PC settings at the point of service delivery. Paper two will explore what would be involved in *becoming* an LP – what might inform the process undertaken. It discusses what forms learning can take, introducing the important distinctions between individual, collective and organizational learning as key to understanding the difficulties in dispersing learning and innovation through complex organizations. In the third paper, issues of leadership, empowerment, reflective practice and protected learning time as key contextual features are explored through their pivotal role as either help-

ing or hindering factors in the development of LPs. Collectively these discussions draw in a wide extant literature to draw attention to the what, how and why of collective learning in PC.

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