

**Making it better**  
**Improving health and social care through**  
**interprofessional learning and practice**  
**development**

**Readings from the Bournemouth University**  
**Regional Interprofessional Education Project**  
**and Public Health Regional Interprofessional**  
**Education Project**

**Edited by Les Todres and Kate Macdonald**

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**Institute of Health & Community Studies, Bournemouth University**

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## **Introduction to the project**

*Howard Natrass*

This collection of occasional papers has been constructed by some of those most closely involved in a major interprofessional learning initiative from 1998 to 2001. It tells the story of the journey and discusses issues that were uncovered. It does not claim to have definitive answers, but only to make a contribution to the debate about this complex and increasingly prominent subject.

It became clear at an early stage that language and meanings are crucial issues in interprofessional working and learning. The term ‘interprofessional education or learning’ is itself open to wide interpretation. For simplicity it was decided at the outset to adopt the definition used by the UK Centre for the Advancement of Interprofessional Education (CAIPE)– learning from and about each other. This carried for us connotations of a dynamic process resulting in some marked change in attitudes, perceptions, and behaviours. This was in contrast to ‘multiprofessional learning’ which was defined as learning alongside people from other professional backgrounds. It is recognised that these are simplistic and somewhat superficial definitions and distinctions, as will become clear from these papers.

The project started in 1998 with the award by the NHS Executive South West of a three-year grant to the Institute of Health & Community Studies, Bournemouth University, to develop interprofessional education. Locally we called this the RIPE (Regional Interprofessional Education) project. This was followed eighteen months later by a further award with a specific Public Health focus which we called the PHRIPE project. Both projects feature in these papers and for most purposes are considered as one.

It was a highly collaborative project. Not only did it involve many people from service agency partnerships locally, but, unusually, it was a collaboration of learning and development between three universities in that NHS region, each of whom received three-year grants: Plymouth University, the University of the West of England, and Bournemouth University. Each university pursued separate but related initiatives. We (‘the collaborative’) met frequently to share our experiences, and were well supported by a steering group of nationally eminent and important people in this field. It is due to the vision and leadership of the then Assistant Director for Education and Training, Steve Annandale, that this unusual collaborative venture was born and is now bearing fruit in so many different flavours.

We have also worked closely with leaders in interprofessional education in North America and Europe who are wrestling with many of the same issues. We are particularly grateful for our close relationship with Professor Linda Headrick and colleagues from the Institute for Healthcare Improvement in the USA.

The RIPE project consists of development work undertaken in practice settings in five ‘sites’: Andover, Dorchester, and Salisbury, and the more disparate public health sites of Boscombe/West Howe, and Swindon/Weymouth. This represented a complex array of agencies and networks, but yielded a rich variety of learning.

The emphasis throughout has been on practice-based, experiential learning. It has involved both prequalification learners, and experienced staff undergoing continuing learning as they work together. Unexpectedly, it has also drawn in a

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range of volunteers and service users themselves as learners, thereby challenging some of our notions of interprofessional learning. On the spectrum of the different kinds of interprofessional/multiprofessional education that Professor Hugh Barr (2000) has usefully described, this project sits firmly towards practice-based team learning with a heavy emphasis on continuing professional development.

The project, like others in the collaborative, had an explicit and central concentration on the concepts and approaches of continuous quality improvement (CQI). One of its central aims was to find out whether CQI provided a useful vehicle for interprofessional learning, and how best this could be done. What this meant in practice, and it will be clear that it was applied variously, is amply described in these papers. Apart from some strong feelings among those involved that this was an unfamiliar model being thrust upon them, it also raised important and evolving questions about what exactly CQI was and how it related to other concepts and approaches, particularly in the field of adult learning, and post-modern thinking. I think this project has yielded rich and valuable learning in this area, as is reflected in these papers.

Understandably, the question, 'Does it work?' is asked frequently, and recurs explicitly and implicitly throughout these papers. I find it interesting that this question seems to arise more frequently and with greater emotion than when considering uni-professional education. This perhaps suggests that the politics of the subject, and the surrounding issues of status and gender, and preserving vested interests, are significant. It is clear to me that much of the kind of interprofessional learning described in these papers is valuable and potentially very important. The interesting and pressing question is not whether it works, but what in particular works best, and how can we organise this most efficiently and effectively in the future. I hope that the reader will be able to draw from these papers some useful ideas as they wrestle with this.

The project was held together by a group of experienced educators working within IHCS, some twelve people from different health and social care backgrounds, and all experienced practitioners. These people facilitated the action learning sets in the sites. The group met every month to review progress and share experiences, and in between meetings worked in smaller site-specific groups, or as task groups developing particular aspects, such as prequalifying curriculum design. This was a major learning experience for all of us. Although we had worked in the same faculty for several years, this was the first time we had really worked and learnt together, interprofessionally. All the issues and barriers that we were seeing in the field were there within us as well, and it took time to create dialogue and arrive at shared understandings. It was an immensely enjoyable, rewarding and enriching experience, so much more so than our usual internal communications. Some of our deeply held mindsets were challenged and transformed. Above all we were developing new capabilities for sustaining interprofessional learning.

The most successful aspects of our work are now being built into the mainstream of our ongoing activities. In particular, the prequalifying experiences described in Salisbury and in Boscombe will form part of the revised undergraduate curricula, and the kind of learning undergone by the experienced professionals can now be accredited within the Institute's new CPD framework, and MA in Professional Development. Most excitingly, perhaps, is the development of interprofessional academic units in particular service agencies, where individuals and teams can go on learning together around the issues they are addressing, adopting the approaches described in these papers.

The context and imperatives for interprofessional working and learning have never been stronger. As Professor Mattie Schmitt (2000) pointed out from her US perspective at the recent collaborative conference, 'the two strands of cost-driven managed care and the quality improvement movement are coming together in a shared concern for better systems management, identification of

best practice and development of care protocols. These are inherently interprofessional activities leading to a requirement for interprofessional education with a quality improvement focus<sup>7</sup>. This is equally true of the UK. We need above all to ensure that these forces, which could so easily become yet another externally driven burden, do not become disconnected from the values and intrinsic motivation of professionals which, if nourished, can be the source of joyous interprofessional working and profound learning. I hope the reader will get a sense of this from these papers.

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**PART 1**

**STORIES OF  
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## The Salisbury site: Multidisciplinary students' learning

*Gail Stuart*

### Introduction

Up until the involvement of the Regional Interprofessional Education (RIPE) project, mental health students in the Salisbury locality had received training experience in a predominantly uni-professional way. Students from each discipline would work with an assessor/mentor from their own profession, and the main focus of the placement was the 'learning of their trade'. Some of these students would have had contact with other disciplines during their training, and would perhaps have done some observation visits with professionals from other disciplines. However, there were no opportunities for different disciplines to work together to learn together. The RIPE project sought to change this situation by bringing students from different professions together to work in a problem focused way to facilitate 'real' improvements to services for clients.

After exploratory planning meetings by the site team, nine multidisciplinary mental health students were brought together in Salisbury (representing social work, nursing, occupational therapy and medicine). Their remit was to work together collaboratively within the theoretical framework of continuous quality improvement (CQI). They were asked to assess young people's first experiences of contact with mental health services, and to draw up a set of recommendations for improvements to these services, based on their findings. They were also charged with assessing their own learning about a new theoretical approach, and, about their learning about the nature of interprofessional work in mental health. Their period of involvement with the project lasted five weeks.

### The process of identifying the project

The Salisbury site team first met as a team in January 1998. The group consisted at this stage of two community psychiatric nurses, one clinical psychologist, one approved social worker, one social work assistant and a team manager / cognitive behaviour specialist. A professional service-user representative joined the team shortly after its formation. The team from Bournemouth University consisted of a general practitioner/ GP educator, a clinical psychologist, a senior mental health nurse lecturer and a practice teacher of social work.

At the time, Salisbury community mental health team was undergoing a big re-organisation. Team members were based in different geographical locations, but were hoping to be united soon under one roof, with one team manager. Senior management in both health and social services were looking for ways to help their team 'gel', and were, it transpired, hoping that the RIPE team would provide them with a common assessment document.

As with any major reorganisation, the mental health team members were experiencing tensions and stresses. Some were happy with new proposals for joint working, whereas others were less so. There was a major upheaval of staff, many leaving, others joining, some finding new and different roles. In hindsight, the timing of the RIPE project in Salisbury was not ideal.

The academic staff led the first team meeting. The Salisbury team members were introduced to the concepts of CQI and the remit and scope of the RIPE project. They were asked to draw up their own overall aim for the project. Experience from other sites indicates that it is important for team members to have ownership of their work, which should, in theory, avoid the types of problems alluded to by Peck and Norman (1999) where CMHT members

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distrust solutions given to them by senior managers.

The team took some time to feel relaxed and able to discuss issues freely across professional fields. However, by the end of the second session they were able to set out their own remit:

New pathways will exist to take the young person through the service using the range of community resources effectively.

In this scenario a 'young person' was envisaged as aged between 18-30, suffering a major psychotic illness.

The group's aim was that it should be possible for appropriate help to be accessed earlier on in individuals' mental health pathways. Fears were expressed that this might lead to early labelling and stereotyping. The group believed that early assessment, diagnosis and service provision could at times avert the necessity for crisis admissions and the trauma and stigma that this involved for sufferers and families alike. The group's feelings were borne out in studies done elsewhere, such as Birchwood et al's work on early intervention and diagnosis (1997), which found that early intervention tended to lead to the development of less severe symptoms, and a more positive long-term outcome.

In order to create a new pathway, the team had first to examine the pathway as it currently stood (see Appendix A). Once they had identified the basic process, the team examined the components, and looked into the areas that they felt needed changing, and were accessible to change (see Appendix B). From this the Salisbury team were able to set their first sub-target towards achieving their overall aim:

To enable sufferers/carers/professionals to detect symptoms early, and access relevant help as soon as possible.

There appeared to be a general consensus that, once an individual was engaged with appropriate help, the process worked fairly smoothly. However, there was a feeling that the system was far less consistent at the first three stages, and that individuals would have different experiences based on:

- their ability to recognise that a problem existed;
- the route by which they came into contact with mental health services;
- the level of knowledge, expertise and assessment skills of the first person/organisation they first contacted.

The group gave some consideration to how these services at this level could be improved. Accessible appropriate information was available, in the form of information about symptom recognition and of help and services, but not necessarily in appropriate formats for the different individuals concerned, i.e., clients, carers and professionals.

The group considered what type of information needed to be delivered to whom, and where and how this type of information should be disseminated.

The general feeling was that the first-time provision of services in the Salisbury area for young people with psychotic symptoms was a bit of a lottery. There was an element of chance as to whether symptoms were recognised early on. When symptoms were recognised, there was uncertainty about where to access help. Once help had been sought there was a lot of variation in the standard and type of response they received, e.g., one person might be assessed as needing psychological help, and be put on a long waiting list to see a psychologist, whereas another with the same presenting symptoms might be assessed as being in need of a mental health assessment, and would be seen that day by an approved social worker.

The group recognised that their thinking was based on their own experiences as professionals. The feedback that the service user representative had received

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from service user groups supported the group's suppositions.

Given the original remit of this group, and in accordance with accepted good practice, the group recognised the need to consult directly with local clients to assess their experiences.

Due to staff changes the local site group changed over time. The two original CPNs left the department and were replaced by two others. The approved social worker reduced her hours of work, and was no longer able to attend, and the social work assistant was allocated to the student group instead. The clinical psychologist also left the group due to a change in her role. The head of the occupational therapy department at the local psychiatric hospital joined the group. The staff team from Bournemouth University remained stable, other than the planned withdrawal of the clinical psychologist.

The changes in the group's structure did not affect the original proposals, and the new members took up themes established by others.

In October 1999, a potential multidisciplinary student group was identified and, was given the task of working in an interprofessional way when approaching clients about their first experiences of contact with mental health services. They were to be encouraged to fit this work into appropriate theoretical frameworks.

### Selecting the participants

#### Ethical considerations

Work carried out by the students interviewing clients about their experiences of service delivery was seen by the Salisbury community mental health team as a form of service audit, and therefore did not require approval from an ethics committee. However, a considerable amount of thought did go into ensuring that clients were given informed choices about whether or not they wished to be interviewed. Key workers were kept informed at all times to ensure back-up support, should contact with the students cause any problems for clients.

### Course requirements

It was anticipated that, for the students, involvement in this project would take up approximately four hours per week, for a period of five weeks. This is a considerable portion of a student's placement. It was therefore important that this work should contribute towards the students' overall learning and assessment. The regional RIPE project had already done some of the groundwork in this area. They had looked at the professional learning requirements of each discipline represented, to ensure that there was a fit between the skills and knowledge required of the individual's profession, and the skills and knowledge that would be evidenced by being involved in this project. The major areas considered were:

- learning about interprofessional and team working;
- learning about resource development;
- learning more about a specific specialism, i.e., mental health.

The regional RIPE project had already ascertained that, to a lesser or higher degree, each of the disciplines required evidence to practice in all of the above areas. It was important, therefore, to clarify with the students that the work they did in the Salisbury RIPE project would contribute to their overall qualification. This was done at their first meeting.

A database of young people aged between 18-30 who had suffered from a major psychotic illness was drawn up. Team managers and key workers were approached, and the rationale behind the project outlined. Local GPs were also written to and a letter was drafted explaining why clients were being approached. Key workers discussed directly with their clients the possibility of being interviewed by students about their first contact with mental health services. A questionnaire was devised by the group, to be sent to clients, but it was decided against using this, as it was felt that one-to-one interviews would reveal far richer data. The questionnaire was adapted to give a list of topic

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areas (see Appendix C). However, of the 65 potential interviewees, only five consented to be interviewed.

### Analysing the learning

#### Methodology

The research methodology took two basic forms, a literature search, and a limited amount of primary research, using an action research approach. Hart and Bond (1995, cited in Bowling 1998) selected seven criteria that they considered characterised this approach.

Action research:

1. is educative;
2. deals with individuals as members of a social group;
3. is problem-focused, context-specific and future-orientated;
4. involves a change intervention;
5. aims at improvement and involvement;
6. involves a cyclic process in which research, action and evaluation are inter-linked;
7. is founded on a research relationship in which those involved are participants of the change process.

All seven of these criteria applied to all the learners of the Salisbury project, whether they were working in the academic team, the local professional teams or the student groups.

Action research lends itself to both qualitative and quantitative research methods and both approaches were used in this project. The approach used was the Langley *et al* model (1996).

### What did we want to achieve?

1. The students would be able to contribute to improving services.
2. They would learn more about effective team-working.
3. They would learn more about one another's roles and develop mutual trust and respect.
4. They would develop an increased knowledge and understanding of problems faced by people with mental health problems in the community.
5. They would develop a more in-depth knowledge of the CQI approach.
6. Students' value and attitude systems might change, especially in relation to the pivotal role of the client in determining service improvement.
7. Their learning might be incorporated into their future work.

By achieving all of the above, they would become more skilled practitioners, thus contributing to the development of more effective community mental health teams, once qualified.

### How would we know that change was an improvement? What would be different afterwards?

This area is a particularly difficult one. It is relatively easy to construct research tools that measure that a change has taken place. It is more difficult to argue that this change is an improvement. It will be difficult to analyse the impact of this work on students' future development, and the effect this has on the functioning of any of the future teams they are involved with. This would necessitate a follow-up study in two to three years.

To some degree then, we must rely on inference. If we can demonstrate that we have achieved points (1) to (7) above, there is a greater chance that the overall

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aim will have been achieved. This brings us back to the points raised by Norman and Peck (1999) where a lack of evidence shows that interprofessional training actually improves team working and services. Many researchers will infer that interprofessional training is effective, because they feel it ought to be.

However, what we can attempt to demonstrate is a change in points (1) to (7) above. If this study is able to do this, there will be some evidence that this interprofessional approach has facilitated team working for this particular group of interprofessional students, and that they have contributed to the development of better services, from the view of the client, for this particular community mental health team.

In order to achieve the above, several sets of measurement tools were incorporated into a student handbook devised especially for this study:

- A basic Likert scale, to measure students' learning profiles at the beginning and end of their involvement.
- A questionnaire asking the students to give evidence of their learning. This gave a measure of their understanding of the concepts involved, and showed if involvement in the project gave the students the opportunity to incorporate these concepts into their work.
- A personal learning profile, examining the significance of the learning to the individuals in question. This was designed with a view to ascertaining if students had internalised their learning, and if this was likely to affect their practice in future.

### The handbook

A handbook was designed to help learners look at the common themes they would learn about and experience during their involvement in the project. It recognised that there were many different ways in which people develop understanding, and was intended to be flexible, so that learners could draw on a range of experiences and learning, to meet common aims and objectives.

Terminology and language were addressed first of all, one of the big obstacles in interprofessional work, as different professions use different words to explain the same thing, and the same words to explain different things. Learners were encouraged to identify what they didn't understand, and to ask for explanations.

The objectives of the project were set out:

- You will consider concepts of user needs and the importance of these at the focus of professional activity and service design.
- You will demonstrate how you place user needs at the base of your work for improving quality of care and for interprofessional working.
- You will learn to identify the key principles of continuous quality improvement.
- You will demonstrate insight into the dynamics, and importance of interprofessional working and an appreciation of how collaboration may be improved.
- You will demonstrate your ability to use a learning framework (incorporating a Plan-Do-Study-Act, or PDSA / action learning cycle approach) to guide the implementation of improvement projects.
- You will demonstrate your ability to appropriately use practical tools which facilitate understanding and analysis of current processes of care, and which help the choice of relevant improvement priorities.
- You will demonstrate your personal ability to reflect on your own learning and its personal and professional implications for improving care.
- You will demonstrate values and attitudes commensurate with

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interprofessional learning for the improvement of care.

Before they started the project, learners were asked to complete a *hopes, concerns and expectations* sheet, and a *learning profile*, to help in assessing their progress.

At the end of their involvement with the project, they were asked to *reflect* in more detail on their learning, and to write a brief account of their involvement in the project, and then relate this to what they had learned. This reflection on their own practice would provide evidence of their learning to other professionals and colleagues, and would contribute to their course requirements and vocational qualification. They re-visited their *hopes and fears* and considered how much of this had been realised in practice.

They re-did their learning profile, and contrasted this with the profile completed at the start of the project. This was to give them a clearer, visual picture of just how much knowledge, experience and confidence they had gained.

During their involvement with the project, learners were asked to complete a *personal improvement plan*, to help them work on improving an area of their lives that they wished to improve. This enabled them to see at least one project from beginning to end, to put their involvement in the RIPE project into perspective, and let them see how their part fitted in to the whole.

While involved in the RIPE project, learners had four main sources of support:

- Their fellow learners, grappling with the same issues and problems.
- Their site team, also learning and developing as they work together.
- Their vocational course mentor / tutor / practice teacher.
- The academic team at Bournemouth University.

Arrangements were made for the final student meeting to constitute a focus group, examining together what they each had learnt as individuals, and how this might affect their practice. Following each student meeting a 'Fast Feedback' sheet was circulated, requesting immediate comments on the content of that session, and any suggestions for improvements.

What changes could be made that would lead to these improvements?

Students would be learning by doing. It was hoped that by involving students in real work, where they would be able to see the impact of their actions, they would be able to see the direct benefits of the approach adopted. This contrasts to being taught theory in the classroom, which has no immediate application. Previous research, such as action research studies, has shown that this approach is highly motivating for students, and generates a deeper learning and understanding.

In essence, the main changes that could be made were that:

- An interprofessional student group would be formed.
- They would be facilitated to work in an interprofessional and collaborative way.
- They would be given the academic knowledge and tools for this particular approach.
- They would be given the opportunity to use this knowledge in practice.
- They would be facilitated to reflect on what they had learnt from this, and how it might affect their future work.
- There would be changes and an improvement in service provision.

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### The student experience

The potential sources of mental health students are myriad: mental health nurses, student social workers, occupational therapists, psychologists, medical students, psychotherapist trainees: the list is as long as the potential list for members of community mental health teams.

Logistics were a big problem in trying to set up a pre-qualification student group in a practice setting. Patterns of placement attendance vary tremendously between professions, and between different courses within the same profession. Salisbury mental health team takes students not only from different professional disciplines, but also from different educating bodies, e.g., from the universities of Bournemouth, Southampton, Exeter, Bath and Bristol, as well as from various Colleges of Further Education, all of which have conflicting intake patterns, timing and duration of placements. These problems were daunting, but by approaching the professions individually we were able to draw up a timetable, targeting a period of five weeks when a reasonably interprofessional student group could be formed. This initial group consisted of four RMN nurses, four social work students, an occupational therapy student and a medical student.

The students were at different stages of their professional careers, and had very varied amounts of prior experience. The student nurses and the OT and medical students were relatively inexperienced in the field of mental health, whereas the social work students were relatively mature, and had been working in the mental health field for several years. Two of the social work students had volunteered to participate in the project in the belief that the work they did would coincide with their professional training. Unfortunately they did not secure places on their anticipated course.

### Meeting 1

Four meetings were set for the student group. At Meeting 1 the students were introduced to one another and the academic team. The background of the RIPE project, and the Salisbury project in particular, was explained to them. The students were introduced to the underpinning theory, values and aims of the project, and were orientated as to where their work would fit into this.

The students were also issued with two workbooks. One was the student handbook written by the author for the Salisbury project. The other was a personal improvement plan, which introduced some of the key concepts and theories underlying CQI, and how one could apply these to one's own life and work.

### Meeting 2

In Meeting 2 the students were given the names and addresses of the clients that had agreed to be interviewed. They were introduced to the topic list for the interviews, and advised on how they could use this. Students from different professional backgrounds were paired with each other, and were encouraged as a group to consider some of the underlying issues. Basic interviewing skills were covered, and the pairs were advised to clarify their roles prior to conducting their interviews. The pairs were then left to decide when they would meet up, who would arrange the interviews, who would record what information, and when they would feed back their analysis to each other. The group was given two weeks to do this work, before the third meeting.

### Meeting 3

At Meeting 3 each pair fed back their findings in turn and were then facilitated to consider what common theories and issues were arising. This was followed by an exploration of where their work fitted within the CQI flowchart. They were asked to consider what processes needed to be changed within the individual's pathway to ensure that appropriate help was accessed as soon as possible. Some important points emerged here.

- All five people interviewed were using illicit drugs in one form or another. The student group felt that there was a need for increasing the

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general level of awareness of drugs' impact on mental health.

- Students felt that education was more than just producing a booklet: they needed to target parents with information about recognising schizophrenia and accessing services.
- All staff in the mental health service needed to be well informed about dual diagnosis, people, services and approaches to treatment.
- There was a need to strengthen links between community and GP practices.
- There was a need to clarify and respect key worker roles.

The group then chose a specific area for improvement based on their findings: improving the key worker / initial assessment. The group adopted the Langley *et al* model (1996).

### **What they were trying to accomplish?**

- A more holistic approach was to be used in assessment. They felt that understanding the client's life would help the key worker to understand what the client wanted their future to be. There was also a need to find out what was achievable for each service user.

### **How would they know that change was an improvement?**

#### **What would be different afterwards?**

- Clients would have shorter contact with mental health services.
- Services would be targeted more effectively.
- Better/broader information would be available, not just about their specific mental health problem, but about their lives.

### **What changes could be made that would lead to these improvements?**

- The students felt that there was a need to establish a resource centre with information for staff to use, and a need to re-design a more flexible assessment.

They were asked to target one particular 'do-able' piece of work to hand on to the next student group in the project (there were four cohorts of students), as, although all of the above issues were important, it was necessary to acknowledge the limitations of time for the student groups. They would need to work on one area, achieve this, and hand on work to future student groups so that the whole service could be improved over time. This group of students considered the area of dual diagnosis and the perceived lack of available information to be an appropriate area to hand on to the next group. They felt there was a need to increase the general level of knowledge and understanding of the problems of dual diagnosis at several levels:

- the young person with dual problems of mental health problems and substance abuse;
- the carer/family;
- friends of young person;
- schools, colleges etc.;
- professionals such as GPs, social workers, community psychiatric nurses etc.

## Meeting 4

The aim of Meeting 4 was for the student group to consider what they had learnt while involved in the RIPE project.

- Did they understand the CQI approach? If so, did they see it as a



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useful model?

- How did they view their involvement in the project? Did they feel it was a valuable experience?
- Did they feel that their work was useful? Did they see the contribution their work would make to the overall improvement of service provision for young people with mental health problems residing in the locality?
- Did they feel that this approach was useful in facilitating interprofessional work?
- How likely was it that they would transfer their learning experience in this project to their future work?
- Had their hopes and expectations been realised? If not, why not?
- What recommendations might they make to improve this type of approach in the future?

The students' views were examined using three different types of analysis: facilitated discussion, completion of the student handbook and fast feedback questionnaires.

## Findings and analysis

The findings and analysis relate to several discrete areas.

- Sessional feedback, relating to how well and/or effectively each session was run, considering what changes the study team could make to the running of each session to make it more effective.
- What changes in knowledge and skills were there? Did the students learn anything by being involved in the process? If so, what?
- Were there any changes that the study team could make to the overall approach that would enhance the learning?
- Were there any results in terms of local service improvements?
- What barriers to learning had the students found? Was there any information gained that might suggest how these might be overcome?
- How might the team's findings relate to the wider picture? Is there anything that we have learnt that might be useful in considering national training initiatives in mental health?

## Sessional feedback Meeting 1

Nine students attended the first meeting. Three students arrived late due to other commitments and lack of notification, and one student was unable to attend. The fast feedback forms indicated that lack of prior notification and information had been a problem for some students, and had given them an initially negative view of the project. By the end of the session all students felt that they had learnt 'a fair amount' up to 'a great deal'. However, they were unsure about their role in the overall process. Students indicated that they found the long theoretical presentations difficult to assimilate, and their attention drifted at times.

Implications for practice:

- Students need to be informed well in advance of dates of sessions.
- They need some initial documentation, so that they can orientate themselves in advance.
- Clarity of student role needs to be established at the outset.
- Sessions need to be more interactive and less 'academic'.

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### Meeting 2

The medical student withdrew from the project. An exit interview conducted by another member of the RIPE project team indicated that although the student thought the approach and work were valid, he had more competing priorities on his time. Interprofessional working was not seen as an essential part of his training, by his assessor.

One of the nursing students and one of the social work students were unable to attend. They sent apologies, and ensured that they would be able to access information from other members of the group. Fast feedback forms indicated that the students enjoyed this session more, as it was more interactive, and they were given a clear remit for their work. They estimated that their learning was, in general, higher than in the previous session. However it was felt that the work of meeting 1 and meeting 2 could have been combined together.

Implications for practice:

- It would seem that interprofessional working is still not highly valued by some in the medical profession. The training requirements do make reference to skills in this area but, in this instance at least, were not prioritised against the other requirements of training. The head of the medical school concerned has been approached, and has expressed a commitment to the work of the project. It would seem from the above experience that the local consultant has a pivotal role to play. If they do not see any clear benefits for a medical student to be involved in interprofessional work, then it is unlikely that their students will participate. Work therefore needs to be done to convince the consultant concerned of the potential benefits.
- Meetings 1 and 2 need to be combined. This will allow students to have a clearer picture, earlier on, of what work they will be undertaking, and will enable a more interactive first session.
- Again, prior notification of dates would have resulted in better attendance.

### Meeting 3

The student feedback indicated that, for the most part, they were now able to locate their work within the CQI framework. They were able to see how the work they had done might impact on service improvement for clients. Concern was expressed that the sample size was low (five clients were interviewed in total). However, the students felt that there was significance in the fact that all the clients interviewed had mental health problems and were also involved in substance abuse. The students were surprised at the level of dual diagnosis clients. It was an area that none of them had considered so prevalent in the locality. The fact that their own limited work reflected growing statistics collected at a national level was new information to all the students, and they all reflected that this was a growth in their knowledge of issues around those suffering from mental health problems in the community.

Implications for practice:

- The experience of 'doing' the work enabled the students to develop a deeper understanding of the theoretical CQI model, and enabled them to put this in the context of their actual practice.
- Meeting together to analyse their findings, and the CQI model, reinforced their learning.
- The number of clients interviewed was low. Only five clients volunteered to be interviewed, even though it was made clear to them that the information given would be confidential, and would be used to improve services. It was speculated that the subject nature of the interviews ensured few volunteers, because clients were to be asked about a particularly painful and traumatic time of their lives, when they first contacted mental health services. This issue was reflected on

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in the focus group, where the students commented on the level of distress experienced by one client when recalling his experience: *'it was getting really personal towards the end ... I thought he was going to jump out of the window'*. The interview might well open up old wounds that the interviewees might prefer to put behind them. However, it was still felt that this approach was potentially better than postal questionnaires. The personal interviews allowed for the collection of richer data, and gave flexibility of response. The original questionnaire designed by the local team did not cover the area of substance abuse, and the team had been unaware of this being a problem area in the local population served by the mental health team.

A new questionnaire is now being drawn up that includes reference to substance abuse. This will be circulated in due course. The results from this will be analysed by the Salisbury RIPE team, to supplement data found by the students.

### Meeting 4

Only five of the original ten students attended this meeting. The students had found the handbook difficult to complete, and expressed a varying degree of knowledge and understanding of the concepts. The students worked in pairs and this was viewed positively. This issue was raised in the focus group later, where students commented that *'Working with someone from another discipline informed the interview, and subsequent analysis of the situation'*. It aided the process as students exchanged ideas on how they had demonstrated various skills. This meeting ended with a reflective group, led by another member of the RIPE project. Here students were encouraged to consider their overall learning from the project, and how this might affect their work in future. Students were requested to complete their handbooks in their own time, once they had assimilated their learning. Feedback from the focus group stated that the students found the handbook *'longwinded'*, *'not straightforward'*, *'off-putting'* and *'time-consuming'*.

Implications for practice:

- The handbook needs rewriting in more accessible language, and needs to be less onerous to complete.
- Joint/group working at this stage again facilitates learning, and gives added bonus to the work.
- Students prioritised this meeting less than the others. More commitment was expressed for attendance for all the other sessions, and to actually conducting the interviews. Students did not seem to see the value of reflecting on their learning, until they actually did it. It would seem necessary to educate the students about the value of reflective practice. Those students who did participate in this session found it a valuable experience: *'You hate it but suddenly you've got the whole jigsaw'*.

### Changes in knowledge and skills

Of the nine students that participated in the project, five completed and returned their student handbooks. This return rate was discipline-specific. The OT and social work students returned theirs, but the nursing students did not. It is only possible to speculate why this dichotomy arose. It is possible that because the author of the handbook came from a social work background, it was written in terms more accessible to this discipline. It is also possible that the social work students felt more allegiance to the project, because they saw the lead being taken by someone from a similar background. Additionally, it is the author's belief that the values enshrined in the CQI approach mirror the value base of social work, i.e., that of client empowerment, and assessing need from the perspective of the client, rather than the needs of the services (CCETSW 1996). This value base is less in evidence in the training

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requirements of the other disciplines represented.

Results from learner profiles gave showed some interesting patterns. It was possible to demonstrate that, overall, the students felt that there was an increase in their knowledge/skills base. The average total score changed from 22 at the outset, to 28.8 by the time they had completed their handbooks. However, a more detailed analysis of the scores indicates that there are some moderating factors in the acquisition of knowledge for this group. Students 1, 2 and 4 felt that they had learnt a great deal, with mean scores going from 18 to 32, 24 to 30, and 18 to 30 respectively. Students 3 and 5 appeared to feel that they had learnt little, with mean scores going from 26 to 28, and 24 to 24.

To consider why this might be so, it is useful to examine their responses to the questionnaire section. Student 5 did not complete this, but sent a covering note. Student 5 already had considerable experience in CMHT working, and stated that she did not have time to complete the handbook.

*What you asked us to do, is what we do already!* Student 5

Student 3 had a very similar personal profile to student 5. Both of these students worked in the same team. This student also felt very pressurised by work commitments.

*I feel that I did not actually learn very much by taking part in this study. This may be because I have been a mental health worker for five years, and therefore have some experience.*

Student 3

The main area for learning highlighted for her was around the use of the clinical value compass, and being able *'to break things down into smaller steps while still being aware of the "big picture".'*

It may be of some significance that both these students were unable to obtain a place on their anticipated course while involved in the project, and therefore were not able to get any formal credit for learning. One could speculate that, at a personal level, they had less to gain by learning from this project, and therefore may have been less motivated to examine their thinking patterns and methods of working. This theory is backed up to some extent by a comment made by student 3 in her handbook.

*I found the questions hard to interpret but, again, this may be because I am not a student as such.* Student 3

Students 1 and 2 shared some similarities in background to students 3 and 5, in that they were both mature students, and were experienced mental health workers. However, they both felt that they had learnt a great deal. These two students both worked in residential units, and were actively engaged in study. The nature of their day-to-day work meant that they spent more time working in a uni-professional way, and had less time in direct contact with colleagues from different agencies. Both students were also keen to use their learning from the project to contribute evidence of learning for their professional qualifications. Student 2 referred directly to this in her handbook.

*It was helpful to have the opportunity to do joint working because the norm is we all do good work, however, [we] don't often do joint working.* Student 2

She also stated that *'doing NVQ helps to identify methods and improvement needed in areas'*, directly linking her RIPE work to her studies. Both students 1 and 2 made comments about developing increased personal confidence, and related this to an increase in knowledge, and an increasing appreciation of how much knowledge they already had.

Student 4 was one of the less experienced workers. She had little experience of mental health work prior to this placement, and limited community work. Not surprisingly, she appeared to gain most from her involvement in this project.

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Her learning was also accredited within her learning curriculum, and she went on to use her learning as an item of evidence in a portfolio of work. She also commented on an increase in her confidence levels following her participation.

The author was interested to see if involvement in the project had increased knowledge and learning in any one particular area rather than another. The results of this are rather ambiguous. Question 1, looking at the relationship between user need and service design, showed least change (0.6 improvement). This result is disappointing in light of the fact that one of the main target areas in which the team wanted to produce change was that of changing attitudes towards placing the clients' needs at the pivot of service design change. The author suggests that there was little detectable change in knowledge acquisition in this area because the students already had quite a good understanding of this before becoming involved with the project. There was little detectable difference in levels of improvement in the other areas (variation went from 0.8 to 1). Perhaps one of the issues here is of a change of understanding, e.g., did the students think they understood the principles of action learning before they started the project, but now have a different understanding of what this approach is?

### Changes needed to the overall approach

Many potential changes to the delivery of this interprofessional student group experience have been alluded to above, and have already been incorporated into action plans for future groups. This section refers to the need to see if the basic model of this approach needs redesigning.

The concept of learning by doing is the underlying ethos that permeates the whole of the RIPE project. It is the belief that models of service delivery are more readily taken on board by students if they are actively involved in using them in practice during training. The learning cycle outlined by Kolb (1984) stresses the need for students to reflect on their learning in order for it to be processed effectively. Among other things, this chapter sets out to see if this approach is actually effective for collaborative education. The section above gives some indication that learning did occur for most of the students, but this might also be true if the students were just participating in a classroom exercise together. What is it that this learning by doing gives, in contrast to an academic exercise?

Most of the evidence we have, that this approach has stimulated learning at a different level, is contained within the focus group write-up. Here we find the students alluding to the usefulness of pair-working while conducting interviews, and in analysing the situation. They also refer to the transferability of learning, from one practice situation to another.

The students also highlighted the learning that they gained around communication, especially around when and how communication breaks down. For the students, their work clearly demonstrated the importance of talking to the client to get a holistic picture of how services were interacting with each other. The students felt that being able to reflect on work in an interprofessional way enhanced their learning. This would indicate that there are distinct benefits of training students in this interprofessional way. Although there may be some adjustments necessary to the precise delivery of this method of interprofessional education, there was sufficient positive evidence from the students' comments in the handbook and focus group discussions to recommend continuance of the general approach.

### Local service improvements

Clearly it is too early to claim that there have been any significant improvements in service delivery. However, although the care pathways have not yet changed, one could argue that there has been a local improvement in the way the community mental health team seeks evidence for improvements. Clients have been directly approached for their own opinions. Even if many of these clients have not felt willing or able to respond, they are aware that their

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views are being sought. There is a growing awareness that they are the people who are the experts in the service, not the professionals. This is important learning for both the client and the key workers approached. It is the beginning of an ethos that puts the client at the centre of service design, not the professional.

Additionally, the work done by this first student group is a beginning. Further work has already been conducted, by a following student group, and it is hoped that within the year new, more accessible information will be available for young people with mental health problems in the locality.

### Barriers to learning

One of the main factors that limited the learning experience for the students was that of time. We had only a five-week period when all the students would be in placement at the same time. This is not long in terms of trying to set up some service improvements. It also does not give the group long to establish a relationship of trust and understanding, and to be able to jointly reflect upon their work. Having said this, the group did actually manage to achieve a great deal in a short space of time. The learning from this was that it was worth going ahead, despite some of the restrictions imposed externally. The team learnt that it was important to go with a less than ideal scenario, rather than wait for an unrealistic ideal. If one is to do interprofessional training in mental health there is a need to be opportunistic, and take chances as and when they occur.

Other barriers to learning have been alluded to elsewhere: students need to feel that there is a personal reward for their work, that it will be incorporated into their professional training, and will help them achieve a personally desired goal. In order to achieve this, the students mentor/practice teacher needs to have a good understanding of the work, and where it fits into an assessment schedule.

An additional factor is that students must have the capacity for abstract thought. They need to be able to conceptualise at the necessary level in order to understand some of the system concepts of the CQI approach.

### National implications

The logistical problems presented by differing placement times and duration have already been referred to (Sainsbury Centre 1997). Our experience in the RIPE project bears testament to these problems. It would appear that until these issues have been resolved at a national level, interprofessional training of mental health staff at a pre-qualification level will remain difficult. This study has indicated that most learning in the student group occurred with those students who were relatively inexperienced. Those students that had a lot of previous experience learnt less, and were less open to re-examining their perceptions of their work. Professional values are also acquired early on in a student's training, and once fixed, can be difficult to change (Kings Fund 1997). Given the above, it would seem that a national strategy for coordinating mental health training would be extremely helpful. This could allow for more pre-qualification mental health training, and promote the value of collaborative client-focused working early on in the professional's career.

### Conclusions and recommendations

How far does the student experience reflect policy changes in relation to mental health

The account of the students' work clearly shows how their work reflects national changes in policy. The students looked at the experience of people with mental health problems residing in the community. The views of these people were sought with a view to redesigning local services. This work was done in a collaborative, interprofessional way within the student group. The students were encouraged to set their work within a particular model of

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education?	working (CQI). This required them to consider the potential clinical effectiveness of their proposed changes, and what evidence they could present to demonstrate this.
Can this method of collaborative education be shown to be effective?	<p>The findings give a mixed picture as to whether or not this method of working can be shown to be an effective educational model. It appears that, for some students, there was a clear, positive change in their knowledge, skills and attitudes following their involvement in the RIPE project, whereas for others this was less so. For this particular cohort of students there was evidence to suggest that learning was directly linked to two significant factors:</p> <ul style="list-style-type: none"><li>▪ the level of commitment to learning expressed by the students;</li><li>▪ the baseline knowledge and experience of the student prior to commencing involvement.</li></ul>
In what ways can the delivery of this project be improved?	<p>Simple issues such as forward planning; prior dissemination of information and advance notification for the next cohort of students has been integrated into the next cycle of this project. More attention has been paid to student background. Students are now included only if they are actively involved in study. Additionally, attempts are being made to include the students and their mentors/ assessors in the initial project orientation. Particular emphasis is being paid to how involvement in this project will help the student meet the learning objectives of their particular profession. The student handbook is being updated, with simplified language, and will require fewer contributions from the student. Additionally, questions will incorporate changes of understanding, e.g., how has the student's understanding of interprofessional working changed since becoming involved in the project? It will also ask more directly about the students' plans to incorporate their learning into future practice.</p> <p>Other changes that are implicated are proving more difficult to resolve. It would be useful for the students to spend longer working together in this manner, but the demands of different courses currently preclude this. It would also be useful to have an established programme and expectation in the locality for all mental health students to participate in the RIPE programme. This would ease the administrative burden upon the RIPE project workers, and would ensure some level of understanding of the project in the locality.</p>
What are the implications this work may have in planning mental health training at a wider level?	<p>The main implication is that this type of client-focused interprofessional collaborative work can be shown to give some definite benefits. This project has established this in terms of developing a better understanding of the roles of other professions, and developing a more holistic view of a client's life. In other words, there is now some evidence that interprofessional training works, in terms of developing better interprofessional understanding, and in service improvement. However, doing this type of work is difficult, and requires a great deal of planning and preparation. This has resource implications. It requires the provision of adequately trained facilitators and administrative support. There are also logistical problems in getting interprofessional student groups together in the practice setting. These problems need to be ironed out within training institutions, and at a national level.</p> <p>Equally, the government has made clear statements about the need for client-focused interprofessional mental health training. If this agenda is to be followed, the various professional bodies involved in mental health training need to ensure that these elements are high on their list of professional requirements. This will encourage students to participate and learn more about projects such as the RIPE initiative.</p>
Personal learning	My personal learning while being involved in this project has been immense,

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and reflections

and has occurred at many levels.

As a practice teacher of social work, I feel that my initial involvement in this project was that of a 'token' social worker. I was there to aid the project's credibility as an interprofessional team. My other colleagues came from a health service background. Most of the work that I have studied in the field of interprofessional working echoes this stance: social work, being separately funded and managed, with a separate training structure, has a tendency to remain outside the main stream of interprofessional work. I find this trend worrying. This project has shown that it is possible to do effective interprofessional training, but that it is very difficult.

I also feel that by using this project for the focus for writing, I have learnt much more than I would otherwise have done. I have read far more around the literature, and have analysed the work more deeply. This has had considerable benefits in that I feel the ongoing work that we are doing in the RIPE project is better informed and is of a higher standard, and that my own professional attributes have increased. This mirrors the findings, where students actively engaged on studying worked better and learnt more. As with these students, my own sense of personal confidence has grown, and I have felt a commensurate increase in my own knowledge.

My work in this project has meant working with people with a wide range of skills, knowledge and power, from heads of mental health services to students at the very beginning of their careers. The range of disciplines represented has also been reflected in the range of jargon and policy background. I have felt able to engage and interact at all levels, translating from one specialism to another, finding common frames of reference with all involved. My own skills as a facilitator have increased, and I have had the chance to explore the beneficial effects of a basic ethos that I feel should underpin all interprofessional work, i.e., the establishment of mutual trust and respect.

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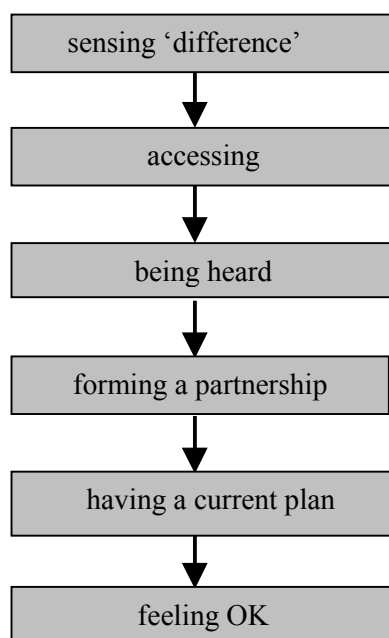
*Making it better*

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**Acknowledgement**

We would like to acknowledge all the students who took part, but especially Diane Yates who played a major part. We are also grateful to the service users that contributed as well as the Salisbury site practitioners.

Appendix A: Service user flowchart showing present mental health pathway.



## Appendix B: Current system for clients, showing mental health pathway from Appendix A

sensing a difference

- user's own perception that something is not 'quite right'
- user perceiving others
- peers noting difference in sufferer
- users perceiving that others are saying something
- knowing options
- fearing

---

accessing

- knowing routes to get service
- primary care referral via GP
- seeing GP
- attending A & E
- contacting social services
- offending
- seeing college medical services/welfare
- housing and social services
- being assertive
- behaving riskily
- discipline behaviour
- seeing social services emergency duty team
- contacting out of hours GP

---

being heard

- taken seriously
- offering primary health care time
- GP referring
- GP knowing appropriate services
- recognising need for time
- being aware of when to use the services, and their time constraints
- what types of problems should go to what profession
- need for good initial assessment

---

forming a partnership

- involving service user in planning, empowering
- matching service user to key worker, where possible
- sharing responsibility
- thinking creatively
- avoiding the development of dependency, maybe using education

---

having current plan

---

feeling OK

---

## Appendix C: Suggested schedule of questions for students conducting client interviews

The following questions are a guide to help you in conducting client interviews. They are not a compulsory list, and specific client responses may lead you to ask additional or alternative questions. The questions below do however cover the main areas of interest to the project team and should form the basis of your interview.

- Can you describe what was happening at the time when you first realised that things weren't right? (for example, depression, excessive anxiety or fear, mood swings, unusual thoughts and experiences).
- What did you do about it at the time?
- How long was it before you sought help?
- Who did you approach for help?
- If you sought professional help, how did you find out about it?
- Is there anything that could have made the process easier or more acceptable for you?
- What was good about your experience of the services involved?
- What was bad about your experience of the services involved?
- What impact has your illness had on your life?
- Are there any changes that you would like to see as a result of these experiences?
- Can you describe how your life has been affected since your first contact with mental health services?

Please prepare for your meeting(s) with clients by considering the interview schedule, deciding who is going to take the lead in asking questions, who is going to note client responses, and how you are going to write up the interview.

## The Andover site: The Stay and Play story

*Keith Brown and Jean Clark*

### Introduction

This is the story of the evolution of an interprofessional project to support 'isolated' mothers, and reflects on how the multiprofessional group worked interprofessionally using the principles of quality improvement to engage with the community and change the way services are delivered (Wenger 1998). Most significantly, this site report reflects the parents' stories and needs, and how they were involved in the project's evolution.

The Stay and Play project took place in Andover, Hampshire, from 1998 to 2001. The focus on child and family services formed one element of a National Health Service Executive project, the Regional Interprofessional Education Project (RIPE), with a combined focus on service improvement, interprofessional learning and collaboration.

### The learners and the learning process

The RIPE project was based on a fundamental belief in learner-centred experiential learning. An action learning approach enabled participants to identify their own needs, priorities and solutions, and it was anticipated that this would be done in conjunction with service users (Lave 1996).

### Methodology

The educational approach used was based on the model of continuous quality improvement (CQI), developed within the Institute of Health Improvement. The application of these principles within multiprofessional learning sets was the intended focus for the interprofessional learning. Quality improvement principles and a range of tools underpinned the teaching and learning delivery.

The basic principles of quality improvement followed were:

- defining a clear aim;
- understanding the needs of the customer;
- using data for decision making;
- continuously improving processes in iterative Plan-Do-Study-Act (PDSA) cycles.

While these principles guided the framework, more specific questions guided the approach of the facilitator within each setting.

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

This learning approach reflected a 'problem-based' orientation based on emergent practice issues and processes. The collection of data for service improvement was envisaged as an action research process, and the reflective element was seen as integral to this learning orientation.

This action research process drew on the influences of key practitioners such as Carr and Kemmis (1986), but also as a variant within a model of continuous quality improvement, viewing 'quality' as a continuous learning process based on service improvement.

Each 'action learning set' used action research principles, or a model of activity learning, in order to develop (or improve) the service being delivered. Existing practice-based working processes were used as a focus to the learning inquiry, applying steps in the quality improvement process, a PDSA cycle.

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The Andover group included a range of health and social care professionals, such as health visitors, the coordinator of the Early Years Centre and voices from a parent support group, together with the local voluntary organisation play leaders. They met for the first time in October 1998. The community orientation of the project was reflected in the first venue, a community hall. Within this setting the boundaries to the project were drawn up to focus on parents with young children.

Initially, the meetings focused on how to identify isolated families and what services were already in place that could be offered to them. During the multi-agency discussion it was found that many services existed but the means by which an isolated parent could access them was piecemeal. Discussion also took place on what experience individuals in the group had of isolated families within their areas of work, and what their perceptions were of what had reduced isolation for those families. This generated such questions as whether a 'professional' label was a hindrance or help, did people need to be accompanied to groups, were our perceptions usually right or did we make too many assumptions? It was felt that the way forward was to speak to parents directly, and ask them.

### Planning

When planning the CQI process there were a series of questions around definitions of 'isolated' people, or people in need who were not using services. Describing these groups of people proved difficult and prompted much discussion. It was agreed to look at all parents of children born during a certain period to ask them how they felt about services currently offered. The group size could be identified and managed by altering the ages of children. It was suggested that groups would be made up of approximately 10 families with children aged six months, two years and three years.

The next steps were to ask families identified by health visitors to tell their stories, describing how useful they found existing services, and exploring individual experiences of being a parent.

### Doing

Having agreed that three group members would each undertake a pilot interview of one parent with a child of three months, by January 1999 pilot interviews with two mothers of five-month old babies had been carried out. These were atypical of the proposed sample but from this an insight into understanding what it meant to be 'well supported' emerged. From this feedback slight amendments were made to the questionnaire.

This early work progressed. Names and addresses of a further nine mothers with six-month old babies were randomly obtained from the local birth register.

### Studying

At the April 1999 meeting feedback on planned interviews was available, although there had been some difficulties. Older children in the families meant that at least half the families didn't meet the sample requirement. Nevertheless the interviews provided some 'very interesting and illuminating' information.

Despite these mothers being familiar with the parenting experience, they considered themselves isolated, challenging some existing health professionals' assumptions. What was particularly striking was that mothers felt isolated not because of socio/economic factors or location of their homes, but mainly because they had few friends. This was particularly so of those mothers who had stopped working at the birth of their child and who had thus lost contact with their 'work' friends.

*'They were saying things like they wanted to join a parent-toddler group but felt unable, unwilling, frightened to join a group because they were cliquey, or they didn't feel confident*

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*enough to walk into a group. One person had had a previously bad experience with professionals because of one of the children beforehand and therefore was very wary of professionals. Another person was saying how hard she found it being a mother of a child, [more] than she thought it was going to be and so [there was] a whole series of potential issues to consider.'*

It was apparent to one participant that even a small data sample very quickly provided rich information, and in this instance enabled the group to see things from new perspectives and be willing to accept the implicit challenge of changing practice, which inevitably required 'unlearning' situated practice. This participant added:

*'I think particularly that was helpful for the health visitors, helpful in helping them move away from their pre-prescribed way of doing things.'*

Action: make a change

The perception was that parents needed somewhere to go with their babies that could provide stimulation for the babies and support and advice for parents in an informal setting. How could that facility be offered within existing practice, or how could practice be changed to provide that model?

The learning issue (or problem) arising from this concerned the practicalities of setting up a different role for health visitors. One voice from the voluntary sector offered a solution. An existing play scheme run by a group called Partners, encouraging and supporting parents in their role as their children's first early education providers, had created opportunities for parents and carers to meet with others and encounter resources to meet with their individual needs. The group agreed that the health visitors could visit the existing Partners scheme to offer themed advice for parents. Mothers would be able to attend with their children and Stay and Play workers would demonstrate and model different play activities. At these sessions parents would be encouraged to play with their children and explore different modes and media for play.

Stay and Play met once a week in nearby primary school premises. The plan was to link the Stay and Play with a drop-in health visitor clinic and information point. Between 10 June and 15 July 1999 the first cycle of health visitors joined sessions at the existing Stay and Play scheme. There had been an initial uncertainty when health visitors discussed whether they should take the scales, seen by some as a 'badge of office' but also, as one health visitor later acknowledged, symbolising a link between generations. The question 'how much does the baby weigh?' was seen as a common link with many of the young parent's contacts, whether different generations within the family, peers or neighbours. The objective was to establish the needs of the service user and tailor services accordingly.

It was decided to aim this Stay and Play group at parents of 0-3 year olds and information was to be distributed initially by health visitors. The group was drop-in and therefore there was no idea of how many families to expect those first few weeks. Initially three mothers came with their children, and after four weeks this had grown to six. At first, with two staff and a health visitor present, we all began to wonder if it was a good use of our time and very limited resources. Several times during the RIPE project the question of 'why are we there, what do we get out of it?' was raised by the health visitors. There were many times when the Partners project staff said the same: 'we are doing all the hard, heavy work, using our limited resources, what do we get out of it?' But the group always felt that the more important question was 'what do the parents get out of it?' The only way to find out was to ask.

The verbal feedback from these six parents was excellent and gave the workers the momentum to keep going. It felt as though they had almost got the mix right, but all that was needed was the people! By Christmas 1999 attendance

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had risen to 10 families. When the sessions resumed after Christmas 15 families attended and by the second week back they had to spread into two rooms. Notes taken at the time recorded how parents had become aware of the group, some by word of mouth but for many by a talk given to their post-natal group by the play worker. These talks informed parents how children develop through play and parents were invited to come along to the Stay and Play sessions. Also significant in the notes taken at the time was the entry 'Health visitors joined in activities; seemed to be approached more by parents'. Records were kept of health visitors' comments at each session, which reflected both positive and negative thoughts. The sessions became more and more popular, with new people attending each week, until by July 2000 up to 30 families were attending each week so that in September 2000 an extra session was started in the afternoon.

Within the action learning groups possible evaluation strategies were explored and then, as agreed within the group, parents were asked to complete a questionnaire about the value of the sessions following the cycle.

### Study – key learning

From this cycle a range of learning points emerged. Health professionals learned the value of seeing children and their carers in a non-clinic setting, and of having their professional expectations challenged. There was an evident need to be open-minded. Those in the voluntary agency learnt from having health visitors present. It was agreed that in the next round of Stay and Play sessions health visitors would be present from the outset, in order that they might feel more a part of the group and not a 'bolt-on extra'. However, some health visitors still wondered whether attending the Stay and Play was the most effective use of their time. It had been agreed that for health visitors to attend a single session was inadequate, and future planning involved taking this into account. They agreed, therefore, to attend for three to four sessions at a time in order to build continuity and relationships.

The action learning group meeting prior to the 1999 summer break included health professionals seemingly motivated to repeat the learning cycle. In the next meeting in October 1999, planning was underway for a further series of Stay and Play sessions. The next PDSA cycle was to include health visitor input in the activity sessions from the outset.

The health visitors planned their next phase of activities, constructing them around a series of themes: the role of the health visitor; accident prevention; sleep; meningitis; health. As the project evolved it appeared that the issue for the health visitors was not merely about planning their time alongside the other members of the group and the mothers with their children, it was about their use of this time in a new context. A health visitor commented:

*'I didn't like standing on the sides looking awkward, so you go and involve yourself in the play and from that some of the parents actually ask you questions then, because they thought 'oh she's all right you know, I'll ask a question now', so it's building up some sort of relationship'.*

Practice is both situated and context-bound and planning for the use of that requires adaptability and flexibility. For the health visitors, learning to work differently was initially a complex, slow and tentative process, and at first there appeared to be some resistance. For some health visitors it was easier to be accessible to the young mothers on a more informal basis, but for others some discomfort was reported.

### Planning the next stage

The next Stay and Play sessions were to take place in a different part of the town. Planning for the next learning cycle included actions for off-line collaboration and activities. Leaflets about the Stay and Play were distributed to parents via the health visitors. An information exchange had begun in this



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embryonic collaborative practice.

In the view of a service manager it was important that the health visitors were seeing for themselves the nature and quality of the provision available within the voluntary sector. In establishing the credibility of its activities they were able to recommend the activity sessions to those with whom they were professionally engaged.

A sensitivity to evidence-based issues created an awareness among those involved in the group towards the need to generate (and sometimes measure) outcomes, also a constituent part of the CQI process.

*'If we are going to do these changes we need to show that they make a difference somehow.'*

Despite the fragility of the project a certain momentum had been gained and less support was required from the university team:

*'But all of a sudden now it's just happening and everyone's doing their bit and it's going OK.'*

A health visitor commented in relation to this momentum:

*'Well, the main thing is what is achievable. What is achievable, if people actually sit down and say, let's all get together, let's think about this and let's put it into action, so it's the achievement, how things can be achieved when, as opposed to talking about them and writing about them, how they can actually be achieved [so] that people can actually follow them up and put them into action.'*

### Involving the parents

The initial focus had been on 'isolated' parents. This service development was entirely experimental, as planning took place it was uncertain whether there was any demand for what they sensed was necessary. This presented another tension, an uneasy, uncertain challenge when much current practice was oriented towards working towards pre-identified objectives. It was unknown whether three or thirty mothers might be involved.

Parents attending Stay and Play sessions were extending the social support network, meeting socially for mutual support and activities such as swimming. Some parents had also put their child's name down for playgroup. The popularity of the activity sessions generated further critical questions to be addressed by the action learning group. Given their success, the question arose of how could new parents be trained to be involved in the activity session, and how could the project be developed further?

There was a suggestion that the parents attending the Stay and Play be asked to see if they would like to form a parents' committee and send two representatives to the RIPE committee meeting. It was recognised that a strong user voice was emerging, and there was no resistance to this idea, with professionals and users collaborating around the table. In due course two mothers and their children joined the action learning set.

*'You know, in other words, they're constantly confirming that actually they think it's OK now, whereas a year ago they were constantly asking 'what are we doing this for? I can't see the point, what are we achieving?'*

Both mothers attending the meeting spoke of improvements in their children, and the benefits and opportunities offered within the session. For some women it had been the first opportunity to meet with other young mothers.

One bilingual mother had spoken of using the resource to investigate language development for her son, who would be brought up able to communicate in the languages of both parents. Another German national began attending the group and both found it helpful.

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According to the parents attending the group, the main reasons for attending the Stay and Play session were the development of play skills, for children and for parents, and in reducing isolation. Benefits mentioned included teaching older children and learning to share. Both mothers mentioned having a child who finds it 'hard to mingle'. Referring to other users, they spoke of another mother of a 17-month old child who had become housebound. Having made an initial contact she intended to visit again. The group also became a contact point for mothers who would exchange telephone numbers.

Transport was an issue for young mothers. Some were able to drive but without access to cars in working hours. Stay and Play was in line with government policy emphasis on facilities in local community-based provision within 'pram-pushing distance', i.e., walking distance.

It was reported that 'people just turned up out of the woodwork' to visit Stay and Play. This was from a beginning when it was unknown how many people would attend, or whether there was any need for such a facility. From this beginning, with just two or three people attending, there had been weeks when more than twenty people attended.

The informal session style, with easy access to information, was appreciated by the users; it was seen to be about reassurance rather than the expressed 'not wishing to trouble' health visitors at more formal clinics where attendance was considered an unsuitable forum for asking questions. An informal approach by health visitors, making personal contact with mums, was appreciated. One user explained that, in the informal Stay and Play setting, a request for advice from a health visitor would not lead to individual feelings of failure if a particular strategy was unsuccessful with a baby, because instead another health visitor would be asked. They were considered to be a useful resource.

A community paediatrician attending one meeting appreciated the value of approaching mothers at the very early stages of attachment and bonding, rather than when children were two or three, by which time problems were already apparent. For existing agencies it was about having knowledge of the availability and use of existing facilities. For all those involved in the project there was a strong sense of personal commitment.

The questionnaire distributed in summer 2000 had been developed to obtain user feedback about the Stay and Play sessions. Responses were overwhelmingly positive, with mothers indicating personal benefits for themselves and their children. The popularity of the group had almost led to overcrowding within the activity area, and concern was expressed by some mothers, for the safety of young babies when many active toddlers were around. The response to this was to arrange separate morning and afternoon sessions, the morning being for babies and the afternoon sessions for toddlers.

The story continues. There are now five separate sessions across the town each week. News of the good practice has spread, with visitors from other areas seeking to emulate the model.

### **What has been achieved**

The outcomes have been plentiful, including gains in confidence, for both mothers and children, increased communication skills, establishing social networks and developing a repertoire of social and communication skills for use with children. The richness of this experience is not captured within simple outcome statements. Crucially, the social isolation identified by a number of people has been addressed, and a positive inclusive model developed.

Also there has been the rich learning of starting out on a project with no identified outcome measures at the beginning. Living with the uncertainty of 'will it work?', 'will anyone come?' taught the participants the value of using the CQI model and also being bold and brave together. The absence of a clear outcome measure at the beginning meant that the actions developed truly met the needs of the users, as these were 'their outcomes', as opposed to the

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professional outcomes.

This powerful learning and experience was also linked to the learning of how difficult it can be to change practice and systems (Wenger 1998). At times it felt that the health visitors would never feel that a change in the way they used their time could be of value. But the constant powerful feedback from the mothers gradually won them over until they too began to see the value of their contribution within the Stay and Play setting.

Thus, Stay and Play tells the story of how isolated mothers were supported and helped and how professionals changed their practice by listening to their clients. It also tells the story of how power and responsibility can be shared to enable all to grow and develop. It also serves to act as a reminder that the CQI model can be a useful tool to aid this process.

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## The Dorchester site: Learning on site and in practice

*Peter Wilcock, Andrew Webb, Judy Cowling and Anne Puffett*

### Introduction

This project of the wider RIPE project originated in discussions between staff from the Elderly Care Unit at Dorset County Hospital, Dorchester and from the Institute of Health and Community Studies (IHCS) at Bournemouth University. Funding was obtained from a successful bid for a grant from the NHSE South West for a project that integrated interprofessional education with continuous quality improvement.

The emphasis was on improving aspects of care considered important by service staff and service users. Learning about the professional education aspects of this was a key aspect of the project, also seen as being in support of the desired service improvements.

Four points to bear in mind are:

- that learners together addressed a specific health/welfare improvement issue, associated with a particular care group or service;
- that, if possible, identifying and agreeing the needs of service users/patients and their carers was an important part of the process;
- that the approach adopted to service improvement and its associated learning of how to do this was based on the principles of, and some specific approaches associated with, continuous quality improvement (CQI);
- that participants were willing to contribute to the learning and to share their experience of this project with others.

After initial discussions at a site steering group, it was agreed to begin with an interprofessional team on Day-Lewis Ward. This is a 24-bed ward that caters for the needs of older people who are acutely ill. The average length of stay during 2000-2001 was 7.8 days, with an average number of monthly admissions of 90 people. Broadly speaking, the focus was on patients who, due to multiple disabilities, were either already subject to repeat admissions or had the potential to be so. The general aim was to look at ways of improving processes of care and discharge/transfer and to reduce the chances of future inappropriate admissions.

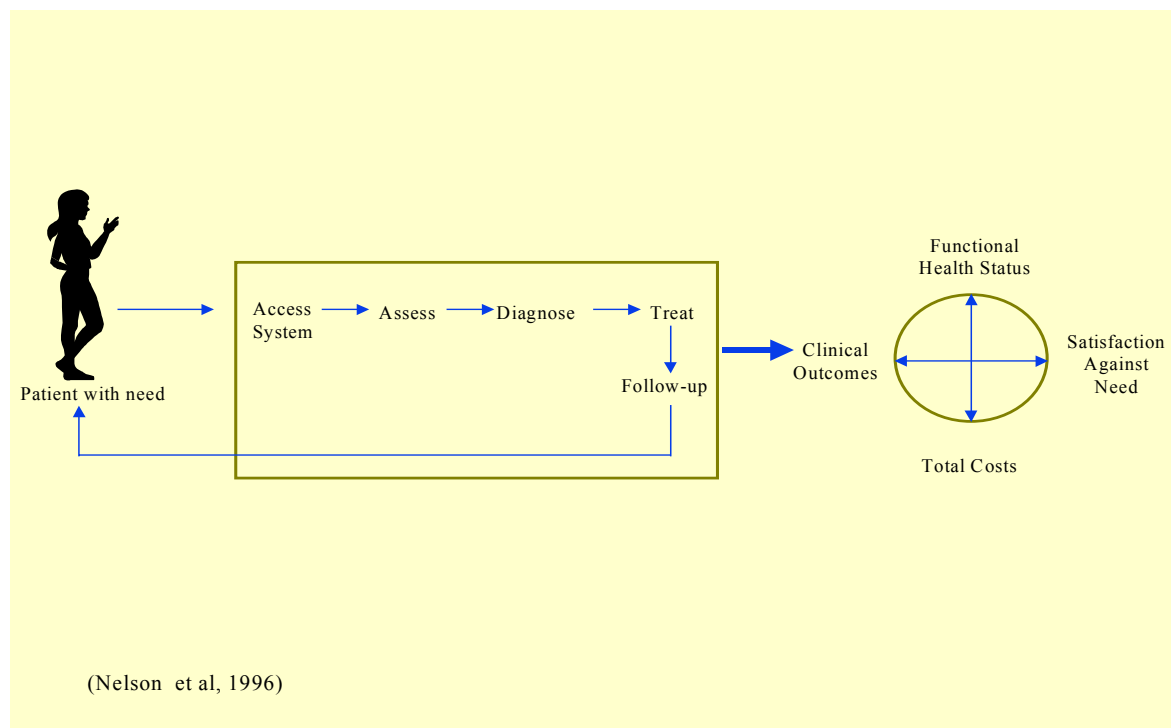
The team bore in mind a very simple model of care as the underpinning framework for their activity (Figure 1). This recognised that the patients had sets of needs to be met and outcomes related to these needs. The fundamental quality challenge for the team was to provide services that matched their patients' needs and that delivered appropriate outcomes. Quality improves as the match improves between our patients'/carers' needs and the services we provide.

Continuous quality improvement is a set of principles and methods that enables people to improve the processes and systems within which they work. At its core is the use of knowledge to identify changes, plan a test and assess the results (Langley *et al* 1996) (Figure 2). Its main driver is the desire, mentioned above, to improve the match between the services professionals provide and

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the needs of the people who depend on them. The principles and methods are currently the subject of much work within healthcare and learning from this work underpinned the team activity described in this chapter (Batalden and Stoltz 1993, Nelson *et al* 1998).

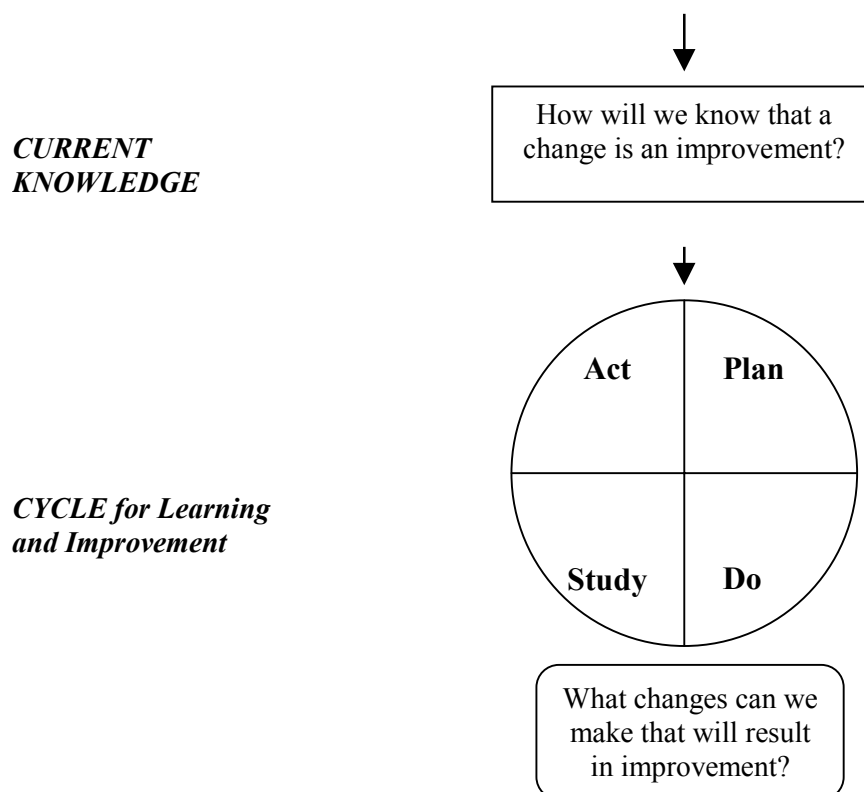
**Figure 1: The Model for Providing Care That Underpins Our Work**



**Figure 2. Continuous quality improvement model, from Langley *et al* 1996.**

*AIM*

What are we trying to accomplish?



The main steps of the CQI process were to:

- identify a specific group of patients as the focus for enquiry;
- agree a general aim;
- clarify what was currently known about these patients and their needs;
- describe the processes by which these needs were currently met;
- use what was learned from steps (c) and (d) to identify areas for improvement;
- turn these improvement ideas into specific actions with simple feedback measures;
- use learning from the feedback to design further improvements.

Approximately 12 months after the Day-Lewis Improvement Team began its work, interest was expressed in beginning a second team on another ward in the Elderly Care Unit. A small meeting of key ward staff was called and the consultant physician leading the Day-Lewis team attended and described their work. As a result, a team was established on Barnes Ward which also redesigned aspects of their ward practice. However, for the purposes of this publication, the story of the Day-Lewis Improvement Team will be told.

## The Day-Lewis ward story

### Beginning the journey

Following the initial meeting, an interprofessional team was established which met every six to eight weeks. Its membership comprised a consultant physician, a ward sister/clinical nurse specialist, a senior staff nurse, an occupational therapist, a physiotherapist and a social worker. Its beginning was the result of the energy and enthusiasm of the ward's consultant physician and ward sister/clinical nurse specialist.

At its first meeting, the nature of the improvement project was established and the framework for undertaking it was broadly described. The team's feeling

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was that they already worked well together, although they had not previously had the opportunity to meet and reflect on their work together.

After some discussion, they agreed two general aims:

- To better meet the needs of frequently and inappropriately admitted patients and their carers.
- To use the team's resources better.

The first aim gave them an explicit group around which to focus their efforts.

### Exploring what they knew about the current situation

Their discussion highlighted how little they knew about their patients' broad needs and, explicitly, about how things worked on the ward. Much of their team-working was based on implicit assumptions about who did what, when and why.

They decided on two strands of enquiry. First, to see what they could discover about their patients' needs, and second, to learn more about the processes of care on the ward. In order to achieve this they drew a flowchart of a patient's journey through their care.

In order to complete the first enquiry, they designed a short list of questions to ask patients as they were being admitted. This proved very difficult to implement in practice because, although they had decided to interview twelve patients and carers, the rate of admission of patients in their target group was very infrequent, leading to few opportunities for interviews. As an alternative, they later decided to try and complete the questionnaire at case conferences but time pressures constrained this as well.

To learn more about a patient's journey, they prepared a top down flowchart. This displayed the high-level steps of the journey and the sub-processes necessary to help each step happen. The final, full, flowchart illustrated the complexity of their service and the inter-relationships that were necessary between different sub-processes, or activities.

The dialogue that was generated between team members as they prepared the flowchart proved to be as important as the finished product. It became clear that different team members had many different, and untested, assumptions about how patients passed through their multiple hands. They discovered that they had several different ways of doing things and different ways of setting priorities. Perhaps the most important discovery was the difference between medical and therapy priorities and the impact this had on a patient's overall care. For example, patients were sometimes discharged or transferred to a community rehabilitation ward when they were medically fit but before it had been confirmed that they were functioning at a level necessary to cope after discharge. It was acknowledged that a significant factor in this was the pressure for rapid turnover and discharge in order to meet service demand as well as to use the resources of the acute wards most efficiently.

### Thinking about possible changes

During the team's discussions, many ideas for possible changes were raised and these were recorded on a flipchart as they arose, the 'Parking Space'. Once the flowchart and its attendant discussion were finished, the team brainstormed a long list of possible changes. After much discussion, they agreed that if they could improve the reliability and availability of information from each team member to all team members, this would have a significant impact on improving the care they provided.

They agreed a specific aim for their next step as:

- To ensure that relevant information only needs to be collected once, and is easily accessible on each patient's next admission.

This aim answered the first question in the Nolan framework for improvement shown in Figure 2 ('what are we trying to accomplish?'). It also provided the

## *Improving health and social care through interprofessional learning and practice development*

team with a clear and specific focus as well as guidance to changes needed. They next addressed the second Nolan question, 'how will we know a change is an improvement?' and answered it as follows:

- Patient information will be more complete and up-to-date.
- Staff will spend less time chasing each other for information.
- There will be fewer gaps in information at case conference discussions.

They agreed that the best way to check progress for the patient-focused objectives would be to build in reviews at case conferences. The staff measure would rely more on anecdotal feedback. The team reckoned that there would be additional spin-offs, since if things worked well, patients would only have to tell their story once and care plans would need changing less frequently due to additional information being made available.

This part of the improvement process is important because although all improvement requires change, not all change is improvement (Berwick 1996) and feedback measures provide powerful aids to learning that helps make this distinction in practice. Focusing in this way also helped the team become clearer and more specific about what they needed to do.

### Choosing changes

The third Nolan question asks teams to decide what actual changes they will make in practice. The Day-Lewis team members found that they had many ideas about what could be done, several of which reflected individuals' beliefs about how others needed to do things differently. However, the aim of this part of the process was to share the team members' best thinking and identify where they could change processes rather than people. They agreed the following main changes:

- Each team member will maintain a brief professional record in the ward Kardex.
- Team members will meet briefly each Monday morning to update each other.

Their aim for changing the Kardex was to make it the central reference point for information about patients and to make its assessment sheet the primary source of information for team members, as all staff would use it to record new information. The team also agreed to try and consolidate use of the assessment pro-forma to discover patients' needs, one of their initial strands of enquiry.

### Implementing the changes

The team used the PDSA cycle to guide them through implementing and learning from the changes. After making the decision to use the Kardex differently, individual team members agreed responsibilities to inform their own professional colleagues. It was agreed that a nurse would be identified to assume a coordinating responsibility for each patient. At this time, they realised that they were struggling with their efforts to learn more about their patients' needs. For pragmatism they decided to put this on the back burner and concentrate their energies on improving their chosen processes.

They planned their first Monday morning meeting at the quality improvement team meeting and agreed a time and date before ending the meeting.

Being mindful of the bigger picture across the hospital, they made contact with the manager leading a multi-disciplinary records initiative project to discuss how they were planning to use the Kardex. It seemed to them that there were obvious connections and an opportunity for joint learning.

### Studying the

The team used their regular case conferences to check whether the information



## results

available for patients was more reliable and comprehensive. They also decided to ask patients informally whether different professionals were asking them the same questions. When they met again as a quality improvement team, they were able to record that:

- The use of the Kardex by the team was slowly emerging.
- Gaps in knowledge at case conferences still existed.
- Monday meetings were very helpful.
- Specific questions about the quality of discharge letters had arisen.

It needs to be appreciated that this feedback was largely anecdotal but team members were able to relate to each other stories of how things had improved, even though it was acknowledged that progress was patchy. As an additional measure, they decided to audit patients who had been re-admitted within two weeks of a discharge and see what might be learned from this.

The Monday morning meetings were considered a positive success, allowing more sharing across different professions, leading to better care planning, less chasing of each other for information and improvements in relationships between team members.

It was agreed that the trend was in the right direction and that it was worth continuing with the changes. Thus the 'Act' part of the PDSA cycle for these particular changes was to maintain them in practice.

## The next improvement cycle

The team spent time trying to identify appropriate outcomes using the Clinical Value Compass (as described in Wilcock and Campion-Smith, this volume and in Appendix D). This proved to be a very complex exercise, partly because the concept of outcomes in the form of 'cure' was not really relevant for the particular patients they were considering. However, the discussion that was generated helped them think further about what they were trying to accomplish for their patients and they came to the conclusion that one important outcome was to provide information that would enable the next team caring for a patient to be able to meet their needs better.

Thus a new question arose about the quality of their discharge letters. It was decided to pick this up as a new improvement project and use the Nolan framework as a guide again. After further discussion, they clarified the question as being:

- Are patients well enough assessed and documented to help the next team taking over their care?

and turned this into a new aim in answer to the first Nolan question 'what are we trying to accomplish?':

- To improve the way we hand information on to the next team so that it is helpful and timely.

In order to learn more about the current situation, they decided to meet a local GP and practice nurse to discuss the value of their discharge letters and discover what would make them more helpful. They addressed Nolan's second question ('how will we know a change is an improvement?'), and decided that this would be achieved when:

- Discharge letters will be available on discharge and will reliably describe the patient's treatment and level of functioning, other agencies to which they have been referred and what actions were required of the GP after a patient's discharge.

The changes they decided to make that would lead to improvement were:

- Each team member will enter a summary directly on the discharge form.

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- Blank forms will be attached to patients' notes after discharge decision.
- Patients' notes will be placed in a specific tray in the ward office.
- Team members will check the tray daily.

They agreed plans to implement these changes and begin their second PDSA cycle. When they met to review the results, they concluded that:

- Implementation had been patchy.
- Properly completed summaries had made things easier for the junior doctors.
- Contents of the discharge letter needed to be revised.

There were still many incomplete discharge letters because team members had difficulty making time to write their summaries. They also frequently forgot to check the tray in the ward office because it was out of their way when visiting the ward to see patients. Feedback from the meeting with the GP and practice nurse indicated that the contents of the discharge letter needed revision and two members of the team agreed to undertake this.

One theme that emerged from their discussion was that confusion existed between team members about what the discharge letter 'process' was. They therefore prepared a top down flowchart for this specific aspect of their working.

The flowchart made it clearer what each team member needed to do and how it fitted into the overall process. It was hoped that this would encourage team members to implement the previously agreed changes.

At their next review meeting, they realised that they were still not checking the tray regularly enough and also that the revised discharge letter was not being used. Problems in finding time to write summaries persisted so that some patients were discharged before it had been possible to make the summaries available.

It was clear that the new pro-forma for discharge letters needed to be easily available and staff properly informed about them. It was also clear that the process needed to be re-designed, on the basis of what they had learned. The steps of writing summaries and checking the tray had put extra work into the system rather than reducing it. Bearing this in mind, a new flowchart was designed with fewer steps and requiring less energy and time of staff. Perhaps most importantly, it was designed to make use of what they already did and to more closely reflect their current processes. With regard to the former, it was decided that if team members had already written reports about the patient such as a 'discharge home visit' report, a copy would be attached to the discharge summary rather than writing the same information down twice. A copy of the revised process would be placed on the wall to serve as a guide and reminder.

They next addressed the Nolan question 'how will we know a change is an improvement?' and decided that:

- Discharge summaries will be consistently available and complete.
- GPs will find them relevant and helpful.

They decided to use their previously agreed measures to check progress at their case conferences.

- Discharge letters will be available on discharge and will reliably describe patient's treatment and level of functioning, other agencies to which they have been referred and what actions were required of the GP after a patient's discharge.

They decided to design a slip to attach to each discharge letter asking GPs to return it, indicating in their responses how useful it had been and what would

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have made it more so.

### Some reflections during the project

At the end of each team meeting time was usually allowed for team members to comment on the process they had just experienced. A sample of these reflections is included below:

Surprise at how limited our understanding is about how we make decisions even though we work well as a team.

Amazed at the practical detail that we've still needed to address even though we've been working together, and in this team, for so long.

We need time to reflect together, helped by someone from outside the team who can be objective.

The aim and agreeing how to approach it feels very positive.

I feel positive that we're trying to achieve something as a team, at long last.

Realising that there is not a right answer to everything has been important.

Focusing on real things, choosing concrete change ideas helped identify where the project is going.

'Systematising' things is not always the right answer.

We have agreed something practical; the Monday meeting will help us as a multidisciplinary team, and to organise and prioritise.

The way we make decisions depends on how we work together and also on external pressures.

If we can get collective responsibility for just this first step it will underpin so much more that we want to do.

We're making more of a difference than six months ago; is this because we've pulled it down to something we can all be involved in?

If we can get a significant enhancement in discharge information a lot of the work we've done as a team will be carried through and handed on to the next team.

We must avoid adding burden to everybody's working lives.

I feel encouraged we've come up with something that is sustainable when the project stops; it's an area we must get right.

A lot has come out; it has been a very clear demonstration of how teams need time to reflect together on how they work and how they can modify it.

The growing ability of the team to make explicit what has been intuitive and implicit makes it portable.

### End note

The importance of this story is that it illustrates how the team turned their work into an ongoing learning/improvement process rather than a one-off project with a beginning, middle and end. At the final facilitated meeting it was acknowledged that the staff group involved needed to be expanded, to strengthen the spread of improvement on the ward. This has been achieved by including other staff nurses and support workers in a new team looking to improve processes around consultant ward rounds. The consultant physician and senior staff nurse will provide facilitation with mentoring support from the

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original facilitator. In this way the cycle of improvement will continue and is becoming part of everyday practice on the ward.

Bearing in mind the very real work pressures with which they are coping, their decision to continue with team meetings suggests that they see time spent applying CQI methods to their work as an investment that will help them tackle these pressures.

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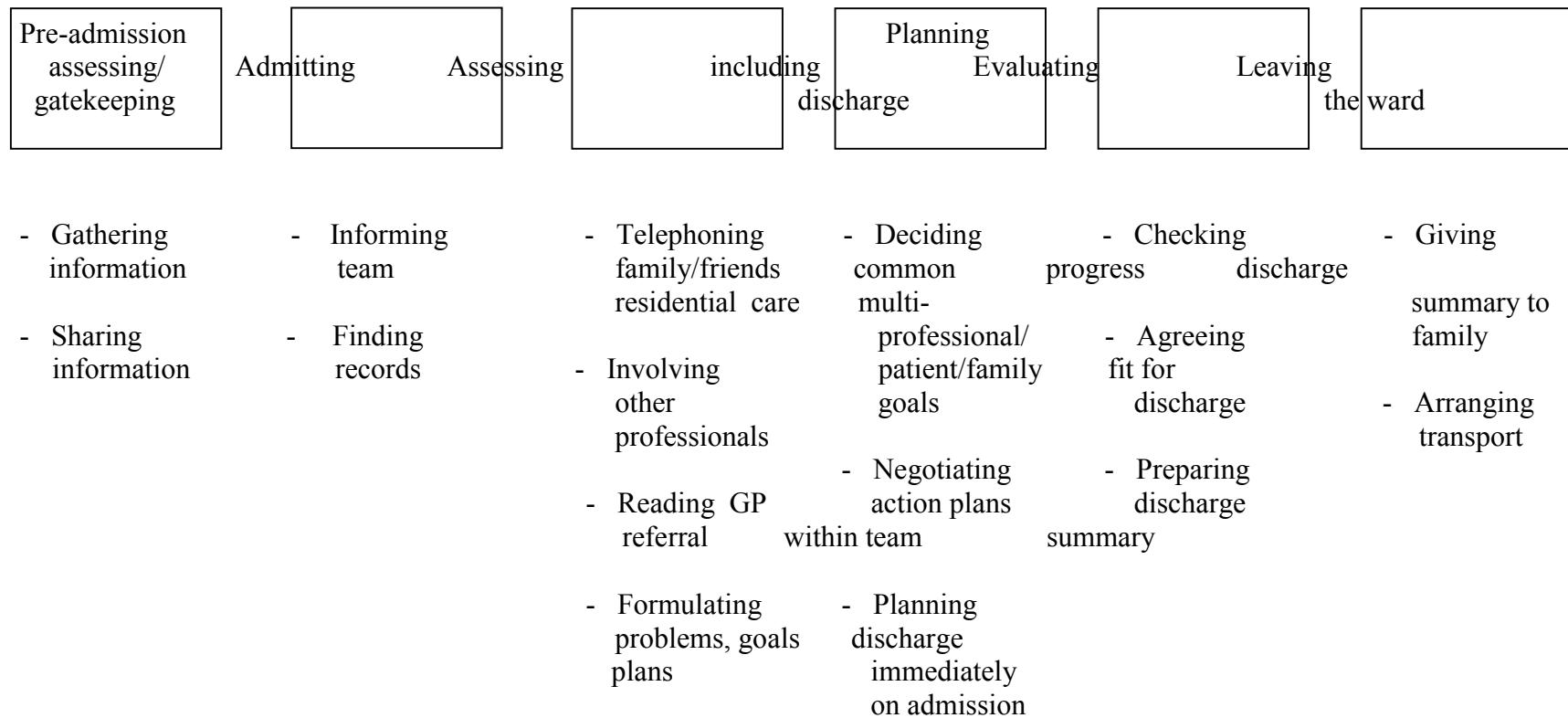
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### Acknowledgement

We would like to thank the teams from Day-Lewis and Barnes Ward at Dorchester County Hospital for their time, commitment and energy.

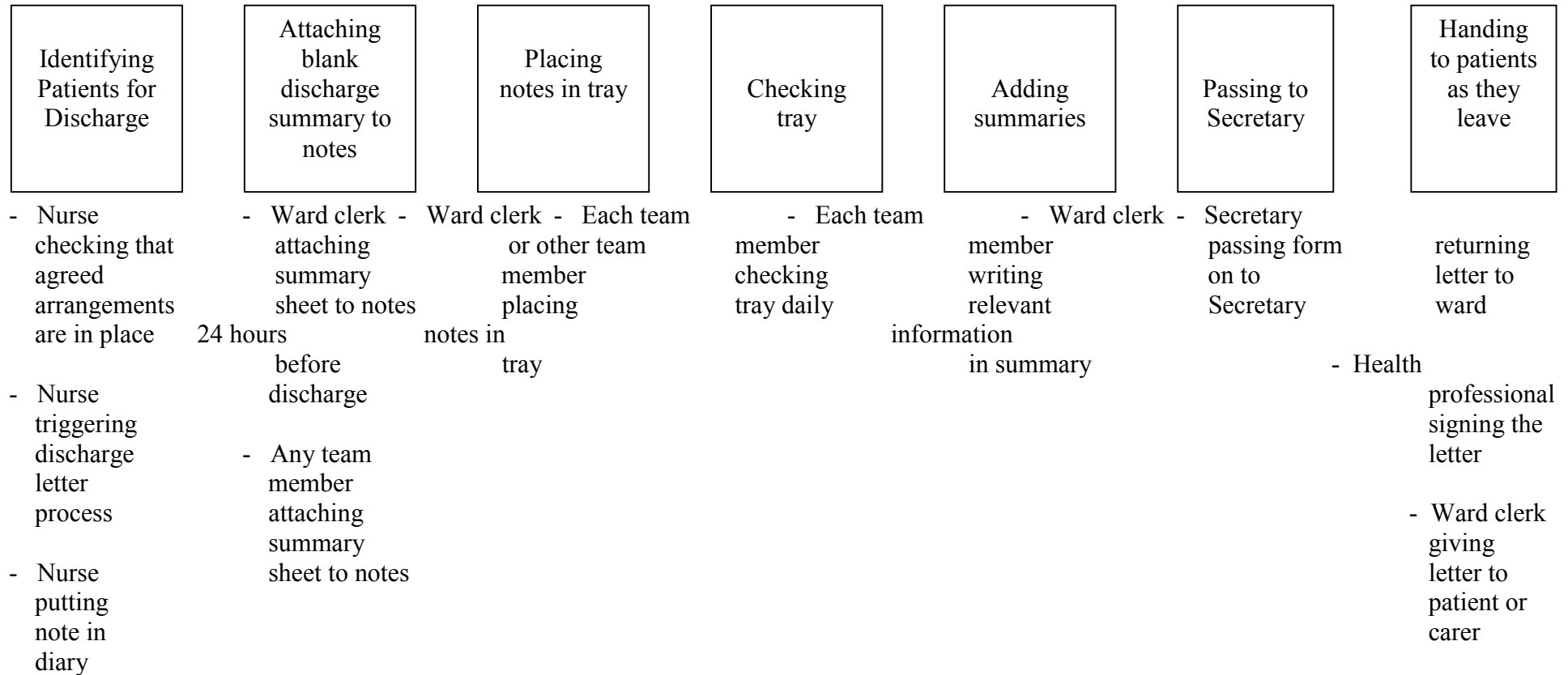
## Appendix A

### Overall Care Process



## Appendix B

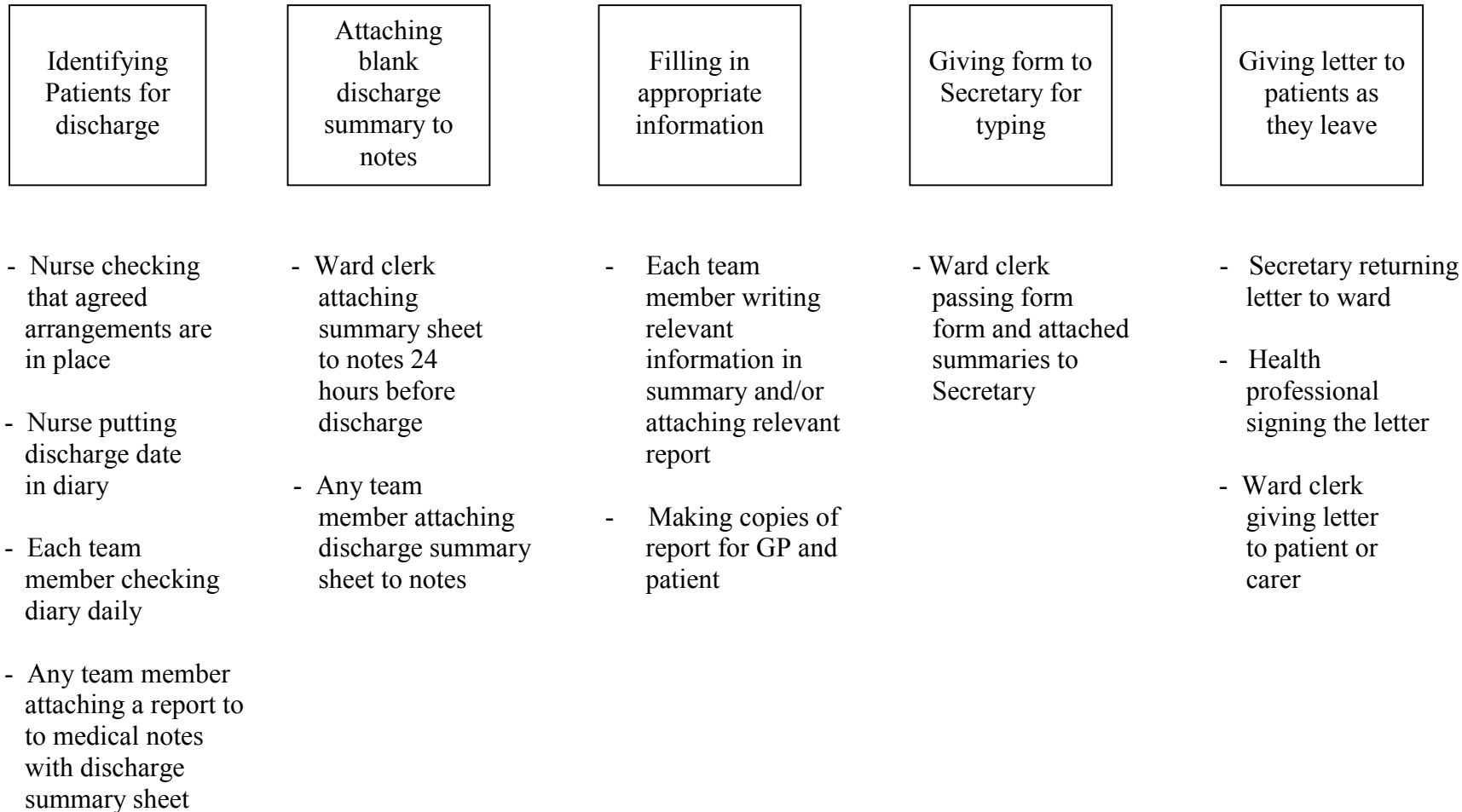
## Improving Discharge Letters



## Appendix C

### Revised Discharge Letter Process

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## Appendix D

### Balanced Set of Outcomes Measures

#### The “Clinical Value Compass”

*Day Lewis Ward, Dorset County Hospital*

##### Functional Outcomes

- Managing own care
- Less dependent on h.care profs
- Less disruption to lives
- Realistic lifestyle
- No unnecessary/avoidable re-admissions
- Living in appropriate home environment
- “slow down functional decline”

##### Clinical Outcomes

- *Don't miss treatable disease*
- Chronic disease better managed – improved symptoms
- Symptom control
- Pain ?
- L.O.S. (optimise use of DGH beds)

##### Satisfaction Against Need

- *Feel listened to and can tell story*
- Feel care is provided by connected professionals and agencies with shared info & goals
- Feel confident re competence of next stage in care process (eg. Com. Hosp.)
- Managing own care
- Realistic expectation – informed esp. relatives
- Know about and can access community services
- Support and equipment to cope
- Honest discussions with profs. re the future – patients and relatives
- Knowledge of post discharge possibilities

##### Total Costs

- *Lab investigations*
- Cost of inappropriate admission
- Transport costs
- Informal care at home
- L.O.S. costs
- Equipment
- Home Care
- Prescribing



## The Weymouth and Swindon sites: Dual-track learning

*Brian MacKenzie*

### Introduction

As part of the public health aspect of the Regional Interprofessional Education project (PHRIPE), two sites were chosen to attempt to measure and explore dual-track learning. The issue for the Weymouth and Swindon sites was teenage pregnancy: education, prevention and support, within the community and by NHS Trust and local authority professionals. Coordinated by university staff, experienced practitioners were involved in doing the work in which they were engaged within the context of some formal learning frameworks. They came together from the two sites in order to learn together and share their practice.

### Background

In 1999, the NHSE called for bids to support interprofessional learning in public health settings. The RIPE project at Bournemouth University was successful in gaining support for a three-year project with two strands:

*Providing interprofessional experiences in student placements.*

*Providing learning frameworks for work in which groups of experienced practitioners were currently engaged.*

The experienced practitioners strand of this project began in November 1999. Two multi-professional, multi-agency and multi-disciplinary groups, one each in Weymouth & Portland and in Swindon, came together to look at developing strategies to prevent teenage pregnancies. The groups met as a whole on a total of 15 occasions between November 1999 and June 2001. In addition, support was given to the groups separately on four occasions.

The project was complex in that it had a number of different frameworks around it:

*Developing skills for leading the health improvement agenda using the Ottawa Charter for Health Promotion framework.*

This is a World Health Organisation (WHO) framework for improving health. It sets out the five domains in which activity must occur in order for health to be improved: building healthy public policy; creating supportive environments in which to live; strengthening community action; developing personal skills; and reorienting the health services from the curative and clinical to the preventive and promoting.

If these are the domains of action, then what might we expect from someone who is working at senior level in health improvement, perhaps an advanced practitioner? If 'building healthy public policy' is the requirement, what skills or competencies would be needed to do that?

The practitioners involved in the Weymouth and Swindon sites of the PHRIPE project used a locally-developed articulation of such skills/competencies as a prompt in assessing their own level of skill, and a programme of workshops was developed to address the areas where significant numbers of people felt vulnerable.

*Assessing community capacity for investment in health, using the Verona Benchmark tool.*

## *Improving health and social care through interprofessional learning and practice development*

This is a developing WHO tool for assessing the capacity of nations, regions or communities to engage in the health improvement agenda (details can be seen at [www.who.dk/Verona/main.htm](http://www.who.dk/Verona/main.htm)).

### *Testing the application of Continuous Quality Improvement (CQI) methodology in public health settings.*

This tool has been shown to be effective in improving service delivery. We are attempting to test its application to population health improvement. There are reports of the use of CQI in community-based service delivery (Speroff et al 1998), but the literature is silent on its use as a tool in public health settings. It has been suggested that, with modifications, it could help health promotion organisations achieve their goals (Kahan and Goodstadt 1999).

### *Trialling the use of a postgraduate framework for accrediting practice.*

The PHRIPE project linked in with the development of a postgraduate programme in professional development (MAPD). This has pathways for nursing and midwifery, but also has a practice pathway that allows practitioners to gain academic credit for pieces of work that they are engaged in while in practice. (For example, an application to the Community Fund may involve the same degree of problem analysis, literature review for evidence of effective interventions, and synthesis of this into a concrete proposal that a postgraduate level assignment would have. Why not accredit it?)

Three PHRIPE participants have joined the first cohort on the MAPD practice pathway.

### *Using an interprofessional educational approach.*

The learning occurs in interprofessional settings, and one of the themes of the evaluation is to capture, distil and disseminate the learning about interprofessional working that occurs.

### *Encouraging the use of mentors, so as to develop mentoring skills.*

The public health issue chosen for the Weymouth and Swindon sites was reducing teenage pregnancies. At the time of the application, the Social Exclusion Unit's report on teenage pregnancies had just been issued (SEU 1999), and so this was a topical issue, for the area and in terms of policy development. An action point within the report was that local strategies would be developed to support the national one. It was clear that considerable work would need to occur, and that the PHRIPE project could support that work.

The project was designed to provide 30 days support over three years. In addition, practitioners could receive support to visit projects in other areas in order to learn about, and share, good practice.

## Participants

The participants in the group, when it began to meet in November 1999, included:

### **Weymouth & Portland**

- public health consultant
- family planning team leader
- director of youth & community services
- health promotion coordinator
- school nurse team leader

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- sexual health promotion officer
- social services policy manager
- community development worker

#### **Swindon**

- health visitor/primary care group board member
- family planning team leader
- public health specialist
- youth worker
- social services team leader
- deputy head teacher (running a mother & baby unit)
- sexual health promotion officer

By mid-2001, active participants (not all of whom were regular attendees) were:

#### **Weymouth & Portland**

- public health consultant
- family planning team leader
- health promotion coordinator
- sexual health promotion officer

#### **Swindon**

- health visitor/primary care group board member
- family planning team leader
- sexual health promotion officer

The project changed slightly in its delivery, and in October 2001 expanded local groups were supported in their locations, rather than trying to persist with combining the groups.

It was also possible that work might begin with a third group, focused on a different issue.

## **Progress in Weymouth and Swindon**

The two local groups continue to respond to developments in local policy. In Weymouth, for example, the Acute Trust was allocated funds for a school nurse to work in the area of teenage pregnancies. Local authorities were all required to produce a ten-year strategy and three-year action plan for the reduction of teenage pregnancies by the end of March 2001, and the groups operated in this context.

The original intention was to introduce the learning frameworks in an orderly fashion, so that they could assist with, and complement, the strategy development.

In January 2000, however, the Teenage Pregnancy Unit gave every health authority in the UK £15,000 to map the problems and services, and develop outline bids against a £6m national fund. It also gave Dorset and Wiltshire Health Authorities an extra £50,000 if they presented a plan to use it wisely. Both pieces of work had to be submitted by 1 March 2000. This had the (understandable) effect of focusing the health authority people on the task in hand, rather than good long-term process. As a result, the various frameworks were introduced more slowly than I would have liked.

There was, nonetheless, strong enthusiasm for the project among the participants.

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The first session focused on the Ottawa Charter competency framework, which was used to ascertain the content foci for following days. Subsequent days focused on assessing qualitative evidence, evaluation, community development, writing for publication, the Verona Benchmark, media advocacy and Continuous Quality Improvement. One session was held in Dorchester, so that the Swindon people could spend the following day looking at some of Dorset's youth advisory centres.

As well, the groups met separately in their business development. An evaluation framework was developed.

### Emerging findings and learning

Because the project continues, it is not yet possible to present a coherent account of its outcomes. The following points, though, seem to be important.

- Interprofessional working (as distinct from multi-professional working) occurs only when there is a blurring of professional boundaries - when the person is more important than the profession. In order for this to occur, there have to be high levels of mutual respect, trust, enjoyment of each other and learning from and about each other.
- Factors that led to the successful establishment of young people's advice and information services in market towns included:
  - the impetus for the work from the community and the voluntary sector, and flourished because of the quality of the people who were involved;
  - the importance of a powerful local individual or champion, usually a respected older woman with very good local connections;
  - the importance of involving voluntary agencies because they can tap into resources that statutory agencies can't, e.g., The National Lottery;
  - someone to keep the vision through difficult times, someone who feels an individual passion for their chosen cause and can communicate that passion to other people;
  - clear lines of accountability and job designations;
  - current practitioners to keep practitioners who become managers informed about what is happening on the ground;
  - good administrative structures and at least one identified individual who helps to pull it all together are required;
  - sharing information and skills;
  - coming to agreements over resources: Who has them? How are they to be shared? Practitioners may view resources as a battleground where they have to fight to get enough to meet the needs they have identified. *'To me it is a frustration because you can see what needs to be done but you don't have enough influence to actually get more money'*.

To be truly interprofessional there must be an integral relationship between working and learning. As one participant said:

*'I think the working is not really working if you are not learning from it. If you are coming together, and intend to do interprofessional work, if you aren't really looking at each other's professions and looking at what you have learned from each other and looking at how you can share information and how you can plan together then all that really involves a lot of learning anyway and so if you are not learning then you are not really doing it in a*

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*professional way at all; you are just meeting together.'*

### Other reflections

With hindsight, it was over-ambitious to attempt to run a project for such a long period, and with so many frameworks. The length of time meant that there was not consistency in attendance, because some people changed roles, and because of the constant pressure to attend to the agency's work agenda. As a consequence, not all the frameworks were introduced comprehensively (for example, the Verona Benchmark was used on only two occasions), and the combined group was running out of attendees when the CQI framework was introduced.

It might have been better to use a single framework for a shorter period of time.

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## The Boscombe PHRIPE project: pre-qualifying learning

*Rob Payne and Gillian Taylor*

### Introduction

This chapter describes the background to the Public Health Regional Interprofessional Education project (PHRIPE) in socially deprived areas of Bournemouth. Nursing, social work and community development students worked alongside communities and health care workers to develop initiatives and start up new projects for local people. They developed their own pre-qualifying skills and the local people gained the opportunities they wanted to improve their own health. Whereas the chapter by Collings and Hemingway (this volume) describes in close detail a number of the initiatives of the ACHIEVE project realised by the Boscombe community, this chapter takes an overview of the planning and learning methods experienced by the project team and the students.

The PHRIPE project is particularly concerned with interprofessional learning among pre-qualifying students and possible outcomes of their work for residents. The practitioners in Boscombe and West Howe who supported students had their public health role supported by the Practice Development Unit at Bournemouth University in addition to the input provided to them by PHRIPE's project team. As the project developed, the work was increasingly coordinated through the ACHIEVE project (the Academic Centre for Health Improvement and Evidence of Effectiveness: see Appendix 1, and see Collings and Hemingway, this volume). The two learning sets, the practitioners who facilitated student learning on the project sites, and the students on placement or having a placement experience, continued to meet under the guidance of PHRIPE. The ACHIEVE and PHRIPE projects can be regarded as interdependent pieces of a jigsaw describing an interprofessional and inter-sectoral public health learning programme. This includes the facilitation of learning, the development of practice educator skills, public health improvement project development and capacity building in local communities.

### Background

In its white paper *The New NHS: Modern, Dependable* (DoH 1997) the new Labour government set out its plans for NHS reform, which included improvements in public health as well as better quality public services. *Saving Lives: Our Healthier Nation* (DoH 1999a) goes beyond the approach adopted by the previous government in *The Health of the Nation* (DoH 1992). It included for the first time the commitment 'not only to increase the health of the population as a whole but also to improve the health of the worst-off in society and to narrow the health gap'. This agenda has also been informed by international initiatives towards defining health in a positive sense as both a fundamental human right and a social goal. The approach is exemplified by the WHO's *Health for All* principles published in 1981 and has been expounded at conferences from Alma Ata in 1978 to Jakarta in 1997.

The UK Government's agenda is now to improve access and choice of services, to modernise roles in order to support the new health strategy, and review the skill mix to support role developments that benefit the public. This includes sustaining and extending the public health role of

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health and social care professionals.

Nurses and social workers are particularly well placed to work with the public to address inequalities and social exclusion. Health professionals may develop and deliver health improvement programmes based on needs assessment.

The Government intends to implement a programme to develop the role of health visitors, school nurses and occupational health nurses as public health practitioners. This will enable them to support developments such as nurse-led walk-in centres offering health information, self-help advice and minor treatments. In addition, as health visitors' public health functions expand, midwives may work more closely with them, on both public health developments and expanded roles in women's health. Social workers too must review their role in preventive and community health as part of new partnerships within local health communities and as part of new intersectoral working arrangements. As part of this vision, integrated health and social care teams must be able to pool skills, knowledge and resources. They may also hold devolved budgets to plan care, training, recruitment and performance review.

The Government wishes to see more practice-based teaching and learning and more flexible learning pathways with more entry and exit points. Work will also be undertaken to boost teacher support for students on placements by creating new learning organisations and enhanced status for lecturer practitioners and practice teachers (DoH 1999b).

Personal and professional development plans need to reflect service needs and health improvement priorities. It is proposed that education should more closely reflect the needs of the NHS and local authorities and include more multi-professional learning and teaching.

### Project focus

This project is learning-centred, improvement-focused and health-gain oriented. The work being undertaken attempts to address one of the fundamental questions facing health and social care: how to combine *public health* clinical governance (in terms of the collection and dissemination of evidence-based practice), health improvement programmes and lifelong learning. The project is based on empowerment, community development and social inclusion. It targets local health needs and service priorities and provides health improvement learning sites as well as interprofessional education opportunities. Furthermore, the work combines research, education and practice development.

### Improvement

The project supports a range of improvement focused, resident-centred targets. Practitioners and students use continuous quality improvement methodology and plot progress using PDSA improvement cycles. Reflection and a learning culture underpin the project.

Health gain is a sustained improvement in the health status of disadvantaged groups. The Health Action targets are set and monitored annually. Health enhancement is pursued through a number of supporting strategies including community development, improving access to health enhancing activity as well as improving access to health and social care services.

### The Boscombe Health Action Centre

- Project period: 1999-2004.
- Setting: urban public health action area.
- Population: vulnerable children, young people and adults.
- Diversity: includes refugees, substance abusers, asylum seekers and a large Portuguese community.

## *Improving health and social care through interprofessional learning and practice development*

The Boscombe Health Action Centre is one of seven Public Health Action Areas in Dorset and related to a national network of Health Action Zones. These areas were set up to tackle poverty and deprivation, to reduce inequalities in health and inequalities in access to health services. All these areas have high deprivation indices scores (Office of National Statistics 2001).

Boscombe Health Action began by completing a series of community profiling activities and public consultation events aimed at engaging local people. This identified expressed needs (Bradshaw 1985) and priorities for health gain. The work supported local and national health improvement priorities particularly in the areas of:

- primary prevention of coronary heart disease (CHD);
- rehabilitation of those with established CHD;
- mental health promotion;
- mental health treatment and rehabilitation, in particular depression, domestic violence and substance misuse.

In the first year, 1999, the priorities set by the local community were to:

- improve access to affordable physical activity;
- improve access to healthy eating;
- improve access to information, advice and support for health gain.

A partnership of different organisations working in Boscombe put together a bid to the New Opportunities Fund to develop a Healthy Living Centre (DoH 1999c) to support health gain and to help individuals, families and communities meet their health needs and self-care deficits. Residents, community groups and voluntary organisations led and are leading the Boscombe Health Action programme.

The project contributed to health improvement work in these areas:

- public health action to build capacity and support social inclusion;
- the needs of children and vulnerable young people;
- family health;
- mental health;
- women and coronary heart disease;
- sexual health;
- men's health.

### **Interprofessional student learning in the Health Improvement Teams**

In response to the agenda for change and in order to develop new interprofessional learning opportunities in practice, students at the Institute of Health & Community Studies at Bournemouth University were given an option placement in a community setting (Payne and Ryden 1999). Traditionally, student nurses, for instance, would have been placed in acute care wards or community hospital or care home placements, so, for the first time, they were offered a placement that was health-focused, rather than focused on illness or disability.

Following an initial piloting session, students were offered placements in project work investigating and researching a potential health need within a deprived population area. Students formed teams of three and were charged with managing the whole project, facilitated by their university tutors and primary care staff. Their brief was to try to get in touch with the people in the area and capture their expressed and felt needs in terms of social and holistic models of health.

In January 2000 two social work students started a placement with the



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project in Boscombe and during February nursing students joined them. By March other health and social care students joined discrete areas of health action activity, for example, the information centre project and homelessness project. The 'improvement team' model allowed students to move away from 'shadowing' experienced staff in order to engage in more adult-centred learning. In improvement teams this might include evaluation of previous improvement activity, direct work with clients, undertaking specific project activity or contributing to the formulation of improvement planning and strategy.

### The role of the Primary Care Group

The primary care group (PCG) welcomed the involvement of student nurses. They were particularly interested in getting them involved with their health improvement planning group. In common with other primary care groups, they were finding it difficult to involve local agencies, and in particular the public, in health needs assessment.

The PCG wanted to use the work of the students and the learning achieved to inform the work programme for the coming year and the priorities to address when setting health improvement targets. In this way the learning would be valued not only by students but also by the PCG, as the learning gained would directly contribute to the health investment plan for the coming year.

It was also hoped that the learning for staff, tutors and students gained from organising an educational experience in health improvement planning, and from using a PCG as a placement, could then be used to inform future placement planning and, in the long term, curriculum development.

### Student experience

Students spent a total of eight weeks full-time on placement, including three tutor-facilitated study days. Two link lecturers provided mentoring for the students supported by staff from the PCG. Healthworks, which is the local community health promotion agency, also supported the work.

Students were given a base in the PCG office with access to a phone, computer and stationery. Students could also access PCG resource files, which contained background information about the local area and known health determinants from health and local authority data.

### Tutor experience

The tutors supporting this programme already had extensive experience of public health, primary and community health care. Both already had practice links with the locality and knew professional staff in the area. This helped the tutors to work with the project and facilitate learning for the students.

### PCG experience

The PCG was very open and supportive of the project and members went out of their way to accommodate the students and facilitate their learning. One of the tutors sat on the PCG health needs assessment group and was aware that the PCG had developed a very broad understanding of factors influencing health and health gain. In what was primarily a primary care organisation, the leaders of the health improvement project had worked to ensure that the view of health needs was not medically driven. One tutor was able to draw on experience of working with other PCGs that were much further away from this 'social model' of health.

### Outcome of the placement

The placement was evaluated by means of an open seminar with local stakeholders, an evaluative questionnaire given to students and informal discussion and feedback from the PCG.

Students were asked a series of questions, and a selection of their answers

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are given in bullet points below:

*What were the good points of the experience?*

- flexibility and freedom to plan, carry out and evaluate the work;
- a well-supported placement;
- being able to put research theory into practice.

*What suggestions would you make for changing the experience?*

- background reading before the placement;
- introduce new concepts early;
- more structure given for report writing.

*What learning have you gained through your involvement in the process?*

- communication and collaboration between professionals of different disciplines;
- team-working with colleagues;
- interpersonal skills when dealing with the public;
- presentation skills.

*How would you evaluate the learning experience?*

One student wrote:

*'I have thoroughly enjoyed taking part in the health improvement programme. It was not only something new but I also feel our final report was extremely beneficial, not only to the PCG but also the residents. Carrying out a project has been very helpful in integrating theory and practice. My communication skills have also developed.*

*The final presentation of our report was fairly nerve-racking, however I now feel prepared for future presentations and will hopefully feel more confident.'*

Overall, the students felt that the whole experience had been very positive, despite reservations early on. They commented on how they found it difficult initially to access community groups and residents to seek their views. One factor they thought was problematic was announcing their student status.

Students valued the adult learning style of the placement, in which they were given a high degree of autonomy and facilitated in developing independent learning skills. Students felt that the placement had helped them to consolidate and build on skills from their nursing programme. This included putting research into practice. Students were surprised at how much they were able to achieve and how many nursing skills that they could draw on to support the process.

Tutors felt that this approach to facilitating adult-centred health improvement learning could have major advantages for higher education and service providers. The learning set approach enabled two tutors to facilitate six students on placement with a high degree of mentoring and educational input, but a low degree of direct tutor mediation. The learning achieved demonstrated to a PCG that students don't have to be a burden to over-stretched human resources. Instead tutor-facilitated health improvement learning sets can be a tool to provide a new primary care placement model as well as much needed support with health improvement consultation, direct user/resident involvement and evaluative report writing.

The PCG was very pleased with the way in which the placement had been conducted and was happy to play its part in supporting students. PCG

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members particularly valued the opportunity to discuss the students' findings with them in the open forum. Above all, the PCG valued the evaluative report that highlighted the key learning and it was able to use this in its health improvement planning.

In addition the whole process helped to teach the university and the PCG how to value learning and support students to engage in health improvement programmes.

This work has already been used to inform the development of future placements based on the health improvement theme. The process and outcomes have also formed the basis of a successful regional funding award to support interprofessional education in public health (the PHRIPE project), which also involves experienced practitioners in Swindon, Weymouth and Portland working to reduce teenage pregnancies.

### Learning outcomes of pilot project

- Integration – bringing people together to work and learn.
- Broad base for work.
- Involving the community.
- Supporting work at grass-roots level.
- Bridging the theory-practice gap.
- Feedback of practical learning experience into planning.
- Supporting students out in practice.
- Sharing experiences.
- How different students are trained and educated.
- Making practice meaningful for students.

### Research strategies

Workers and researchers on the project attempted to capture the diversity of learning and health improvement through a variety of methods, and used their findings to inform education, research and practice development strategy. The PHRIPE project included funding for research to look at the nature of students' experiences and learning, and the research strategies developed involved the use of qualitative and quantitative methods. These included:

- attendance at both student and practitioner learning sets;
- semi-structured interviews with students and practitioners;
- negotiating access to students' reflective diaries kept while on placement and, in the case of some nursing students, the write-ups of their community visits.

In addition, questionnaires were developed to look at students' attitudes to interprofessional working, and the use of continuous quality improvement methodology within the project was monitored.

Research into processes and outcomes for residents were undertaken mainly by the practitioners who had worked with them and who therefore were likely to be better placed to deal with sensitive issues that might arise.

Currently (November 2001), a health visitor on secondment to the project for one day a week, spent time getting to know the women involved in the exercise class in Boscombe by taking the class with them. Under the guidance of ACHIEVE's researcher, she planned to conduct qualitative interviews to assist the women in articulating what they had gained from participating in project activities. In West Howe residents were encouraged to keep portfolios of their learning to help them realise how much they had learned through community initiatives in, for example, computer skills or from their involvement in community groups. Workers there also used a

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revised version of the curriculum development model. The original model had a hierarchical structure that documented progress from first contact with a group to helping to run it. This was developed into a spider diagram that the residents felt more comfortable using. This may be because a linear progression through levels framed residents' experiences in a particular way, one that directed them to look back to the time when they first encountered the group, when they may have been at a low ebb and felt powerless.

### Residents' learning and health gains

Outcomes from earlier research and anecdotal evidence suggest that likely outcomes for the women who attend the exercise class are profound gains in self esteem that flow not just from physical exercise, but from many other complex and interacting factors (see also Collings and Hemingway, this volume). Through the work of developing a Lunch Club in Boscombe and a range of initiatives in West Howe, project leaders believe that these projects produce benefits that go far beyond the obvious. These projects lead to real health gains and real learning about working together to combat isolation among young mothers and develop important skills, which leads to the building of 'social capital'. The provision of affordable crèche facilities has been a vital enabling factor in this participation for the mothers who attend the exercise class.

### Student learning

After this first phase of pre-qualification learning was completed, the evaluations from the students were very positive, and were shared with their peers through presentations and informal feedback. Two students from different disciplines also shared their work as part of the project team's presentation at a public health conference (Payne and Hemingway 2000).

The students reflected how interprofessional learning had changed their perceptions and understanding of health and social care. They said that they now looked much more widely at issues and in finding solutions to questions raised in their practice experience, learning captured via reflective portfolios and interviews with the project's researcher. Students also stated that they had gained a basic understanding of the CQI process, which they had used to plan and review their work.

Practitioners and practice educators who worked with the students also reflected on how the students' interprofessional experience had developed their own practice skills. The different practice placement models used were compared and contrasted. The public health placement was considered to give a broad and deep experience and an in-depth understanding, which clearly showed in the learning achieved by students.

However some concern was expressed that social work students might not be getting sufficient formal report writing experience on the project to prepare them for the demands of the statutory placement that they would undertake later, and this issue is now being addressed in the planning of future placements

### Social work students on placement

- Students felt that they were always treated with respect within the project as people who had much to contribute.
- The value of naiveté for them as first year students. 'Why must it be done this way?'

### Organisational issues

- Value of the placement in the first year for social work students as opposed to later on, arguments for and against.

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- Difficulties arising for student interprofessional working; 50-day block placements for social workers versus part-time placement for nursing students.
- Social work practice
- There was little social work involvement in the community.
  - Students felt that social work, as a profession, had been slow to take on new interprofessional ways of working.
  - They felt that power differentials between social workers and clients in interprofessional community-based placements were less than they would be on a statutory placement.
- Preventative versus crisis intervention ways of working
- Health visitors behaved in a similar way to social workers on assessments, e.g., asking similar questions and taking a holistic approach to health.
  - Public perceptions of different professional groups. Social workers may feel ‘damned if you do and damned if you don’t’.
  - Different public perceptions of nurses and social workers. Latter sometimes seen in less positive light than nurses.
  - General negative public view of social work, especially child protection work and ways to overcome this by working in an equal way with clients.
- Interprofessional learning issues, seeing the crossovers, seeing the gaps
- Learning from nursing’s theoretical models and recognising their value for social work practice.
  - Learning from health’s perspective and working in a preventative way e.g., emphasising healthy eating, exercise, community involvement and social networks and realising the implications of these for social care.
  - Learning one practical justification for interprofessional working; lots of money wasted by duplicating uni-professional work and assessments.
  - More consistent emphasis on anti-discriminatory language and anti-oppressive practice in social work in comparison with nursing training.
  - The excitement and rewards of seeing change in action.

A nursing student described her most significant learning while carrying out her community visits in Boscombe.

*‘Finding out about all the soup kitchens that were available for homeless people - I did not realise that there were so many and, as with the meetings, seeing how individuals from various backgrounds (i.e., healthcare professionals, council workers, social workers and public representatives) collated their ideas and different knowledge bases towards achieving a common aim.*

*It has made me realise that individuals and families finding themselves in adverse situations is not their own fault ... these people can think for themselves and do not like being patronised or told what to do by others who think that they know best. Instead they like to be asked what their own needs are, so that they and the helping agencies can work together for the appropriate kind of change.’*

Project management tasks to date have included:

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- coordination of a range of projects at the three sites;
- preparing practice and service development proposals to establish sustainable funding and programme activity;
- supporting and developing involvement of a range of practice, university, voluntary and statutory sector staff;
- education, training and support for the inclusion and development of residents and volunteers in the public health activity at each site;
- preparing reports of the work for dissemination of the learning;
- participation in the interprofessional collaborative activity including a local learning set (facilitated by the project leader) and regional learning sets and conference activity;
- supporting students out on placements or with their involvement in undertaking a range of public health project activity;
- contributing to the overall programme, its activity, profile and development;
- establishing, maintaining and developing a project database;
- participating in project development activity assisting the project's practice-based coordinators;
- supporting the team in data collection, analysis and report collation;
- assisting in the development of education and project materials to support the work and learning of the project.

### Levels of student and tutor participation

Nursing, social work and community development students have taken part in the project so far. Although the numbers to date for social work and community development have been low, it has predominantly been students from these disciplines who have had the most intensive project experience. They have been in the best position to benefit from the extensive community knowledge and mentoring from the placement supervisor in Boscombe. Nursing tutors and practice educators have been very active but social work practice teacher involvement was limited in the early stages of the project. Formal involvement of a member of the social work department in the core project team was agreed to begin in September 2001 in the hope that this would facilitate further student involvement.

Community development tutor involvement has been restricted to learning set participation, although a community health promotion worker has participated in the learning set and practice-based projects. A midwifery tutor has taken part in the learning sets but no midwifery students have been involved in practice. A meeting has been held to discuss the potential for a specialist registrar being linked to the project as part of their learning programme but this is subject to funding and local support from GP practice educators. No medical or PAMS (professions allied to medicine) students have participated in the learning programme to date.

Student learning has mainly been restricted to the Boscombe Health Action Area, with limited student involvement in West Howe due to a lack of practice teacher support. Students also found it more difficult to access community members here, possibly because West Howe tends to be a more static and enclosed community than Boscombe. There has, however, been student learning supported at a satellite site in Townsend.

### Project outcomes

- Health action project centre.

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and successes (see Collings and Hemingway, this volume)

- Learning centre for public, students and local professionals.
- Family health advice open access sessions.
- Women's health project run and evaluated.
- Five public health placements, 20 pre-qualifying students supported receiving direct mentorship and 50 students having a public health learning experience.
- Public health placements for social work students.
- Learning sets for practitioners and students.
- Homelessness project.
- Food project.
- Oasis project.
- Satellite centres established in Townsend and West Howe with major family health and interprofessional learning projects established.

Practice-based multi- and interprofessional education has enabled learners to reach a new understanding about the benefits of sharing roles and responsibility for health gain amongst health, social care and community development students and practitioners. The work to date has identified the potential for interprofessional learning to support workforce planning and integrated health and social care delivery. In order to work in new ways, learners and their practice educators are beginning to realise that they need to learn in new ways as well. The 'local improvement team' model adopted with a range of placement- and project-based student involvement has facilitated interprofessional learning and improvement-focused practice.

The successes to date have been due to the hard work and dedication of the project coordinators at Boscombe and West Howe and the many University and Primary Care Trust staff who support them.

The project has developed an exciting and innovative profile of research, education and practice development activity. It has also provided a basis for the personal and professional development of the lecturer practitioners who work within it and has supported others who have worked with the project. This includes support for two postgraduate dissertations, one on teenage sexual health, and one on women's views of pornography, and one doctoral thesis on the relationship between low income and coronary heart disease in women.

The work of the project has been central to the Healthy Living Centre bid in Boscombe and the Sure Start bid in West Howe. In addition, an interprofessional continuous quality improvement module has been approved within the University's Institute of Health & Community Studies as a result of this and other interprofessional initiatives, in order to help ensure the sustainability of the work. This learning programme will be offered to students as a third year option unit from Autumn 2003.

Dissemination of findings

Findings from the PHRIPE work to date has been published and reported at a number of national and international conferences (Collings and Hemingway 2001a; Collings and Hemingway 2001b; Hemingway 2001a; Hemingway 2001b; Hemingway 2001c; Hemingway and Collings forthcoming; Payne & Hemingway 2000; Payne & Hemingway 2001). The learning has been shared with other institutions that have also received NHS funding to develop interprofessional working. As part of this collaborative, which involves several universities in the south west of England, a major report will be published in 2003. The dissertations and interim doctoral findings of students involved in the projects, will form another basis on which to publish and disseminate the work.

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### Main challenges and the response

A number of issues and challenges arose during the project that needed to be addressed, including:

- Developing a clear work programme, which responds to the health needs and health improvement priorities of the local population (accountability agreement).
  - A review of current resources available and equity of access across the project sites (asset profile).
  - Identifying project resource needs and development plans, including mobilising human and physical resources i.e., staff and space (capacity building).
  - Commitment of stakeholder organisations to develop the project (ownership).
  - Models and frameworks on which the work is based (clinical governance).
  - Presentation of the work to stakeholder organisations (reports and dissemination of findings).
  - Mechanisms for informing practice development and investment plans (sustainability).
  - Organisational and management structure necessary to take the project forward.
- 
- Integration of the project into ‘mainstream’ education and practice, including the development of new units of learning / course development; and widening involvement of local health and social care staff.

It was therefore decided during 2000 that the ‘Bournemouth Collaborative’ should meet more regularly and plan to manage a work programme that addressed the key issues for the project, identified above.

It was suggested that the following format might form a basis on which to meet to develop and review the work programme, as well as support staff and students in health improvement teams across the area:

- a monthly meeting of the ‘Bournemouth Collaborative’, the Health Improvement Learning Group;
- a monthly learning set for staff involved in the collaborative projects;
- a two-weekly learning set for pre-qualification learner support;

By December 2000 there was a range of public health improvement project activity across the Bournemouth locality. Boscombe developed work around a Healthy Living Centre bid to the New Opportunities Fund and West Howe had been successful in its bid for Sure Start funding. In addition there was a range of activity around improving food health across Bournemouth, including a project based at Townsend.

To create sustainable learning and improvement teams the interprofessional education team joined forces with the Bournemouth Health Improvement team. The new team had its first away-day in December 2000 and planned to work with the Bournemouth Primary Care Trust to develop an Academic Centre in Practice for Health Improvement. The team will continue to work closely with the Public Health Action area management teams, Sure Start and Healthy Living Centre management boards, as well as part of the Bournemouth Health Improvement strategy



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and partnership teams.

The work already enjoys the backing of the Bournemouth Primary Care Trust and Bournemouth social services and will be looking to formalise further joint working arrangements during 2001.

The Trust is interested in developing an Academic Centre as part of their education and training strategy and development of Teaching Trust status. The team has already held meetings to discuss this development and a conference for stakeholders was held early in 2001 with the support of Academic Centre teams in West Dorset and South Wiltshire.

## Appendix 1: An Academic Centre for Health Improvement in Bournemouth (ACHIEVE)

The regionally funded interprofessional public health improvement learning programme (PHRIPE) has demonstrated how working and learning in new ways can secure real health gains for local residents. In order for this work to be further embedded into mainstream practice there is a need to engage with sponsors in establishing a new operational structure to support the work programme.

The Academic Centre model has been pioneered in the United States and Australia, although there are also examples of this in other vocationally-based learning programmes, such as those in business studies and service industries. An Academic Centre is best understood as a practice-based part of an academic institution such as a college or university. It serves to support learning in practice as well as a range of research and practice development activity.

More recently there has been an Academic Centre in primary care established in West Dorset and a Centre focused on clinical governance in South Wiltshire. There is currently, it is believed, no Academic Centre specifically developed with a public health improvement focus.

There is a real opportunity to harness the resources and potential

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established by the project work to date to support health improvement working and learning in the Bournemouth area. This work could underpin future workforce development to establish the capacity needed to deliver real health gains as well as support more integrated health and social care working and learning programmes.

The Bournemouth Primary Care Trust and Bournemouth Social Services, as well as a host of community development, regeneration and health improvement initiatives have recognised the need to develop new programmes of working and learning which are inter-agency, cross sectoral and interprofessional. In its widest and most far-reaching context the vision is for a 'learning community' made up of an integrated system of 'learning organisations'.

For an Academic Centre to be successfully established it needs to be born out of a shared vision of what it might achieve and what its core functions would be. The Academic Centre may be part of the education and training strategy of the Bournemouth Primary Care Trust as well as part of a shared strategy for learning and integration across the wider health and social care community in Bournemouth.

The stakeholders need to be fully engaged in this development in order to help shape its strategic intentions and an operational plan to progress it.

The plan for 2001-2 is to continue to run monthly practice-based learning sets involving pre-qualifying learners from nursing, social work, community development and midwifery as well as residents and representatives from voluntary organisations. In addition there will be a learning set for practice educators run bimonthly. The frequency of both learning sets has been reduced in order to lessen the demands on the time of both staff and students.

The student learning sets continue to be open to any pre-qualifying learner in practice in the Bournemouth area, including those who have been studying at other institutions. To date 1<sup>st</sup> and 3<sup>rd</sup> year nursing students, 1<sup>st</sup> year social work students and 2<sup>nd</sup> year community development students have attended. Due to the sheer numbers of nursing students at the Institute this group continues to be over-represented. The project is currently reviewing ways of attracting more social work, community development and midwifery students to the programme.

Students will be supported in a range of practice settings but primarily from the Boscombe and West Howe public health action areas and the Townsend project. As the Bournemouth area has now recognised five locality areas there is an opportunity to link students from other practice sites. Students will continue to have one of two main types of experience:

- a public health practice experience;
- a public health placement.

Students will continue to be involved in work around public health action areas, a healthy living centre development and the Sure Start programme. These include 'drop-in' facilities, health information, healthy eating and physical activity projects.

During 2001-2 it was anticipated that the project would be able to support six students on placement and between 20-30 students in total gaining a pre-qualifying interprofessional public health experience. Students will continue to be supported in using continuous quality improvement methodology to develop their learning.

The public health lead for the Bournemouth Primary Care Trust was recruited to the ACHIEVE group, which is working actively with the Trust and social services colleagues to look at ways in which to develop this work into mainstream practice. The Healthy Living Centre bid successfully came through the first round (July 2001) and more detailed work was

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planned to develop it further.

### Future directions and sustainability

The challenge is now to increase the capacity for interprofessional health improvement working and learning as well as embedding the learning and working models used into mainstream practice. This will only be achieved through the active support of all stakeholders and by addressing issues that the project has raised.

The proposal to work closely with stakeholders to establish an Academic Centre for Health Improvement may provide an opportunity to further realise a shared vision for health improvement learning and integrated health and social care working. It will ensure that there is ownership of the work programme and the development of core resources to facilitate new working and learning models in practice.

This has been a recurring theme of the work to date in terms of continuing to support and facilitate learning, improvement and health gain. The Academic Centre model has helped to develop the ideas of the project team and strengthen alliances between the university, the Primary Care Trust and the local authority.

### Teaching Primary Care Trust (DoH 2001)

From this work and in line with national drivers including the NHS Plan and the development of Care Trusts, the project team is now supporting the development of a Teaching Primary Care Trust (PCT). The stated aims of the Teaching PCT are to 'develop a workforce not defined by professional boundaries, integrating care workers with overlapping skills who will work across traditional boundaries'. As part of the development of a learning organisation that will support the local health community, the focus will be on facilitating opportunity for joint training and development of staff.

The teaching PCT will provide a multi-agency learning resource centre, a public health skills programme, generic practice educators to support integrated health and social care teams and improved public health through strengthening partnership-working practice.

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## The Boscombe PHRIPE Project: Working with families, not for them

*Ginny Collings and Ann Hemingway*

### Introduction

This chapter describes one of the sites of the community-based health improvement project in Boscombe, Bournemouth. This work is part of a public health improvement project based in three sites in Bournemouth: Boscombe, Townsend and West Howe. Two of the three sites (Boscombe and West Howe) are local Public Health Action Areas. Each site has a project coordinator whose post is jointly funded by Bournemouth Primary Care Trust and Bournemouth University. Whereas the chapter by Payne and Taylor (this volume), took an overview of the planning and learning methods experienced in all three sites by the project team and the students, this chapter describes in close detail a number of the initiatives of the ACHIEVE project realised by the Boscombe community and the students.

The ACHIEVE (Academic Centre for Health Improvement and Evidence of Effectiveness) project arose out of a need to review health visiting services in one local area. In addition there was a desire among local practitioners to link service development to the expressed need of local residents. It is now jointly funded by Bournemouth University's Institute of Health and Community Studies and Bournemouth Primary Care Trust and is supported by Abbey Life. The work has also been supported through regional interprofessional education and research funding.

The Boscombe team of workers is made up of residents, volunteers, university staff, local family workers, private business staff and statutory agency representatives. The project is based on health improvement through empowerment, community development and social inclusion. The work combines research, education and practice development. It targets local health needs and service priorities. The project contributes to health improvement work focused on building capacity and promoting social inclusion. The project work concentrates on these areas of health improvement: family health and well-being; mental health and well-being, and; coronary heart disease prevention.

The ACHIEVE project has many strengths:

- a multi-professional approach to service delivery;
- student placements for a variety of disciplines (nursing, social work, community development, GP trainees);
- the project provides community-based learning opportunities for students providing a multidisciplinary arena for experience and application of theory;
- the students gain experience in working with local agencies and private business and work alongside residents to develop the project further;
- the residents in each area are provided with learning opportunities through their support of the project.

The project coordinators (one for each of the three areas) also practice as health visitors within these local communities, which gives them an intimate knowledge of issues affecting health. It also enables the project to gain the most from their strong existing interprofessional networks and has

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enabled the development of a public health-focused health visiting practice model. This model may, through evaluation, ultimately prove useful for the future development of health visiting practice, locally and nationally.

The project has several research projects attached to it, supported by the university. In Boscombe there are currently three studies. One is an investigation of older people's eating habits while living at home. Another is considering partnership working to prevent coronary heart disease, and in addition there is an ongoing evaluation of the exercise component of the project.

Various services are currently offered by the project, and are actively supported by local residents:

- easily accessible exercise and crèche facilities for local families (£1 per session);
- a weekly lunch provision with opportunities to learn new skills and access cheap healthy food;
- a 'walk-in advice centre' and the development of a community information newsletter to meet the needs of local residents;
- family drop-in sessions to offer advice and support;
- a variety of specialist skills in public health, child and family health, education and research.

### The exercise group

The 'Bums and Tums' group was set up in response to local residents' requests for cheap, accessible exercise opportunities with crèche facilities. The sessions are run in the local community centre and are both managed and taken by residents who have trained as fitness instructors. They are suitable for all levels and cost £1 per session, which includes crèche provision.

Two local residents who trained to be instructors are now confidently running and developing the classes and four others have been involved in the group as administrative support workers. Two more residents are planning to train as fitness instructors.

The sessions are fun and informal and health professionals are available for advice and support. Residents have found them to be socially rewarding and an opportunity to get fit. The crèche has catered for children aged between a few weeks and five years and is run by trained crèche workers (supported by local social services). Some of the individuals who initially attended the exercise class have now gone on to do further training in order to work in the crèche. The crèche also provides a voluntary placement for a local individual with learning disabilities, an arrangement which has proved to be a very positive experience for all involved.

### What a local resident says

*'To be honest, two years ago I never imagined that I would have the opportunity to exercise, that I have today. This is all thanks to the 'Bums and Tums' classes that I began when they started in spring 1999. To explain my situation, I am a very busy mum who looks after two young children aged four years and 18 months and also works 22 hours a week, mainly in the afternoons. I can't drive and have no family living in Bournemouth who can watch the children or give me 'some time for myself'. The classes began at an ideal time for me, my daughter was just four months old and I was ready to tone up my flabby muscles.'*

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*My child-care is split between myself and my husband, meaning that as soon as he comes in from work I have to leave to start my shift, subsequently the only way I would be able to exercise would be if the classes provided a crèche. Secondly, as I am unable to drive, the classes would need to be within walking distance, or else I would be looking at a dreaded bus journey! Finally the classes would need to operate within an affordable budget, with a young family we simply can't afford the luxury of expensive health clubs.*

*'Bums and Tums' fulfilled all these criteria for just a pound. It gives me the opportunity to exercise, meet other mums and give me a well-earned break away from the kids! It has also been a wonderful chance for my children to mix with others and to benefit from the company of other adults. In conclusion, today I couldn't imagine life without my weekly 'Bums and Tums and I feel lucky that in Boscombe we have such a brilliant facility provided for us.*

*I began attending 'Bums and Tums' because I had been to aerobics previously and had enjoyed the class. I was told about the classes by my health visitor and realized that it would also be an opportunity to put my son Tai in the free crèche for an hour and have some time to do something for me. It also gave me the chance to meet other mums, which was what I needed. I thoroughly enjoyed the classes and it gave me something to look forward to every Friday, as it was the only real time I had for me. When the classes expanded to both Wednesday and Friday I began attending twice weekly.'*

What the resident instructor says

*'After a year I was approached about training to be an instructor and I jumped at the chance. Not just for the chance to teach, but also to give something back to the group of people that had given me so much. Since starting at 'Bums and Tums' I have changed as a person. I have gained in confidence immensely and it has helped me learn to communicate with people, which I found so hard before. I now teach the Wednesday class and I have found so much support and encouragement from everyone and I feel truly close to everyone. It is such a relaxed and comfortable atmosphere that people can come along and not feel self-conscious because it's not a room full of skinny women in leotards. We are normal women who just want to keep fit and live a healthier lifestyle. My fitness has improved immensely and I can relay that back to the women, that when I first attended I could do about five sit-ups and now I'm teaching the class. I believe that it has benefited me greatly. I love it and it's more than just an aerobics class to me.'*

Family lunch

Access to cheap, healthy food was one of the three priorities highlighted by residents during a public consultation day held in the local shopping precinct in October 1997. The first planning meeting for the food project was held in 1999 with local residents, health visitors, family workers, a local restaurant owner and a dietician. The Boscombe Family Drop-In, a local facility for homeless families, was considered as a venue and the group shared ideas and views on provision. Subsequent meetings were arranged with families to find out their views. It was agreed to start a lunch club at the Drop-In in October 1999 charging £1 for a meal with children

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eating free.

The first lunch saw 18 adults and 14 children enjoying a delicious meal ably cooked by the volunteer cook assisted by residents. Since then the project has continued to provide a wholesome cheap lunch that can be copied by families at home, and on average 12 families sit down together with family workers, health visitors, students and researchers. There have been opportunities to learn more about food hygiene, nutrition and organization. Four residents have successfully completed their basic food hygiene certificate with the local Environmental Health Officer using the lunch as a learning base, and more training along these lines is planned. Various topics have been raised over mealtimes such as faddy eaters, food allergies and temper tantrums as well as housing, relationship difficulties and coping with stress. The project has the potential to contribute to the needs of some local families as a learning tool but also in the provision of cheap, healthy food. There is the opportunity to enjoy a family setting around the meal table as well as learning new skills and increased confidence with food preparation.

### OASIS

In November 1999 an 'Information and Advice' group was set up as part of the Healthy Living Centre bid, to concentrate specifically on investigating the information and advice needs of the local community. OASIS (One Stop Access to Support and Information Services) provides information resources under one roof and offers a range of information, advice and advocacy services to improve quality of life/health and well being of the community. The multi-agency team continues to meet on a regular basis and some funding has been secured. It is planned to have students from the university involved with OASIS.

### Links with business and Dorset Community Action

Dorset Community Action is a countywide voluntary organization and charitable company, which works to promote thriving, diverse and sustainable communities. One of the projects they manage is called Business Partners, which aims to link businesses with charities and voluntary organizations in Bournemouth, Poole and wider Dorset. Business Partners has facilitated a link for the Boscombe Project with Abbey Life, a local insurance company. Abbey Life have been able to offer photocopying and printing services and meeting rooms. The company is also actively supporting the OASIS project by being on the steering committee and providing project management and marketing expertise.

### Teaching and learning

The Boscombe Project has been able to make contributions to the teaching programmes at local family centres and the university as well as having the opportunity to present posters and papers with local residents at conferences. Working alongside residents has meant that the project team has been able to identify learning needs and facilitate opportunities.

Residents asked for advice on training prospects, volunteering opportunities and the project team located information about local courses and supported them through these.

Two residents have trained to be exercise-to-music instructors, including cardio-pulmonary resuscitation training. The project supported them financially by accessing funds from various agencies, and with child-minding arrangements, support, advice and encouragement.

Two more residents were involved in administration support and gained confidence in basic skills of organization and preparation for the exercise class. One of these residents, having developed her confidence and self-esteem through working with the project, is now working for a certificate in welfare studies. Her assignment is based on the links between postnatal



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depression and exercise.

The project's resident cook works on our food project and has been an enormous support to project workers and the helpers and has taught much about remaining calm under pressure and coping with minimum facilities.

What the project co-ordinator says

*'It's been extremely hard work but very rewarding and worthwhile. I feel the project has laid an important foundation for community development and an approach to health improvement, which is appropriate for this local community. The full potential is yet to be developed and will probably take a few more years, but the direction in which we work has become much more client-centred/client-led. Working so closely with clients I have learnt a lot and gained a lot of experience. I have probably gained more than I have given in experience and depth of knowledge. Now some of the hard work and 'stickability' is beginning to bear fruit we have got good resident involvement in both the exercise and food projects and a clear sense of ownership by residents. I feel the workers involved are beginning to gel and work well together. There is a real sense of individuals 'catching the vision'. The areas of learning for me are in team-building, project management, communication, time and budget management, prioritisation and the differences between rhetoric and reality. The project work has made a major contribution to the successful (first stage) Healthy Living Centre bid for Boscombe and there does seem to be a general acknowledgement now of what we are achieving.'*

Future development plans

In the future the project team is aiming to gain physical space for this work which needs to include space to provide exercise and nutritional facilities to the local communities in these three areas. It aims to offer opportunities for local residents to be involved in service planning and development and to continue to consider what will make a positive difference in peoples' lives and how it can help to make it happen. However the main focus for the project will remain exploiting this chance to be proactive and reflective with residents, instead of for them.

Acknowledgement

We would like to formally acknowledge, and offer our thanks for the effort and enthusiasm of all the residents and local agencies, whose support is essential to the project development.

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**PART 2    LEARNING TOGETHER:  
THEORY AND PROCESS**

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## Using the principles and methods of continuous quality improvement within the RIPE project

*Peter Wilcock and Charles Champion-Smith*

Continuous quality improvement (CQI) is a set of principles and methods that enables people to improve the processes and systems within which they work. At its core is the use of knowledge to identify changes, plan a test and assess the results. Its main driver is the desire to improve the match between the services professionals provide and the needs of the people who depend on them. These ideas are based on the premise that the foundation of quality is matching service to need and that quality improves as the match improves (Nolan, Undated). The principles and methods are currently the subject of much work within healthcare and learning from this work underpinned the team stories described in this volume (Batalden and Stoltz 1993).

Within the context of the RIPE project our general aim was to help participant professionals and pre-qualification students gain some understanding and knowledge of the underlying theory and practical experience of CQI implementation within a quality improvement team. We wanted to explore with them how the application of quality improvement theory could help them to improve everyday practice and at the same time respond to current government challenges to change healthcare. Thus participants were encouraged to examine approaches to designing care that crossed traditional professional and organisational boundaries and provided measurably better outcomes.

More specifically our objectives were to help participant professionals and pre-qualification students:

- explore issues around systemically linking people and processes in order to continually improve the match between the services they provided and the needs of their patients/clients;
- learn from practice as they used these techniques to plan and implement improvement of some aspect of the care they delivered;
- help develop their understanding of the relationship between continuous quality improvement and interprofessional learning and working.

We also hoped that members of the academic team would consolidate and deepen their own understanding as they gained experience of leading local teams.

### Methods

We considered and rejected the idea of extensive theoretical teaching of CQI theory and methodology at the outset, as we had a group of professionals who had come together because they wanted to change and improve clinical services. Bearing in mind principles of adult learning we chose to help them learn while 'on the job'.

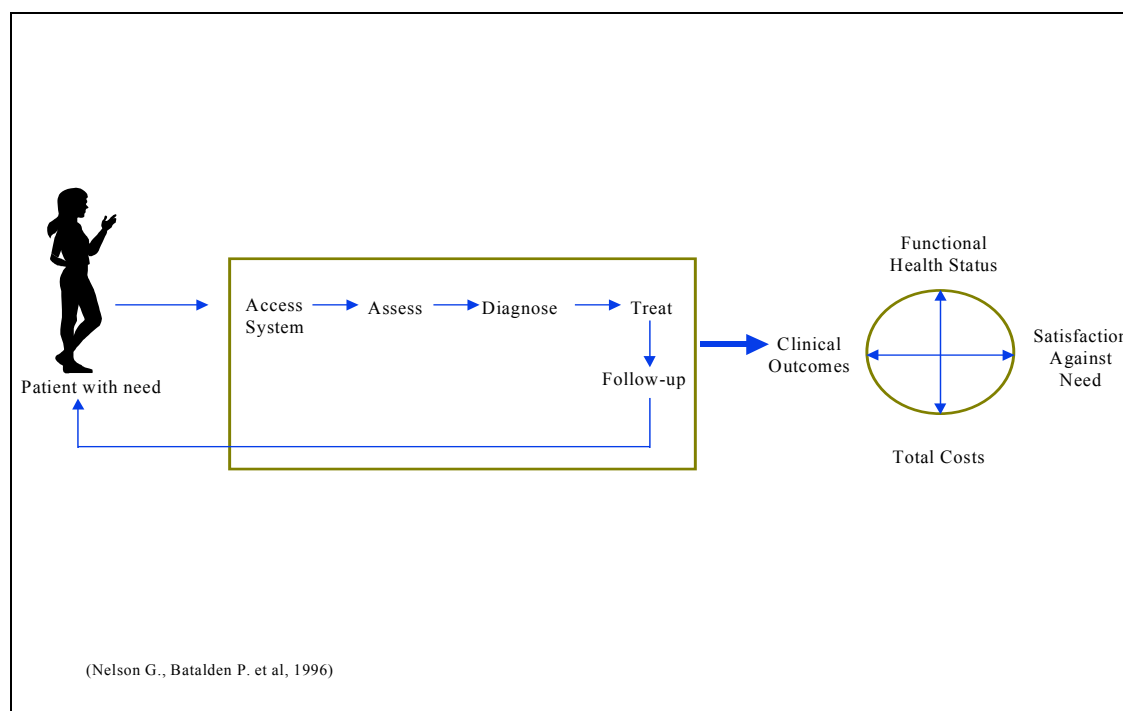
Perhaps the first important message was that CQI was not a newly-developed theory that they had to learn afresh, but that it was based on values and principles that were neither new nor controversial and with which they were already familiar. What was perhaps new was the attempt to integrate them into a framework that could be used by practitioners in

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their everyday work to produce improvements that they themselves considered relevant to their clients/patients.

We began from the premise that to improve care you need a model for providing care. At its simplest, this is illustrated by the model in Figure 1. Although simple the model has profound implications for service providers once it is un-picked. It makes connections between patient needs, outcome measures that reflect these needs and the processes of care that link them. It is a universal model that applies equally well to health and community care and begs many questions if we are to truly provide care that continuously improves the way it meets the needs of those who depend on it.

**Figure 1: The Model for Providing Care That Underpins Our Work**



### Improving processes of care

Much of the emphasis of published CQI studies to date has been on the middle part of the model, with professional teams working together to redesign the processes underpinning their practice (Cox *et al* 1999, Headrick *et al* 1994, Neuhauser *et al* 1995). This is critically important since it is impossible to improve care without improving the processes by which it is delivered. This has also been a significant focus for activity within the RIPE project. Teams discovered, for example, that when they try to draw simple flowcharts describing the way they currently do things it stimulates much discussion about the assumptions on which they all operate. It is usually the first time that they have pooled their separate knowledge and used it to make joint decisions about where and how to improve the care they provide. This very patient-focused discussion seems to serve an important purpose in creating new ways of doing things that strengthens interprofessional team-working.

However, there is also a need to look at each end of the care model.

### Discovering patient needs

One currently emerging challenge is how to ensure that the processes being improved are relevant to the needs of their beneficiaries? Most contact with patients/clients has focused on measuring their satisfaction with the

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services they receive. However it is being acknowledged that this has had little impact on improving care per se. It has been hypothesised that this is because such measures tell us little about them or their needs (Gustafson *et al* 1993, Guaspari 1998). More recent work is attempting to design methodologies, which learn about patients' needs by listening to them tell stories about the impact of their illness on their lives, rather than answer questions about the services they received, listening to them as people rather than merely patients (DoH 2001, McKinley *et al* 2001). By doing so service teams can identify for themselves the needs to which they can respond and can establish their own improvement priorities based on what they learn.

### Building balanced sets of outcomes measures

The concept of the balanced set of measures as applied to organisations is not new (Kaplan and Norton 1992, 1993). More recently Nelson and colleagues have adapted the concept for clinical care describing what they refer to as the 'clinical value compass' (Nelson *et al* 1998). The underlying principle is that because both health and healthcare are complex, no single measure can provide a clear picture of critical areas of performance. Nelson *et al* have pointed out that what is needed is a way to provide a fast comprehensive overview of a few, critical measures. It is necessary to identify a set of measures relevant to a particular client/patient group which are considered to be significant by the staff group providing their care. One aspect of a 'balanced set of measures' is to check that improvement in one area has not been at the expense of quality in another. The clinical value compass has its greatest impact when it is being used to drive improvement since it can translate into operational measures that can become the focus for team efforts.

The four elements of the clinical value compass are:

- **clinical outcomes:** these may be considered to be direct consequences of interventions, e.g., signs, symptoms, complications etc.;
- **functional status:** measures of health status that provide insight into the impact of clinical outcomes on quality of life, for example;
- **satisfaction against need:** the important factor here is the integration of need with the concept of satisfaction, thus making it patient-referenced as well as service-focused. Thus measures may relate to processes of care or the personal benefits realised by patients/clients and their families. Underlying principles are referred to above;
- **costs:** where costs are recognised to be an outcome of care. They may be direct service costs or indirect social costs.

Different teams within the RIPE project have laid different emphases on the four elements outlined above and these are described within their stories in other sections of this volume.

### Building knowledge for improvement

The second key message that has proved important to share with staff is that creating the conditions for learning is at the root of everything and produces the best improvements. Our focus in the RIPE project has been learning by teams and individuals. Continuous improvement depends upon continuous learning and stories of successful improvement are stories of people learning together. This may be learning about the needs of their patients/clients, about the outcomes of the care they provide to these people or about the processes by which they provide this care. Reflecting on what they learn will provide clues to areas where improvements are necessary. Implementing changes and establishing key feedback measures creates another tier of learning.

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At this point it is worth noting that the two most important paradigms seem to be:

- focusing on patient/client needs, which is close to the hearts of all professionals;
- creating opportunities for adults to learn. This is a natural human ability and is fun despite what their previous experiences of education may have done to undermine this during their school and college careers.

When these two paradigms merge in practice settings, very powerful conditions for real and sustainable improvement exist.

### Having a framework for learning

Experience with improvement teams suggests that they benefit from having simple frameworks to guide them through their efforts. The framework that has received most attention recently is based on the work of Tom Nolan and his colleagues (Langley *et al* 1996, see also this volume, Wilcock *et al*, Fig 2).

The Nolan framework consists of three questions that offer a systematic way to turn ideas into action and increase the chances that it will lead to real improvements in practice. Addressing these questions leads to the PDSA cycle used as the guide to the implementation of, and learning from, the changes. As Berwick noted, all improvement is change but not all change is improvement (Berwick 1996). The Nolan framework influenced the work of the different teams whose work is described in this publication, either explicitly or implicitly. Reading their stories will provide helpful insight into how it can be used.

As far as possible the idea is to choose small changes that can be implemented quickly. This is highly motivating for staff and the learning begins quickly, thus maintaining their interest. Larger improvements are realised by the cumulative effects of rapid improvement (PDSA) cycles underpinned by serial learning ( Fig 2).

In sites where there were several successive cohorts of pre-qualification students, these simple messages were repeated to each cohort when they joined the project and reviewed as they came to the end of their attachment, to strengthen their learning about the process they had been following as well as its specific content.

Broadly speaking the Nolan framework can be translated into the following major steps that were used as a guide by the RIPE teams (adapted from Nelson *et al* 1998).

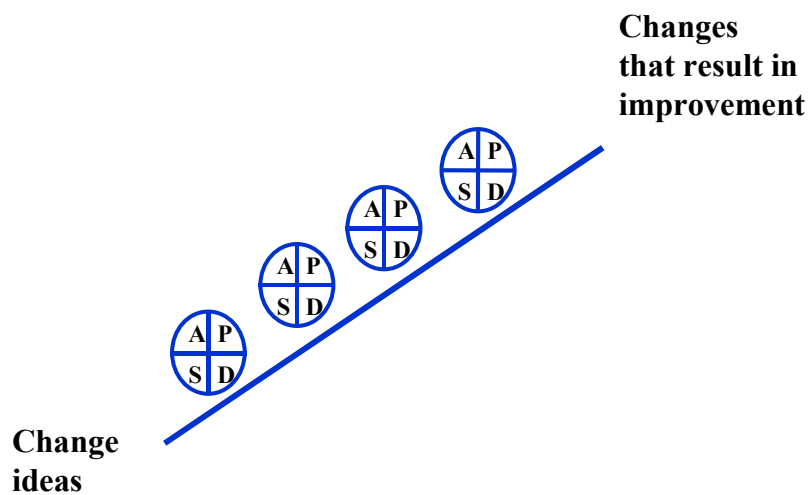
- Identify a specific group of patients/service users as the focus for enquiry.
- Agree a high level, general aim.
- Clarify what you currently know:
  - about these people and their needs;
  - about the processes by which care is currently being provided (drawing a flowchart with your colleagues might be helpful);
  - from available data e.g., audit results, complaints etc.
- Use what you learn from the above to identify areas for improvement. Choose one or two to begin with.
- Turn these improvement ideas into specific actions using the Nolan questions to begin PDSA cycles. Make sure you build in simple feedback measures.



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- Use learning from the feedback to design further improvements using PDSA cycles as appropriate.

A member of the academic team took responsibility for facilitating the process of the meetings of the Local Improvement Teams (LITs) and so had opportunity to offer CQI tools at an appropriate point as they tackled the problem that was important to them. The Dorchester and Salisbury stories in particular illustrate their use by teams in practice settings.



**Figure 2: Building improvement through a sequence of PDSA cycles**

### Some learning

We have learned much from our attempts to introduce CQI methods to the interprofessional RIPE teams. Some key points are listed below:

- Topics must feel important. Ensuring they will produce benefits for patients/service users seems important to initiating projects, while providing parallel benefits to staff seems important to

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sustaining their interest and energy.

- Professionals from different professions learning together have great knowledge and understanding. No one person knows it all.
- Protected time is crucial. This produces initial reactions of horror but teams that have managed it consider it to have been worthwhile for patients/service users and to have working benefits as well.
- Teams value structure and guidance to ensure that time spent is an investment.
- Improvement teams have fun.

### Summary

All the teams using this methodology within the RIPE project were enthused to work together when using the deep knowledge they already possessed about their patients/service users and were able to plan and implement improvements to the service they give. In particular they produced positive outcomes in terms of:

- Services provided.
- Understanding of systems view of care provision.
- Improved understanding of roles, strengths and limitations of other professions and improved interprofessional communication as a result.

The individual stories reported in this set of occasional papers suggest that using the methodology described above ensured that precious protected time was an investment that produced both tangible and intangible results. Staff enjoyed attending the meetings and there was a general consensus that the improvement team meetings were different to the ordinary round of meetings.

Despite this commitment, problems of maintaining the team throughout the project remained, due to very heavy workloads. There is a crucial need for support and commitment to protected time from high levels within Trusts. A problem of time-tabling to establish good interprofessional representation on student teams was a major headache that was not satisfactorily resolved. As well as logistical difficulties there is a need for professional supervisors / teachers to understand and value this learning. In addition, there is a need to ensure academic recognition for time spent in this work so that learning improvement skills becomes a crucial part of professional education alongside the learning of professional and technical skills (Batalden and Stoltz 1993).

### The next challenges

Teams have largely remained dependent on external facilitation and, with one exception, we doubt that they have really developed their own capability to continue this beyond the end of the project. Future projects are being expressly designed to explore how to help healthcare organisations build in the necessary capability and capacity to facilitate and support their own continuous improvement. These may form the focus of future occasional papers.

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## Interprofessional working and learning: clarifying the conceptual issues

### Section 1

### The design and implementation of a reflective group exercise

#### *Les Todres*

#### Introduction

One of the aims of the regional interprofessional education project (RIPE) co-ordinated by Bournemouth University was to develop a way of linking interprofessional education with interprofessional quality improvement projects in practice. This meant that people who were working together could learn together, creating the potential for the learning to be formally accredited at different levels for different professional groups. An academic team was set up to co-ordinate this link between education and practice. This group was interprofessional, and represented the medical profession, clinical psychology, social work, nursing, health management and education.

After two years, the team became increasingly aware of the need to clarify the fuzzy area of interprofessional working. It had been defined in many different ways, using different terminologies (Leathard 1994). What was the model on which this project was functioning? Our assumptions needed to be made more explicit so that our learning could become more transparent to ourselves and perhaps transferable to others.

I had one or two ideas about how applied philosophy could help to do this. I drew on some familiarity with existential-phenomenology, values-clarification and concept-clarification to give me some direction in beginning to design a day in which the team would get together and attempt to clarify the assumptions, values and methods that were underpinning our model of interprofessional working.

#### Planning

At this stage, the thoughts that were running through my mind were: What are the essential themes of our model of interprofessional working? How do we construct its core components or dimensions? Can an innovative model be constructed which offers a 'map' of categories and how they interact, as well as some defining statements within each of the categories (elements or parts)?

I proceeded to prepare members of the academic team by email for this 'away-day' by outlining some initial thoughts and asked for feedback and suggestions:

Dear Colleagues,

Interprofessional working: Clarifying what we mean and value.

I would like to suggest an away-day in which, following Wittgenstein and phenomenology, we do not start with a definition. Rather, we start with what we are already living towards and valuing towards in this area and clarify that further.

The goal of the day would be to:

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- Generate the core categories of the model/conceptual scheme. For example, categories such as core values, rationale (including historical drivers), philosophical issues (such as the interdependence of learning and working), social or political context issues ('realities' and trends), core skills/competencies/capabilities (different levels such as psychological, organisational, theoretical or disciplinary, and types such as facilitation, leadership, co-operative enquiry etc.);
- Generate interesting essential statements within each category. For example, under philosophical issues: 'interprofessional development is part of a larger philosophical movement which wishes to recover more holistic and ecological ways of thinking and acting';
- Consider whether the emerging categories and statements form a picture or have colours, a shape or sound: can the categories and statements be hierarchically arranged or has eco-feminism pulled this rug from under our feet forever?

I would be grateful for any comments on this proposal.

This was followed by a further email in which I suggested that we should enter the day in a focused way and come with some agreed categories and responses to certain prompt questions. Building on the thoughts of the first email I reiterated the categories I suggested, and asked that they consider these further and suggest others that might form important headings within which the elements of the model could be articulated. The emphasis at this stage was not to discuss what core statements to include under each heading, but to agree whether we had arrived at an inclusive set of categories that might be useful for focusing our discussion on the away-day.

I undertook to come up with an economical and inclusive set of categories to be considered with some prompt questions.

After some useful feedback, I synthesised what had come back to me and added them to my suggested categories. I was then able to design the away-day in a more definitive way and emailed this design to members in advance so that they could begin to reflect on the relevant issues.

Dear Colleagues,

### *Preparing yourselves for the away-day*

Here are my thoughts about our away-day (between 9.30am and 3.30pm). I received three responses to my previous email and, on the basis of these, further refined and reduced the categories within which we can organise and generate core statements and elements.

Topic: Articulating Interprofessional Working: towards our core concepts and a distinctive model.

Aims of day: To generate an interesting and distinctive understanding (model) of interprofessional working.

Methodology: There are a variety of definitions and models of interprofessional working. My suggestion is that we 'jump in' and develop 'our' model. As such, the challenge will be to reflect on our experience within the RIPE project as well as our values and concerns, and to generate the essential features or elements of our approach under the core categories offered below. Under each category I have offered two or three 'prompt' questions that could guide our reflections and discussions. We can designate some protected time to each category. I foresee two stages within each category: a brain-storming stage and a more disciplined consideration of refinement, essentiality and distinctiveness as to which elements to include as essential and how to express them as clear and

## *Improving health and social care through interprofessional learning and practice development*

concise statements.

After a brief orientation period, the day will be broken up for five categories or tasks. It is my preference that we not split up into smaller groups to do this but rather do the whole thing together. I have played around with the order of the categories and have come to the conclusion that the following order is logical and progressive.

1. Historical drivers (socio-political context issues, realities and trends).

- Why is what we are doing needed, necessary or important historically?
- What are the important broader context issues?
- Is there anything important or distinctive about this time and place that needs to be acknowledged?

2. Purpose and value.

- What are the aims/benefits of working interprofessionally in this kind of way?
- Who does it serve?
- What values does it express?

3. Philosophy, language and definition.

- What links or concepts do we wish to tie in as essentially expressive of the kind of interprofessional working that we are portraying? (e.g., interdependence of working and learning?)
- What 'language' do we use in our definition, aims etc that is inclusive of all those we want to embrace? (e.g., is the term 'professional' limiting and does it exclude users?) (e.g., awareness of different disciplinary biases: care languages, cure languages, community development languages).
- Can we arrive at a distinctive definition of the *kind* of interprofessional working that we are pursuing (what makes it what it is, what makes it distinctive, what makes it interesting)?

4. Core skills/competencies/capabilities.

- What would we see/notice when an individual is being 'skilful' in pursuing interprofessional working?
- What would we see/notice when a team/agency/organisation is being 'skilful' in pursuing interprofessional working?

5. Representation of the model.

- Is it possible to bring all these categories and elements together in a way that articulates a distinctive model of interprofessional working?
- Is it possible to 'map' this model and to choose its most important elements in a way that we, in the RIPE projects, can own and live with? (This may require a model with core elements and elements that can vary depending on need and context.)

You may find it useful to reflect on some of these categories before the away-day. I look forward to our discussion.

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### The process on the day

On the away-day we nominated a scribe who kindly agreed to capture our words on flip-charts that were fastened to the walls as we progressed.

The goals for the day were:

- to consider each category, and, by focusing on the questions within each category, jointly generate interesting essential statements within each category;
- to jointly consider whether the emerging categories and statements formed an integrated model.

There were two steps to the method by which this consensus on the model was to evolve:

- Share and brainstorm a range of responses to the questions.
- A process of refinement: generate essential and distinctive statements (e.g., this model of interprofessional working aims to be needs led rather than profession-led).

So, for example, under the heading *Historical drivers*, members would share their responses to the question: why is what we are doing needed, necessary or important historically? We would begin by brainstorming to be followed by attempts to formulate succinct statements, which captured the essential features of the elements. The outcome of this process was thus aimed at generating elements (essential sentences) under each category. I offer my particular formulations here as an example:

**Historical drivers:** The complexity and specialization of health and social care can lead to fragmentation on two levels:

- It can fragment a coherent management strategy.
- It can fragment the patient's/user's experience.

It therefore behoves us to integrate our working in order to humanise care and manage services in a coherent way.

*Values:* Acknowledging the unique contributions of practitioners does not necessarily need the traditional structures of hierarchy and power. The importance of valuing our own capabilities and resources is a basis for valuing others (partners and patients/users).

*Purpose:* To help professionals and partners connect with transcending values that can make their unique contribution coherent in response to patient/user needs.

*Philosophy:* (guiding concepts)

- moving toward shared meanings and actions and mutual ownership;
- practice-based;
- disciplined by user's needs;
- atmosphere of inclusion, empowerment of participant's and 'we'-ness';
- the intimate connection between working and learning.

Capabilities:

*Team:* The capacity to care about a central vision that could unite the individual members and to be open to the kind of non-hierarchical learning and doing that this requires.

*Individual:* The capacity to use generic facilitative skills to:

- enable meaningful needs-led learning;

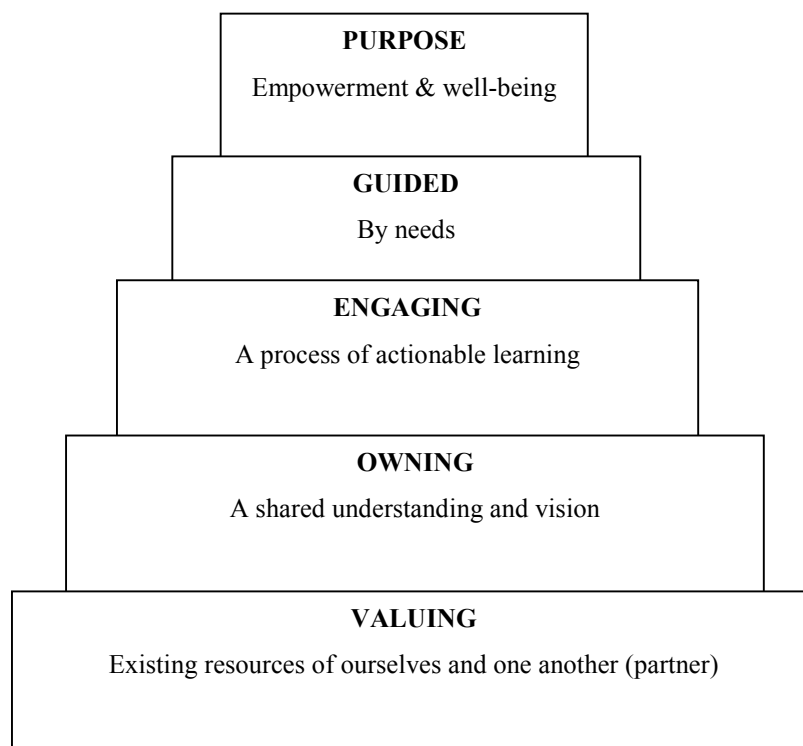
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- guide the team in the use of processes which support such development;
- help the team find a workable balance between reflection and action.

A representation of a model for these processes is shown in Figure 1.

Discussion was limited to about an hour and a half for each category. By the end of the day we had covered all the categories and had generated a range of statements under each category. The process at this stage, however, was not felt to be complete. It was felt that the statements could be refined and essentialised further. The group nominated three members to further synthesise the meanings that had been discussed. When this exercise was complete, it was fed back to the group for comment and ownership.

**Figure 1: The wedding cake model of learning for improvement**





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### Conclusion

The outcomes of this exercise are described in the next two sections. The present account was written to focus on the design issues of constructing a process by which a group can reflect on the nature of interprofessional working. The group felt that the discussions had been deep and far ranging, and provided a meaningful forum by which understanding could be shared and deepened. The experience of the day encouraged me in the belief that this format could be used in other settings where people wish to clarify the meaning and purpose of interprofessional working in relation to their own practice.

I have since used this format with a group of health professionals at a hospital who wished to reflect on their experience of interprofessional working. Many of them felt that this exercise would be a good starting point whenever a new interprofessional team was formed. They felt it was a good way of getting to know one another's professional values, to clarify common purposes, and to consider the principles by which ground-rules for constructive interprofessional working could take place.

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## Section 2

# Process: Identification of the range of ideas through brainstorming

*Keith Brown, Charles Champion-Smith, Dianne Hinds, Tom Hopkins, Brian MacKenzie, Andy Mercer, Howard Natrass, Rob Payne, Gail Stuart, Gillian Taylor, Les Todres and Peter Wilcock*

This section presents the range of ideas expressed by the group. It is not yet a consensus and synthesis of view points. This is presented in the final section.

### Historical drivers

The team's first task was to brainstorm the issues to generate an understanding of the drivers within 'interprofessional working'. Themes within these historical drivers emerged within the group dialogue.

### Professional

- The fragmentation of professional groups, and an increasing awareness on the part of professional bodies of the need for interprofessional working. This also presented a challenge to the dominant bio-medical orthodoxy.
- The emergence of a powerful managerial culture within the health service, with an implicit challenge to the power base of professional groups and an agenda of de-professionalisation.
- A perceived trend towards economies of time in medical education, combined with increased educational opportunities for nurses and the emergence of 'para-professionals' and a reforming agenda for learning.

### Ideological

- 'Radical' 1970s ideas are now mainstream and have influenced current practice, with a movement from 'macro' to 'micro' approaches.
- Some suspicion of the Thatcherite 'reform' agenda, and the value base underpinning this.
- The World Health for All principles emphasising inter-sectoral collaboration, based on healthy alliances with working practices crossing sectors, which has influenced current delivery.
- An underlying shift in health service politics, with a democratic imperative. Inclusion and access were identified as the contemporary presentation of equal opportunities policies and practices.

### Service delivery issues

- Funding attached to technological innovations emphasised the dangers of ignoring human resources, and the need to foster the capabilities of those delivering the service ... targets and time scales, economic issues, demands on services and expectations, all increased demands on the service ... a tension between the time

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required for fulfilling the demands of performance management and the time necessary to generate 'joined-up thinking' required by health and social care agendas.

- Impossible to deliver a modern service across historic structures ... sustainability dominated the picture of how the service was delivered and supported in communities.
- Aspirations towards a more educated and empowered society, with a capacity for self-care. The move towards a 'flatter' organisation in the commercial sector driven by the consumer was more problematic, given the size of the organisation within the health service. The notion of the individual or consumer orientation was a challenge to the established power base of professional groups.

### Personal drivers

The shift to interprofessional working was fundamentally a subversive activity, challenging professional boundaries, acknowledging personal skills and abilities. The personal aspect was prevalent, with a shift from an 'arrogance' of assuming that needs could be met individually to those being met on a team basis. This was considered to be liberating. Insights were gained from personal experience.

Core influences were those such as Freire or Dewey, emphasising the range from the personal to the political, the notion of empowerment, and the stultifying educational anomalies of non-education and mis-education.

### Re-introducing a human element

There was some frustration regarding communication problems. 'Hurt' was expressed at the treatment of service users, with an insight from personal involvement. The service user had been used psychologically as a container of anxiety. Sensitivity to the subtleties of working in this way was paramount; the question of 'when is a team a gang?' was mooted.

### For the service user

The experience of de-personalisation introduced the possibility of interprofessional shifts, catalysing a humanising process. This way of working was tailored to improve services for the client rather than promote bureaucratic interests. Hitherto there had been a 'naïve' assumption that services were designed around patient needs.

### For those involved in the RIPE model

This way of working created a forum for people, rather than professionals, working together. A focus on co-operation and collaboration, with an implicit awareness of 'fences and barriers' created the possibility of accepting tensions between the professions. The manner in which actions took place was paramount; how things were done was considered to be equally important as what was done.

Valuing individual, unique qualities, and caring being about valuing resources and learning more highly, were evident within this perspective.

### Purpose and value

Such a way of working and learning aimed to meet the needs of all involved in the process, whether patients or students. Working in this way fostered a wider vision of care, enabling some individuals to develop a capacity to work in new ways. Addressing patient needs rather than focusing on the threatening overlap between professions promoted connection. It also increased effectiveness and efficiency as individuals learned to work 'smarter'. Work within the project emerged as an affirming process, characterised as a respectful, creative, enriching process which was also challenging. There was an absence of hierarchy, and drifts to hierarchy could be challenged. Something energising in this way of working mitigated against burnout and promoted enjoyable practice. A

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reflective space was created, with time in and time out allowing for reflection and facilitating the creative thinking process, thus enabling a real difference rather than a 'sticking plaster solution'.

### Philosophy, definition, language

- The person is paramount, transcending professional interest.
- Inherent tensions in the language of work, the nature of 'professional' and 'inter' required analysis.
- At one site the participants shared a common set of values and appeared to be like-minded, working towards a common goal. This was an inclusive approach, and demonstrated key characteristics of partnership working.
- Key paradoxes highlighted awarenesses such as the notion that the capacity to act flexibly and respond differently drew on professional knowledge and expertise without imposing it on others.
- Shared action, perhaps embodying the principles of action learning or experiential learning, characterised this approach, with shared meaning evolving as participants increasingly engaged in constructing shared meanings. Paradoxically, while shared learning is important, it may also limit.
- An awareness that individuals are involved in change reinforces the action and draws attention to the need to identify what is being done that makes a distinctive difference.
- The authenticity of the project, with a real user focus, places an emphasis on active participation in the change process. This process is exciting for some, but others may initially not appear to be engaged.
- Transformation is a key issue, acknowledging the human element within practice (including 'professional' practice), that feelings drive behaviour. An important part of being professional is allowing and acknowledging feelings.
- There is a holistic enterprise to the process, with a 'felt' sense an important aspect. This contrasted with regarding the experience as exclusively intellectual. Learning is driven by feelings.
- There is an emotional dimension to the educational process and to learning, needing time to critically evaluate the process. There were tensions, between closeness and distance, between engagement and intimacy, and some individuals may require support in working in an interprofessional way, which may be challenging.
- It has been acknowledged that the Institute at the University exists within a business context and careful definition was required. The possibility that elements may 'sound twee' highlighted possible cultural dissonance, between the ethos of health and care and a performance-related agenda.
- At one site, participation within an egalitarian team prompted a question on the requirements for enabling the transition to interprofessional or collaborative working. Individuals entered with differing life experiences, and participation required no competency criteria. Learning together was seen to remove boundaries, and the answer to the question, 'is this interprofessional working?', was considered to be 'I don't think it can be interprofessional unless you are learning from it'. This may help clarify a distinction between multiprofessional working and interprofessional learning. There was an aspiration to move

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beyond interprofessional learning to working at a higher level. This was seen to be based on a Rogerian model, perhaps as in 'Freedom to Learn'.

- The model of team working within the University provided a model for the workplace, implicitly linked with practice. The tensions were complex, the term 'chaordic' (drawn from the banking sector) illustrates this. It is critical to be sensitive to the local culture, conditions and settings. The implications of working in an interprofessional, service-user-oriented way was viewed as 'seeing without professional blinkers'.
- This has been a reflective journey with a gradual evolution from a group to a team, mirrored also in several practice settings. The corollary of being open, working through professional defensiveness to better understand patient need requires appropriate facilitating frameworks.
- The relationship between learning and change is evident, with a need to develop (or enable) a capacity to learn and change; grow and develop. Such a model contrasted with the more mechanistic model of team 'role' within commonly used approaches to team work and development (e.g., Belbin).

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Core skill/  
competencies/  
capabilities

Table 1 attempts to cluster together main statements generated within this stage. The distinction between ‘capabilities’, and ‘competencies’ implies an awareness of knowledge underpinning particular capabilities.

**Table 1: Core Skills/Competencies/Capabilities**

Capabilities	Competencies	Skills and Attributes
Appropriate style of leadership	Awareness of patient needs and responses	Basic elements, listening respectfully
Facilitation capabilities: flexible according to time and stage of group/team	An awareness of guiding concepts and principles	Sensitivity
Interprofessional group working inter-sectorally		An appropriate personality
An ability to help team learn		Possessing vision of destination and process of achieving it
Capacity to help team learn		
Understanding process of team learning		
Enabling learning – not necessarily team building/learning		
Awareness of team being greater than the sum of its parts		
Responsiveness to situation		
Ability to move beyond individual barriers of service and client		
Awareness that this is not a therapeutic journey		
Capable of working from undergraduate to continuing education levels		
Understanding basic concepts of needs being drivers to action		

The model and next steps

Following this exercise individuals were asked to ‘give form to’ the emerging shape of the model. These included analogies to music, *A Kind of Blue*, a fragmented representation of the process of care, as fragmented and (dis)embodied within the current structure of medical education from which a butterfly emerged through interprofessional learning and working; a honeycomb like structure (a cell); and a wedding cake (see Fig 1).

The next step consolidated the day's actions. Participants emailed their responses to the away-day.

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Towards refining a model Historical and personal drivers	Ideologically, the maturing of ideas ‘seeded’ within the 1960s and 1970s. The civil rights movements gave purpose to interprofessional working. Addressing historical privileging of occupational groups within the education system led to increasing access to education within the health service. The increasing complexity and specialisation of the health service gave rise to fragmentation, in implementing management strategy for users. For those delivering the service increasing work-based struggles and challenges led to a ‘need for succour’ within working lives. Integration achieved a humanising focus in the delivery of care, for those delivering and receiving the service.
Political	<ul style="list-style-type: none"><li>▪ A sharper focus on user interests and concerns deriving from radical 1970s practitioners, matched by individual practitioners seeking to deliver improved services in a more holistic manner.</li><li>▪ An enabling, empowering framework based on principles of equity and inclusion, an increased recognition that the user experience may be fragmented by service delivery. Thus the prevailing zeitgeist is with government initiatives and funding streams promoting ‘interprofessional’, ‘joined up’ or ‘partnership’ working.</li><li>▪ Increasing expectations for delivery of health services.</li></ul>
Purpose	<ul style="list-style-type: none"><li>▪ To help professionals and partners connect with transcending values that can make their unique contribution coherent in response to patient/user needs.</li><li>▪ To better meet the needs of those we serve, simultaneously enriching the working lives of those providing the service.</li><li>▪ To erode professional barriers and boundaries to improve services to and interactions with users and clients.</li><li>▪ To promote the personal over the professional, privileging humanity above systems.</li></ul>
Values	<ul style="list-style-type: none"><li>▪ The unique contributions of practitioners do not necessarily need the traditional structures of hierarchy and power.</li><li>▪ Respect for all participants and users for the contribution they have to make. There is a reciprocal valuing process, individual to partners/ patient (service user).</li><li>▪ Shared beliefs in everybody’s right and ability to contribute, develop and grow.</li><li>▪ The value of personal engagement.</li></ul>
Philosophy	<ul style="list-style-type: none"><li>▪ Shared learning within the emergence of shared meanings, understandings and philosophy within the team.</li><li>▪ Moving towards shared meanings and actions and mutual ownership, based on being open to all opportunities to learn from and about each other.</li><li>▪ Action- and practice-based with the ascendancy of values historically regarded as female.</li><li>▪ Producing actionable knowledge.</li><li>▪ Respect for individual contributions offered.</li><li>▪ Atmosphere of inclusion, empowerment and ‘we-ness’, capturing the richness of individual experience in groups.</li></ul>

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- The intimate connection between working and learning when connection is made between head and heart based on meeting the needs of users. Reduction of professional distance in embracing the ‘feeling’ aspect of the educational enterprise. Integration between the emotional and the rational, historically regarded as oppositional and gendered. Affirming the emotional dimension to teaching and learning within health.
- A vibrant emergent process tailored to individual contexts.

**Further steps  
towards refining  
the model**

On the day, participants’ thinking evolved towards gradual refinement of the categories. Emails indicating participant statements were received following the event.

These further comments were integrated into the final stage, which is presented in the next section.



Section 3

## Outcomes: interprofessional working consensus statements

*synthesised by Howard Nattrass, Dianne  
Hinds and Les Todres*

The group nominated three members to further synthesise the meanings that had been discussed. When this exercise was complete, it was fed back to the group for comment and ownership. What follows are the consensus statements that were agreed.

### Historical drivers

Interprofessional working is an attempt to find a creative and coherent way of responding to a number of forces which seem to be coming together increasingly in our joint awareness. These forces include:

- The recognition that increasing specialisation of professions and services is leading to fragmentation of the service user experience, and presenting organisational difficulties.
- The living realisation of a set of values, which put civil rights issues, such as equal opportunities and empowerment, to the fore. People are challenging hierarchical ways of working and returning to more holistic perspectives.
- Increasing demands and expectations in health and social care are generating demands for working interprofessionally as a way of increasing efficiency and effectiveness. Politicians and policy makers are now stressing the importance of interprofessional working.
- Access to increased educational opportunities by different occupational groups and their evolving appreciation of the structures of power relationships are leading to a challenge to traditional hierarchies and ways of working.

### Purpose and value

The purpose of interprofessional working is to facilitate an authentic and appropriate response to service user needs.

This is done by creating a working environment which supports and values equality in all interactions while maintaining the value of individual contributions.

This is underpinned by a belief:

- in the importance of connecting in an empathic way with our human stories;
- that dialogue and shared meanings are essential if a group is to take effective action, and that this is best done in the workplace, requiring a continuous fostering of a capability to generate actionable knowledge;
- that ‘communities of practice’, communities of people working and learning together, have the potential to develop a high degree of shared ownership, an important aspect of participating in a dynamic process of change.

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**Core skills,  
competencies and  
capabilities**

The team as a whole need to be able to:

- create, maintain and care about a central vision, a shared purpose around improving services for mutual benefit;
- develop, articulate and live by a shared philosophy, acting inclusively and valuing one another;
- take effective action, and take risks;
- reflect and learn together.

The individuals making up the team need to be capable of playing a full part in these activities and of helping others do so. They need to be able to help with the development and maintenance of processes for effective action and interaction, to be sensitive to all elements of the communicative process, able to check meanings and understandings, and to participate in and be committed to inclusive dialogue, open to others.

# Collaboration and teamwork: A framework for interprofessional learning

*Dianne Hinds*

This paper draws on material originally presented at the British Educational Research Association Symposium, September 1999.

## Introduction

In addressing several issues related to interprofessional and multiprofessional collaboration, I shall focus on 'teamwork', suggesting that the process of 'teamwork' and, perhaps the critical role of 'team thinking' may be facilitated when the vocabulary of learning is actively structured using a framework for quality improvement.

I tentatively suggest that there appears to be potential in using a common language of improvement to facilitate the group process and establish a foundation for dialogue, reflexivity and the development of particular domains of knowledge. This is illustrated by a vignette, outlining the first complete action learning inquiry cycle within one setting.

## Background

The word 'collaborate', derives from the Latin *com* (together) and *laborate* (to work). The same derivation leads to two usages reflecting contrasting positions. One is to work with others on a joint project, frequently of a creative nature; the other is to collaborate with an enemy. This duality reflects tensions inherent in any endeavour such as this project, where the situation is inherently dynamic. Thus collaboration may be seen to imply a creative tension, which will require resolution to avoid fragmentation.

This project had a combined focus of service improvement, collaboration and interprofessional learning. Collaborative relationships existed at a number of levels, between Bournemouth University and service providers, together with two other universities working within this interprofessional improvement initiative.

The Regional Interprofessional Education Project (RIPE) involved groups of learners in three settings utilising a continuous quality improvement (CQI) model to explore aspects of their practice as a learning focus. The learners worked with a Bournemouth University team, including a CQI facilitator (either an organisational psychologist, social worker, nurse or general practitioner) and practice teacher. There was diversity in the settings; the first was a hospital setting based in a rural county town, the second a community-based child and family health service serving a post war 'new town'; the third an embryonic community-based mental health team in a rural cathedral city.

Each action learning group was supported by a site support team, comprising members of the action learning groups and agency representatives, together with relevant members of the Bournemouth University team.

The implementation of this initiative in each of the settings, and the complex issues within each sphere of service delivery merit close attention. Both family and child services, as the first aspirational services to be delivered 'seamlessly', and the community-based mental health team, represent 'the clearest manifestation of the aspiration within adult mental health services to work in an interprofessional way' (Norman and Peck, 1999). Further, the service user involvement in mental health services anticipates the increasing involvement outlined within the NHS at all

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levels (including within the research and development programme) for the consumer of health services. Aspirations for such consumer orientation has been expressed within recent government publications, particularly *A First Class Service* (DoH 1998) where the centrality of learning in achieving quality is pivotal within a framework of clinical governance and lifelong learning. The monitoring of quality standards includes information derived from a new patient survey. The consumer was re-positioned within a renegotiated professional partnership.

### Collaboration with a service orientation

Key to the project was addressing in some way the difficulties of what has become recognised as the theory practice gap (Eraut 1994). In the model the central emphasis on learning transcends the boundaries of training, education and development, conflating the concepts of continuing professional development and experiential learning. Within the region there was experience of projects built on principles of service improvement within the Dorset Seedcorn Project (Headrick *et al* 1998).

Within the RIPE project the learning agenda in each setting was facilitated using principles derived from the continuous quality improvement framework. It was not intended that project work should add to existing work and team processes, but that it should be integral to these. As such, the application of PDSA cycles, focusing on aspects of the service delivered, mirrored action research cycles.

### The improvement focus

The major steps within this improvement model as applied to each learning setting involved firstly selecting a patient/user/consumer group, and agreeing with the action learning group members the aim of the inquiry. The next stage involved finding out additional information about the needs of the consumer, thus informing potential outcomes from the user perspective. In time the group chose a balanced set of outcome measures to improve their knowledge of the current situation, and used the resultant learning to select ideas for change, confirmed what might be accomplished and how this could be measured. They were then ready to begin a small PDSA learning cycle to implement and learn from the change.

### Methodological considerations

One aim of this study was to identify barriers to change within the innovation, with a focus on describing the process through which the different action learning groups developed an improvement-oriented project focus that benefited clients and service-users and which incorporated principles of evidence-based decision making.

There appeared to be two dimensions to the learning inquiry, the process dimension of the organisational learning and the implementation of the initiative bounding the individual learning. I found it helpful to use the metaphor of a tapestry, and consider the two dimensions of the methodology the warp and the weft woven within a piece of fabric. On this model the phenomenological inquiry constituted the warp, with the weft created by the case study framing the phenomenological inquiry.

Because of the complexity and unique nature of each practice context it was decided to adopt an illuminative evaluation model (Parlett and Hamilton 1976), constructed as a case study. The nature of the research study was to tell the story of the improvement, and to use phenomenological inquiry to ascertain the learning experience of individual group members.

Secondary sources provided the data to chronicle the evolution of the action learning sets. Project minutes of each learning group provided a formal account of each learning event. The flow charts used to record the high-level team process, which is a key tool within the CQI approach,

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provided a further source of documentary evidence.

An initial plan to collect an agreed learning record, described as a ten minute 'mop-up', identifying the key learning events within each session, was abandoned due to there not being enough time. Instead, a 'systematic de-briefing' of each CQI facilitator following the action learning set added texture to the content of the documentary record.

At key stages a process of backward mapping on the model of Ainscow et al (1995) further illuminated individual perceptions of the implementation process. Focus groups and group interviews provided a nexus of perspectives at key points.

Further elements to the case study framing the phenomenological interviews included semi-structured interviews with key players, both stakeholders and with members of the academic team. The academic team also aspired to the model of team learning. Learning profiles, indicating individual learning histories, were constructed.

The phenomenological interviews were based on the approach used by Giorgi, aiming to elucidate full descriptions of the learning. A similar model was outlined by Kvale (1996). Since these interviews require participants to have sufficient experience of the phenomenon under study, they were planned to begin within the next academic year.

## Interprofessional education

For the purposes of the RIPE project the term is used as within the definition of the Centre for Interprofessional Education. The central feature associated with this definition is the emphasis placed on the necessity to work together.

Whereas the term 'interprofessional', as defined in the literature, relates to the learning about other professional groups, the problems identified in this area are extensively documented. From the sociological perspective we have the identified problems of tribalism, addressed cogently with Pirrie's 'Rocky Mountains and Tired Indians' (1999) to an alternative 'Magical Mystery Tour' identified by Harden (1998), so that, in Pirrie's words, the whole area resounds with 'white noise'. Further, in response to Barr's (1996) call for a typology of multiprofessional learning, Harden (1998) positioned interprofessional learning at a tenth point of a continuum with a new term, 'transprofessional' education, at the pinnacle.

Pirrie shifts the debate, recognising that the whole sphere is redolent with 'white noise'. Accepting Leathard's conclusion about the ultimate futility of the debate, she dismisses the observation 'What everybody is really talking about is simply learning together and working together' as based on the assumption that all participants in the debate engage in the same discourse. The experience within Pirrie's study was that there was little evidence of shared meanings. Pirrie's 'white noise' illustrates the problematic nature of 'tuning in to the right frequency'. There appears to be too much interference for messages to be transmitted.

What is necessary then, to shift beyond this impasse? Following Pirrie's clarion call, I shall direct my attention to the actions and processes underlying the need for interprofessional education, learning to work together. The issue is as Leathard maintains, and as the World Health Organisation originally determined, but some vehicle for facilitating dialogue appears to be necessary.

## Finding the right word....

Just as the literature is redolent with allusions to communication problems and the language barrier in interprofessional working, the problematic nature of language is reflected in interprofessional learning. Language structures thought processes, enabling and restricting. The burgeoning literature on interprofessional working highlights many associated difficulties, but whether (in the words of the ENB conference) it is a noble ideal or a practical reality, hinges on a number of issues. The gap between ideology and evidence, as Parsell and Bligh (1998) inform us, is not yet

closed.

I have focused on the word 'collaboration' rather than 'interprofessional', attending to the process of multiprofessional working. Whereas the term 'interprofessional' as defined in the literature relates to learning about other professional groups, problems identified in this area are extensively documented and the diversity of meanings associated with the word interprofessional is not the subject of this paper. Indeed, as Pirrie reported, in her study 'multi-disciplinary' was used because of the difficulties in definition and meaning.

Language is central to the learning process, since language allows participation in a culture, and the generation of meanings. The situationists (Lave 1988) point out the intricate involvement of learning and activity. In this shifting arena of health care, what are the implications for the relationship between learning, activity and change, when the language is a problematic barrier, and few meanings appear to be shared? The communication divide appears a veritable chasm.

## Interprofessional working

Interprofessional working, according to Headrick *et al* (1998), may be considered a spectrum ranging from loosely coordinated collaboration at one end, to more tightly organised work teams at the opposite end. Headrick *et al* cited West's (1994) work on learning in teams, suggesting that the characteristics of collaboration draw on the same material as the requirements for good teamwork.

Learning and change are intrinsically related. The study of interprofessional communication and collaboration by Bond *et al* (1985), cited in West, remains one of the best known studies of interprofessional collaboration in primary care. Considering the concept (and practice) of team work problematic, the term 'collaboration' was adopted. In 1992, an Audit Commission report drew attention to the elusive nature of the concept, with effective communication and team working practices prevailing in fewer than one in four healthcare teams. West identified very real problems of team working yet the notion of teamwork is particularly important in healthcare.

Certainly, when applied to naturally occurring work groups, the question of whether or not a working group constitutes a team is critical, given the wide need for effective team working. In this instance the meaning of team is based on that of Rubin and Beckhard (1972), and Gilmore *et al* (1974, 5-6), as cited by Pritchard: A group of people who make different contributions towards the achievement of a common goal' (Pritchard 1995).

While Pritchard (1995) suggested that there is an absence of objective evaluation of multidisciplinary work in primary care, West (1999) contended that limited research has suggested positive effects of multidisciplinary team working, improving both health delivery and staff motivation (Wood *et al* 1994). Improved patient outcomes identified in a US study in primary healthcare settings included a range of benefits from a reduction in hospital admissions to fewer physician visits. West and Slater (1996) noted a range of potential benefits in team working in areas such as communication, constructive debate, receptiveness to innovation. However, such potential was not being realised.

Emergent findings support West's observations in relation to receptiveness to innovation. The increased knowledge of their own processes were considered to have benefits on their working practices so that they were able to participate in the pilot of a further innovation regarding multi-disciplinary assessment at an earlier stage than originally considered.

## Towards a language for reflection

Language structures thought processes, and as a seminal WHO report on multiprofessional education maintained, patterns of thinking are different within different groups of health workers (WHO 1987). From this statement the need to learn to understand how others think was articulated.

Reflexivity and the language of reflexivity frame many of the academic discourses on professional learning. Within the brief and very limited history of the project the first pre-qualification learner group had a very unbalanced mix of nursing (3), physiotherapy (1), occupational therapy (1) and social work (1) students. One common theme to each professional group within their university-based studies was an element on reflective learning.

Within the action learning sets the reflexive process was structured around the framework of continuous quality improvement. Central to the theory of improvement was the underlying structure of systems theory, and the reflexive inquiry into the processes of the service delivery.

Collaboration requires communication; reflexivity into services requires effective communication and transcending the language barrier. Reflexivity is an important element of re-framing experience in order to articulate a language for practice.

In a study of teaching student teachers to reflect, Zeichner and Lipson (1987) described a particular curriculum and drew on the work of Dewey (1933) and his distinction between reflective and routine action. While reflective action entails sustained and careful consideration of any belief or apparent form of knowledge in the context of antecedents and consequences, routine action stems from external influences in the guise of tradition and authority. Van Manen (1977), in his three levels of reflection, appeared to offer a conception of practical action directed at clarification and explanation of the assumptions underlying practical situations parallel to that reported within the action learning groups.

## Reflexivity and the learning team

West (1996) cited reflexivity as being the key to more effective team processes, fostering innovation within their organisations. Reflexivity necessitates team members standing back and critically examining themselves and their performance to communicate about these issues, and to make appropriate changes.

An initial thematic analysis suggests that the use of the CQI framework enables such a process; in an interprofessional context it provides, in the words of one participant, a 'non-threatening tool' which facilitates constructive dialogue, an element considered essential to team learning. The first local improvement team considered, before their involvement in the project, that they were a good team. They now consider they are far more aware of team processes.

Dechant *et al* (1993) drew on an underpinning of group dynamics and built on Senge's (1990) work on teams in learning organisations, basing their work on the notion that teams, rather than individuals, represent the main learning units in modern organisations. Indeed the capacity for learning is, according to the framework outlined, essentially about 'enhancing a team's capacity to think'. Considering that team learning would enhance the effectiveness and satisfaction of its members, Dechant *et al* based theoretical learning models on those of Schon (1983), in the context of re-framing, linking thinking and action. They also drew on Mezirow's (1981) work on adult learning, particularly noting the emphasis on the centrality and 'transformative power' of dialogue in constructing new knowledge.

The theory of dialogue, according to Senge, draws on the work of such twentieth century thinkers as the philosopher Buber, psychologist De Mare and physicist David Bohm. In this model there is a declared focus on bringing to the surface the 'tacit infrastructure of thought', so that underpinning assumptions may be examined collectively in a reflective

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way (Bohm 1990).

Reporting a case study from which they construct a team learning model Dechant *et al* (1993) made no claims to generalisability of their findings. However from this case study four phases of team learning were identified; fragmented, pooled, synergistic and continuous. It is not until a team reaches the synergistic stage that teams are able to construct new knowledge. It appears possible at this stage that the Local Improvement Teams (LITs) are developing the capacity to do this. One aspect of new learning derived from the improvement process is that of building knowledge of patients, using the CQI as a tool to facilitate this knowledge. Another aspect of knowledge structured within the learning sets is related to the processes of the team, besides an increased understanding of the rationale underlying decisions. The dialogue enabling participation in the learning process appears to facilitate this knowledge.

### Re-framing experience to learn

The changing nomenclature of patient/client/service user/consumer reflects the changing paradigms of health care. From the passive beneficiary of paternalistic expertise the patient has been redefined within the arena of consumerism to an aspirational relationship as 'partner' implying an equal relation. In the health services this appears to reflect a considerable distance. Using the example of the medical profession where, for example until recent curriculum innovations the initial 'clerking' of medical students in pre-qualification learning, probably following a period studying scientific disciplines, student learning included 'clerking', a process emphasising a 'history-taking' routine aiming to obtain information (according to a medical agenda) and secure a diagnosis in which an important principle was to secure patient compliance, albeit governed by the 'duty to care'. Underlying principles of the relationship could arguably be considered to represent a patient role characterised by passivity; structuring the patient as a passive recipient of services, implicitly acknowledging the expert role of the professional. This is far removed from the postmodern era when an NHS publication states, 'the consumer knows best about their own individual health'. The transition from the paternalistic relation to equal partner represents a considerable journey. Besides doctors, in this interprofessional arena there are social workers, health visitors and collaborations across agencies.

The following vignette highlights one improvement cycle carried out by members of one local improvement team.

### A vignette

The Child and Family Support Service serving this Newtown area are based in the local hospital. The first sessions of the local improvement team met in a local ward building, not a hospital ward, but a community hall, set in an electoral ward. However, this building proved cold and inhospitable, and meeting venues were arranged within the operational base at the hospital, providing the relative comforts of warmth and restaurant space.

Collaborating with the health visitors were members of a voluntary organisation working with education agencies to support parents while introducing their children to school. The idea was that when parents (or carers) brought children to school, there was a 'drop-in' service to familiarise younger children with school.

The original project plan had intended to support 'isolated' parents. In practice exploration of this proved problematic. Discussions faltered, the notion was considered paternalistic. Finally, selected interviews took place. These were not with the group originally planned, but the narratives provided crucial information in finding out the needs of a particular group. One mother reported alienation; another that the challenges of parenting were something for which she was unprepared; yet another was lonely but



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lacked the confidence to join a group of strangers, while a further parent reported previous bad experiences with health professionals. The narratives were powerful. As a result of these interviews a plan was developed which was to form the basis of the first experimental change in services.

The plan entailed exploring the possibility of locating a health visitor in the same building as the playgroup facility. There was to be a weekly visit every Thursday within a six week period. At the end of the period the team members planned to evaluate their actions.

There was considerable discussion. The health visitor's scales were like a 'badge of office'; should it be one scheduled health visitor who visited weekly, or should there be a rota of different team members? Various alternatives were discussed, and it was agreed that a book would be constructed.

Within the action learning group feedback included reports of mutual benefits. The regular staff experienced benefits from being observed, the health visitors explored the new relationships generated from observing known (and unknown) parents with their children. They exchanged views on the play and interactions between parents and children, which informed their view on the services necessary for this particular group.

## Conclusion

The continuing emphasis on learning transcends the structural boundaries of education, training and development. In the words of one key stakeholder, education and training, historically the 'last bullet point on the agenda', are simultaneously re-positioned and re-defined as learning is recognised as central to change and implementation in the shifting paradigms of the health and social services.

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