Evidenced-based practice combines the best research evidence with clinical expertise and patient values. The prize is the implementation of robust research knowledge into practice, ensuring patients receive the most effective treatments.

This requires busy clinicians to engage actively with research, updating their knowledge continually based on the best available evidence (McQueen, 2008). While everyone acknowledges the value of evidence-based practice, clinicians may benefit from further support if this is to become reality. Finding time to question practice, and source and read research papers while maintaining a busy clinical caseload is not easy.

Researchers have an incentive to produce research rather than engage with clinicians. Gaps are often found between how healthcare should be delivered, as defined by high-quality evidence, and the care patients actually receive (Health Foundation, 2014). It is time to address this challenge, but finding the right way to facilitate such improvement is not easy. One solution is knowledge activation, a collaborative approach using research literate facilitators to work with clinicians in a community of practice.

**Bridging the research–practice gap**

Clinicians report problems around interpreting research, viewing studies as too academic, too statistical or too complex (Humphries et al, 2000). Within healthcare generally, there can be little support to overcome these barriers, which combined with a busy clinical workload makes evidence-based practice challenging. Research suggests postgraduate education alone is not sufficient to enable therapists to overcome the research–practice divide (Forsyth et al 2005). So it seems more needs to be done.

In this piece I want to pose a potential solution. Having spent 6 years successfully engaging with clinicians around this topic as a practice development lead across a number of general hospitals, and 4 years as an AHP consultant in vocational rehabilitation, I’d like to focus on the value of leadership around the community of practice model.

As a practice development lead, I worked collaboratively with groups of clinicians around priorities identified from clinical practice. The outcome was changes in practice in line with current best evidence and improved patient care outcomes. Clinicians implemented changes into mainstream practice more easily through feeling more engaged with the evidence (McQueen, 2008). More recently, in my work within vocational rehabilitation, the mismatch between the evidence and practice was again evident.

For those with severe and enduring mental health issues, there is clear evidence that using the Individualised Placement Support Model results in better outcomes than sheltered workshops or the more traditional ‘train then place’ models (Crowther et al, 2001). Many health boards across Scotland have now adapted this Model, resulting in more people with mental health issues realising their full potential, moving into work, and developing an identity past their mental health condition.

Judging the impact of initiatives is not straightforward and observed changes in practice may not be solely attributable to the community of practice approach. However, during the course of my work I’d like to share a few tips, which the Health Foundation (2014) report appears to back.

**Tips for a collaborative approach**

Implementing evidence into practice is easier if clinicians work collaboratively. Collaboration should be based around a unified direction of travel and a common purpose forming a community of practice. The leader should be highly research literate, acting in partnership as the facilitator rather than as an expert who knows exactly how to implement the evidence at individual practice level. The process of improvement should: be social, generate enthusiasm, create a learning forum, and pool ideas to support change.

In the vocational rehabilitation initiative, the individuals in the community of practice act as local champions spreading successful change quickly across health boards using social, professional connections and partnership working to implement evidence into practice. Collaboration and shared ownership between clinicians and the leader was important as successful evidence-based practice often requires behavioural changes among front-line staff. Overall, the community of practice, focusing on evidence synthesis, acts as collaborative professional network, generating enthusiasm and peer support to overcome the challenges associated with evidence-based practice making it more accessible to busy clinicians.

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