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**UNDERSTANDING DIFFERENCES IN PRACTICES – HOW ‘BEST
PRACTICE’ INITIATIVES FAIL**

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Abstract

Spreading innovation through sharing ‘best practice’ has become a feature of contemporary work. Differences in practices across settings are thought to have created difficulties in spreading and sustaining such innovations, particularly in increasingly fragmented inter-organisational settings. The way these differences emerge is poorly understood, but is likely to have implications for innovating through ‘best practice’. Drawing on a comparative qualitative case study of three inter-organisational primary healthcare teams, differences in practices have been traced using an activity theoretical analytical framework. Practices differ in similarly different ways across settings. This has implications for innovating through ‘best practices’ in complex work situations.

(100 words)

KEY WORDS: differences in practices, activity theory, best practice.

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1. INTRODUCTION

The notion of ‘best practice’, comprising codified knowledge in the form of pre-determined organisational routines and procedures, has become a recognised aspect of contemporary organisational life (Francis and Holloway, 2007; Leseure et al, 2004). Favoured as one way of spreading innovation, such recipes for success are often distributed amongst organisational members ‘for implementation’ (Duguid, 2008a).

This approach interprets best practice (and therefore innovation) as knowledge which may be codified and transferred unaltered between settings (Nicolini, Gherardi and Yanow, 2003a). However, a major challenge confronting those charged with spreading innovation – and uniformity of practice – through ‘best practice initiatives’, is the stubborn continuation of apparent differences in practices. This may be interpreted as a failure of implementation or knowledge transfer. Difficulties in understanding the apparently resilient continuation of differences in various practices have generated frustration amongst practitioners and researchers with an interest in such matters, as exemplified in UK public services (Walker, 2007; Van de Walle and Bovaird, 2008).

Complexities concerning practices have been identified which may shed some light on this situation. These may be found in studies within what has become known as practice-based studies, featuring a shared interest in investigating the link between practice and knowledge from a variety of theoretical perspectives (Gherardi, 2009a). Insights from this literature suggest that learning, and/or knowing, is collective and enacted, socially, culturally and historically situated. Learning – and therefore innovating – has been shown to occur through participation in human activity, including working (Lave and Wenger, 1991; Lave, 1993, 1997; Gherardi, 2000; Engeström, 2001; Brown and Duguid, 1991). From these perspectives, ways in which efforts to spread innovation through ‘best practice initiatives’ may be undermined have been identified, for example within - and at the peripheries of - single organisations (Bechky, 2003; Yanow, 2004).

These findings are increasingly relevant given the current economic challenges faced by those in the increasingly complex and fragmented world of contemporary work and organising (Barley and Kunda, 2001; Blackler and Regan, 2009; Engeström, 2006; Marchington et al, 2005). In these circumstances, differences in practices may have even greater implications for sharing knowledge and spreading innovation through ‘best practice’ (Sobo et al, 2008). The need to understand the ways in which differences arise becomes more urgent as work becomes more spatially and temporally distributed amongst a wider range of professional groups and organisations, as exemplified in the area of healthcare (Nicolini, 2007).

In this paper the thorny issue of differences in practices is addressed. Taking a cultural historical activity theory approach (Blackler, 1993; Engeström, 2000), three examples from the complex, fragmented, inter-organisational and multi-professional world of primary healthcare provide empirical insights into the nature of, and the way in which, differences in practice arise across inter-organisational settings. It assesses the implications of these findings for efforts to spread innovation through ‘best practice’ initiatives.

2. INNOVATION AND DIFFERENCES IN PRACTICES

2.1. Spreading Innovation through ‘Best Practice’

Innovation is often associated with radical change driven by, and controlled through, predetermined change management programmes, often resulting in the introduction of ‘best practice’ initiatives. This entails two assumptions: that the problems to which an innovation is the solution may be identified in advance, without undue difficulty, and subsequently managed (Carlile 2002); and that knowledge may be transferred within and between organisations as a way of innovating and improving performance (Hamel, 1991; Grant, 1996). These reflect the rational, cognitive approach to organisational learning, especially where the aim is to spread innovation, encourage continuous improvement, and achieve uniformity in the quality of the work done across the organisation (Duguid, 2008; Gherardi, 2007).

The difficulties encountered when spreading innovative ‘best practice’ within and/or between organisations have been acknowledged and have become the focus of more recent, nuanced research within this area of work (Easterby-Smith, Lyles, and Tsang, 2008). These have sometimes been perceived to be due to resistance on the part those working within the organisation, and may be overcome through effective management (regardless of other relevant - and perhaps required - aspects of working) (Yanow, 2006). This brings attention back to the difficulties arising between design and implementation of ‘best practice’ as a means to share knowledge / spread innovation across different settings, regardless of whether these are ‘top-down’ or ‘bottom-up’ (Engeström, 2007 mindcultureactivity; Sobo et al, 2008).

2.2. Difficulties and differences in practices

A good departure point to explore this basic difficulty is to acknowledge that such approaches do not accommodate readily the complex linkages between innovating, learning and working (Brown and Duguid, 1991). Given the increasingly fragmented and complex nature of contemporary organisation, there have been calls for further empirical studies of work - as it is, rather than how it should be - to explore how knowledge is “translated” (rather than transferred) *across* organisational boundaries or borders (Yanow, 2006). More work is needed to investigate what binds (sometimes widely distributed) “networks of practice” together (Brown and Duguid, 2001), and what differentiates those groupings from one another (Bechky, 2006 OS; Østerlund & Carlile 2005). Clearly such issues raise significant questions for notions such as “best practice”, which continues to be a feature of working lives, part of “what workers – we – actually do” (Yanow, 2006, p1753).

Studies which focus on the work being done in organisations (Barley and Kunda, 2001), including practice-based studies, have begun to delve into these issues and address this lacuna. Many of these draw on cultural historical activity theory (CHAT), referred to as activity theory hereafter.

2.3. Using Activity Theory to Examine Differences in Practices

Stemming from a lengthy cultural historical tradition within Soviet psychology and philosophy (Vygotsky, xxxx; Leont'ev, xxxx; Illyenkov, xxxx; Engestrom, 1987), activity theory shares a conceptualisation of the individual as socially constituted with other practice based social theories (Bakhurst and Sypnowich, 1995). Introduced in organisation studies to offer as one of the alternative practice based approaches to collective learning and knowledge (Blackler, 1993), it confers particular advantages which facilitate the exploration of differences in practices and how they emerge over time (Nicolini, 2007 HR). These primarily concern the emphasis on the collective nature of practices, known here as activities, and the object-focused nature of those activities (Engestrom, 2001; Engestrom and Blackler, 2005).

The most basic unit of analysis within this approach is the activity system, within which the object encapsulates the mutual motivation of those engaged in the activity (Engestrom, 1987; Axel, 1997). It emphasises the mediated nature of objects of activity, through a variety of material and psychological means which are imbued with meanings specific to their use by those involved in activity (Bakhurst, 1997). This reflects the partially given and partially created nature of objects of activity (Miettinen and Virkkunen, 2005) and highlights the tensions or contradictions within activity (Engestrom, 1987; 1993). These reflect the necessarily contested and negotiated nature of activity within each particular setting (Blackler, Crump and Macdonald, 2003). This specific configuration involves the way activity or practice is organised locally, the rules that apply, the roles people play and the tools they use in its execution (Engestrom, 1999 rad local ref; Nicolini, 2009). It recognises the presence of multiple overlapping activity systems within practice, which provides analytical purchase on processes of collective learning and knowledge across complex organisational settings (Blackler et al, 2003; Nicolini, 2007).

Differences in practices have been well documented from an activity theory perspective (for example, see Engestrom, 1995; Nicolini, 2009). Such studies necessarily focus on activities relating to the 'primary task' which is central to the organisation concerned (Blackler, 2009, S, D, G book). (For example, for healthcare organisations this would be patient care.) The organisational aspects of such practices have also been explored which have demonstrated the contested and negotiated relationship between these two distinct areas of activity (Blackler et al, xxxx; Engestrom et al, xxxx), and the challenges this poses for managers (Macpherson and Clark, 2009).

Whilst such studies have provided helpful insights into these related activities, they are often restricted to one organisational setting (Blackler incomp, xxxx). Those which have spanned more than one organisational setting have concentrated more on the way activity is mediated and how that affects patient care and clinical practice, rather than on the broader activity of organising (Engestrom Kerosuo, etc; Nicolini, 2009). Follow-up research has found difficulties in sharing and sustaining innovation through 'best practice' in different settings, even when it is derived from those within the settings (Engestrom et al xxxx). This raises important questions about the relations between the 'primary task' and the work of organising, across and between organisational and inter-organisational settings and activities, which remain largely unexplored empirically (Østerlund and Carlile, 2005; Blackler, 2009 SDG).

Despite the modest growth in the number of empirical studies (relative to the overall number of papers published) in the literature on organisational learning and knowledge,

a continued need for comparative qualitative studies based on in-depth primary data has been identified (Easterby-Smith, Crossan and and Nicolini, 2000; Easterby-Smith, Li and Bartunek, 2009). This paper contributes to the on-going debate about differences in practices and their implications for innovation through best practice initiatives, by drawing on such a study in the empirical setting of Scottish healthcare. This will now be introduced briefly.

2.4. Spreading ‘best practice’ in primary healthcare

Scottish healthcare policy has endorsed the UK government’s reform agenda in public services to promote quality and standardised ‘best practice’ (Cabinet Office, 2001; OfPSR, 2002) by encouraging healthcare provider organisations to become ‘learning organisations’ in order across the country’s health services (SEHD 2000a; 2000b). This has been overseen through a “clinical governance framework” (SEHD, 2000c), which emphasised the need to standardise practice and adhere to evidence-based protocols, arguably demonstrating an aversion to the potentially risky process of learning amongst policy makers (Sheaff and Pilgrim, 2006). If this were successful, differences in practice across areas would be reduced and high quality standardised healthcare practice would have been engendered.

These policy strands were introduced against a background of on-going policy efforts to promote and support greater integration amongst publicly-funded healthcare providers and their social service colleagues. This was emphasised for a range of reasons, including demographic change (an increasingly aging population with a corresponding decline in the number of tax payers) and the fast pace of technological change (in healthcare treatments and procedures). These developments have produced large financial demands on the public purse within the UK. Consequently policy makers issued specific directives to reduce the numbers of hospital admissions, particularly amongst older people by enhancing community-based clinical and social care support services to help people remain at home ((Joint Future Group, 2001; SEHD, 2001). This would involve healthcare organisations (responsible to the Scottish Health Minister), and social work departments (responsible to local government Councillors) working together to achieve this aim. One way policy provided an impetus for health and social care organisations to achieve this aim was the identification of a ‘best practice’ solution: health and social service organisations were required to introduce “rapid response teams”, comprising a range of health and social care staff (SEHD, 2001; SEHD/COSLA, 2004). These teams would support elderly people in their homes for a short time and at short notice, until on-going support provision could be arranged for them, thereby avoiding the need for an otherwise unnecessary hospital admission.

This provided a concrete example through which to examine the notion of using ‘best practice’ to eradicate differences in practice and foster the same high quality and standardised service regardless of setting, by spreading ‘best practice’.

2.5. Primary Care Teams

Scottish primary care teams are complex groupings, for which no precise definition exists. Each features a core organisation known as a GP Practice. These are usually

small businesses, owned by professional partnerships comprising (sometimes some) of the General Medical Practitioners (GPs) who also work as doctors in each Practice. They employ a range of clinical and administrative/managerial staff. They work together with other clinical colleagues employed directly by a National Health Service organisation, who are often known as “attached staff” (ultimately Health Boards in Scotland). They work together, perhaps with others from voluntary or local government agencies, to meet the healthcare needs of local people who are their registered patients.

The purpose of this paper is to explore the nature of differences in practice in three such inter-organisational and inter-professional primary healthcare teams, through activity theory, to identify implications for ‘best practice’ initiatives as a form of sharing knowledge and spreading innovation.

3. METHODOLOGY

A comparative instrumental case study (Stake, 2005) of three primary care teams was conducted over two years, following an iterative-inductive ethnographic approach (O’Reilly, 2005).

Teams were purposively sampled drawing on the author’s prior knowledge of the empirical setting (Malinowski, xxxx; Mason, 1996). This was gained during a thirteen year managerial career in healthcare, eight of which were spent in primary care, and by reviewing relevant literatures. Three teams were chosen partially on the basis of their likely professional and organisational makeup, which reputedly and characteristically varies (RCGP, 2005), and partially because of characteristics theoretically identified as being related to organisational learning. These included learning from mistakes, not being risk- or otherwise averse to new ways of working, and – in line with healthcare policy requirements - being perceived by professional colleagues to foster a reputed “learning culture” (SEHD, xxxx; Senge, 1990).

In order to maintain some analytical consistency, all participating teams were overseen by the same official NHS organisation, known in Scotland as a Health Board. But some of the characteristic diversity of primary care teams was also sought through the sampling framework, as set out in table 1. Requisite ethical approval for UK healthcare research was obtained from the relevant NHS ethics committee, a condition of which was maintaining participants’ personal and professional anonymity, including locations. Therefore team names have been changed and participant names and locations obscured or omitted.

[Table 1 about here]

Data were gathered through non-participant observation within each team’s location and environs, attendance at meetings, 56 semi-structured in-depth interviews (see table 2) of between 30-90 (usually 60) minutes duration with primary care team members and managers from associated health and local government organisations, and analysis of NHS, policy, team and local area documentation. A total of 23 working days, over two main phases of approximately three months each year, were spent directly with

participants. Interviewees were chosen through a combination of advance purposive sampling, according to team roles, and *in situ* snow-ball sampling.

[Table 2 about here]

An initial exploratory phase was undertaken to identify empirical and theoretical issues to inform subsequent data gathering (Foote Whyte, 1984). Given the complex inter-organisational nature of primary care teams, issues concerning the ‘who, what, where, when and how’ of organisational learning (Huysman, 1999) were the focus of the initial research phase (see appendix 1 for details).

When using activity theory, open-ended exercises to confirm – or otherwise – emergent themes and findings flowing from ethnographic data gathering techniques may be helpful (Christiansen, 1996). A vignette exercise, featuring an everyday situation or object of activity in primary care, was used to explore emergent findings about similarities and differences in each teams’ activities:

You receive a call from the family / relatives of an 80 year old woman, their mother, about whom they are concerned. They do not live locally / near her. She has fallen a few times at home, but there is no clear indication of why she has fallen. She is not very well and is not managing very well at home, her mobility isn’t very good and they are generally worried about her. What would happen upon receipt of such a call?

This was presented to groups of clinical and managerial members of each team. It provoked a type of discontinuity of practice to enable participants to reflect collectively on - and talk through in detail - the practical steps and actions they usually take within this particular aspect of the overall practice of primary healthcare (Gherardi, 2000; Engestrom, Engestrom and Kerosuo, 2003; Nicolini, 2009b). The researcher’s role was to ask clarifying questions but to leave the content and direction of the discussion to participants as much as possible. Additional observation and semi-structured follow-up interviews with key respondents from each team were also undertaken.

All interviews were recorded, transcribed and analysed, together with all other data gathered throughout the study. Two main forms of analysis were undertaken. First, data relating to each team was analysed holistically to provide in-depth insights, including internal processes within each team (Langley, 1999). Data were also analysed across all three cases in relation to important themes and issues identified through the holistic team analyses (Mason, 1996). This allowed similarities and differences between the teams’ activities to emerge and provided additional insights into the way these three teams’ activities articulated with one another, and with other teams. This proved to be important for understanding how differences in practices arise, and consequent implications for efforts to standardise practices across and between organisations.

4. FINDINGS

Given the focus of this paper, a summary of the initial phase of the research will be provided, prior to comprehensive reporting of the findings of the subsequent phase when the vignette exercise was conducted and all data were reviewed in light of the findings generated through it.

4.1. Exploratory Phase

In this initial research phase, questions concerning the ‘who, what, where, when and how’ concerning the process of collective learning, through which knowledge might be shared in primary care teams, were asked.

In summary, all three primary care teams were revealed as complex groupings of people from a variety of professional and organisational backgrounds. Their exact composition depended on what was being discussed and participants found it difficult to provide an abstract description. Most reframed questions about team membership to reflect the type of activity being undertaken, often around patient care. Clearly, the variety of patient needs for which these teams catered meant their perception of teams was flexible. But given the status of Practices as small businesses, this also reflected involvement in organisational activities. In short, primary care teams were conceptualised as protean groupings, changing shape and function across the three sites, depending upon various needs at particular times and places. The content of knowledge sharing seemed to be simultaneously similar and different across all three teams, and also tended to reflect team role(s).

The processes through which it occurred were identified through observation and participants’ accounts. This suggested a mixture of formal, informal or “formalised informal” social and situated interactions between colleagues in all teams, rather than through institutionalised and retrospective routines and rules. For example, in each team there were specific spaces in which people tended to gather. In Thistle, this was a filing bay where reception, administrative, managerial, nursing and medical personnel interacted between patient consultations and surgeries, and a conference room where GPs had regular twice daily periods of time together to look through mail. In Primrose, the table in the centre of the open-plan reception was a spot where people congregated around a message and call book, in addition to the upstairs coffee room and corridor space. In Harebell, due to a physical lack of space, the manager’s office was a space people frequently popped into to leave or collect things, and to talk to each other and the manager, in addition to the filing bay in the reception area. The opportunity to congregate informally over coffee or mail provided times when people could exchange news or ask questions. These “formalised informal” sessions allowed people to try out ideas sometimes prior to raising them through the formal Practice meetings which were a feature of all three teams. In Thistle, ward rounds and hand-overs at the community hospital were important times which served this purpose.

These findings indicated similarities across the teams. Yet observation had clearly suggested that there were substantial differences between these teams in terms of composition and what they did. The reframing which participants did in order to make sense of the questions about teams and processes of collective learning indicated a more

fruitful line of enquiry might be to focus on activity. In the second research phase, the vignette exercise was conducted to surface the differences which seemed stubbornly out of reach, yet visible through observation.

4.2. Second stage – the vignette exercise

In the vignette exercise, the partially given object of activity (of meeting the healthcare needs of an elderly woman), which provided a “motivating force that gives shape and direction to activity” (Engestrom, 1995, p397). Participants from each team were instantly engaged in the process, having no trouble in recognising the situation as a reasonably frequent aspect of primary care team practice. The exercise provided insights into the similarities and differences in practices. First, the similarities will be presented.

4.2.2. Similarities in activity

Participants from each team responded in similar ways: they identified similar required actions upon receipt of such a call; the same most likely diagnosis, based upon their experience of such situations over time, of the presence of an infection, most likely a urinary tract or perhaps chest infection which often results in a normally reversible condition usually encountered in older people in which the person becomes temporarily incapacitated, confined to bed and sometimes confused as a result of infection; and discussed commonly experienced problems in relation to responding to the needs of such patients.

These similarities were identified through a process of abstracting commonalities from each narrative account, whilst filtering out dissimilarities. This approach provided the following distal account (Gherardi, 1999) of what might happen in primary care in the face of such a presenting problem:

1. call received
2. initial triage/response – information gathering
3. decision made about response to the presenting problem
4. assessment of patient need vis a vis condition and circumstances
5. investigations/tests to aid diagnosis and/or treatment or referral
6. confirm diagnosis – test results: interpretation
7. treatment plan & treatment – usually antibiotic treatment for infection
8. disposal options as required - home care package or hospital admission
9. discharge back into community normally or on-going care at home/nursing home

Additionally, there appeared to be substantial similarities in those who would be involved in meeting the needs presented by patients in such situations, as indicated in table 3..

[table 3 about here]

All in all, it appeared that the process was similar across the three teams and therefore practice appeared similar, despite the differences which had been observed when spending time with each of the teams.

4.2.3. Differences in activities

When teams' accounts were analysed taking into account the differences they identified, a completely different set of findings emerged based on participants' articulative or proximal accounts (Gherardi, 1999). These accounts are presented next in diagrammatic form which provides three processual representations of team discussions.

[FIGURE 1 – Thistle team – pink indicates primary care team aspects of activity]

[FIGURE 2 – Primrose team – yellow indicates primary care team aspects of activity]

[FIGURE 3 – Harebell team – blue indicates primary care team aspects of activity]

The results of the vignette exercise, presented in diagrammatical form, revealed a very different picture to that produced when seeking similarities between accounts. It became evident that activity was undeniably similar across all three teams which echoed the distal view, but from the visual depiction it became equally and importantly evident that activity was simultaneously different in each team. This paradoxical finding mirrored the issues raised in the first phase of this research. In effect, the findings of this second research phase initially suggested that each team appeared to be *doing the same thing differently*.

4.3. Exploring differences through analysis of mediating means

In order to analyse these contradictory findings further, the differences teams identified in terms of what would happen whilst meeting the needs of their vignette patient. Teams identified a range of ways in which they would usually mediate their activities. Those which were most readily identifiable as being different are set out in table 4.

[Table 4 about here]

However, they also identified things which on the face of it seemed similar, but which upon analysis of all sources of data gathered during the research, revealed differences between the teams' activities. Of particular note were: hospitals, rapid response teams, and ambulance services. These were analysed in respect of each team's activity, to provide insights into the nature of differences between these three teams' practices.

[Writing note: additional quotes needed in each of these sections to explain the findings and the contradictions within each team's activity with overlapping activity systems – see below]

4.3.1. Thistle

Within the Thistle team, as demonstrated in figure 1, the most likely course of events would be to admit the patient to the local community hospital. This would be done by arranging an ambulance to transport the patient there. Once admitted, the patient would be cared for by a local GP and the community hospital nursing staff and attached allied health professionals, prior to discharge hopefully to their home. Although social work support should be available for such a patient, there was no rapid response team in the area. If the patient had had an injury which required major surgery (for example, had broken her hip) she would go to hospital some three hours and hundreds of miles away, but would be discharged back to the community hospital as soon as practicable. Liaison between the tertiary hospital where this would be done, and the GPs at the local community hospital, was good. Tertiary hospital consultants provided good professional support to enable local GPs to undertake a broad range of hospital care. This meant the range of activities these GPs and their community hospital/primary care nursing and allied health professional colleagues undertook was different to their colleagues in the other two teams.

4.3.2. Primrose

Within the Primrose team, the picture was less clear-cut. Here, the patient might be able to access rapid response team cover, but only if she lived at one end of the Practice area, nearest to the small nearby town where the rural district general hospital – and the rapid response team – was based. This would only be possible if this were prior to 9.30pm, Monday to Friday. Outwith those times, there was no one available to authorise the mobilisation of the team, although it did work over 24 hours. In most instances, such patients would be admitted to the rural district general hospital. This usually meant those patients who lived furthest away, within the large rural area with poor public transport facilities. This was often a complex procedure given the difficulties of arranging ambulances following the centralisation of ambulance control to location over 100 miles away from the Primrose team patch. Lack of knowledge on the part of controllers meant they did not always appreciate the time implications of the distances, and GPs sometimes dialled 999 rather than the dedicated GP line, in an emergency. For this team, the safety of their patients was of paramount importance, and their activity involved careful stratification of risk to determine the most beneficial course of events. They tried to help patients to stay at home wherever possible, but this was sometimes not feasible, particularly in light of recruitment difficulties and staff shortages amongst their community nursing colleagues. All in all, difficulties in arranging adequate support for patients, and the time factor involved in travelling around this large, sparsely populated area, meant patients were frequently admitted to hospital because no other course of action was available.

4.3.3. Harebell

This team had various means at its disposal to mediate its activity. There was a rapid response team which could be readily arranged in circumstances like the one in the vignette, but only if it were organised during ‘office’ hours. If the problem occurred during the day, but needed more than the support of the rapid response team (but not a

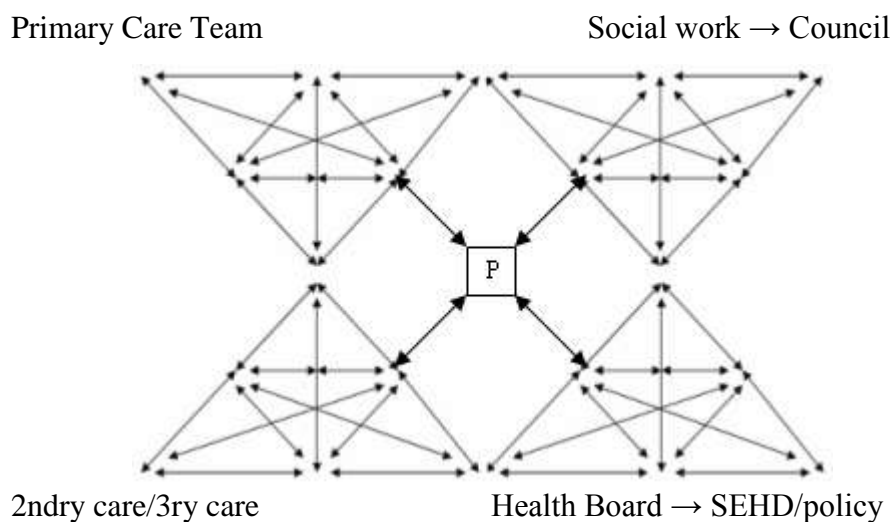
full hospital admission), the GPs would often refer these patients to the out-reach team from the District General Hospital, under the care of a consultant geriatrician and associated colleagues. This effectively represented a hospital admission in managerial terms, as the patient was no longer cared for directly through the activity of the primary care team. In addition, when such events happened after 5.30pm, and the patient was unable to manage at home until the morning, the GPs would often have to admit the patient to the large District General Hospital as there was no other option.

4.4. Analysis of patterns of differences in practices

The vignette identified the involvement of four overlapping activity systems in relation to the object of activity presented through this exercise (the care of this patient). Activity systems are often depicted in the following way:

[Engestrom's activity system model about here]

Therefore, the object of activity in the vignette could be depicted in diagrammatic form as follows:

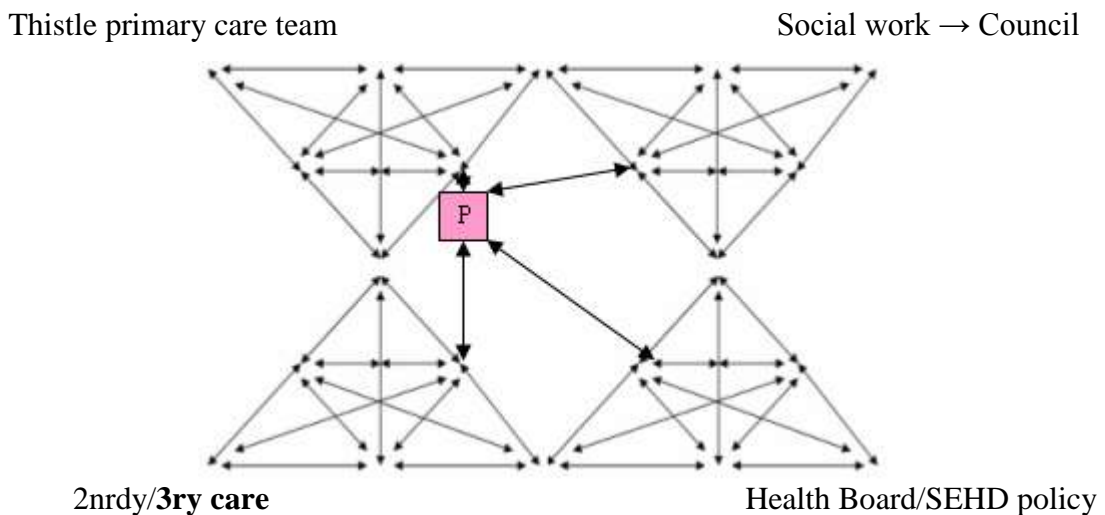


Characterised as they are by contradictions or tensions, the analysis of activity systems within these examples provided insights into the differences in activities which related to policy makers aims of reducing hospital admissions and the introduction of the 'best practice' solution of rapid response teams. In practice, the exact formation of these linkages differed according to the way these activity systems articulated with one another in each primary care team studied, which reflected the contradictions between different elements of each of the overlapping activity systems. These differences are presented now.

4.4.1 Thistle

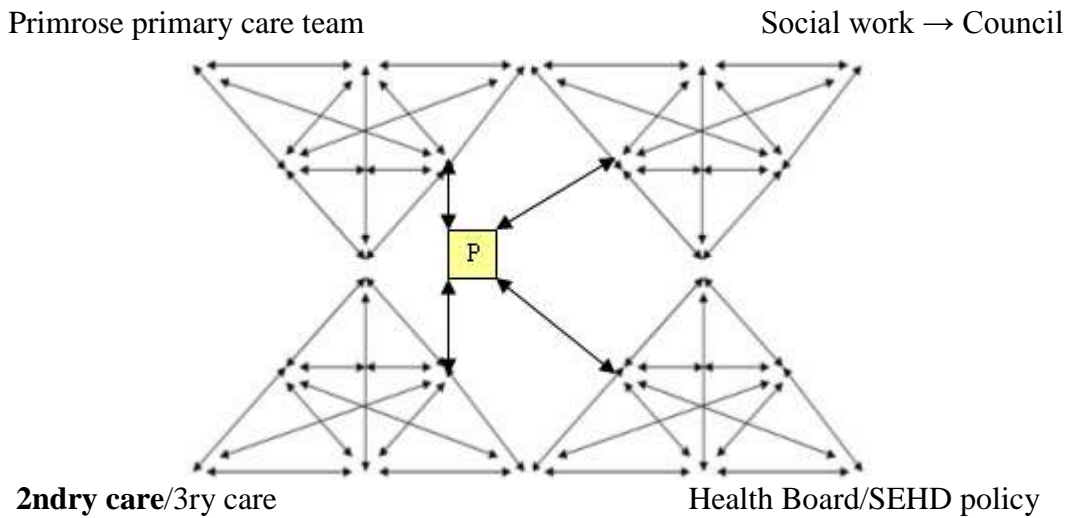
The location of the patient within the horizontal or spatial interlinked activity systems [writing note: need explanatory note about this] demonstrates the range and scope of activity within the Thistle primary care team, most of which was mediated through the

artefact of the local community hospital. This form of activity was partially related to the lack of social work provision in the area as indicated by the lack of rapid response team provision, together with the simultaneous efforts of the local social work department to re-provide the long-stay care of the elderly inpatient beds within the Thistle community, which were currently located within the local community hospital. But it was also partially related to the links between the local primary care team incorporating the community hospital, and the tertiary hospitals providing specialist support to the local team in order to avert the need for patients to travel for three to four hours in order to access services.



4.4.2. Primrose

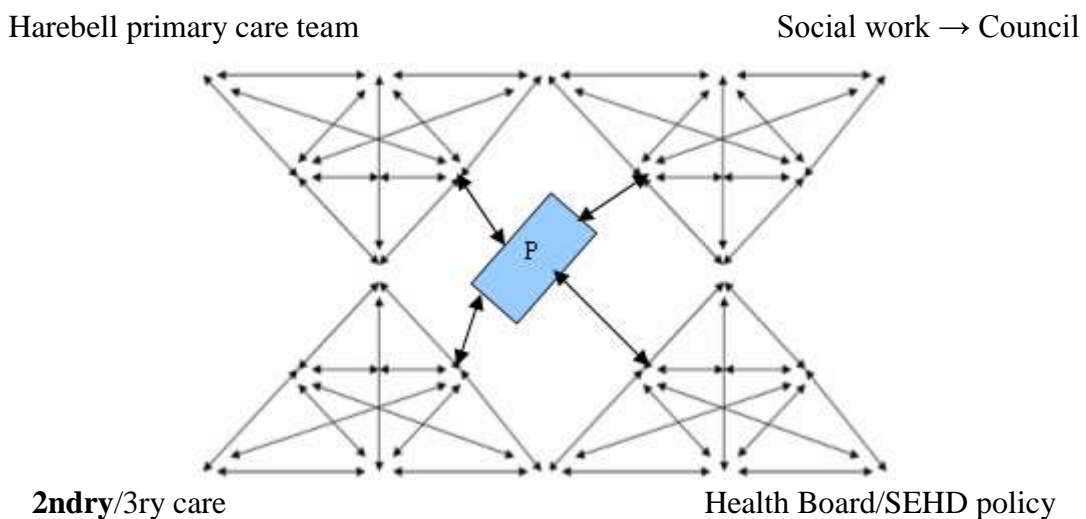
For the Primrose team, the almost complete absence of services provided by the rapid response team meant that most of the likely activity to meet the needs of the elderly presenting patient would be carried out by members of the Primrose primary care team activity system, mediated by the nearby secondary care activity system in the form of the rural general hospital. This highlights the obvious contradiction between the Joint Future policy and the responsibility of social work to provide 24 hour access to packages of care or support through the introduction of mediating artefacts such as the rapid response team. This brought another inter-activity system contradiction to the fore as the social work department was attempting simultaneously to re-provide the service for elderly patients, which previously had been provided through the long-stay beds within the nearby DGH, through the local care home within the Primrose area and for whose residents care was provided by the Primrose team members.



4.4.3. Harebell

The Harebell patient’s position within the horizontal or spatial interlinked activity systems was shaped by the contradictions arising between those four activity systems. Briefly these involved the access afforded to the primary care team to the 24 hour rapid response team (social work activity system) which was limited to specific times during “office hours” when care packages could be arranged; the probable ensuing admission outwith “office hours” to the unit within the DGH established to deal with the ongoing needs of elderly patients both in hospital and the community (secondary care through the district general hospital); the responsibility of the local health board and CHP to “implement” the Joint Future policy to reduce hospital admissions for elderly patients through the introduction of objects such as the rapid response team, together with the movement of long-stay service provision for elderly people from hospitals like the local Harebell DGH to the local council social work department (SEHD policy); and the primary care team members to whom the patient’s problem would be presented and who would then seek to initiate mediated activity to meet the patient’s needs, probably through the use of the rapid response team or referral to the DGH unit.

Harebell diagram:



4.5. Empirical conclusions

The data presented here from these three examples of primary care initially suggested that primary care teams were doing the same thing, differently. However, through subsequent analysis using activity theory, the differences in practices were shown in a different light. As the positioning of the partially given object of activity presented through the vignette exercise of each team shows, teams were not doing the same thing. They were actually doing *different things*, according to the exact nature of the object of activity particular to their teams. This was being produced through the overlapping activities of four interlinked activity systems as shown, which means teams were not only doing different things, but in *similarly different ways*. These patterned differences in activity demonstrated the differences in practices which emerged through the focus provided by object-oriented activity theory. These had serious implications for the policy of reducing hospital admissions (admissions were not reduced on the whole). The fortunes of the example of ‘best practice’ in the form of rapid response teams were also mixed. These were not being introduced to a vacuum but to situations where established patterns of practice, and the contradictions between these and the new ‘best practice’, influenced whether or not it was successfully adopted. [writing note – need more explanation about the reasons behind this in the main findings/empirical analysis section].

5. DISCUSSION

Drawing on the empirical examples provided here from primary healthcare teams, differences in practices across inter-organisational settings have been identified through the use of activity theory as an analytical framework. By analysing the means by which primary care teams mediated their object-focused activities, differences in practices emerged.

Differences in views about objects of activity are characteristic of activity systems (R. Engestrom, 1995; Blackler, Kennedy and Reed, 1999). These reflect the different roles and identities of those involved, and are often surfaced through talk (Engestrom, Engestrom and Kerosuo, 2003). What is regarded as the object of activity for one group may be the mediating means of another group, which reflects local ways of organising, and associated values and norms (Bakhurst, 1997). Changes within activity systems are triggered by mutual need when contradictions between established and proposed new ways of practising arise (Engestrom, 1999).

Some established objects of activity prove to be more durable than others over time (Engestrom and Blackler, 2005). In the empirical example provided here, despite the broad support from policy makers, clinicians and managers to avoid its continuation, hospital admissions remained durable in the face of attempts to transform these into episodes of home-based support.

The durability of this mediating object could be accounted for through the contradictions which arose between the differing objects of activity in the other related activity systems [writing note: explain these in finding section then discuss briefly here]. For example, the unease of consultants in the rural district general hospital related to the Primrose team about the move towards community-based care for patients they regarded as “theirs”, contrasted with the views and activities of the tertiary hospital

consultants related to the Thistle team in supporting GPs to deal with quite challenging clinical conditions within the locality. The inability of the social work department to provide access to rapid response teams on a 24 hour basis reflected the difficulties arising between Health Boards and Councils concerning the transfer of funding (from health to social work) for such service transformations, and the priorities of local Councillors to be re-elected. The support of the local community in Harebell to prevent any reduction in service in its local district general hospital, supported by the local Labour MP, was at odds with the aims of the local NHS organisation (which involved moving money from the hospital provision to community provision).

The difficulties entailed in the work of organising, related to competing priorities (Blackler, Kennedy and Reed, 1999a) combined in particular ways across the overlapping activity systems involved in the example object of activity. Whilst some objects prove to be durable, others fail to be adopted and despite best efforts, become “disassociated” from activity (Blackler, Crump and McDonald, 1999b). Such was the fate of the ‘rapid response teams’, especially in the Thistle team, where the innovation remained unadopted.

The often painful way objects of activity are co-configured in contemporary work settings (Blackler, Crump and McDonald, 2003), characterised by fragmented and distributed work teams like those described here, result in complex differences in practices which are partially shaped by that fragmentation. The range of overlapping activity systems within the overall activity system, in this case the health and social care system, are therefore likely to differ across settings and in relation to different objects of activity. This means it is difficult to assess how ‘best practice’ might fare in certain circumstances, and that the outcomes of efforts to spread innovation in such ways are predictably uncertain.

Of course, there are limitations to the use of activity theory in this study. It would have been preferable to study the processes of potential changes in activity in real time, rather than in two main phases, and to have studied the process involving three similar patients. However, for a variety of ethical reasons (related to NHS ethical approval procedures) and practical ones (it would require a team of researchers to do such a piece of work and patients are all different, so comparison would have been difficult) this was not possible. The approach’s strength in embracing the uncertainties and differences of practices perhaps makes it relatively unattractive to managers whose activity seems to frequently involve reducing such uncertainties. Nonetheless, it provides a powerful analytical lens through which to understand how differences in practices emerge.

6. CONCLUSION

In this paper the complex nature of differences in practices has been discussed. Its contribution has been to show the way in which overlapping activity systems combined in each empirical setting gave rise to differences in practices, which undermined efforts to introduce an innovative ‘best practice’ across the teams studied.

This has implications for sharing knowledge and innovation across inter-organisational settings and perhaps accounts for the difficulties encountered in the production of ‘best practice’ guidelines or protocols (Engestrom, 2007), and their implementation across settings.

The relations between the work of organising and the primary task of the organisation, or inter-organisational grouping, have become ever more complex as work fragments and becomes more distributed. By centralising organising or by seeking to standardise it in such situations, across all settings, can create new problems which have unforeseen outcomes. The main conclusion to be drawn may be that variation in practices occurs for good reasons and attempts to eradicate it may be counterproductive to a large extent.

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APPENDIX 1: CASE STUDY QUESTIONS, EXPLORATORY PHASE

1. How are primary care teams composed in a variety of settings and why?
(who is learning and at what level?)
2. What is the nature of the services they provide in relation to the context, and vice versa, and how is this changing over time?
(what is being learned and why?)
3. How is knowledge of various sorts acquired and how do people within the primary care teams learn?
(how does learning take place, where and through what processes?)
4. What are the underlying values, beliefs and vision of the various members of the primary care team, and how do these impact on intra- and inter-organisational learning?
(where and when does learning take place?)
5. How and to what extent is knowledge shared within local primary care teams, and with other primary care teams? Is there evidence of how this is done?
(through which processes does learning take place?)
6. How does the primary care team fit within the whole healthcare system – is there any evidence of suitable “architecture” to facilitate the transmission of learning?
(what are the learning processes and how effective is the learning?)
7. How and why does the wider healthcare system have an impact (if at all) on the work of primary care teams, e.g. relating to culture, values and beliefs?
(where does learning take place and what are the situational constraints if any?)
8. How do issues of power and conflict impact on the ability of primary care teams to learn within and between their parent organisations?
(how do teams learn and does this result in changes?)
9. What are the implications for the management of primary care services (and perhaps the whole health and social care system), of issues of accountability, organisational structure, and organisational cultures?
(how does learning occur and at which levels?)

Participant questions as guide for semi-structured interviews:

- a) Given this research concerns primary care teams, how would you describe the primary care team in this area?
- b) How would you describe the way “the team” is organised to carry out day-to-day clinical (or other work-related) activities? Why is it like that?
- c) How much interaction/contact do you think is needed between yourself and other colleagues to allow you to provide services to patients, and is that available to you? Could you give me any examples of clinical / work situations which would help me to understand this a bit better?
- d) If you have an idea about improving the way something is done in your daily work practice, how would you go about trying to implement that? Could you give me an example to help me understand what happens?

TABLES AND FIGURES

Table 1: sampling criteria for primary care teams

| Teams | Thistle | Primrose | Harebell |
|--|---|---|--|
| Type of area | Rural, remote, 400sq miles, complex topography, small town / regional hub, pockets of deprivation | Rural, partially remote, 800 sq miles, 3 main villages + sparsely populated landward area, pockets of deprivation | Urban, densely populated (c85,000), post-industrial area, high levels of deprivation |
| Population served | c7,000 | c4,750 | c6,000 |
| Educational role | GP registrar/students | GP registrar/students | GP registrar/students |
| No. of GP Partners | 6 | 4 | 3 |
| Premises | Own Practice premises in town, plus work at local community hospital | Own Practice premises in two villages, third - rented premises | Rented premises in large health centre housing 45 GP Practices |
| ‘learning characteristics’ influencing sampling | Developed innovative advanced training for GPs and associated nursing colleagues | Enthusiastic innovators in team development and collaborative local healthcare provision | Participation in ‘learning organisation’ project, innovation in team development collective learning |

Table 2 – interview breakdown

| Type of interview | 1st phase, year 1 | 2nd phase, year 2 | Total |
|--------------------------|-------------------------------------|-------------------------------------|--------------|
| 1-1 interview | 46 | 4 | 50 |
| Group interview | 2 | 4 (3 vignette, 1 follow-up) | 6 |
| Total | 48 | 8 | 56 |

Table 3: participants in “epistemic object”-oriented activity (*italics denotes those outwith the local primary care team in broadest sense*)

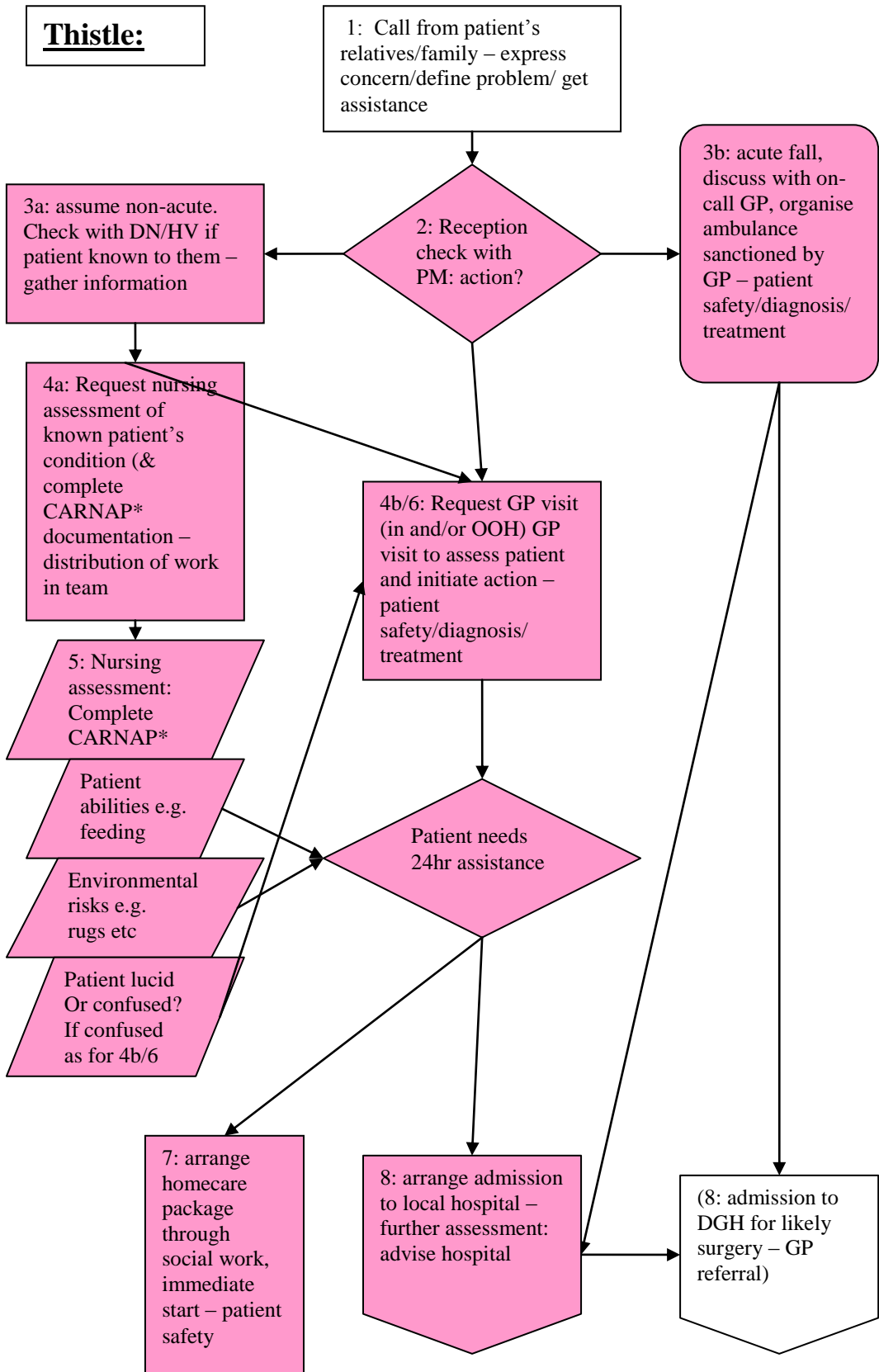
| | Thistle | Primrose | Harebell |
|----|--|---|---|
| 1 | <i>Patient’s family</i> | <i>Patient’s family</i> | <i>Patient’s family</i> |
| 2 | Patient | Patient | Patient |
| 3 | Receptionist at Practice | Receptionist at Practice | Receptionist at Practice |
| 4 | General practitioner | General practitioner | General practitioner |
| 5 | District nurses | District nurses | <i>DGH: on-call medic</i> |
| 6 | Health Visitor | <i>NHS24</i> | Ambulance service: - <i>hub (Paisley)</i> - local crews |
| 7 | <i>Mental health professional</i> | OOH GP (maybe local) | OOH Doctor/GP (maybe local) |
| 8 | Ambulance service - <i>hub (Paisley)</i> - local crews | Ambulance service: - <i>hub (Paisley)</i> - local: hospital transport - local: patient transport | <i>NHS24</i> |
| 9 | Community hospital in-patient staff – nursing | Police | District nurse: - on-call DN - “own” DNs |
| 10 | <i>NHS24</i> | Community alarm key holder | Health Visitor |
| 11 | Community hospital out-patient/triage staff | Neighbours | Neighbours/friends |
| 12 | Social work dept care manager | OT from nearest DGH | Mental health team |
| 13 | <i>999 call operator</i> | Social work care manager | S.W. care manager |
| 14 | Community alarm key-holder | <i>Mental health officer and psychiatric staff</i> | Rapid response team |
| 15 | Hospital transport van for tests | Pharmacy service within dispensing parts of Practice | <i>Geriatrician, local DGH</i> |
| 16 | <i>Biochemistry lab – nearest DGH (?linked)</i> | Local pharmacist in 3ed Practice area | <i>Specialist care of the elderly unit, local DGH</i> |
| 17 | CH Radiographer | <i>DGH nearest:</i> - <i>on-call medic</i> - <i>geriatrician</i> | Van for transporting tests |
| 18 | CH OT | <i>Rapid response team for 1 Practice area</i> | <i>Biochemistry lab at local DGH</i> |
| 19 | Social work dept OT | Private nursing home | Electronic patient record |
| 20 | CH Physio | <i>999 call operator</i> | Health centre pharmacist |
| 21 | CH SALT | <i>Hospital OT, DGH</i> | Local pharmacists |
| 22 | <i>Tertiary orthopaedics</i> | <i>Biochemistry labs:</i> - <i>nearest DGH</i> - <i>Glasgow</i> | Domicillary OT |
| 23 | Practice nurses | Van for transporting tests | Domicillary physio |
| 24 | Neighbours | | |

Table 4: Differences in teams' accounts of likely activity

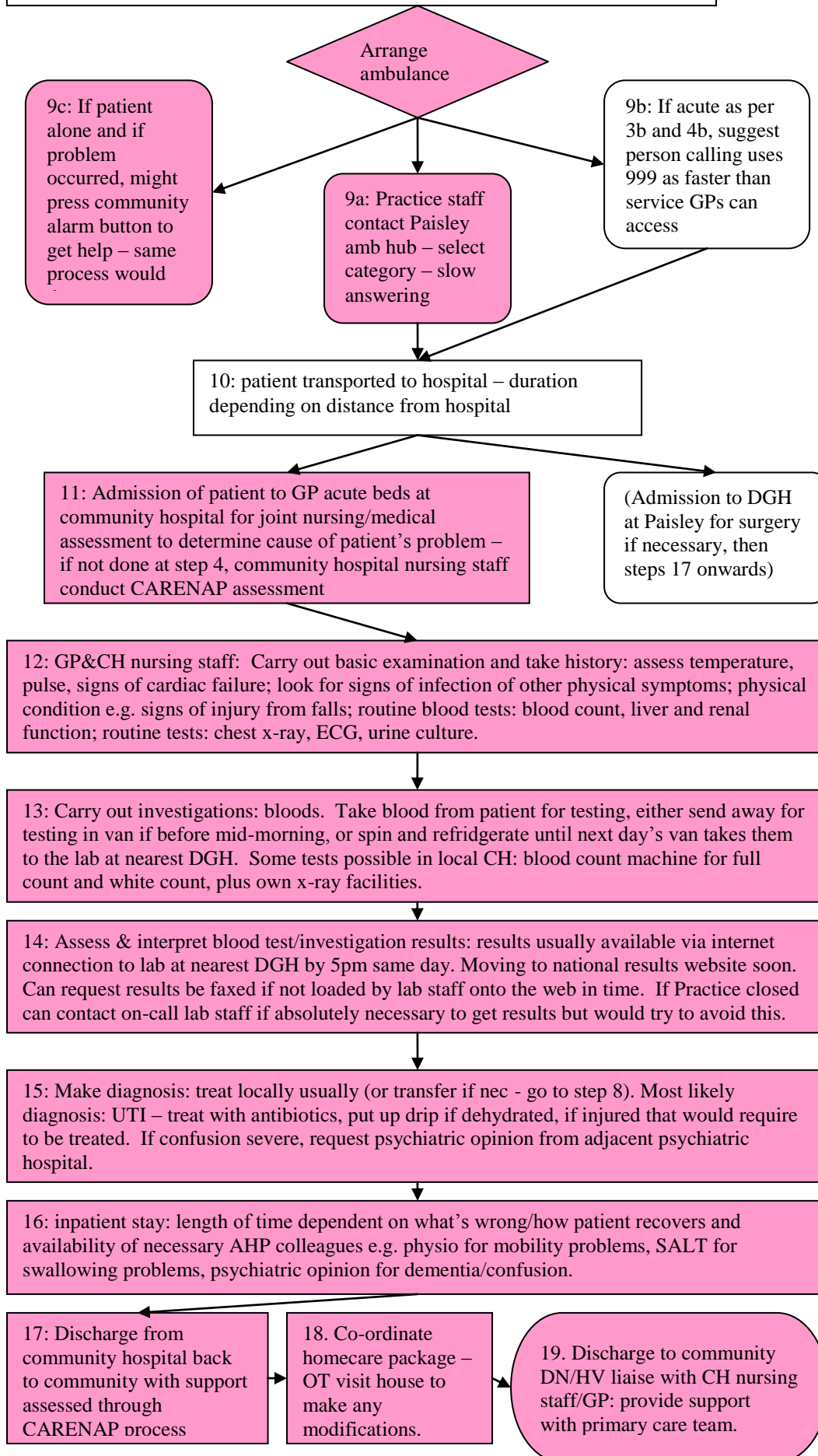
| Team | Mentioned | Did not mention |
|-------------|--|---|
| Thistle | Community Hospital: - inpatient service - outpatient service - Radiography - SALT - Physiotherapy - Occupational Therapy | - OOH GP - Consultant Geriatrician - DGH medical admission - Rapid Response Team - Pharmacy |
| Primrose | - Private Nursing Home - Police | - Health Visitor - Physiotherapy |
| Harebell | | - 999 call operator -Community alarm key holder |

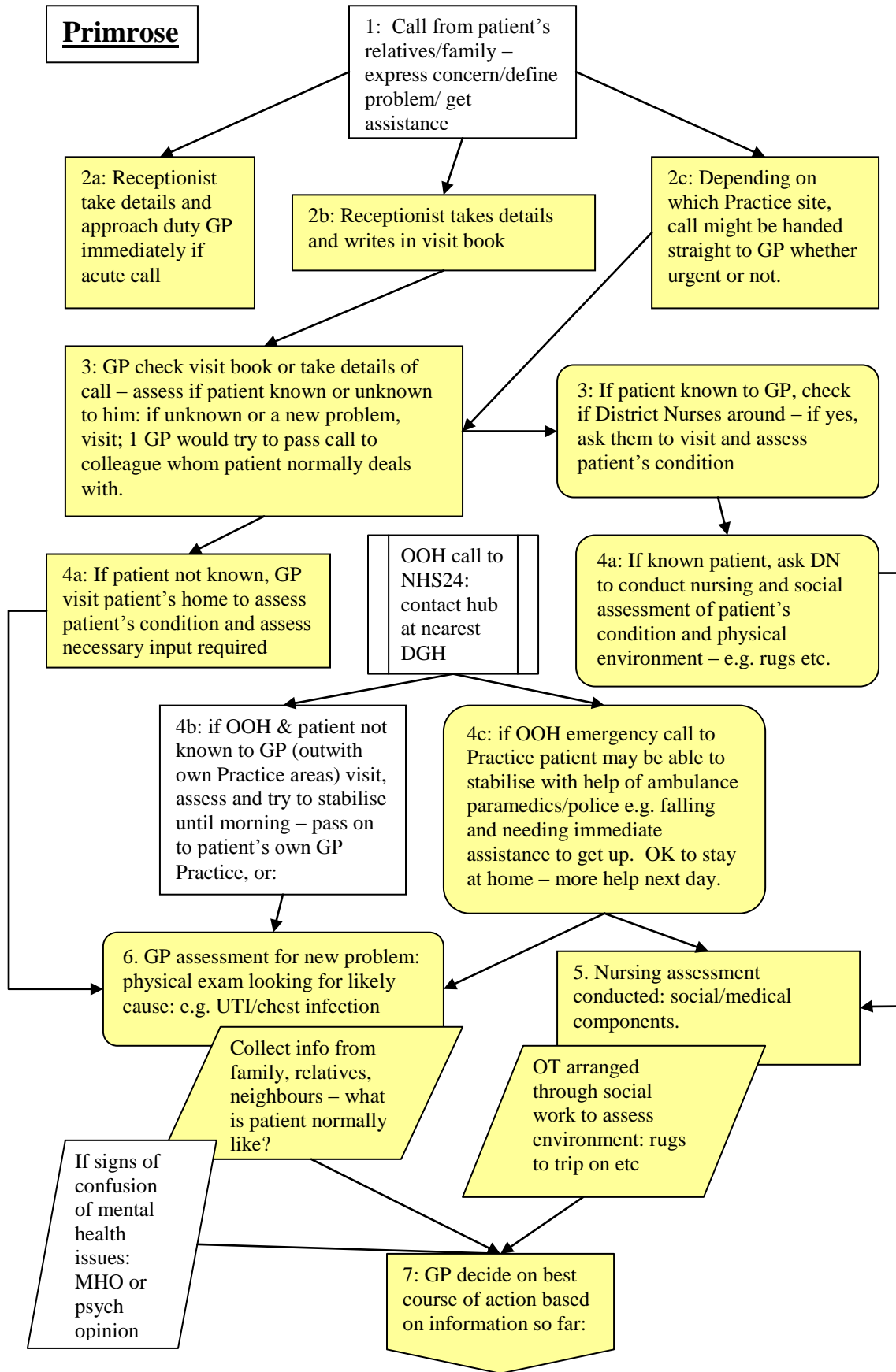
[FIGURES 1, 2 AND 3 MAY BE FOUND ON THE REMAINING PAGES]

Thistle:

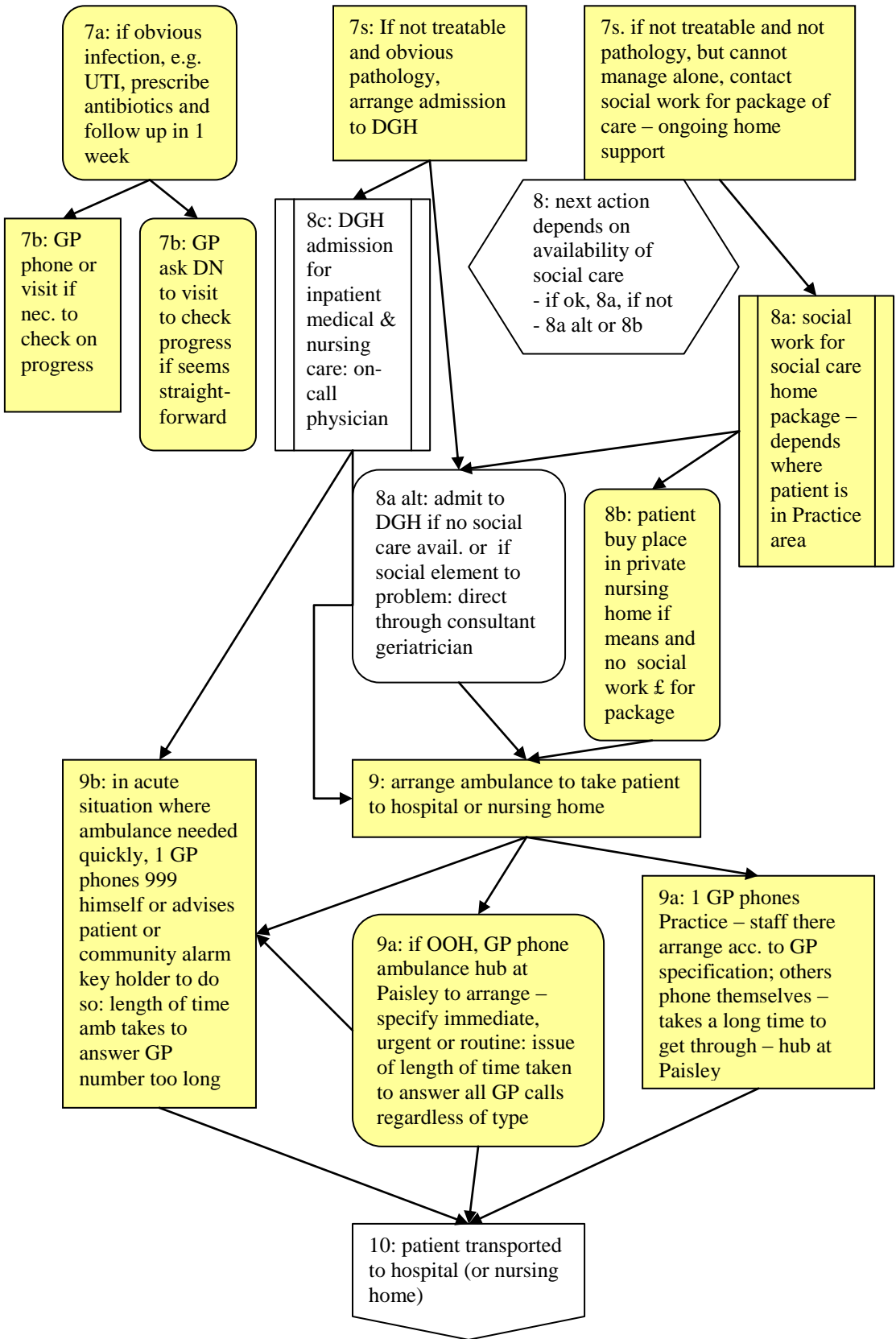


Thistle (cont.): following on from action 8





Primrose (cont.)



Primrose: (cont.)

