The RIPE Project: A Regional Interprofessional Education Project co-ordinated by Bournemouth University

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Acknowledgments

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Executive Summary

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This project was made possible by a major NHS Executive award reflecting a regional focus on interprofessional education. The project aimed to combine principles of interprofessional teaching and learning, as articulated by the UK Centre for the Advancement of Interprofessional Education (CAIPE), with principles of health improvement.

The intention of the award was to encourage educators in the region to explore and test novel ways of embedding interprofessional education in curricula and professional development activities.

Broad Educational Model

The approach that Bournemouth University took was to develop a flexible framework of learning in which the following characteristics apply:

- Interprofessional groups in practice settings would be constituted to form ALGs.

- In each setting such a group would come together to pursue an improvement project relevant to their setting.

- The improvement project would be informed by the principles and strategies of Continuous Quality Improvement (CQI).

- This approach includes a strong emphasis on being informed from the 'ground' up by the needs and experiences of patients/clients/users of services. They are considered important sources of evidence for evaluating the quality of health and social care.

- These improvement projects in practice settings constituted an enquiry-based or problem-based learning strategy. The members of the ALGs met to learn about continuous quality improvement principles and strategies, to learn from one another across professional and agency boundaries (interprofessional education), and to learn from their patients/clients/users of services.

- This broad educational model was designed to pursue the dual and inter-related goals of learning and health improvement. The outcomes of the project would thus be such as to evaluate both the nature of learning that occurred as well as the nature of the improvements that occurred within each site.

- This broad educational model was also designed as a 'process' model. That is, it did not start out with 'knowing in advance,' the kind of learning that would occur beyond certain broad parameters (about interprofessional learning, CQI, and user-informed learning). The particular 'content' of the learning was to be discovered and described through the evaluation/research process. Both the process and the kinds of learning that are discovered could then inform further curriculum design. Although there are examples of this already happening in Bournemouth University's recent design of pre-qualification and post-qualification programmes, the full significance of these discoveries for embedding into mainstream education lies in the future.

- This broad educational model was also designed in such a way as to provide different placement opportunities for pre-qualification learners

from different professional groups. The central ALG experience was thus targeted at post-qualifying learners who were in practice. The model for how the pre-qualifying learners would relate to the improvement project was different in each case and depended on a number of factors that were challenging, such as length of placement, requirements of different pre-qualifying professional groups, and the nature of the particular improvement project in each setting.

- This broad educational model had various levels of co-ordination: an academic team that met regularly together to discuss cross-site learning and improvement issues. This academic team (itself interprofessional) included, the facilitators of the ALGs; the site-specific ALGs themselves which met regularly with the educational facilitators from Bournemouth University to learn together and pursue their improvement projects; in some cases, site-support meetings in which managers, the university team, and members of the ALG would meet to negotiate any logistical infrastructure support that may be needed. The NHSE, which commissioned the projects, also provided a regular series of meetings called "the collaborative". They had awarded grants to two other universities and their practice partners to pursue interprofessional education initiatives in ways that were overlapping but different. These 'collaboratives' provided the opportunities for these grant-holders, from different parts of the region, to come together regularly to share practice and discuss challenges.

Evaluation/ Research Methods

The evaluation strategy was designed in such a way that it is able to answer the evaluation questions that are documented in the later section of this executive summary entitled: Brief answers to the evaluation questions.

The complexity of these questions requires a descriptive qualitative methodology, which is able to articulate:

- The story of improvement;

- The story of learning – how it took place;

- The kinds and levels of learning that took place.

In order to do this an 'illuminative' case-study approach was designed and qualitative data was gathered from the following sources: minutes of meetings; systematic de-briefings; field notes; in-depth learning interviews; group interviews; exit interviews, and; records of improvement cycles.

The qualitative data was analysed using thematic analysis, and in the case of articulating the learning themes, a phenomenological analysis of essential meanings.

Findings

The Settings and the Stories of Improvement

The names of the settings have been anonymised.

1.   The Castlebury elderly care site.
        This was a hospital site with a focus on acute care needs. Two improvement projects occurred on this site with the development of ALGs in two different wards. In the first project, the team produced improved ways of formulating a discharge summary informed by interprofessional and interagency issues and patient needs. This procedure makes it more likely that a better continuity of service will occur in future for patients. In the second project, the team produced a revised patient assessment procedure that was interprofessionally

informed. This procedure makes it more likely that staff will be able to communicate with patients about their needs in a more holistic way.

2. The Oldburgh mental health site.
The project took place within the context of a community mental health team with a focus on young people (less than 30 years of age) who were referred for the first time to the community mental health team. The general aim was to develop new ways to take the young person through the service using the range of community resources. By means of the CQI process, information was elicited from patients/clients/users about where the most important gaps were in accessing the service at timely stages. The project outcome was the production of a patient information leaflet which gave useful information relevant to their needs and which would facilitate better informed access to services.

3. The Newton child and family care site.
This improvement project took place within a local child and family support service that had statutory responsibilities to provide services for children under five and their families, together with associated agencies within the voluntary sector. The group focused on the need to reach isolated families who were less able to take responsibility for their own health and that of their children. The outcome of the project was improvement in the way that mothers within this target group could come together, support one another and build up relationships with different professionals such as health visitors, and other voluntary workers. Such an improvement is likely to reduce the mother's sense of isolation and facilitate information and access to help when needed.

The Story of Learning. Post-Qualifying Learners in the ALG

Essential Themes: Kinds and Levels of Learning

Understanding roles

1. There was an increased understanding and valuing of others' roles and the different valuable perspectives that these bring.

2. Participants at times had to learn to change their own and others' attitudes about the roles and histories that they had in relation to one another.

3. In learning about one another's roles, a new perspective or understanding of the patient was also sometimes achieved.

4. Tribalism: there was a greater appreciation of the historical barriers to interprofessional understanding and the importance of having an opportunity to address these barriers.

Stretching boundaries

5. There was learning in which participants had to stretch their imagination beyond professional boundaries. As such, learning was transferable between personal and professional boundaries. The 'real' nature of the learning environment meant that connections were made with other situations, times and roles.

Reflective learning using PDSA (Plan-Do-Study-Act) cycles:

6. The importance of the PDSA cycles as a framework for learning is that the learning led to some form of action. This gave members confidence in their ability to reflect and how this can lead to action and results.

7. Learning the PDSA cycle as a way of proceeding was also considered valuable because:
    - It unified the aims of the group beyond their differences by focusing on the needs of clients and patients.
    - It became implicit to their way of working – it thus became 'tacit learning'.
    - Participants could see the transferability of the model to other contexts.
    - Seeing how the use of PDSA cycles led to actionable improvements, and resulted in an increased feeling of confidence in participants.

Practice-related, experiential learning:

8. It was learnt that small steps of change and joint ownership of these changes were important.

9. It was learnt that practice-related learning required patience as there is a 'feedback loop' with the real world in which the need for agreements occur as well as sequential steps in time.

10. There was evidence that the multiple and complex challenges of the projects called on some participants to draw on their relevant experience from the past and apply this in new ways to the present project.

Learning about the service:

11. There was an increased learning about the nature of the service they offered, the problems they needed to address, their possible solutions, and the resources they had at their disposal.

Personal and interpersonal learning:

12. Through observation and participation in the interpersonal situation there was private, individual learning about interpersonal dynamics and how to cope with these on both an emotional and behavioural level. This led to acknowledged improvements in functioning as a team.

Learning facilitation skills:

13. Members learnt group facilitation skills by having a facilitator who functioned well as a high level CQI facilitator.

Learning the value of a patient/client centered perspective:

14. The value of a more patient/client centered perspective was learnt through experiences in which patients'/clients' views became a credible source of evidence. In this regard, a range of learning from service users occurred such as:
    - The value of talking about difficult and emotive issues with the service user.
    - The common desire of the service user to have accessibility to resource and support.

- Understanding how 'basic' the starting point is from the users' point of view regarding their needs.

Barriers to learning:

15. Barriers to learning that needed to be addressed were the difficulty of finding protected time due to other priorities and the differing working patterns of different professional groups.

Pre-Qualifying Learners in their placements

Learning the value of taking a patient/client perspective:

1. Students learnt to value a more patient/client-centred perspective:
   - To consider patients/clients within their domestic environment; in their everyday lives and not just within the treatment situation.
   - To consider the patient/client view about desired care outcomes and how resources could match this.

Seeing the larger picture:

2. The reflective practice model facilitated the kind of learning in which students were able to "see the whole jigsaw"- how needs are matched by resources of various kinds and levels.

Gaining confidence through seeing the practical relevance of their knowledge:

3. Students were able to clarify the relevance of their own knowledge base in practice and this enhanced their personal confidence.

Learning to value communication procedures between agencies and professions:

4. Students learnt about the importance of recording and communicating about the patient across professions and contexts and how there were often gaps in such procedures.

Learning through taking a critical perspective:

5. Students learnt about the negative effects of hierarchical professional relationships and developed an attitude that this needed attention.

Essential Themes: Learning from the way the project was organised

Lessons learned about the organisational aspects of the project

The constitution of the ALGs:

1. Setting up partnerships between a university and practice context is challenging. The model for forming such a collaboration still needs to be explicitly articulated. Is it a new learning/improvement team or is it an existing practice team with university facilitation?

2. For such an improvement project to succeed, the ALG group needs to 'own' the project and such ownership depends on consistency of participation.

The value of CQI as a trans-professional framework:

3. The basic framework of CQI can provide a 'language' that can transcend some of the differences in professional and disciplinary background, especially if it attempts to be jargon-free.

The importance of a skilled CQI facilitator:

4. A skilled 'Continuous Quality Improvement' facilitator is important. This is different from a 'steer' or 'chair' of the group. His/her role was in managing the CQI process as well as facilitating inclusive participation.

Taking time to explicitly articulate the 'learnings':

5. Participants need to be helped to find the 'learning' in what they are already doing. We are learning all the time but tend to take this for granted. In the CQI process it is valuable to make some time to articulate this 'taken for granted' learning.

The need to redefine 'leadership' in less hierarchical ways:

6. The concept and nature of 'leadership' may need to be re-framed. Traditionally, professional education has stressed one's distinct professional identity; for example, a 'nurse leader'. This sets up power relationships that may need attention within a model of encouraging less hierarchical, and more inclusive participation.

Collaborative meetings with similar but different projects is helpful:

7. It is valuable to meet with others doing similar projects ('The Collaborative') in order to learn about different ways of seeing and doing things.

The importance of 'protected time':

8. Although a challenge to achieve, the establishment of 'protected time' for the project appears to be crucial for it's success.

The importance of political and management support:

9. It is useful to have various levels of support that underpin the ALGs, as was the case in this project. There needs to be management support for the project, ideally meeting as a 'site support group', as well as an academic team to co-ordinate the learning experience (which needs to meet regularly).

The value of drawing on 'synergistic' developments beyond the project:

10. There were indications that resources and learnings from beyond the boundaries of the projects could be used synergistically to progress activities within the projects. Such 'snowballing' is a mutually enriching experience and such serendipity is unpredictable but inevitable.

The value of the project for educational developments:

11. The academic team benefited from the projects in that it informed and paralleled their thinking when they participated in:
    - the design of a new interprofessional Masters Course (MAPD – Practice Pathway);
    - the incorporation of interprofessional themes into a rewrite of a pre-

qualification nursing curriculum.

12. The academic team engaged in ongoing learning in their own right apart from the ALG activity and this led to greater clarification amongst them about the nature of interprofessional learning and working.

Barriers:

13. In some situations there was evidence of a lack of 'organisational memory'. This emphasises the need to provide information to the other relevant teams about the improvement team's work which impacts on the care of the individual/patient/client.

14. Moving towards a patient/client needs-centred model of care from one that is led by professional dictates is a slow process. This is due to both logistical problems (the constitution of appropriate interprofessional groups) and attitude (different values, 'languages' and state of working).

Brief answers to the evaluation questions

Was the main aim of the project achieved: to assist qualified professionals and pre-qualification learners and students to learn and work together across professional boundaries so as to improve services for patients/clients/users?

Yes, in general, there was evidence that members of the ALGs were able to learn together in such a way as to improve services for patients/clients/users. In all cases, there were improvements in working practices. In general, it is too early to say how much these improvements in working practices will make a difference to patients'/clients'/users' lives. There was some evidence that in some cases it already did (for example, clear evidence in Newton).

Is there a transferable model that has emerged from the RIPE project? (of linking improvement projects with educational opportunities).

Yes, a transferable broad educational model has emerged from this project. Its broad structure and processes are flexible enough to apply to a range and variation of practice settings (the project tested three settings). The challenge is how to translate the model into mainstream, validated units of learning. It is suggested that both the processes and 'learning essences' of the project could be fruitfully utilised in curriculum design. A 'portfolio' approach with 'learning contracts' would be well suited to this.

This includes the following sub-questions:

- **Did members of the ALGs learn in a meaningful way from their involvement with service users?**

Yes, there is evidence that in all cases, the ALGs learned in a meaningful way from their engagement with service users. The pre-qualification learners found this particularly helpful as a source of learning.

- **Did members of the ALGs learn in a meaningful way about what it means to improve the quality of practice?**

Yes, there is evidence that learning about the principles and strategies of CQI was specifically relevant as a way to pursue improvement in a way that built confidence and step-wise results.

- **Did members of the ALGs benefit and learn from interprofessional interaction?**

This varied across sites. It depended on the nature of the group that formed. An important variable in this regard appeared to be whether interprofessional interactions could build gradually over time through consistent attendance of ALGs. Such a logistical issue provided the minimum condition that is needed for cross-professional exchanges that were inclusive and non-hierarchical. Where interprofessional learning happened best appeared to be in ALGs where the tasks of building a team had already happened.

- **What was the variability in the model between sites?**

Although there is a definite broad educational model, because of differences on the ground, the model had to find local solutions depending on the following variables:

✶ the absence or presence of a supportive management structure and how much freedom was given to develop the projects 'bottom up';

✶ the kind of contact and relationship with the service user (a community setting allowed a high degree of participation by the service user compared to the time limited stays of service users in a hospital setting);

✶ the prior history of the ALG in working together as a team (this takes time);

✶ Different emphasis in the nature of the facilitation of the groups may need to be locally negotiated (some require more structure, some less).

- **What are some of the 'products' of the projects that could be used elsewhere?**

Some of the 'products' of the project were:

✶ Pre-qualification learner booklet on continuous quality improvement.

✶ Student produced health information posters.

✶ Basic interview schedule used by health visitors to guide their interview with service users.

✶ Assessment form developed by a hospital based team.

✶ Discharge summary developed by a hospital team.

Does this model of learning in the context of an improvement project have the potential to be sustainable given the ongoing complexity and changes in health and social care provision?

Yes, the sustainability of the model lies in its potential to 'kill two birds with one stone', to use an unfortunate metaphor. As an educational framework, participants can be formally accredited for improvement-oriented, practice-related, interprofessional learning. At the same time, the improvement projects are consistent with many of the goals and strategies of clinical governance.

This includes the following sub-questions:

- **What are the main capabilities that were facilitated by the RIPE project?**

The main capabilities can be summarised as:
- a confidence to act – learning led to results;

- a capability to change – learning from others' roles;
- a valuing of the learning from patients/clients/service users as an ongoing evidence-base for quality improvement;
- the capability to use structured principles and processes (CQI) to pursue improvements in quality.

- **What are the implications of these capabilities for developing these experiences into mainstream, accredited, educational opportunities?**

  For pre-qualification learners, the broad educational model could form the basis for designing interprofessional placements that are project based. This particular model suggests a needs-based learning project based on the principles of continuous quality improvement. Such a design would lend itself well to a pre-qualification learning framework across health and social care disciplines.

  For post-qualification learners, the broad education model could form the basis for designing Masters level units similar to those that have been recently accredited by Bournemouth University as a Practice pathway through the Masters programme. Practitioners are accredited for documenting their learning in practice while engaged in improvement projects. They are assessed on 'process' units such as critical analysis of a project, practice development through group supervision, and portfolio units of personal and professional development.

- **What are the most significant barriers/challenges that are negotiated in this model of learning and working?**

  ✶ The development of a 'microculture' within the workplace that is supportive of ALGs in which practitioners learn and work together.
  ✶ The development of skilled CQI facilitators.
  ✶ Logistical and resource barriers of prioritising and dedicating protected time and space for these activities as part of the working day.

- **What are the resource implications of this model of learning in the context of improvement projects?**

  It is difficult to answer this question on the basis of the evidence that is available and this aspect may require further research. The main resources for practice contexts involve dedicated time for practitioners to come together to reflect on their practice. However, the additional cost of this may be justified in three ways:

  1. That real improvements in working practices occur that can benefit patients / clients / users through this form of learning;
  2. That it could be built in and budgeted for as a mechanism of clinical governance;
  3. As an ongoing team building exercise that can mitigate against burn-out.

  The main resource implications for educators involve the availability of well trained CQI facilitators and the time it takes to organise placements for groups of pre-qualifying learners that come from different professional courses.

Theoretical Questions:

- **Does this project contribute to the debate on the meaning of the term "interprofessional"?**

The centrality of learning from the patient / client / user (needs based approach) provides a transcending value for interprofessional interaction which cuts through divisive conflicts.

- **Does this project contribute to debates on emerging policy directions and documents?**

Yes, the approach taken is congruent with certain trends such as clinical governance, the focus on quality, the 'expert patient', continuing professional development and life-long learning and a 'health service for all the talents'. It provides one possible way forward in addressing these agendas.

Chapter One   The Broad Educational Model

On learning:

Concepts can never be presented to me merely, they must be knitted into the structure of my being, and this can only be done through my own activity.

M.P. Follett
Creative Experience

Cited by Marian Milner
"On Not Being Able to Paint"

Introduction

The Regional Interprofessional Education Project (RIPE) began in 1998, the year the National Health Service celebrated its 50th anniversary. For the university the award to undertake this project reflected continuing developments within the contested sphere of 'interprofessional education', initiatives supported regionally by the NHS.

The ensuing period reflected a time of massive change in the wake of the government's modernisation agenda, with a raft of radical reforms aiming to shift the balance of power within the NHS. The mechanisms for securing these changes were outlined within the framework illustrated by documents such as A First Class Service : Quality in the New NHS (DoH, 1998), and latterly updated within the NHS Plan (DoH, 2000). Further strategic development strands shaping the service, such as The Expert Patient (DoH, 2001) acknowledge the untapped resource of patient knowledge. At the core of these changes were the development of a more patient centred NHS, together with an emphasis on quality. Underpinning these reforms was a new focus on learning, with aspirations such as 'lifelong learning' increasingly appearing in the rhetoric of government policy documents. Concurrent with these changes were a series of challenges to the NHS as custodians of the public health.

The issues reflected within this project, with its focus on the development of a more patient centred focus and service improvement, and with a learning focus, could not have been more timely. In many ways therefore, the aspirations represented within the 'shifting the balance of power' agenda (for instance, a more patient centred service, and making organisational changes designed to support a bigger and longer term change in culture and ways of working) are reflected within aspects of the project.

The RIPE project was based in practice settings. Specific services within the project were microcosms of the broader NHS, whether delivering services for the elderly, developing mental health in the community, or accessing the under-served and potentially vulnerable, and thus addressing social exclusion issues. In this instance the service was a child and family support service. Contexts were volatile.

In the light of discovery, the following chapters aim to share the experiences of those involved in this 'blue skies' project. There are no apologies for the style of this document, which perhaps does not follow the orthodoxies of project presentation. It has been presented in this way as a genuine attempt to share and learn from this collective endeavour. It is perhaps a collective way of

collectively reflecting reflexively on practice.

In an endeavour to learn from the lessons of this experience the ensuing chapters of this case study are presented in some detail. The first chapter covers the background to the project, and introduces the broad educational model. The second chapter introduces the methodology, whilst the third relates the stories of improvement across the three sites. The fourth outlines the story of learning, both the post-qualifying and pre-qualifying learners involved in the project. Chapter five introduces the lessons learned from the organisation of the project. Chapter six formally addresses the evaluation questions implied elsewhere in the report.

Background

The genesis of the Bournemouth University involvement in the Regional Interprofessional Education (RIPE) Project lay in a major NHS Executive award reflecting a regional focus on interprofessional education. The project aimed to combine principles of interprofessional teaching and learning, as articulated by the UK Centre for the Advancement of Inter Professional Education (CAIPE), with principles of health improvement. There were local and international precursors to the project. Locally, a similar approach had been adopted within the Seedcorn Project (Campion-Smith & Wilcock, 1997), albeit within a primary care setting, but adopting a team approach to patient focused service improvement. A transatlantic influence existed within the work of the Institute for Health Improvement in the USA, advocates of a continuous quality improvement model within health care.

The proposal for this Major Regional Interprofessional Education and Training Award had been drawn up in partnership with three NHS Trusts and associated Social Services Departments, it was also supported by the local Education Consortium. These agencies were co-signatories to the bid to the NHSE. By contracting with partnership agencies Bournemouth University aimed to work within priority service areas.

The Broad Educational Model

The underlying aim of this Project was to assist qualified professionals and pre-qualification learners and students to learn and to work together across professional and agency boundaries in order to improve services for patients and clients.

One specific aim of the Project was to develop and test ways of doing this with a view to extending effective practice and embedding this within mainstream education activity.

Subsidiary and interrelated aims are outlined below:

- To develop interprofessional education which has patient/client service improvement as its focus.

- To make higher education more practice-based.

- To build evidence-based decision making into the education process.

- To integrate practice-based, project focused, interprofessional education into mainstream academic activity.

- To gain an understanding of the barriers and limitations to effective interprofessional working and learning, and to develop ways of overcoming them.

- To develop appropriate skills within the multi-professional team.

- To understand the contribution of service users in interprofessional education.

- To gain a deeper understanding of the nature of multi and interprofessional learning.

- To capture systematically the learning from the Project, to share this among all participants, and with those associated with other projects in the Region.

- To develop approaches that are transferable.

Realising the aims

In order to achieve these aims it was planned to establish three sites, each with a different care/client focus, and the involvement of different agencies. The interprofessional learning project team aimed to work with experienced staff and prequalification learners working and learning together in each of the three settings (Newton, Castlebury and Oldburgh). The plan was for experienced learners to come together in ALGs of between six and eight people and to work either on improving a specific aspect of care or the service being delivered. The anticipated time period for each ALG was of some nine months duration. It was envisaged that within the project life-span this process be repeated twice by each team. Pre-qualification learners from three or four uni-professional programmes would learn together in parallel and join with the experienced learners in their improvement work.

The Bournemouth University academic team comprised practice teachers for each practice area according to service delivery in each setting. The Bournemouth University team was joined by a highly experienced CQI facilitator who acted as CQI facilitator within one setting, but also as a resource to the further sites for the project.

Teams were recruited to the project within each site. The academic team met with those involved in the service delivery in each of the three sites in the autumn term of 1998.

Each group of combined university practice teachers and practitioners were identified by the NHSESW as a Local Improvement Team (LIT).

Learning and the learners

There was a learning orientation to the project from the outset. Common to the practice teachers attached to each site was a fundamental belief in learner-centred experiential learning. An action learning approach would be facilitated to enable participants to identify their own needs, priorities and solutions to issues generated within the action learning set, aiming to develop health improvement projects. It was anticipated that this process would be carried out with service users, who would either be involved through existing mechanisms or through focus group processes.

Adult learning principles underpinned the delivery of the core quality improvement framework, with participation within a facilitated group, thus lending an experiential learning dimension to this concept of learning for health improvement within interprofessional contexts.

Experienced staff

Experienced staff providing the service, were to meet in action learning sets and improvement teams. Using the CQI model (described below) they would become involved in continuous improvement, continuous reflection and learning and with progressively reducing lengths of time involved in developing improvement cycles.

There was a recognition of the need for the process and the time to fit in with the time constraints of practitioners. It was envisaged that it would be seen as part of existing work and team processes, and not as an additional requirement.

Pre-qualification

Pre-qualification learners from a range of disciplines (nursing, social work and

learners	medicine) as well as students from the undergraduate Health and Community Studies degree of Bournemouth University would be received at each site. It was anticipated that a proportion of the placement time scheduled within existing programmes would be spent in one of the three sites where students would engage with improvement work and learning being undertaken by the qualified staff. In this guise students could act as a resource to the group. Suggested activities given as examples were assisting with some aspects of data collection and analysis, or consulting service users.
The CQI model	The educational approach to be used was based on the model of continuous quality improvement (CQI) developed within the Institute of Health Improvement in the USA. At this preliminary stage it was suggested that quality improvement principles and tools could usefully be applied within a community health improvement application in the UK. The application of CQI principles within multiprofessional learning sets was the intended catalyst for interprofessional learning.

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 service-related 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. The principles and methods are currently the subject of much work within healthcare (Batalden and Stoltz 1993).

Within the context of the RIPE project, the general aim was to help participant professionals and pre-qualification students gain some understanding and knowledge of its underlying theory and practical experience of its implementation within a quality improvement team. The intention was 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 to be encouraged to examine approaches to designing care that would cross traditional professional and organisational boundaries and provide measurably better outcomes. The novel element to this CQI process was the attempt to integrate principles into a framework that could be used by practitioners in everyday work, to produce improvements that they considered relevant to those using the services.

Underpinning this approach is 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.
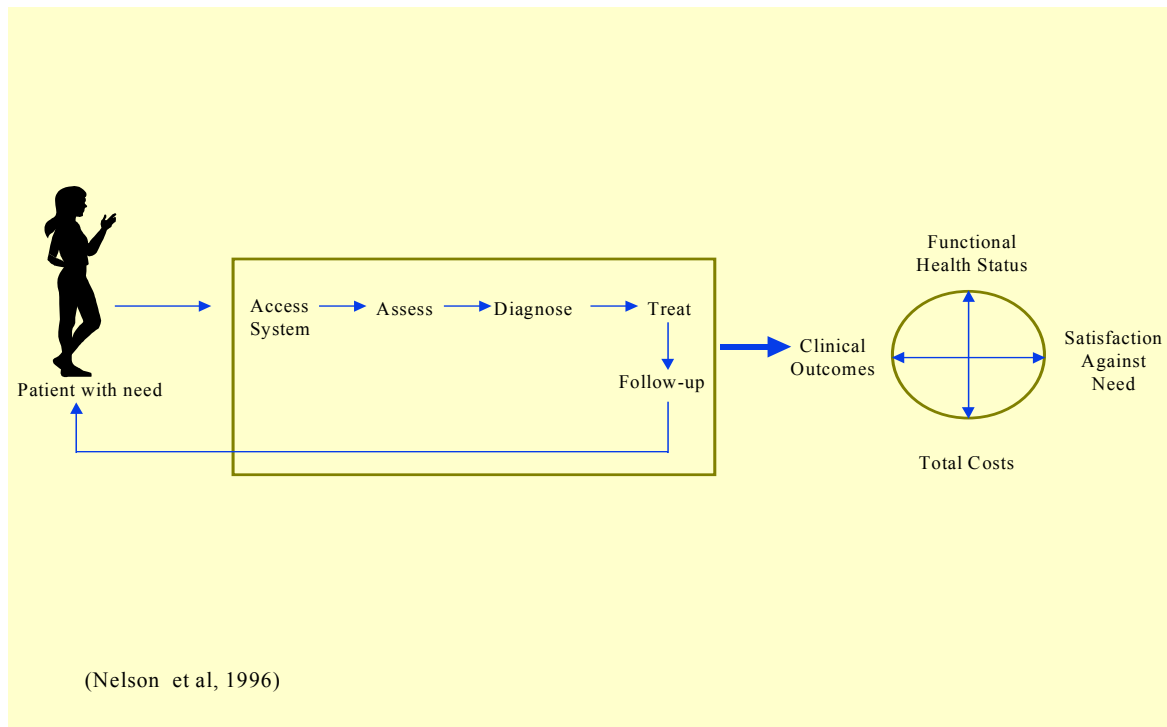
(Nelson et al, 1996)

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

In practice, it had been found that although simple, the model had profound implications for service providers. It appeared to enable people to make connections between patient needs, outcome measures reflecting these needs and the processes of care linking them. It had been found to be a universal model applying equally well to health and community care and one which stimulated many questions when used to truly provide care that continuously improves the way it meets the needs of those who depend on it.

Much of the emphasis of published CQI studies to date has been focusing on the middle part of the model, with professional teams working together to redesign the processes underpinning their practice. This aspect had been found to be critically important since it is impossible to improve care without improving the processes by which it is delivered.

Discovering patient needs

One emerging challenge to be addressed within the project was how to ensure that the processes being improved are relevant to the needs of service users. Most contact with patients/clients has focused on measuring their satisfaction with the services they receive. However it has increasingly been 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 has been 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 that they received. It is about listening to them as people rather than merely patients (McKinley et al, 2001). By doing so service teams can identify for themselves needs to which they can respond and can establish their own improvement priorities based on what they learn.

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).

Building Balanced Sets of Outcomes Measures	Within the US the work of the Institute of Health Improvement had adopted what is known as the "clinical value compass". Underlying this model was the principle that, because both health and healthcare are complex, no single measure could provide a clear picture of critical areas of performance. It was necessary to identify a set of measures relevant to a particular client/patient group and that are considered to be significant by those staff providing their care. These measures are; functional health status, satisfaction against need, total costs and, clinical outcomes (see Figure 1). The clinical value compass has been perceived as having 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.
Having a framework for learning	Experience with improvement teams suggests that participants benefit from having simple frameworks to guide them through their efforts. The framework adopted within the project was based on the work of Nolan and his colleagues.

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.

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

Addressing these questions leads to the Plan-Do-Study-Act (PDSA) cycle used as the guide to the implementation of, and learning from, the changes. As Berwick has noted, all improvement is change but not all change is improvement (Berwick, 1996). The Nolan framework was to structure the approaches adopted within the RIPE project, either explicitly or implicitly.

Broadly speaking the Nolan framework can be translated into the following major steps to be used as a guide by the RIPE teams:

a. Identify a specific group of patients as the focus for enquiry.
b. Agree a high level, general aim.
c. Clarify what was currently known about these patients and their needs.
d. Describe the processes by which these needs were currently being met, using flowcharting if helpful.
e. Use what was learned from steps c) and d) to identify areas for improvement.
f. Turn these improvement ideas into specific actions with simple feedback measures.
g. Use learning from the feedback to design further improvements.

This approach was to provide the framework to be delivered to multi professional groups within each site.

Levels of project co-ordination	The project was supported internally and externally. Within IHCS the establishment of a Regional Interprofessional Education Project Academic Team constituted an internal mechanism for project management.
Within IHCS	Meetings were held on matters relating to the activities of the action learning sets and project management, providing a forum for sharing and learning from developments at each site. Working sub-groups were 'spawned' from these meetings, and at a later stage the team also used the opportunity to use the

group structure to examine and generate shared understandings on several project-related areas.

There was a 'team leader' with an overall project management brief. The professional backgrounds of the university team frequently included multi-disciplinary or multi-agency experience within their professional lives, which may be described as a 'dual aspect' or interface to their professional profile or 'professional biography'.

The twelve staff who originally signed up to the project included the following range of health and social care occupational orientations.

Dual aspect:	nurse and social worker qualification
Dual aspect:	GP educator and improvement practitioner
Dual aspect	nurse and leading edge clinician with an interprofessional focus
Dual aspect	mental health nurse and academic manager
Dual aspect	social worker, educator and technology developer
Dual aspect	mental health nurse working across health/social care boundaries
Dual aspect	psychologist and social worker qualification
Dual aspect	clinical psychologist and psychotherapist (phenomenological orientation)
Dual aspect	clinical psychologist, educator and improvement practitioner (systems orientation)

At site level

Site support groups were set up at each location. The precise format varied from site to site, according to the local service structure. There were several meetings between university staff, ALG members and NHS Trust representatives. Meetings were held on matters relating to the activities of the action learning sets and project management.

Issues raised at site support group meetings included whether Ethics Committee approval was necessary for the activities of the hospital based LIT; how to re-engage with a professional group no longer attending meetings; and whether the work of the ALG was congruent with the management focus originally planned.

Within the collaborative

The Bournemouth University element of the RIPE project is framed within the broader context of the NHS SW collaborative, together with other major regional award winners (the University of the West of England and the University of Plymouth). External co-ordination was provided through NHSE sponsorship in terms of collaborative and evaluation events and for instance, providing an initial literature review. This collaborative process is subject to a separate external evaluation.

The aspiration of learning from on-going projects was reflected in the structure of the regional collaborative events, which provided opportunities for those involved within improvement activities to meet and share experiences with other members of the forum. Such events took place twice a year, and reflected the overall aims of the NHSE South West.

Typically there would be poster presentations and a number of representatives from practice settings. Issues raised by the Programme Board would be discussed, together with issues of commonality between the site and NHSE members. Such issues included assessment, evidence base, extending the

project (or mainstreaming) and the involvement of medical staff.

Variation across sites

The Castlebury elderly care site

In the Castlebury setting, the focus of the project was upon services to elderly people within the Elderly Care Unit at this rural County Hospital. This building, constructed to harmonise with the local landscape, was part of a purpose built unit opened by the Queen in 1998. The Elderly Care Unit was designed to focus on acute care needs, with patients assessed and moved onto their next stage of treatment within a short period of time.

The patients to be considered were those with chronic disabilities and diseases, presenting with multiple and ill-defined problems developing over time and which may have been amenable to interventions other than hospital admission. This group was chosen because they were perceived as being resource intensive and may have been receiving inappropriate care.

Two teams were involved in the RIPE project. The first team, with staff from Brookes ward, began to meet in October 1988. The second team, from Yeats ward, met for the first time in May 1999.

ALG membership

Participants in the first hospital based ALG to be established included a range of health professionals. Their clinical roles included consultant, nurses with a range of roles including lecturer practitioner and clinical nurse specialist. A physiotherapist, occupational therapist and a social care professional completed the group.

A similar profile of participants engaged in the second Castlebury ALG, including a range of nurses in parallel roles, a consultant, individuals within professions allied to medicine, and a social work professional.

Within this hospital context medical consultants were male and all other participants female.

The changing membership in this team was reflected principally through naturally occurring life events; for example, one member of the team went on maternity leave, only to return and make a career shift into a community location.

The Oldburgh mental health site

The participants in this site were to be members of community mental health teams in Oldburgh and a southern rural conurbation. The teams had recently been formed, and leaders appointed from social work and nursing backgrounds. At the planning stage it was anticipated that they would shortly be located together and would be embarking on a major phase of service and team development.

Within this site one specific objective was to draw on outcomes of previously completed work to develop occupational standards for community health teams. This project was The Conrane Project, which identified a number of implications for community health teams and for their training.

ALG membership

The core membership of the Oldburgh ALG for post-qualified staff comprised members of the psychiatric nursing staff, a manager of the therapeutic service, also a nursing specialist, and an occupational therapist. At various times members of the social work department joined (and left) the group. One psychologist also joined the group until moving into another area. A service user development worker, formerly trained as an occupational therapist, also joined the group.

The Newton child and family care site

The focus within the Newton setting was to be on supporting and empowering parents in order to reduce the number of children presenting as a "cause for concern" to health and social service agencies. The intention was to involve a

range of professionals, together with representatives of parents and voluntary groups.

Professional workers in the area aimed to provide a collaborative multi-agency child and family service empowering individuals to take responsibility for their own health and that of their children, with a particular emphasis on the development of parenting skills.

There was a community orientation within the Newton setting. The first meetings were held in the community hall of an electoral ward. However, there were few facilities and after several meetings, hospital accommodation was used.

ALG membership

Members of the child and family support service participating in this ALG included a health service manager with a nursing background and several health visitors. Collaborating with these health professionals were members of several voluntary organisations working in partnership with parents. At various times the ALG provided a forum for mothers to participate in the group and express their views on the 'Stay and Play', and what it had meant to them. (At this time several children attended the forum). Similarly a paediatrician and key staff member from an Early Years centre in Newton, also visited the ALG. A member of the Social Services Department attended the first few sessions, but ceased to participate.

With the exception of one member of the Bournemouth University team all those participating in this project were female.

Chapter Two   Methodological Considerations

Study design

The evaluation objective of the collaborative framing the RIPE project was to "assess the impact of a collaborative approach to achieving health and social care improvements through interprofessional education, using continuous quality improvement in health professions education and, to determine the implications for future curriculum change".

The university proposal aimed to capture and tell stories of learning and improvement within the project, thus gaining a range of meanings and insights about practice-based, needs-based learning in interprofessional learning contexts. As such the evaluation was framed within a 'constructivist' model (Guba and Lincoln, 1989), based on a belief that there is no reality other than that individually created by people in the process of 'making sense' of their experiences. Reality is both individually and socially constructed. Individual meanings are themselves products of biography, history, and local circumstances besides broader social divisions of class and gender. Synonymous with this constructivist approach was an underlying philosophical orientation towards capturing 'the lived experience' of the project.

The notion of 'the lived experience' reflected the underpinning phenomenological orientation to the research, and a case study approach was adopted to frame the phenomenological inquiry. Similarly, there was an emic view to the construction of the case study, in that it aimed to portray both concerns and experiences of project participants. There were thus two strands to the evaluation of the project, the case study itself and the story of learning. Such an approach was considered to be appropriate methodologically because of the complexity of the project.

Three sites were to be the project settings, and these formed the settings for this naturalistic inquiry. No sampling decisions were made. The sites were all to be included in the case, thus lending maximum variation to the diverse characteristics of sites and settings.

An extensive literature review of interprofessional education had been commissioned by the NHSE (SW) (Tope, 1998) and undertaken on behalf of the region, and this was circulated to collaborative project participants prior to the beginning of data collection.

An evaluation perspective

However, the purpose of this case study was to evaluate a specific project, and the underlying frameworks supporting the rationale for evaluation were drawn from educational approaches.

Given the strong lead on learning within the project it was decided to draw further on educational influences. A seminal conference took place in December 1972 on evaluation practices in education. The arguments which took place then, although almost thirty years ago, remain relevant to explorations of learning in many contexts.

Conventional approaches to evaluation, according to Parlett and Hamilton (1972) were shaped by experimental and psychometric traditions then dominant within educational research. These authors argued that such evaluations were inadequate for confronting the complex problem areas they encountered, and as a result constrained effective input to the decision making process.

In contrast the introduction of an illumunative evaluation into educational

research was seen as belonging to a contrasting 'anthropological' research paradigm. In this:

> *"Attempted measurement of 'educational products' is abandoned for intensive study of the programme as a whole: its rationale and evolution, its operations, achievements and difficulties. The innovation is not examined in isolation, but in the (school) context or 'learning milieu'...Observation, interviews with participants (students, instructors, administrators and others), questionnaires, and analysis of documents and background information are all combined to help 'illuminate' problems, issues and significant programme features"* .
>
> (Parlett & Hamilton, cited in Stenhouse 1975)

Crucially, in Parlett and Hamilton's model two concepts are central; the 'instructional system' and the 'learning milieu'. Within the RIPE framework the 'instructional system' corresponds approximately to the experiential learning approach adopted within action learning sets, combined with the process of continuous quality improvement (CQI). The learning milieu within RIPE is the 'facilitating framework', the social-psychological and material environment in which the students (in this instance practitioners) and university co-workers function together, that is, the crucible for learning known as the ALG. Clearly within the project each setting and combination of settings, participants and service constitute a unique learning context.

To capture this intricate process of learning and change the evaluation strategy was further influenced by lessons from school improvement (Ainscow, Hargreaves and Hopkins, 1995). Having adopted a particular approach to the evaluation, it became critical to select appropriate data sources in order to construct a case study congruent with project aims.

Data gathering

Data were gathered from a range of sources including interviews, de-briefings, e-mails, written accounts, field notes and a number of policy and media documents. A "watching brief" of relevant web sites was also maintained (for instance the Department of Health website). The following indicates the range of sources and the details of a number of interviews conducted.

Interviews were an important method of data collection, taking place at a range of levels. In order to construct the boundaries of the case interviews took place with key stakeholders within the NHSE. Interviews took place with pre and post qualification learners; most of the pre-qualification learner interviews took place within the practice setting; there were two exceptions. These took place within the university.

It was decided to adopt a range of techniques to capture the process of learning, change and potential improvement as experienced by those participating in the project. This may be regarded as the first level of data collection. There were several different types of interviews, which took place across the three sites; these included **exit interviews, systematic de-briefings and in-depth learner interviews**. There were also several **group interviews**.

The in-depth learner interviews and exit interviews took place with members of post-qualification ALGs; whilst the systematic de-briefings took place with members of the university team. In total 23 in-depth learning interviews took place. Several also functioned as exit interviews.

The initial **exit interviews** were carried out with the aim of gleaning experiences from all stakeholders; that is, everyone involved in the project. These interviews served to inform subsequent focusing, and highlight any emerging issues. These took place with staff leaving the project ALG stage in order to move onto further practice settings, or simply, in one case, to leave the

group. Analysis of data signalled, revealed and highlighted themes emerging in the case study within the final data analysis. These informed subsequent progressive focusing. The variation in the range of individual in depth **learning interviews** across sites at post qualification level is shown below:

Castlebury	In-depth learning interviews	10
Newton	In-depth learning interviews	7
Oldburgh	In-depth learning interviews	6

At Castlebury, group interviews were also held at the conclusion of the ALG, in order to further explore, at a group level, the group learning experience. This did not take place in the community based settings. In both instances closure did not happen in the same way; in one case the project essentially built on and enabled further developments. In the second case the fragmentation of the group and the service re-organisation rendered this problematic within the time frame.

Interviews with pre qualification learners were necessarily more opportunistic and reflected the differences in timing and structure of experiences.

At the Castlebury site the single pre-qualification learning experience was explored within a group interview at the conclusion of the student experience. The duration of the project made it possible to follow up these students one year after this event, and two further individual interviews took place. There were also two email responses to interview schedules.

Learners within the Newton Stay and Play were interviewed in pairs following the conclusion of their placement. Two of these paired interviews took place. A further individual interview took place when a single student was learning and working within the Stay and Play. (This participant was also trained to interview service users).

Focused group interviews also took place with two groups of multi disciplinary and agency sets at the Oldburgh setting. The final interprofessional experience was carried out in uni-professional sets, and capturing this experience proved problematic. Two telephone interviews were conducted. One learner was involved in several groups, continuing project work across sets. A double interview took place in this instance, with six months between interviews. Two exit interviews also took place at this site with individuals who attended single sessions.

The **systematic debriefing** is explained subsequently; this practice was carried out across sites with CQI facilitators following ALG meetings with both pre and post qualification learners. 54 of these took place. The interview was unstructured, aiming to capture the process and content of the ALG meeting, together with any important learning; this process was in itself a reflective process. The prompt for the interview would be:

> Could you tell me something about what happened at the….?

Data from these interviews formed an important part of supplementing accounts of ALGs, fleshing out the skeletal structure of the notes. The action oriented bullet point style yielded information about actions, but not about process.

There were two levels to the data gathering for evaluation purposes. Each site was pursuing its own improvement project, and within the CQI model they were independently responsible for the collection of evaluative data as part of the PDSA cycle. The second level of the evaluation focused on the study of the ALG carrying out this process.

The issue of collecting data from the practice-based ALGs was addressed at the outset. It was recognised that non-participant observation would be helpful but impossible across the three sites. Initial discussions included the possibility of using 'reflective diaries' for individual participants within action learning sets, but it was considered this would place an additional demand on those already fully occupied within the service context. An alternative explored was for a 'wash up', a term used within social care for the process concluding team meetings; this aimed to capture and reflect the substance of the meeting. In practice this did not happen.

A modified strategy was therefore adopted, incorporating a *systematic debriefing* from the CQI facilitator following the meeting. These interviews, focusing on the process of the ALG, were tape recorded and transcribed. These mostly took place within the university, although some occurred with other contexts. Inevitably they reflected the life of the project. (One took place within a university academic team Away Day; the setting was a hotel bedroom). The de-briefings aimed to supplement *written accounts* of the ALGs circulated amongst other members of the ALG, within the university team as well as practice partners involved in the site teams.

Several months into the project access was negotiated to attend ALG meetings taking place within one site (Newton). Initially intending to be a non-participant observer, this role evolved, although as researcher there was no intention of taking an active role. Rather, support was offered to the work of the developing LIT for the purposes of data collection. It was also felt that broad experience in the educational sector was transferable. *Field notes* and observations provided further insight into project evolution in this setting. At times, limiting personal involvement was akin to maintaining a precarious balance on a tightrope.

To assist with constructing the case study, interviews were conducted with a range of stakeholders, including members of the NHSE commissioning executive, and pre-qualification learners engaged in the project. Since the strong 'learning orientation' related to the 'organisational learning' associated with the project, 'learning biographies' of the academic team were collected, to create a profile of project participants. In the early stages 'time lines of change' were also used with members of the academic team, again drawing on educational influences (Ainscow et al, 1995), in order to capture early experiences associated with the evolving project.

The following table shows the range of methods that were used:

GOAL	APPROACH	TECHNIQUES
The story of improvement	Action research based on CQI	PDSA (Plan Do Study Act), fast feedback questionnaires, interview guide, parent feedback questionnaire
The story of learning (process)	Case study	Accounts of ALG activities; minutes of ALG activities; observation at ALG, debriefings, learning inventory, field notes
Meanings and insights about learning	Phenomenological Study	In-depth interviews and analysis

Table 1: Research Framework

Post qualification learners

Within ALGs, interviews were conducted with project participants as key informants. The criteria for inclusion was based on attendance at a minimum of four ALGs. In the early stages several *exit interviews* were conducted with former ALG participants.

The phenomenological nature of the inquiry endeavoured to explore the 'lived experience' of project participants as they learned within the project. In practice the stimulus question led to further in depth interviewing. The stimulus question was:

In engaging with this project I would like you to refer to any experiences that were significant to you in terms of your learning.

The 'learning interviews' proved to be an important source of data collection. In order to verify emergent findings on the nature of the learning within the groups, a 'learning inventory' was developed and distributed to members of site based learning groups. The purpose of this was to verify emergent areas of learning identified within data collection and analysis.

At the outset the intention was to carry out a phenomenological analysis of interviews, however, principally because of the importance of the social context emerging within the interviews, this framework was amended to a thematic content analysis.

A phenomenological analysis was limited to the activities of the academic team as they developed their joint views of interprofessional working based on individual and collective experiences.

Pre qualification learner groups

The initial proposal was to collect data from focus groups of pre-qualification learners. Collection of data became more individualised as groups evolved. In the first (and only) group based in one setting, (Castlebury) one set of pre-qualification learners participated in a focus group at the end of their learning experience. One year later these informants were contacted to conduct second interviews, this was not possible in all instances, and several email exchanges conducted an outline follow-up interval.

Interviews with pre-qualification Newton participants took place in paired combinations, or on an individual basis. In the case of Oldburgh several focus groups took place, supplemented by several telephone interviews and one individual interview with participants, in order to capture learning experiences of as many ALG members as possible. Despite this it was not possible to capture the experiences of all learning group participants.

Several exit interviews also took place with pre-qualification ALG participants who attended single sessions. Both informants were from high status professional groups, and it was considered this might influence further focusing within evolving aspects of the evaluation.

Constructing the boundaries of the case

A range of supplementary data sources contributed further to the emerging construction of the case study. These included policy documents and other relevant artefacts.

In the initial stages of the project an on-going chronology was maintained, detailing events such as the collaborative, relevant site and practice based developments, together with the emerging pattern of ALG events. Field notes were derived from external events (such as within the Collaborative), site based Evaluation Support meetings and significant internal events such as team Away Days. There were a total of 53 field notes in this context, some of which were reflexive.

Data analysis

The data (transcripts, documentary evidence and field notes) were transcribed and analysed using content analysis. An initial thematic analysis was the basis for a continuous iterative process. (This information was recorded on summary sheets identifying key issues, context, and main themes). Midway through the

project the research co-workers verified the emergent categories, identifying codes and categories.

Emergent categories were used to focus subsequent data collection and frame the case study. Final categories provided the analytic framework for the case study.

A concluding data analysis prior to the construction of the case study was structured within previously agreed categories. All data from the learning interviews was coded and categories entered onto cards. Some categories were compressed. A slightly different approach was used to data analysis providing a 'monitoring account' within the stories of change and improvement. In this instance the analysis focused on action-oriented decisions within the educational approach, relating these to instances occurring within the data, or relevant issues. This was a computer assisted process. From this combined analysis outcomes were identified, initially on a site by site basis.

Ethical considerations

All interviews were tape recorded and transcribed. Assurances of anonymity and confidentiality were given to interviewees, from whom permission to tape record the interviews was sought. A copy of the transcription was subsequently sent to project participants. Individual interviews have been anonymised, and case study sites given similar treatment.

Copies of case studies have been presented to RIPE participants in practice settings; the partners in this project.

Trustworthiness issues

A number of techniques were built into the study in order to address trustworthiness issues, on the model described by Lincoln and Guba (1985). Triangulation of data was one way of endeavouring to strengthen claims to trustworthiness prior to construction of the case; this was principally in terms of triangulation of sources. In addition to field notes a number of field journals were maintained; reflexive journal supplemented the chronology maintained in the first part of the project. A methodological log evolved from this.

Peer de-briefing with the project supervisor provided the opportunity to relate work and evolving issues to another project team member. Category sets were debated at various key stages, and ensured no issues were overlooked.

In the early stages of the project, these issues were particularly significant because, as so many participants maintained, the process of 'holding' an innovation together in the early stages of the change process is to be, by definition, working in a manner which is 'counter-culture', and therefore, likely to generate tension. A reflective journal addressed the ramifications of researching within this process, together with the 'invisible support' of colleagues working in the broader context of learning within health settings, besides what is known as the nebulous area of 'interprofessional education'.

Chapter Three

The Story of Improvement: Three Sites

Part 1   The Castlebury Experience

The story of improvement

A story of a clinical team learning about itself and how it worked in action is key to the journey of change and potential improvement in Castlebury, a rural county town. In this setting members of Bournemouth University and health service professionals met for the first time in October 1998.

The ALGs in this setting all worked within a hospital setting. The Elderly Care Unit within this hospital trust comprised three wards within a purpose built unit opened in 1998. The aim of the unit was to assess the needs of those members of the local population in order to ensure their optimum placement elsewhere in the community, whether at home or in alternative provision.

Members of the ALG were drawn from those involved in care delivery on one ward, Brookes Ward. This multidisciplinary group included a physiotherapist, a ward sister/clinical nurse specialist, an occupational therapist and the consultant in elderly care. They were joined by a social services professional based in the hospital thereby creating a multiprofessional group. The Bournemouth University team included the CQI facilitator, together with a lecturer practitioner with a nursing background in elderly care, and an educator with a background in social work and educational development.

A project site support group was also established. This met on several occasions, reflecting practical issues related to the project. Partners from the university met with clinicians participating in the project to discuss project progress, and any practical concerns such as ethical matters.

This extended presentation of the project's progress chronicles the steps of the team's learning development using the continuous quality improvement model. This framework structured the journey towards improvement, based on naturally occurring work and practice situations. All sessions took place within the hospital setting.

As stated previously, in each of the three sites within the RIPE project, the broad educational framework remained within the context of health improvement aiming to provide pre- and post-qualification interprofessional learning experiences.

The RIPE project also aimed to develop interprofessional education with a focus of patient/client service improvement, whilst also gaining an understanding of the contribution of service users to interprofessional education.

In the following case all statements by ALG participants are shown in italics.

The first session
Getting started -
Finding a focus

As an introduction to the project the model of care underpinning this piece of work was introduced, showing a continuum with a patient with unmet needs at one end, and a 'clinical compass', showing satisfaction against need at the opposite end of the continuum. The process between the two represents the system of care.

In this case after some discussion the focus for study was agreed. The team's

decision was to focus on patients perceived to have been frequently and sometimes inappropriately re-admitted to beds in the unit. Such patients were sometimes known as 'revolving door patients', and frequently presented a challenge for those engaged in delivering the service.

Agreeing an aim

Having identified a focus it was possible to identify an aim. This was to ensure patients and carers needs were met both more appropriately and satisfactorily. There was a concomitant aim on the appropriate use of resources.

Building knowledge of patients

At the first meeting it was agreed to interview the next twelve patients and their carers who the team felt to have been inappropriately admitted. The existing Kardex information form was to be used as the basis for these interviews, adding extra questions on the admission episode and circumstances from the patient perspective. This form was to be piloted on the next three patients to establish whether it was tapping into the right information.

Building knowledge of processes as a team

The use of the flowchart is an essential ingredient of the PDSA approach. Using this, the team prepared a "high level" flowchart to identify major activities undertaken on behalf of these patients. These illustrated the following stages:

- Referring to the ward;
- Pre-admission "assessment" "gatekeeping";
- Admitting;
- Assessing;
- Planning (including discharge);
- Implementing;
- Evaluating;
- Leaving the ward.

As part of the facilitated process a 'parking lot' of issues arising within the group's discussion were recorded as they arose. These are ideas which although valuable, do not necessarily inform the specific action agenda.

Next steps planned for the following meeting included feedback from patient and carer interviews and a range of further questions.

To recapitulate, the following steps were achieved:

- Aims identified;
- Patients and carers needs to be met more satisfactorily and appropriately;
- To ensure the appropriate use of resources;
- Next steps planned;
- Twelve patients and carers to be interviewed;
- Decision on adapting existing information system;
- Form to be piloted on next three patients.

Moving forward

The next meeting reviewed the project focus: patients considered to have been inappropriately and frequently admitted to the consultant's beds. The aims, about patient and carer needs being better and more appropriately met, were re-visited.

Checking

Building

There had been some difficulty in assessing the three patients that it had been agreed to assess. A proforma had been produced in an attempt to capture the nature of the information required along with the source and who obtained the data. It had been tested with one patient and was presented as an example. Use

knowledge about patients	of this format was to continue, with the additions of the patient's referring GP and referrer's expectation. It was anticipated that this might highlight reasons for admission.
Building knowledge of processes as a team	Key issues emerging at this stage focused on personal and interpersonal aspects of individual and team processes. Qualities such as the personality of the consultant and questions such as 'who meets with difficult relatives and how is this tackled?' were issues that arose during the session. The process of decision making proved more difficult to understand.
Issues that emerged	It was recognised that using the proforma, whilst improving knowledge of patients should not be burdensome to staff. Ways to cope with this were considered and there was agreement that capturing information during the admission process rather than retrospectively would be preferable. It was considered that intervention at this stage would enhance the chances of discovering the feelings of individuals at that time.
The outline improvement process	The flipchart was used to illustrate the major steps of the improvement process guiding the project. The first two steps had been addressed, steps three and four were being worked on, information gathered from step 3 enabling step 4 (see Appendix A).
Reflecting back on the meeting	The last fifteen minutes were devoted to reflecting back on the meeting process and in particular addressing two questions: What have we learned so far? How have we learned it? Responses included: • Surprise at the limited understanding of what and how decisions are made, despite the team's belief that they worked well as a team. • Disciplines need time to reflect. Time was often needed to listen to others outside the multidisciplinary team who may have more objectivity. • For one person there was powerful personal learning regarding their own motivation and how this impacted on their chosen area of care. • Another person discovered how people got into hospital, something which had not previously been clear. • The need to work together as a team.
Planning	In this early stage of the improvement process planning was limited to receiving initial feedback on the patient and carer interview, preliminary actions in planning an improvement cycle. It also anticipated the practicalities of the next meeting.
The next meeting Building knowledge of patients	The group had changed: a social worker had joined and one nurse had also moved back into the community following a period of absence. In providing feedback on activities following the last meeting, an unexpected finding emerged. Few patients coming within the category of "inappropriate and frequent" had been admitted since the previous ALG meeting, despite the fact that in elderly care the winter season was their busiest period. Therefore it was not possible to learn more about the needs of this group through the admissions proforma.

Some discussion related to whether the actual focus of the group on inappropriately and frequently admitted patients was being used to illustrate the overall process of team working rather than on the patients themselves.

It was suggested (and all agreed) that the proforma would be used at the regular team case conference to consider individual patient's needs. This would also have the advantage of involving a wider range of staff including more junior members, besides building on existing working practices by using existing mechanisms wherever possible.

Building knowledge of our processes as a team

The team 'walked through' the flowchart mapping their activities and extended this to include actions relating to social worker involvement (see Appendix B).

Possible change ideas

This was the third meeting, and the group was keen to make actual changes. From reflection on the learning to date, an initial list of possible change ideas was produced. Team members agreed to share these with other colleagues and check their responses. This re-focusing helped individuals, some of whom reported feeling somewhat 'lost'.

The identified change areas addressed a range of issues. One concerned the locus of authority within the team, particularly whose sanction was necessary to change plans, and thus exploring and increasing the flexibility of decision making. Information gathering was seen as crucial, there was a desire to make this less 'ad hoc' and fill any identified gaps. It was recognised that a process was necessary to ensure full information was available to inform decisions. There were repercussions beyond the team, it was recognised that improvements may be necessary in the consistency of information supplied to other professionals. There was a need to be more explicit about the department's role, both to GPs and other referrers, but also within the internal Medical Directorate. Unified notes were suggested as being a common document potentially available for all to work from.

Developing more explicit educational roles was also mooted as a possibility, including some which may appear to reverse or invert traditional hierarchical structures.

It was planned to confirm the list at the following meeting and establish priorities for the first tests of change to take place. The aim would be to have begun implementation planning by the end of the meeting.

Pre-qualification learners

Each site aimed to provide educational experiences for pre-qualification learners from different health and social care professional groups, and planning for groups of pre-qualification learners was underway. Students on practice placements for five weeks from February 22 would be engaged in an interprofessional ALG.

A number of points were agreed with ward based ALG members, including a decision to restrict nursing students to those on placement on Brookes ward, and a decision to invite the doctor on placement from the GP vocational training scheme. At the suggestion of the practising health professionals it was decided to focus on actual patients with the pre-qualification students, rather than hypothetical illustrations.

Reflections on learning within the meeting

The following observations were made:

- Key learning focused on dealing with the uncertainty of working in this way, with an apparent emergence of a preparedness to accept the gradual process.

- The action orientation was clear and reassuring when it emerged, yet paradoxically action was recognised to be more difficult than talking. New working practices, such as identifying and developing measures was a slower process, with a 'new vocabulary' to be learned.

Key learning:

- Doctors realising that there is no "right answer" .
- 'Feeling lost' at the outset of the meeting was ameliorated by generating change ideas and clarified the project path.
- Concrete changes can be chosen and measured.
- The 'wooliness' is being refined.
- The possibility of using nursing staff to educate medical staff is positive.
- It will be interesting to see how using the information pro-forma in case conferences will work.
- It will be interesting to see how outcomes are measured.
- It is easier to talk than do.
- "Systematising" real things is not always the right answer.
- Focusing on real things, that will make a difference, is important.
- The need to be flexible and pliable.

This team were also keen to start involving other teams in the unit. There had also been a question relating to a query on questions for the Ethics Committee for which a response was sought.

Once again the meeting ended with a review of items to be considered at the next meeting.

Moving forward

As previously mooted, the next meeting initially focused on change ideas raised at the previous meeting, considering those which most affect the patient. It was suggested that when a patient was admitted, the physiotherapists gained much information from the Kardex. This was a 50:50 balance of information gained between patients/relatives and notes. It was suggested by this person, that talking was more productive than notes. Essentially the discussion was focusing on an information exchange, with gathering information a key area.

From this a key change aim was agreed:

To obtain relevant information, collected once and available to all and accessible on next admission.

This change in working practice would have a number of consequences, structured in the language of CQI as:

How will we know if a change has had an impact?

- Staff will find it easier to obtain relevant information.
- The information will be more complete and up to date.
- Patients/carers/agencies will have to give their story only once.
- Staff will spend less time finding information.
- Plans will need changing less frequently due to extra information being available.

The following alternatives were suggested as a means of moving towards actioning a change within the immediately following weeks:

- Look at assessment (possibly using list previously developed).

- Home environment different professions could add information to these.

- Support network.

- Medical diagnosis.

- Use Kardex system. All disciplines to contribute.

- The use of an additional sheet is possible.

All staff needed to be aware that basic information would be available in that sheet, to which anyone could add bits of information. This document would be the primary source from which to gather information, and might be a precursor to electronic gathering.

- Need to ensure assessment sheet and add-on sheet are automatically available.

- Need to identify the data required.

- Sheet must be kept with the discharge summary.

- Design and use an add-on sheet for the Kardex, if assessment sheet does not provide adequate recording space.

As previously mentioned, within this action oriented, inclusive, and facilitated model, a number of items are 'parked' in a 'parking lot'. These are ideas which, although valuable, do not necessarily inform the specific action agenda. However, to illustrate the nature of these items, two are given below, based on this team's working practices:

- Doctors tend to ask staff for information rather than use the notes.

- Use assessment sheet to inform discharge plan from the beginning.

The following actions were agreed, in order to move the action forward and ensure that participants in the ALG had the opportunity to learn from their changes:

Operationally what next?
What changes can we make?

- Everybody will put basic information into the assessment sheet.

- Assessment sheet to be used as the primary source of information.

- Design and use an add-on sheet for the Kardex, if assessment sheet does not give enough space

- Design useful data that could be stored electronically now, but be available for next admission – an electronic discharge summary.

An action agenda of dissemination with other clinicians and students regarding the new practices was developed. Essentially all items were interprofessional collaborative processes.

There was also a short discussion on extending the approach beyond Brookes ward to other areas.

The next meeting

Linking into the hospital and existing project on multi-disciplinary notes

An internal visitor to the ALG explained that a format for multi-disciplinary notes had been designed by the hospital working group and would be piloted on selected wards. It was agreed that the work of the Brookes ALG fitted very well with the outcomes of the hospital working party. Following discussion it was clear that the process of using the notes in practice was as important as the design of the notes themselves. This was an important consideration, since it was considered the experience of the Brookes ALG could make a significant contribution to helping other teams to think and work interprofessionally. Building on the ALG's aim to improve, the use of the Kardex was confirmed as contributing to the possibility of Brookes Ward becoming one of the early pilots for the hospital project. This fitted well with the framework of making a small change and using feedback from appropriate measures to plan next steps.

The improvement cycle was re-presented, with the original change aim repositioned:

To design a process to obtain relevant information which only needs to be collected once, and make it available to all, and easily accessible on a patient's next admission.

The next question (**"How will we know if a change is an improvement?"**) produced the following measures identified by the group as providing useful feedback about the impact of the changes:

- There will be fewer gaps in relevant information: this would be measured at case conferences by noting how many times questions were asked for which the group did not have answers.

- Asking selected patients if they had been repeatedly asked the same question.

- Asking nurses if they're being asked fewer questions, by professional colleagues.

In considering this question the group identified the following tangibles:

- Everybody would use the Kardex as the **primary source of information** and use a continuation sheet to add extra information if necessary.

- For each patient there would be an identified person with co-ordinating responsibility – initially this would be a nurse. Hopefully this would reduce gaps in information about each patient.

From this the next stage of action planning emerged:

Plan

- Ensure that everybody knows how to use the Kardex in the new way.

- Ensure that continuation sheets are available (this would be discussed at a weekly ward meeting).

- Ensure that a nurse with co-ordinating responsibility is identified for each patient and that staff from other professions understand this.

It had become increasing apparent to those involved that although this was a good team, many assumptions had been made about the reasons for this, and the complexity and mystery of those team processes became evident.

The use of the flow chart within this CQI model was recognised as being a valuable tool in actually helping the team explore their working relationships in a non threatening way:

As a CQI facilitator observed:

> *"It is a brilliant tool for getting non threatening conversations going around people wouldn't necessarily otherwise do it, talk about things."*

Feedback provided at the next meeting included a reiteration of points from the previous meeting besides providing more information on which to develop the action learning.

There were signs that using the Kardex as the primary information source had been accepted. Inclusion of information from the social worker was proving particularly useful.

An attempt to record how often there were gaps in the information needed about individual patients had not been successful. It proved difficult to establish what was missing, and it was perceived that gaps were sometimes filled by assumptions. Questions focused on whether more information was necessary about patients: should it be about the patient's illness or more broadly about their lives? Different professionals needed different information (e.g., nurses and social workers).

Equally the value of specifying information considered "useful" or "essential" was discussed.

Different recording systems across teams produced difficulties in sharing information (for instance, different medical teams, community hospitals).

Continuation sheets would prove valuable to record information obtained later. It was felt that late or incomplete information about patients contributed to the need for re-admission.

There was a discussion about the content and design of discharge letters and whether they should be personalised to individual GPs. GPs should also be alerted about patients who have been discharged and whose family have declined help, especially if the team have misgivings.

The Kardex is public and questions about storing sensitive information arose in discussion, particularly that whilst such records may be subjective, they were essential if, for instance, at a later date enquiries about patient care arose.

The team agreed it is very important to know that their practice was improving outcomes.

The team agreed that it would be useful to learn from the care of patients who had to be re-admitted rapidly and to check whether they could have done anything differently.

The possibility of establishing patient held records was considered.

Plan

Actions agreed as a result of this discussion included the identification of patients re-admitted within two weeks, and in the case of an inappropriate admission, check whether the initial admission could have been handled differently.

Other actions included liaison with those involved with unified case notes to establish what was emerging on discharge information. Further, the team would explore the feasibility of establishing patient held notes.

A 'testing ground' of patients with difficult problems who were in danger of 'bouncing back' was outlined.

As a first step it was agreed it would be useful to discuss ideas raised with those in primary care receiving the information, including a GP, a district nurse and a social worker.

Feedback on action

The next meeting included feedback from the CQI facilitator on 'the Castlebury story so far'. This was agreed to give a good summary of the team's activity. However the Brookes team felt there were also a number of less tangible differences in the way they worked although it was not clear if these were related to the RIPE project. Following the established pattern, feedback on actions occurring since the last meeting were sought.

The change in practice - feedback

The increased information on the Kardex was perceived to be accompanied by a resultant increase in recording and interaction.

Nurses were still asked for information already recorded in the Kardex.

The use of a continuation sheet had worked very well for the recent discharge of a patient with complex needs. This was because all information was in one place. However it was recognised that not all information necessary (about support networks, previous levels of functioning etc) was available to answer the team's questions.

Care was needed to ensure that personal contact between staff was not lost.

Discussion about the team's current operation

There was an underlying concern that the time spent discussing the team working and relationship practices almost impeded the improvement tasks, leading into a philosophical debate rather than focusing on the action orientation towards patient needs underpinning the continuous quality improvement approach.

A particular issue on the ward concerned a sensitive issue (in this instance resuscitation) and there were strong and sometimes conflicting views amongst team members. It was recognised that time was not available for the team to discuss what was potentially a difficult and divisive issue on which there was then a need for practice development.

The CQI facilitator suggested that some consensus was necessary and this could be tackled as an improvement project at the end of the planned audit meeting on this topic. The methodology was explained, and how the questioning format could be applied to guide the team in their working on this matter.

Besides this consideration, the team's use of the Kardex led to a discussion about their interprofessional working. From this a number of issues emerged.

It was felt that:
- Improved understanding of how the team operates would make it easier to adopt the multidisciplinary notes.

- The working practices of this team were quite non-hierarchical, a situation frequently requiring a briefing for new junior doctors:

To quote the CQI facilitator:

"Because one of the conversations they had last week was the difficulties junior doctors have coming into the ward and especially

then leaving the ward when they come in and find the nurses telling them what to do, as opposed to you know, touching their forelocks to them. B was saying that he has to brief junior doctors as to how decisions are made on this ward and quite often, team meetings ratify the decisions that the nurses have made, as opposed to making the decisions."

Whilst this aspect of an evolving service was recognised to be an important agenda, it was not necessarily parallel with the design of services based on patient needs, since essentially it was perceived to be serving professional interests rather than those of the service user, those originally described as 'revolving door patients'.

This was one of a number of tensions at this stage, with a particular challenge for the facilitator between an experiential adult learning model, with the team fully controlling the agenda for discussion, reflection and potential learning, and being more prescriptive.

The value of patient focused discussion was considered to be very helpful and could, it was suggested, become part of everyday practice on the ward. Application of the quality improvement approach would also help in designing changes.

**One year into the project
Aspects of team working**

There was some reflection on the progress of the past year. It was recognised that there was a desire to address present needs, outcomes and processes of the patient centred model of care within the CQI framework, yet it was acknowledged that there was a parallel stream of development on less tangible issues regarding team-working, power relationships and team development. These were both considered to be important. This way of working promoted such development.

As the CQI facilitator commented:

"That this is not just about professionals coming together and er..re-designing ways they do things – it is about that, but it's also about reflecting on the quality of their relationships with each other in a much more personal way, er.. and that grows out of this I think and that's very important"

Further discussion on 'types of teams' compared sporting analogies of teams, and generated a powerful response from the consultant that it was important to have clarified shared goals for each patient. The use of the Kardex facilitated this process.

This generated the following aim:

To clarify what we as a team have agreed are the goals for each patient – during this hospital stay.

This was to be carried out by the nurse responsible for care planning, who would make sure that goals were written for each individual patient, together with the doctor writing individual goals for each patient. Goals would be brought together at an appropriate event such as a ward round or case conference.

It was recognised on reflection that use of the Kardex, and linkages between re-admission and discharge letters were important, and that these should be given priority. It was recognised that this was about large changes in practice.

As a result of this work one of the ward team, an occupational therapist, had

decided to change her work routine and come to the ward every Monday to find out what had been decided.

The CQI facilitator commented:

"It's just interesting how this is not about new stuff, er.. it's about people coming together and just working in new ways, and the old ideas are still the right ideas but every team has to learn those ideas for itself as if it's new – and in a way it is new, you know."

The facilitator continued to state his view on this:

"This is not just about having a prescription for some professionals re-designing a process. This is about creating opportunity for people to talk to each other and to listen to each other and reflect with each other so the people issue is really important...I do think it's actually coming together around needs, er.. and around processes er.. it takes the blame out and focuses other people's attention outside themselves, and er.. maybe think about changing the way they do things, you know."

At the same time it was considered that this shared experience was also enabling personal development and personal growth.

The next meeting

Study

The project focus on continuing use of the Kardex was reviewed in line with the established aim of agreed team goals for patients. This review provoked a number of my issues including the following:

- Delays in discussing patients at weekly case conferences.
- Maintaining care and rehabilitation on the ward for patients for whom discharge has been agreed but which has been delayed due to bed shortages.
- The current tension for rapid turnover.

One of the important pieces of learning emerging from this discussion was the enormous pressure for fast turnover, an issue appreciated by this effectively performing team achieving high turnover rates. There was a concern that increased turnover was impacting on some professionals (in this case therapists) who were finding that patients were being discharged with an incomplete assessment. The fast turnover resulted in some individuals being unable to use their professional skills.

It was suggested that this may affect the patient discharge into the community, and the consequence that appropriate follow up care may not be received.

From this a further question emerged:

When patients are transferred, are their problems well enough assessed and documented to help the next team?

Deep team learning emerged from considering these issues fundamental to their effective service delivery, and three elements were raised:

1) setting specific goals for each patient;
2) maintaining an ongoing log of progress;
3) preparing a useful discharge summary.

More specific changes were agreed amongst the team to ensure more explicit goal setting at the Thursday case conference and planning necessary assessments.

From this it was finally possible to produce the following intended outcomes:

- Team members will be better informed.

- Using the key nurse in this way will make it easier for team members to check progress.

Reflections offered by members of the group included the observation that in making aspects of the team process explicit there had been a very clear demonstration of how teams need time to reflect together on how they work and how this could be modified.

The next meeting's feedback focused on continuing aspects of the Kardex project, specifically about the Monday morning meetings, and also about the goal setting at Thursday's case conferences.

Feedback around the Kardex project

There was consensus about the value of the Monday morning meetings, particularly since these were perceived to help the process of information sharing about patients and increase each other's awareness of team actions. This assisted planning and they also served as a useful relationship building opportunity.

Differences of opinion sometimes existed, it was acknowledged, between morning and afternoon nursing shifts, or about a patient needing specialist referral to OT, physiotherapy or social work.

The meetings had not influenced the use of the Kardex.

Goal setting

The Thursday Case Conference

It was recognised that the important question for the team was to establish the answer to:

What prevents this patient going home?

Planning

For the team the above question was considered in a way which enabled each profession to contribute towards an answer. It was felt that doing this was a more patient centred approach than filling in check lists.

The team discussed current tensions for rapid discharge and the different perspectives on this between doctors/nurses and the therapists and social workers. Beneath this were questions about the overall purpose of the whole ward.

One consequence of this was the possibility of discharge decisions being made during the doctor/nurse ward rounds before the multi-disciplinary case conference. If the patients had already been told about the decision, then it would be difficult to delay even when other professions thought this may be desirable.

Agreed actions following this meeting were based on continued use of the Kardex to record what it was mutually considered a patient needed to achieve before they could be safely discharged.

The balanced set of outcome measures

The team began identifying desired outcomes using the four elements of the clinical value compass. Undertaking this seemed helpful when considering patients for whom they were working.

Final reflections included a feeling of amazement at the practical detail it had been necessary to address even though this was a well established team, who

were positive about how they were working. Now it was considered that the team was also becoming aware of, and sensitive to, their working processes.

Some reflection focused on practical issues. There was some excitement about generating outcome measures that were both practical and useful; there was also a need to think carefully about how information might be disseminated to other nurses and also to other departments working with patients in elderly care.

The process continues

Next meetings

Between meetings the ward consultant had been inspired by a conference on the CQI methodology. This enthusiasm had been conveyed to the ward team. It also appeared to influence perspectives towards the team meetings, framed within the Nolan approach characterising this multiprofessional CQI work within the RIPE project.

Improving working practices: Feedback about the Kardex project

There had been some slippage with the Monday morning meetings because of recent bank holidays and uncertainty about timings. Feedback continued to be positive and it was recognised that these were helpful. Agreeing to meet on Tuesday mornings appeared to address the practicalities of 'Bank Holiday slippage'.

Thursday case conferences were reported to be improving in structure and also in how they met individual professional goals. Better documentation at case conferences had helped focus on individual patient needs outside the case conference.

It was felt more attention needed to be paid to the previously agreed change of using professional goals to identify limiting factors that might prevent a patient returning home. To encourage this practice it was decided to record the frequency with which such information was available, or unavailable, at case conferences.

The agreed use of the Kardex for individual professionals to record goals had not started.

Moving forwards

It was agreed to use the problems being experienced around discharge letters as a topic for a very small focused improvement project using the Nolan framework and PDSA cycles.

The following illustrates this approach in action:

General aim

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

The current situation

Discharge letters written by junior doctors were often late, incomplete and inaccurate. Nurse's discharge letters to community nurses seemed to be more useful. A proforma was available for doctors to use but it had not helped because they often did not have all the information needed. Information from other professions was not explicitly included anywhere.

Change idea

From several possibilities it was decided to focus on improving the value of the content of discharge letters. Again, using the Nolan approach, the team addressed the following questions:

What is this change trying to accomplish?

- To improve the information about a patient's level of functioning.
- To include a list of who else they have been referred to post-discharge.

How will we know a change is an improvement?

- Discharge letters, when checked, would contain complete and reliable information about the two areas identified.

What changes can we make that will lead to this improvement?

- Each different professional member of the team was to enter a brief summary into the appropriate place in the discharge pro-forma (i.e., "capacity for self care" or "problems and outcomes"). This was to take place on the patient's day of discharge.

The Plan Do Study Act Cycle

Plan

This would be tested with patients who have a clear discharge date set for some time ahead. Five patients were to be chosen at the case conference on 11 May 2000 for an initial trial. A date one week later was selected for the ensuing case conference review of these patients.

It appeared that crucially an important collective decision was made. Each member of the team would accept personal responsibility for ensuring they knew which patients were being discharged and for writing a summary into the letter.

Named members of the team were identified with specific responsibilities of informing individuals beyond this team of these actions. The groups concerned were nurses, the ward clerk, and Senior House Officers (SHOs).

Do

Everybody would accept collective responsibility for doing this and make notes about their experiences of undertaking it.

Study

The discharge letters and everybody's experiences would be considered at the case conference on a named date.

Act

Decisions about what to do next were to be considered at the case conference depending upon what was learned.

Balanced set of outcomes measures (clinical value compass)

It was agreed that all would look at the measures listed previously and check to establish that they were sufficient. Thought was also to be given to the most important measures that would provide the team with feedback about the care provided to patients.

The meeting concluded with a series of reflections, preceded by addressing the impending project closure, and how the team would take things forward after external facilitation was ended. This was to be discussed at the next meeting.

Final reflections

These included positive feelings on a 'team achievement', with an emphasis on practical action rather than 'just talking'. Crucially, it was recognised that points discussed were consistently the subject of complaints.

The value of collective responsibility for this initial step was acknowledged as a significant underpinning for future development. It was also recognised that enhancing discharge information would also be productive for the next team working with the patient.

Applying the Nolan Model **The Discharge Letters Trial**	Feeding back on this at the next meeting it was reported that the new arrangement had been tried, although things 'had stuttered a bit'. The plan to trial the new process with a few patients had been extended to include all patients being discharged. Different team members were adding information to the summaries and this made life easier for the SHOs. However this was patchy and there was a discussion about whether there was a need for an overall co-ordinator, and if so who this should be. A flowchart of the desired process was drawn, with an identification of specific activities to be undertaken. Discussion produced a number of points relating to team actions, including cover arrangements for staff absence, changes in information included within the summary, and information about onward referrals and action required of the GP. Any member of the team could sign the letter as a health professional, not just a doctor. One person spoke of this process, which had been counter to practices in which this individual had been trained, and the nature of group support in subscribing to a new practice was indicated. It was agreed that the new process would be trialled immediately. As the CQI facilitator observed: *"One important aspect of the process appeared to be that the process had delved deeper than PDSA cycles and process change, which had served into a catalyst into more personal development, individually and between themselves. Some feedback reflected this, with a change in relationships."* Feedback measures: At case conferences summaries would be discussed and checked to establish whether complete and reliable information was included. The ward clerk was to be asked to maintain a record of whether a discharge letter was available for each patient on departure.
Kardex project	The nature of the conversations regarding the Kardex changed substantially, with fuller information available. Monday morning meetings had all taken place and had proved helpful. There was discussion about the length of time they took, especially since the team move from bed to bed. It was agreed to meet in one place (possibly the office) and try to restrict the meeting to fifteen minutes. The use of the Kardex to record different profession's inputs: This was seen to be improving but there was some discussion on the extent to which this was the case. Everybody present confirmed the value of this overview process that included opinions of all team members as a basis for decision making. It was considered that the inclusion of a record of CPR by the doctors in each patient's Kardex would be valuable. Actions promoting the use of the Kardex included discussion at case conferences and also with the nursing team.
Balanced set of outcome measures	The team discussed the clinical outcomes section of the clinical value compass. The complexity of choosing a set of measures and the lack of follow up information post discharge were considered in detail:

The themes emerging from this discussion were:

1) The need to discover what outcomes measures were being used elsewhere. This would require a literature search and contact with other services.

2) Short term action that could be taken by the team to obtain feedback about important aspects. One aspect of this was to learn about the value of the information passed on to other agencies post discharge. At this stage the NSF was soon to be published and it was likely to emphasise this.

It was agreed that continuous feedback relating to every patient's discharge was necessary. The team agreed to take time at the next meeting to consider both content and process for obtaining feedback. This was then to be shared with other key external 'customers.'

Ultimately, the possibility that, for this team, one outcome measure could be that the patients had accurate enough interprofessionally-based information when they left, so that this information could be passed on to the next team.

Final reflections

Reflections included the expression of a continuing commitment to maintaining Monday morning meetings; another on the increased momentum of recent team meetings, and also a query on the evolution of a question/project that all could be involved in. One reflection focused on feeling encouraged that the team had come up with something sustainable when the project stops. This was reported to be important to the team as the CQI facilitator reflected:

"They really believe they have changed something that's survived. It's the whole reason we needed to do the whole project"

The next meeting entailed revising the flowchart developed through the team's use of the Nolan framework, based on their own working practices. Essentially this was seen as a portable care plan.

Purpose

Flip chart summary

- Anyone involved in future care will have a comprehensive record.
- Easily accessed from patient.
- Up to date record.
- Patient carer will be aware of what's there.
- Needs to reflect past, present and future.
- To inform new team re: previous diagnosis, functional ability, drugs etc.
- Ethically based decisions will be clear to all (e.g., DNR).
- Patients will be cared for by informed staff.
- It will be geared to the patient e.g., a personal profile.
- It could prevent delays in beginning treatment.

Content of Kardex

Past
Name, date of birth, blood group.
Demographic information, GP. Next of kin.
Important past history   key worker.
e.g., medical conditions.
Social situation and support.
Mobility functional ability.
Ethical decisions made – needs a framework and process.
Problems – past and present.
What's been done in hospital.

Drug treatment – current on discharge.
What patient has been told.
What action is required of them and PHCT or whoever is receiving communications.
Current functional ability.
Support networks: informal and formal.
Future care plans.
Ethical decisions/discussions.

Making it work

- place it in Kardex at end of bed.
- make it available on admission.

Action

1)   A named person will lead the design of the form – check with the team and with the consultant.

2)   Design a process for using it on the ward. Take time out at case conferences, involve other teams within the unit, share with professional groups as appropriate.

3)   Have a go.

By the time the action learning set met in June 2000, the facilitator was talking of 'winding down' the project, and addressing the need to decide how things might be taken forward after external facilitation had ended. This was to be discussed at the next meeting.

"What they want to do as a follow up, and what was really quite nice in a sense, was there was a very clear feeling that they wanted to continue meeting in some way. What form it will take I don't know, we have to decide and help them do that, and how they're going to run meetings and what they're going to do with them at the time just quickly degenerate into general chats which aren't any different to any other meetings"

Final meeting

The Discharge Letters

The final meeting was held in November 2000. Following up the previous meeting the team considered the flowchart and how this was affecting their evolving working practices. There was some uncertainty about whether it was being used, and it was also dependent upon whether time pressures at case conferences prevented discussion of all patients with complex needs needing team discharges.

Delays in putting names of patients to be discharged in the diary meant that other team members might not have their summary input available until it was too late.

Changes that may lead to improvement

It was agreed that the discharge summary would be used as a working document from admission, and also used at each case conference. This could also serve as a transfer letter. The document also needed to be extended to allow more space.

Planning

The Kardex, originally a focus for information seeking, was again mentioned. There was a suggestion that the discharge form should be kept with this, although this could create difficulties for the doctors involved in the service.

Doing

The importance of individual staff taking personal responsibility for these actions was stated, and a revised flowchart was to be produced to support the introduction of the new working practices.

Communication across the team was a necessary action in order to ensure spread and adoption of the new working practices.

Regular interprofessional ward team (ALG meetings), beyond the remit of the RIPE project, would be used to review progress in an ongoing way. The first stage of the journey was drawing to a halt.

Outcomes

In the following section categories on outcomes related to this site are outlined as improvements in terms of health and social care working processes.

Improvements in health and social care working processes

The CQI facilitator commented about the process of working within this framework:

"What we have been doing is helping people design their own change and not saying to them 'you have got to change' but it helps them think about what they are doing and design their own changes and so they manage their own change and they are very different approaches"

- *Developing capability within a 'community of practice'*

    In the project this occurred through the gradual emergence of team capability as part of an integrated combination of knowledge, skills, personal qualities and knowledge. This is illustrated through member's increasing insights into the contribution of others to the service delivery.

- *Developing a capacity for change and improvement in collaborative team based practices*

    In this project this is demonstrated through the gradual progression and evolution of working practices based on patient focused information systems.

- *Establishing a climate favourable to collaborative learning within the team*

    In the project the climate established within this ward based action learning set was grounded in mutual respect and equitable relationships rather than hierarchical relationships. This enabled contributions from all team participants, which in turn, is likely to have engendered collaborative learning.

- *Understanding decision making processes within the team*

    This was indicated within the project by the team having previously considered themselves as being an 'effective team', but realising there was limited understanding of issues contributing to team decision making, and acknowledging the complexity of this process.

- *Developing the capacity to understand more fully issues related to evidence based practice and developing outcomes*

    In the project this aspect occurred through the increasing attention paid to the issues of developing outcomes based on the team's own practices.

- *Developing actionable knowledge*

    In the project this occurred through the team's increasing awareness of how information systems, and the gaps in them, presented obstacles to the effective delivery of patient care, and how improvements might

be made. The team were then able to transfer the knowledge to other contexts, such as case conferences.

- *Generating the capability to reflexively collaborate on service change*

  In the project this occurred through the realisation that 'time to talk' and consider team actions was a vital part of establishing awareness of current practice in order to improve.

- *Establishing a culture and environment in which individuals may challenge deeply held professional assumptions*

  In the project this was indicated through the expressed views of a number of those involved in the working group. A personal challenge to deeply held professional assumptions on working practices, was enabled within the conditions framed by the action learning set.

- *Facilitating role exploration and development within the working team*

  Within the project one example of this occurred implicitly through sharing the development of the notion of the 'health professional'. Roles of nursing staff and medical practitioners had evolved but extending this to enable recording in patient records to be made by all those involved in patient care appears to represent a major step. Another example would be the changes in practice through knowledge being shared within the group, for instance, with an occupational therapist changing practice to be at handover following the weekend.

- *Developing collaborative communication and information systems across professional boundaries*

  In the project this occurred through the joint development of the Kardex as a shared communication and information system.

- *Developing knowledge of existing services across organisational boundaries*

  In the project this occurred through gaining information related to the patient's needs and the patient journey through the services and circumstances leading to admission and discharge. In this instance information gaps in their own systems led to an appreciation of information gaps potentially impeding effective care at the next stage of the patient journey. Feedback on the discharge of a patient with complex needs also informed this outcome.

- *Making explicit matters of practice implicit in team based service delivery*

  In the project this occurred through examining all aspects of practice derived from patient involvement through the process of care as delivered by the team.

- *Developing a team capacity to produce patient-focused goals in service delivery*

  The primacy of the patient was a key aspect of ward philosophy prior to the project. However, in the project the team endeavour in jointly producing patient-focused communication systems appeared to contribute to a flexible capability in terms of service delivery. They

were thus able to see the transferability to other settings and systems, such as case conferences.

- *Establishing a microculture in which the team may collectively and collaboratively produce conditions for learning*

  A statement has been made concerning 'climate'. However in the project the idea of microculture is seen as integrating the sensitivities and awarenesses of notions such as power relationships which are frequently not directly addressed within learning contexts. In this project this microculture occurred through sensitive facilitation based on authentic and equitable relationships within the group in order to address problem based team learning issues.

- *Developing a heightened awareness of interpersonal aspects contributing to the team's practices in delivering services*

  In the project this is illustrated through the manner in which aspects such as individual personality and personal attributes were recognised as being integral to the process of care delivery and team working relationships.

- *Developing a supportive microculture in which to support the interface between the personal and the professional*

  Within this project this occurred through the strong framework of the ALG experience which allowed individuals to acknowledge aspects such as individual motivation in the care process.

- *Developing a microculture in which to mutually support personal development in order to maximise the potential of continuously improving working practices*

  Within this project this occurred through enabling a range of practitioners to find a voice with which to contribute to changes and improvements in practice. Similarly, some shifts in practice contradicted previous learning experiences, for instance, for some social care staff to contribute to the medical record was a forbidden practice. Group support enabled this development in practice to occur.

- *An appreciation of the value of time to talk about practice issues*

  In the project this occurred through the increasing recognition of the value of the team reflexively examining working practices in a non-threatening and supportive manner in order to learn from previous experiences.

- *Building a capacity to jointly negotiate the boundaries of individual professional working practices in order to maximise professional contributions to team work*

  In the project this occurred through the joint examination of contributions to particular events, such as discharging patients. In doing so perspectives and contributions of other team members were gained.

- *Developing the capacity to address as a team, sensitive working practices in order to maximise collective responses to patient focused care*

In the project this occurred through raising and discussing practices which, on discussion, were recognised to have been problematic, such as where there was an absence of protocols for resuscitation procedures.

- *Fostering interprofessional collaborative processes to generate patient focused service improvements*

   In the project one example of this occurred through the discussion on the rapid turnover of patients within the unit. It emerged that the speedy turnover impeded the effective delivery of some professional's services. They were unable to use their skills appropriately and a holistic approach was not therefore possible.

- *Establishing a capacity to reproduce a supportive environment in which to address significant challenges to individual professional roles, and respond flexibly*

   In the project this was shown through the discussion of the relative roles of the nurses and doctors in the decision making process, and allowed exploration of the issues beyond those of power sharing and influences of stereotypes.

- *Developing the capacity to address situated working practices in a supportive and non-threatening manner in order to modify and adapt existing practices*

   In the project this occurred in addressing the issue of discharge letters written by junior doctors in order to improve them. (As one of the change ideas it had been decided to focus on improving discharge letters.)

- *Demonstrating the capacity to identify situations to which evolving processes and practices may be applied*

   In the project this occurred through the identification of case conferences as a further avenue in which to develop practice development issues around information needs to promote patient care.

- *Developing a concrete, collaborative patient focused multi-disciplinary discharge summary*
   In the project this was shown by actioning the approach learned within a 'rolling care 'plan.

- *Actioning the improvement approach learned within a 'rolling care' plan*

   In the project the basis for this occurred through addressing information gaps in the system when following the patient through the care process, leading to the community as the destination for the following team responsible for patient care.

Outcomes for service users

Although at this stage there were no measurements of user outcomes for service users there was broad agreement on the impact of patient centred practice on the systems developed within the unit.

Part 2 The Further Castlebury Experience

The story of improvement

Services for the elderly, along with mental health services have in recent years been considered amongst the "Cinderella" services. Nevertheless there have been regional developments within elderly care. The Castlebury hospital unit was established as a response to meeting care needs within the extended local population.

Approaching the hospital, the new unit is constructed sympathetically of local stone. Adjacent to this pivots a carefully balanced large mobile. A series of stone benches positioned nearby bear inscriptions meaningfully etched into the material.

The second working group within this hospital setting was instigated at the suggestion of one sister working within the unit. At that time she also had a role as a university link practitioner, and has subsequently been promoted to a senior position. Three consultants were working within this elderly care unit, and patients occupying the beds of a further named consultant were to be the focus of this ALG.

In April 1999 the group met informally for a working lunch with the university CQI facilitator and members of the first ALG in order to investigate the possibility of establishing a further learning set under the auspices of the RIPE project. This group included a consultant, nursing staff, therapists and a social care professional. There was a brief introduction to the work being carried out by the team on Brookes ward. Some allusion was made of the need to approach the work without expectations, but with an open mind.

Numbers of the ward team participating in the subsequent ALG ranged from five to seven. In the early stages of working with this group the university CQI facilitator was accompanied by other members of university staff. However, as time progressed he increasingly became exclusively responsible for managing both the learning process, and the facilitation process at the site.

As in other sites, the university aspired to provide an opportunity for pre-qualification learners to parallel the learning experience of the post qualification learner group.

The first meeting

Groundrules

At the first meeting the following month, hopes and fears for the project were addressed as ground rules were established. Amongst the hopes expressed was that improved relationships and communication would give more efficient working and greater team cohesiveness. This in turn was perceived to lead to better patient care and more satisfied clients.

Conversely, concerns were expressed around the potential expansion of the project, of losing focus, and of potential complexity. Those present also agreed that progress may be difficult to capture. There was a concern that original objectives (of improving management, care and better information to patients and family) may be lost.

There were concerns around meetings creating additional demands in terms of time and documentation. There was also a perception that meetings might become 'a talking shop' without a result, leading to a waste of that most valuable commodity - time.

The CQI model was introduced by the CQI facilitator, showing the individual journey of a patient with needs, and with outcomes diagramatically displayed.

The group was, according to the facilitator, interested in being able to develop outcomes, which were shown as one element of the clinical compass. (Other compass points included functional health satisfaction against need, clinical outcomes and cost positioned at different compass points - see section on CQI within broad educational framework).

After some discussion the group to be the focus of the study was to be patients with dementia. The aim identified was:

> **To improve management, provide better quality of care, together with patients and family who were better informed.**

Exploring potential clinical outcomes as one aspect of the clinical value compass, the group identified a range of indicators including appropriate use of medication, fewer adverse events, reduced symptoms and more emotional and behavioural signs such as mood, disorientation, aggression, agitation, and anxiety. (In the CQI model meaningful outcomes may potentially present potential items to be measured).

Functional status would include increased independence as shown by the A.D.L. (a disability index). There would be improved independence and maintenance, and potential of patients would be maximised.

There was considerable work around what had been learned within the group in order to begin working together. It was acknowledged that a different perspective on looking at clinical outcomes had been developed, particularly around satisfaction against needs. There was a question about whether, as a group, enough was known about the subject. There seemed to be a question about the group's own knowledge of the subject, and recognising the expertise within the team itself as a source of expertise, seemed to contrast with acknowledging such knowledge beyond the team. However, within the discussion it was acknowledged that this was the first time group members had joined together to hear concerns of other team members. The view was expressed that individuals were 'thinking along similar tracks'. They recognised mutual understanding and this was considered to be a beginning to working together in this way.

Planning at this stage included drawing up an agreement that some five or six patients would be approached for further information in order to gain some insight into their situation. This information would be attached to the assessment sheets, and there would be some liaison with the first hospital based action learning set about this.

Debriefing on this event, the facilitator commented on the group response to the process, when led by patient need, contrasting it with the sterility of the audit approach:

> *"I can't remember whether they came up in context of this discussion. And it will, it is bound to come up at some time. Hopefully as they begin to see all of it as potentially a tool to help with improvement. So it gives a context for audit. And naturally, it helps you reframe audit as an information gathering exercise as opposed to an inspecting 'do we get the standard yes/no exercise?' which is something which is obviously, which is a very sterile approach."*

He continued:

> *"Looking at themselves, looking at their patients, but looking at their trying to look at their patients through their patients' eyes, but then doing it."*

In summary the principle areas to be covered in this first meeting included the following:

- Hopes and fears for the action learning set articulated.

- Group identified on which to base knowledge needed for service improvement.

- Aims identified for the group's learning process.

- Group learned about similarities rather than differences between group members.

- Planning for interviews with five or six patients.

The second meeting

Meeting for the second action learning set some weeks later, the group addressed issues emerging from the first ALG, and also re-considered both hopes and fears.

Studying

Only two patients with dementia had been identified, and neither patient was aggressive in behaviour. The group discussed in more detail feedback based on the two patients and their needs.

It was acknowledged that providing care for this patient group was personally demanding. The constant reassurance, demanded by this group were acknowledged as being time consuming. Particular issues impinged on this, such as short term memory within individuals. Communication difficulties made it difficult to assess levels of pain and understanding. Besides individual patient needs there were also 'environmental' needs to minimise the effect on other patients in close proximity to a disturbed patient. It had been recognised that other people on the ward became distressed when disruptions or incidents occurred.

Use of the flow chart highlighted steps of the patient journey through the care process. Once again, using the clinical compass it was possible to consider outcomes.

Within the CQI model used, some ideas are 'parked'. All ideas are valued, but those 'parked' do not further actions, although they may inform learning. Included on the parking space were questions about information regarding people who live alone, information to families about the condition and the illness, and support services. It was recognised that each profession held slightly different information on people using the service, and also that care is not always delivered in a logical sequence. One example of this was that patients arrive with different knowledge known about them.

From this information exchange, considerable learning was reported. This was primarily about the processes of care in relation to patient discharge into the community, and an insight into the work of other members of the team contributing to this. Importantly, the complexity and informality of the work process was highlighted; the value of being able to take time out to reflect was also reinforced.

It was recognised that the shift towards the community orientation of the service led to a diminution in the dominance of the medical model. There were implications for the team about the extent to which their working processes might be the source of improvement practices. To be able to better understand existing practices and learn from them as a team, an appropriate 'secure' and confidential environment for discussion was needed. Involving everybody necessitated a safer environment than the opportunities afforded within the existing practice of ward rounds.

The third meeting

Refining the focus

At the third ALG meeting, there was an initial discussion relating further to team issues. The flowcharting tool guided further in depth exploration of the team's working processes. Fundamentally this appeared to be an amalgam of both community oriented and medically oriented aspects of care. Many insights were gained during this, although it was not possible to record them all. The flowchart which emerged at the end of the session, was significantly different to that originally presented to the team. In the words of the CQI facilitator:

> *"The flowchart that we ended up with at the meeting, was significantly different to the flowchart that we started the meeting, and that was partly about reconciling the medical influence around the other sorts of influences, and I think a recognition that medical and functional assessment is happening at the same time. We actually took out of the flowchart the step that talked about the referral to the multidisciplinary team."*

Some costs of the services were identified, and once again the value compass was used to illustrate this aspect.

One group member made the point that people with dementia were not being discussed in the action learning set. It was considered that some conflict for the ward team resulted from this, in that they were neither a dementia service nor a medical service. This tension generated an avoidance of certain issues in order to maintain harmonious relations. As a consequence it was considered unlikely that specific ways of handling people with dementia would be addressed.

Again using elements of the CQI toolkit, patient needs were discussed, as the group shared recent experiences of trying to meet patient needs. Examples given were of a disorientated, distressed and agitated lady, who was at risk of falling. Another female was in isolation, and also very distressed. She had needed to see staff.

The demands of such patients required time from the health care team, particularly when maintaining dignity and privacy in the delivery of care. Practical issues raised on this point given as examples by group members included inappropriate bowel and bladder movements, patients confusing their beds with those of other patients, and the management of aggressive or abusive patients. Within the group there was consensus around the issues of what could be changed.

At one point a participant made a useful contribution to the group's shared understandings in highlighting the World Health Organisation (WHO) terms for illness, disease, impairment, disability and handicap. This gave all group members a common vocabulary from which to work.

Amongst the reflections on the meeting was another re-affirmation of the complexity of the care process: it was recognised that the group were no closer to improving things for dementia patients. Their needs would be considered in order to see what could be changed in the general way of doing things, yet it was acknowledged that there were possibly specific problems to be addressed for people with dementia.

In the discussion it emerged that another ward (Witney) had experience with such patients, and that a closer dialogue might be established. Colleagues on the psychiatric ward might be consulted for their expertise.

It was agreed that at the next meeting the idea would be to brainstorm a list of things that might be done differently to meet the special needs of people with dementia. From the list of change ideas it would be possible to plan the next

steps.

To summarise, the principal points emerging from this meeting included:
- In depth analysis of working processes.

- Shifting perceptions visually represented within flowcharts.

- Increasing sensitivity to other available resources.

- Moving towards identifying specific problems that would inform future actions relating to this group of patients.

- Next steps were to brainstorm a list identifying potential changes to meet the special needs of patients with dementia.

Fourth meeting

The next meeting began with the completion of the top-down flowchart (part of the 'CQI toolkit' analysing working processes) using this, together with information from previous meetings, as a basis for reflection from which a list of possible change ideas for improvement might be constructed. The CQI facilitator subsequently commented that what emerged was a very focused agenda for action.

The list of potential change ideas generated included ideas as diverse as checking whether, on admission, a patient has a social work record; having a multidisciplinary record; joint goal planning; helping patients engage in appropriate activity; and responding to patients who are in distress and who call out. To improve case conferences was another point raised, possibly including attendance of key staff; checking availability and competence of voluntary groups; bringing and keeping staff up to date regarding dementia; increasing contact with Witney, perhaps anticipating earlier whether patients should be placed on their waiting list. Providing medicine for patients once they were in the community was another suggestion made.

Items within the list were divided into three categories;

- those which were relatively simple and more easily actionable;

- those already being considered on the ward;

- those which will need planning by the team in order to implement them.

The Nolan framework was offered as being a helpful guide to frame this process. Using this structure it was necessary to address the following questions for each topic.

1) What are we trying to accomplish?

2) What do we predict will be different afterwards and what simple measures can be used to provide feedback?

3) What actual changes can be made that will lead to the predicted improvements? Use the Plan-Do-Study-Act (PDSA) cycle as a guide to learning from action.

The question, "What changes can we make that will lead to the predicted improvements?" was applied to each area. Addressing 'the next steps' included action planning based on each of the three categories, and ascribing particular actions to named individuals. Planning addressed the questions "Who, what where when, etc? A named person was identified to begin the PDSA cycle.

All activities were framed within the team's operations. It was necessary next to consider ways of obtaining feedback about changes in their activities and processes.

The final reflections from which potential learning may be gleaned, included an observation from one person within the ALG who would not have thought it would take eight hours of talking to reach such a point. Staff reported feeling happier that the stage of 'merely talking' had been transcended, satisfied that something practical was emerging. One individual believed some really positive ideas would require developing some sensitive outcomes. The 'whole being greater than the sum of its parts' was fully appreciated, together with the need for sensitive measures. That identifying sensitive measures for this group might be challenging was fully appreciated. The group of people whose needs were being discussed, were those who were frequently distressed, emotions which could in turn unsettle other patients. Staff were sensitive to both ethical and care issues, and the relationship between the two. One 'treatment option' was to sedate individuals, but this was not a preferred choice. Pressure from visitors arriving to see family or friends frequently seemed to require speedy solutions (requests for other patients to be 'restrained' or 'locked up' were reported to be examples of such pressures from relations themselves perturbed by a situation). Other more acceptable options were to be considered without having explored a whole range of alternatives. Some quite simple alternatives (such as requesting a new lock) had already been attempted internally, and bureaucratic procedures were perceived to be something of an impediment to simple actions.

On debriefing, the CQI facilitator reflected that this meeting had been the fourth event. He suggested that this was relevant to the team gradually understanding the process of their services and patient needs. This was in response to the observation from ALG member expressing surprise about the time taken to reach 'this stage'. The CQI approach parallels an evolving learning process with emergent working processes based on change (improvement) ideas. The facilitator considered this to be fundamentally a process of culture change.

It appeared that his subtle and parallel process affected team dynamics and relationships and, in his experience, the fourth event contributed to this. Speaking of the importance of the learning process underpinning the working processes he maintained:

> *"What you want to ensure happens is that teams don't just come together once a month for a couple of hours of chat. You know, dialogue is important, but it needs a purpose, it needs some sort of framing, some sort of grounding in theory and grounding in practice."*

Observing that the 'comfort factor' was increasing within the team, the CQI facilitator commented that this could be related to the nature and function of dialogue within the group. This had become friendlier, more open, with individuals feeling less threatened and others increasingly able to articulate and listen.

In summary, the agreed actions for group members involved several steps, including the following areas:

- Prioritising of future action.

- 'Parking space' considered.

- Change ideas considered .

- Change ideas divided into three categories (those which are relatively simple and more easily actionable; those which are already being considered on the ward; those which will need planning by the team in order to implement them).

- Each category to use the Nolan framework as a guide.

Planning next steps

From this position the group were able to consider next steps, based on the three previously identified categories. Action planning focused on identifying staff to engage in the improvement activities within each of these. Activities within the first stage included helping patients engage in appropriate activity, checking the availability and competence of voluntary groups to provide support, bringing and keeping staff up to date on dementia, establishing mutual staff training with Witney ward, and checking resources within the Education Centre.

Items already being considered on the ward were similarly considered, with tasks allocated between named individuals. These included checking whether a patient had a social worker or a community psychiatric nurse (CPN) on admission; improvement of case conferences, perhaps by involving CPNs or establishing a regular time. Increased contact with Witney was another identified measure.

The final group of items were those requiring planning by the team for implementation to proceed. This included responding to patients in distress (and this would be given priority as an improvement project). A flow chart was used to support learning about the patient journey through this process. The next item to be addressed was providing medicine for patients once in the community. It was agreed that this was also a priority for the team and would be considered following the 'patients in distress' project.

In developing an improvement project to improve the service 'for those patients in distress and calling out', the Nolan Model was used. Addressing the question of what the team was attempting to accomplish, the issues of alleviating patient distress and reducing the concomitant distress of other patients on the ward were identified. The team discussed how they would be able to identify any improvements. (Within the CQI model, specifics are identified). It was agreed that they would know things were different afterwards because patients would sleep better, and staff would feel less stressed. Staff would also complete tasks better because they were not being interrupted, and levels of care across the ward would improve. It was agreed that the team needed to consider feedback about changes in such areas to individuals beyond the ALG.

Changes leading to anticipated improvements were discussed amongst the group. These included ensuring that basic needs, such as going to the toilet, or having a drink, were met; fitting a keypad to the ward door; exploring night-time medication; investigating patient management techniques and trying to create a social environment.

The fifth meeting

Six months into the project a new Bournemouth University facilitator joined the ALG, which still included the core group of nursing, medical, physiotherapist and occupational therapist, together with social care representation. Initially there was little momentum, principally because those actions which individuals had agreed to undertake at the previous meeting, had not materialised.

The CQI facilitator considered this to be principally a consequence of pressures on the team at that time rather than any lack of commitment to the project. (A considerable amount of internal support was considered by the facilitator to be necessary in order to ensure that this type of work was perceived as being of some importance). On this occasion, rather than continually revert to the fact that the group's undertakings had not materialised, it was considered that to progress the work of the group, the solution would be to address the focus on the issue the team had most wanted to tackle, which was to be their

improvement topic. As the CQI facilitator commented:

> *"And you need to perceive each time, that it is always a learning cycle and even if you agreed to do something and not doing it, becomes an opportunity for more learning and going deeper. It is not about saying 'oh we failed, we have got to reorganise, we've got to go back and do it again'. I could have, I suppose, in the meeting say 'well okay why couldn't you manage, how can we plan it so you could actually do this, but actually having some free space to actually talk about things and a theme started to emerge from that conversation. It is very interesting and it is a bit different from a very focused prescriptive approach to doing it."*

In reiterating the original improvement topic 'the journey so far', the CQI facilitator charted the patient's journey through the processes of health care, culminating with the clinical compass showing 'a balanced set of outcomes'. From the use of the chart it was possible to identify once again the general aim of improving management, providing better quality care and creating better informed patients and family.

Reconsidering the previously identified improvement project, the facilitator suggested that the original list was composed mainly of solutions, with a decision making aspect about how decisions might be made when based on individual needs. This deeper level of understanding led to an increasing awareness of information necessary to build knowledge about patients and their individual needs:

> *"One is they had realised they couldn't have a universal solution to the difficulties of lots of different patients, that what was going to work with one patient, wouldn't necessarily work with another patient. They also realised they didn't know enough about the individual needs of different patients, to be able to make decisions about how best to respond to their needs."*

Within the team discussion, a number of points emerged relating to team development. This focused on relationships, and working at a more personal level. The CQI facilitator reported that one ALG member considered that the team had become more stable as they worked together. There was an increasing understanding of issues that was now emerging as team based knowledge. Once again, as within another team within this setting, issues focused on communication processes.

Having focused at a deeper level on those issues (issues to be addressed and factors to be considered in deciding what changes might be made), the group considered factors involved in reducing the disturbance or anxiety of individual patients. For the next stage of the process, the group re-visited the changes it had previously been agreed to pursue. Finally, there was further action planning promoting previously identified actions.

For the group, agreed changes included moving to a more proactive approach in managing this issue. This was to be done by using the care planning stage for planning aspects of dementia care in addition to those of physical care.

This would entail modifying the care planning process, ensuring that each assessment gathered as much information as possible about this aspect of the patient. Included in this assessment would be information available from the community psychiatric nurse. Documentation would be amended to include aspects of dementia. Ward staff would also require education on the management of patients with dementia.

From this the group moved towards two principal actions:

- To devise a modified care planning form, drawing upon the experience of those used on the psycho-geriatric wards, and sharing this across the team.

- To identify possible staff educational content and process.

Members of the ALG reported learning on a range of issues, particularly that it is possible to 'pull together' to solve practical problems, that expertise is sometimes needed above that which exists within the team, and that an individual might not realise this. On the theme of unification and communication, there was a recognised need to unify the approach and an awareness of the importance of the multi disciplinary record. Communications within the team were recognised as being crucially important, and the value of everyone's perspective on a single issue was affirmed.

To summarise the meeting, agreed actions from staff members were:

- To devise a modified care planning form, drawing upon the experience of those used on the psycho-geriatric wards, and share this across the team.

- To identify possible staff educational content and process.

The sixth meeting

On this occasion, the CQI facilitator was again joined by a further member of the academic team, with the core staff team remaining as previously. It was reported that an animated group joined the facilitators, having previously had a productive meeting with colleagues from Witney Ward, who were experienced in dealing with patients with dementia.

Rather than focusing on the previously agreed action points, the facilitator built on the opportunity offered by this visit, thus responding to the learner's immediate interest. Exploring what the learning had been from this visit, the information incorporated three strands:

- Ideas about some possible caring solutions.
- Information about assessment procedures.
- Educational support.

In the visit to the Witney ward team, a number of possible solutions had been presented. A range of practical ideas including a netchair for wandering patients, a St. Anthony's cocoon; a Snoozelen, or diversional therapy. When discussing assessment procedures it had been suggested that assessing/charting individual patients characteristics on matters such as sleep or behaviour patterns, rather than using anecdotes for information, would be preferable. With regard to the education issues, there was a suggestion of mutual staff training with Witney and use of the services of a doctor from the Alzheimer's Society. Witney staff were also prepared to be a resource in understanding legal and ethical issues as well as the management of risks.

It had been recognised that there were no simple solutions. The Witney team considered staffing levels to be insufficient for the kind of patients involved. Issues of confidentiality arose when discussing issues with patients' relatives.

Responses to this information gathering

Staff felt that the work had been very helpful and had been illuminated by their preparation within the action learning set. Their experience had been validated; Witney staff had been very interested in the project the team were doing and felt they could learn from it themselves. It was recognised that solutions would have to be tailored to individual patient need. The issue was:

How to develop a process for doing this	Such a process also needed to incorporate a sound understanding of the context to which the patient would be returning. The team were also aware of the challenge of disseminating information and good practice within the whole ward team.
	In addition to this, one team member had undertaken a review of educational materials available in the library. This survey had proved disappointing, leading her to the conclusion that the section on confusion/dementia needed upgrading. Videos available were mostly aimed at carers and families. The book section was particularly disappointing and outdated, and there was no relevant journal in the library, although the Team recognised there were journals to which individuals subscribed. The possibility of circulating these more widely was discussed.

From this work it was possible for the team to consolidate this in pursuit of their aims, concerned with three interrelated aspects:

- Individual care planning.
- Matching possible solutions to patients as care progresses.
- Educating staff and carers in support of agreed aims.

Following an analysis of the first two items, it was suggested that the remainder of the meeting would focus on the initial assessment. It was suggested that initial assessment processes might be directed towards getting to know patients better and understanding their biography. At a later stage one ALG member discussed this in relation to the use of music. It had been learned that one patient had been a particularly able musician. The use of music had a powerful effect in relieving the distress of this person.

However, for the remainder of this meeting there was broad agreement on focusing exclusively on the four questions within the broad Nolan framework (see section on broad educational model).

Discussion around the question 'What are we trying to achieve?' produced a range of patient focused statements, including getting to know the patient better, understanding if their behaviour is the norm for them, identifying problems and needs in order to provide a responsive service, identifying interests so the ward team could engage with them. Additionally, they would discover previous successful approaches to working with each person. From this a broad picture of patient needs would emerge.

The following question: "What will be different?" produced three succinct responses. Patient goals would be met; problems would be better managed; patient distress and the concomitant distress of other patients would be reduced.

Planning	Planning for activities beyond the meeting emerged in response to the third question "What changes can we make?" when actions were identified and agreed. These included designing a modification to the team's assessment procedures and incorporating this into the existing form or forms. An identified off line group would be responsible for this step. The revised documentation would then be trialled in one of the ward bays for a period beginning the end of the first week in December. To help evaluate the new procedure, an audit would be undertaken, and a log book maintained to capture staff comments. It was agreed to organise introductory sessions at handover times to ensure all staff were aware of the new procedure.
Reflection on the learning	The group concluded with a reflection on the learning since the last meeting. Comments included recognition of copious help available 'out there' with people enthusiastic about helping the ward team. Group activities were well

received by others and this was both affirming and encouraging. The value of joint team action was recognised; this issue had been individually problematic and was difficult to tackle in isolation. Different perspectives and support, together with encouragement, were required.

The team also recognised the amount of hard work involved and valued having someone 'keep us on track'. They were also aware of the need to find solutions and achieve aims without additional resources.

Beyond the group, there was a report on a recent Site Support meeting focusing on the educational/learning goals of the project. The team were asked to consider the possibility of a type of portfolio approach as part of a more structured framing of the learning experience.

In summary, actions agreed for the next meeting incorporated the following:

- A modification to the assessment documentation to be designed and incorporated into the existing form/s.
- Revised documentation to be trialled for a period.

An audit would be undertaken from the outset to help evaluate the new procedure – a log book would be maintained to capture staff comments.

The seventh meeting

There was a reduced and changing membership at the seventh meeting, with the absence of a second facilitator and the consultant, who provided his apologies. There was a further absence as the sister originally responsible for introducing the group had been seconded to another ward. However a welcome was extended to include the ward night staff nurse who had also received psychiatric training.

General feedback included reporting a very positive meeting about improving liaison between acute and community services for people with mental health problems. They had been encouraged to discover that their ward was not the only area where difficulties were being experienced with people with dementia.

One of the potential 'solutions' on the previously identified list had been attempted. This had involved placing 'stripes' on the floor to reduce the wandering of a visually impaired patient. It was not clear how well this had worked but had reinforced the need to address issues such as locking doors on the ward. This was to be followed up at an appropriate meeting. Such issues as patient security presented a need for apparently simple solutions which staff found themselves unable to address.

Providing educational support to promote learning

Several activities were reported within what may be regarded as the emergence of a broader learning framework. This was however, not one of the articulated project aims, more a result of another orientation towards learning. One of the ALG members had identified a suitable book to use as a resource; charity money was requested to purchase this. A potentially valuable video had also been identified. Another team member undertook to ascertain whether this would be available from the library. A further team member reported that there would be further exchanges between nursing auxiliaries on the ward specialising in dementia (Witney), in an endeavour to increase informal learning opportunities. At the final evaluation meeting one group member commented that staff were:

> "being encouraged to use the facilities within the hospital as education for ourselves rather than to feel we've got to go outside and do courses to keep ourselves, updated, you know."

A number of nursing auxiliaries had attended a valuable Alzheimer's disease

course. This had been validated with a final assessment. After some discussion it was agreed that such events would also be helpful to physiotherapy and occupational therapy assistants. One group member undertook to find further details.

Feedback on the improvement project

There had been obstacles to progress. The actions agreed at the previous meeting had been prevented by a combination of reasons. These were given as patient volume, holidays and staff sickness. Once again aims and changes were confirmed. Copies of assessment scales obtained in the interim period, contained items it was felt might be useful within the documentation design work. The team agreed to use these to help them draw up the additional sheet and, further than this, the team member with psychiatric training agreed to contribute items based on personal experience. Action planning included identifying dates to carry out the preparation and plan the trial, which would be extended beyond the patients of this ward consultant to include all patients.

The team obtaining feedback on results

It was considered that additional feedback would be used to elucidate staff benefits on using the sheet, which was in itself to be designed to enhance patient focused questions. There was some concern about the task of obtaining feedback proving onerous. To counter this, an emphasis was placed on the importance of not relying exclusively on memory.

One key theme to emerge from the team's discussion was the importance of previous learning, specifically that of tailoring interventions to match individual patients' needs rather than mechanistically applying solutions. However, the CQI facilitator considered that it would be a considerable time before such an approach became internalised and part of routine action.

At the November meeting the team had agreed this should be the focus of a second project. At this stage it was agreed that difficulties being experienced with the implementation of hospital multi-disciplinary records suggested that this would not be a good time to begin such a project.

Beyond the project: also addressed within this meeting was the issue of 'winding down' the project, and project evaluation.

Final reflections

Once again group members were more positive with increasing action orientation. They reported being less happy with initial processes where discussion appeared to take precedence above action. At this stage one group member considered that the group had been meeting for a year, (this was nine months after meetings had begun) but had yielded little value from what had been contributed. Group membership was also considered in relation to the pace, with an expressed view that some decisions could have been accepted more speedily because senior staff members were participating. Another staff member noted that the process had been interesting, but questioned its relevance. Conversely, another group member suggested that, without the investment of time, there was a possibility of more mistakes being made. Similarly, another individual reported that decisions being made by the group were already part of practice, confessing that there would have been no information sharing within the group without the meetings. This view was supported by another group member who suggested that team members worked unaware of other team member's practices, and considered useful learning to have emerged.

In summary, the planning for the next meeting iterated that which was previously agreed:

- Group of people to meet and prepare assessment sheet.
- An additional person with psychiatric experience to contribute.

- Planning for trial on all patients.

The eighth meeting

A repeating situation had emerged within this group. Towards the end of meetings individuals would express relief at agreed actions, only for pressure of work and other circumstances to intervene and create further inaction. For this reason the CQI facilitator produced a list of all actions to have been agreed at different meetings.

On this occasion the planning meeting had been held, and the additional contributions made. A revised form had been designed, but a lack of suitable patients meant that the team were unable to test it. This would therefore be the next step.

Planning the next step
Piloting the form

The next stage was to agree the suitability of the form for patients who either lacked communication skills or who were known on admission to present behavioural difficulties. It would also be applied to those who developed them during their stay. In an attempt to ensure a user-friendly focus for patients and carers, particular care was taken with the style and appearance. A suggested heading was "Getting to Know our Patients". Writing several introductory sentences would also be of assistance, ensuring questions were written in a personalised way.

It was considered that there were to be a range of potential users for the form, for instance, social workers, community psychiatric nurses and home care assistants. There was a further application for use in that information gained using this document should be used as a basis for reporting at case conferences. The Primary Nurse responsible for each appropriate patient would assume leadership in getting it completed and use it to help care planning if appropriate.

Checking the usefulness of the form

Clearly, there were concerns about the utility of the form, and to address this issue several questions were to be added. Suggested questions were:

Is there anything else you think we need to know that would be helpful?

Were the questions written clearly enough?

Answers to these questions would help future modifications of the form.

Implementation

The implementation of the forms was agreed amongst the ALG members. All staff at the meeting agreed that the aim would be to check the form with five patients. All staff at that day's ward meeting would be informed about the process and asked to identify any patients for whom it might be useful. Named members of the team were identified to arrange a review meeting when forms had been completed for five patients.

As soon as the form was completed, this was to be photocopied and a copy placed in the RIPE file. In addition to this, the forms would be used to inform case conference discussions about particular patients. The form's usefulness for this application would be checked at the case conference.

The broader learning framework

The team was informed that books mentioned at a previous team meeting had been purchased. In order to use them most usefully it was agreed that team members would familiarise themselves with the books' contents so they could guide other staff to relevant parts. A good next step would be to copy the contents pages for each team member and to pass the books around for everybody to familiarise themselves with them. A named individual was to lead and co-ordinate this activity. The emphasis here was on a collaborative learning activity.

Another resource mentioned at the previous meeting had been videos. Those mentioned had proved to be very expensive, with only a small part being relevant. No purchase would be made.

Attention was also drawn to a seminar being held by a consultant the following month, which might be a useful learning opportunity.

Review of actions agreed at previous meetings

At this stage there had been a number of meetings where agreements had been made that actions would be taken, but despite this undertaking, nothing had transpired. There had been good reasons for this in many instances. As the CQI facilitator observed:

> *"..that's an interesting phenomenon that we were really struggling with but now we've got the form and the pilot I feel more positive and the meetings I think people go into meetings, not all of them but a lot of them, at the beginning feeling a bit pessimistic and negative at the beginning because there is so long between the meetings that they're not connecting, easy to connect to them in time, they're so busy that they're not thinking and actually guessing. It's not a criticism, this is the world they are trying to survive in, and not a lot of activity actually follows the meetings in practice."*

The slow progress of the ALG had emerged as an issue for some participants. The CQI facilitator considered that there was a tension in the potential levels of learning when the agenda becomes the action list for the remainder of the meeting. Nevertheless the issue of pace and time was important. This meeting had lasted for only a little more than an hour, in contrast to the usual length of two hours.

The final review

In the final reflective session the group addressed issues which ranged from initial feelings of negativity, to becoming more positive as a form and a pilot plan were introduced. The project raised awareness for the team and in the ward. One contributor maintained that involvement in the project shaped thinking in daily working environments:

> *"It makes you ask yourself: 'am I doing this well?" which is a stimulus."*

Another participant considered that the project made individuals aware of existing constraints, especially around resources such as money, time and people. Finally another ALG member had been absent and admitted having missed a considerable amount by not attending a meeting. Scheduling meetings in order to ensure participation of all team members was recognised to be of considerable importance. Whilst this had previously been agreed as a formality, there was now an increasing recognition that key elements of the process depended on prolonged and continuous engagement.

In summary:

Next steps planned as a result of this meeting focused on piloting the interview. In order to progress this, the following steps were agreed:

- The aim would be to check the form with five patients.
- All staff at the ward meeting that day would be informed about it and asked whether there were patients for whom it might be useful.

One year on
The ninth meeting

It was a small group that met on this occasion, because of high staff sickness and heavy patient workload. For this reason the meeting was to be kept short.

Feedback on the Assessment Project	It had not been possible to pilot the redesigned assessment form because there had been no appropriate patients and staff sickness had led to great pressure on the ward team. However one recent admission was considered to be a person whose care might benefit from the expanded assessment.
	One contributor questioned whether the knowledge gained from the form would actually change care. After some discussion it was agreed that it probably would, but the pilot project had been set up to establish this. Within the discussion it was agreed that continuing staff shortages and high number of patients made it difficult to see how forms might be tested, even though they might reduce working pressures.
	In an attempt to ameliorate this situation, it was agreed that ten minute 'teach-in' times would be used to involve more staff, including unqualified staff. Again, identified individuals were to work with team leaders to identify potential patients who could be assessed by either trained staff or nursing auxiliaries. This could be undertaken outside heavy nursing times, perhaps with a carer present. It was also agreed that further consideration could be given to asking carers to take it home and fill it in.
	In discussion one significant challenge was identified, that is, for staff to develop the routine of using the form within everyday practice. It would be used with the previously identified patient.
Reviewing progress	It was agreed that a meeting in November would take place in order to allow a longer period for piloting to take place. In order to establish and maintain this practice, the weekly interprofessional case conferences would be used to check implementation.
	Emphasis was placed on the importance of obtaining feedback about its usefulness and measures agreed earlier would assist this, as would maintaining a logbook, an idea also previously discussed.
	Once again consideration was given to the issue of the book. The contents pages had been photocopied and the books had been reviewed as previously agreed. Interesting and pertinent information potentially helpful to ward staff had been identified. From this, a number of ways to share this knowledge were considered:

- Point the relevant sections out to staff when appropriate patients are on the ward.

- Hold short 'journal club' type sessions to discuss them.

- Present the ideas at the 10 minute teach-ins.

- Consider the possibility of the ALG taking short, intense sessions to share information.

- Have a monthly discussion of specific topics at the end of a case conference.

Final thoughts	It was agreed that the action learning sets provided 'time out' and enhanced motivation. Those involved also considered they must attempt to achieve something as a result of the past year; whilst a considerable amount had already been agreed, no destination had been reached. The final question from one participant was on whether there would be an evaluation.
The final meeting Learning from experience – the	Some months had elapsed between the previous meeting and this event. It had not been possible to use the assessment form for as many patients as had been hoped, but when used, this form had helped staff with patient management. It had been given to carers to complete at home. They reported having found it

assessment project	helpful and easy to understand. One carer reported feeling more involved and in control.
	The reason for this lack of application was given as a combination of high patient turnover and staffing shortages, which had hindered developments. Priority had to be given to acutely ill patients and this had resulted in staff forgetting to use the assessment on occasions when it would have been helpful.
	It was recognised that this situation was paradoxical – a "Catch 22" situation with staff experiencing too much pressure to use the assessment designed to reduce pressure. This was considered to be a reflection of the ward situation generally with very little available time to assess patients.
	In summary it was reported that the team felt the form they had designed was beneficial and they had missed opportunities of learning from current practices.
Planning next steps	The team brainstormed a number of ways to increase the likelihood of patients being assessed when appropriate, despite the current pressures on the ward. Ideas included the following:

- Use nurse auxiliaries, carers, volunteers to undertake the assessments.
- Use primary nurses, but this group are particularly busy with acutely ill patients.
- Designate a nurse coming on duty to always check whether patients have been admitted whose management would be improved by making the assessment.

Following further discussion between group members it was agreed to designate specific nursing assistants (possibly those who have attended the Alzheimer's Society course) to check each time they came on shift, whether there were any patients who would benefit from being assessed. It would be necessary to have a clear guideline about when this should be used.

It was agreed that all staff from different professions needed to be informed about this policy.

The broader 'non formal learning' framework Learning from experience	A number of issues were discussed within this section ranging from the ongoing multidisciplinary sessions, about managing people with disturbed behaviour, run by a consultant, to the practicalities of creating time on the ward for staff to learn together. This had proved to be impractical. One example given was that changes to arrangements for case conferences for different consultants, had made it difficult to allocate time at the conclusion of the session.
	The book that had been purchased for the ward had been "borrowed" and not returned.
Planning next steps	It was considered that it would be more helpful, and relevant if 'educational' sessions were built around the needs of specific patients. Additional opportunities to do this could be identified by using the revised assessment form within case conference discussions. There was a suggestion of including patients of a further consultant.
	Following further discussion the team decided to use the extended assessment form for all patients by putting it in the admissions pack. This was then to be kept in the notes beside the patient's bed. Printing it back to back on a single sheet and attaching it to the admission sheet for the Kardex, would make it more accessible.

The occupational therapist pointed out that the form was similar to the Headingley Lifestyle Questionnaire used by occupational therapists for patients with head injury. This form had proved invaluable and all OT staff would be asked to use Yeats ward assessment when working with patients on this ward.

The group recognised that it was important to establish a ward process to ensure that the document was used as agreed

Liaison with Witney ward

The consultant reported that he visited this ward regularly to assess patients and he reiterated that staff could always use this ward as a resource. A telephone call requesting advice was all that was necessary.

The future of the ALG

It was recognised that this was the last meeting where a facilitator would be present. The team felt that nothing would have been achieved if meetings were to stop. Several points were agreed:

- To hold another meeting in the future to review experience of using the extended assessment form.

- To ensure that the team continues to meet regularly. The discussion was recognised to have served a useful function with respect to changing things on the ward, as well as providing positive encouragement to staff in a more general sense.

The group considered that to continue with the meetings a further improvement area would need to be chosen. The value of the assessment was increasingly appreciated, with one member of staff considering there was "a missed opportunity" because the use of the consent form would, in practice, have been very helpful. (As reported previously, there was a paradox in that the time to consolidate and develop the new practice was not available). The combination of tackling an issue and learning together at the same time had proved to be a productive combination.

It was planned to adopt a more 'educational' orientation to case conferences in order to link the patient focus and a learning agenda, building questions around patients' dementia and thus maximising and integrating learning opportunities.

Broadly, the team felt the meetings had been successful and that they had learned to work better together.

Outcomes

In the following section categories related to this site are outlined as improvements in terms of health and social care working processes.

- *Creating a climate which re-frames the notion of learning around health and social care issues*

  In the project this occurred through the gradual emergence of learning resources available within the location, such as the availability of expertise on other wards.

- *Developing knowledge of existing services across organisational boundaries*

  In the project this occurred through active use of resources within other parts of the organisation.

- *Developing interprofessional collaborative knowledge*

  In this project this was demonstrated through the learning the team gained about each other, their roles, and learning to work together.

- *Making explicit matters of practice implicit in team based delivery*

  In the project this occurred through examining all aspects of practice derived from patient involvement through the process of care as delivered by the team.

- *Improving specific items related to ward practice*

  In the project this occurred through developing improved multi-disciplinary and patient centred assessment forms.

- *Developing a team capacity to produce patient-focused goals in service delivery*

  The primacy of the patient was a key aspect of ward philosophy prior to the project. However, in the project the team endeavour, in jointly engaging in the development of patient focused goals, appeared to contribute to an increasing awareness of the value of team approaches in tackling problematic issues.

- *Developing the capacity to address as a team, sensitive working practices in order to maximise collective responses to patient focused care.*

  In the project this occurred through the discussion of personally challenging issues relating to patient care, and which it may have been problematic to approach individually.

Producing outcomes in patient care

There had been a number of actions towards enhancing patient services, such as the stripes placed on the ward floor to deter a particular patient from wandering off (although these had become un-stuck from the floor covering). Attempts had been made to make use of a piece of equipment offered by the specialist ward, but this was being used at the time requested, and was therefore unavailable. Staff had also learned of other approaches to patient management, besides specific items and approaches towards meeting the needs of people with dementia.

The assessment form which had been developed for staff to complete was used on one occasion by a carer from an 'unusual family situation' who was reported to have felt somewhat excluded in the hospital, and had been given the assessment form to complete. She subsequently gave very positive feedback on being involved in the process.

Within the project the tendency towards inaction on the part of these university-driven improvement initiatives paralleled an awareness of apparently simple improvements inhibited through the bureaucratic structure. One example given was of patient security on the ward, which required replacing a lock. Staff had recently had to search for a patient who had wandered off the ward and was found in the County Museum nearby.

> *"...I mean, she was quite happy to wander within a safe area and we would have been quite happy with that, but we didn't have a lock on the door, she ended up at the county museum, which took, you know, again it's time for us searching for her, time away from other patients whereas just, as I say, if we could have locked the door and we, she was, and we could have let her wander within the bounds of the ward it would not have been a problem."*

Using staff to search for patients in this way was clearly not the best use of resources, and staff were 'learning' that their ideas were not valued within the organisation.

> *"And it's also the fact that you feel you've come up with a good idea, a positive idea, a simple idea and you get blocked and therefore do you bother to do it again, you know?"*

As one group member commented:

> *"And it just wants one patient to fall down these stairs, you know, which they go down to get out and we would feel dreadful and quite possibly the hospital would get sued goodness knows how much"*

Nevertheless the delays on processing the lock was the source of some amusement:

> *"It reminds me of the thing in "The Hitchhikers Guide to the Galaxy" where they couldn't see a prehistoric designing the wheel, couldn't decide what colour it was going to be, when the whole development of the wheel was held up because they couldn't decide what colour it should be."*

However, it was recognised that this issue would shortly be addressed once again at a further management meeting in order to achieve a solution. It was recognised that pressure of work frequently was the cause of such delays and apparent procrastination.

Part 3   The Newton Experience

The story of improvement

An underlying story of gradual evolution, development and change is key to the improvement story in Newton. 'When is a change an improvement?' is a central question within the continuous quality improvement (CQI) framework. As previously described, individuals representing both sides of the three site partnerships between Bournemouth University and service providers met for the first time in the autumn term of 1998.

In the following pages there will be a brief description outlining the service being delivered. The continuous quality improvement project will be presented as a case study, followed by data on improvements in generic working practices and improvements in health and social care working practices. In this instance there is also a section on reported outcomes for service users. A similar format will be adopted within each site, as applicable.

Each 'action learning set', used action research principles, or a model of activity learning, in order to develop (or improve) the service being delivered as described within the case study. Existing practice based working processes were used as a focus to the learning inquiry applying steps within a quality improvement process known as a plan-do-study-act (PDSA) cycle. This was broadly based on developing a needs centred model to drive improvements in service delivery. The learning theory underpinning these aspects will be described at a later stage.

There was a sequence of small learning cycles as gradual modifications were made to the changes introduced to the service.

The Newton Experience

The focus service for the action learning team in this new town setting was the Child and Family Support service, with statutory responsibilities to provide services for children under five and their families, together with associated agencies within the voluntary sector. The locality manager for the under fives service has been actively involved throughout the project, although with an increasingly altered professional profile and responsibilities. However, all aspects of the job description entailed a distinctive community orientation. There have also been changes in the participant profile within the voluntary organisation representation. Social services involvement has not been maintained throughout the project.

The original Bournemouth University team included the CQI facilitator, together with a nursing and child branch nursing specialist, and a social work practice teacher. All were practitioners based at the university.

According to one participant in the Newton RIPE experience, there appeared to be two beginnings to the project. The first meeting associated with the RIPE project involved senior managers from the health Trust, including a Director of Operations/Nurse Advisor, several officers from local voluntary organisations and a social worker. From this meeting a decision was made to establish a further action learning set to work with the university team on this interprofessional improvement project. This was to include those practitioners actively delivering services.

At this meeting the Family Services Manager had been tasked with setting up a multi agency group to work in partnership with the university. This was built on the networks known to the community oriented service manager and included a range of health and social care professionals, such as health visitors, the co-ordinator of the Early Years Centre together with the local voluntary

organisation play leaders. Those recruited from the voluntary sector were previously involved alongside health and social care agencies in the countywide Under Eights Network. Members of the ALG met for the first time in October 1998. The community orientation of the project was reflected in the venue for the first learning session, which was a community hall. Within this setting the boundaries to the project were drawn around a particular electoral ward. At that time multi-agency interest had been prompted through the relative status of some primary schools within the published League Tables. Currently the same ward on which there was originally a focus, has again featured within the two worst wards for literacy scores in the country.

Local influencing issues included a phenomenon known as "The Newton Factor", described in one broadsheet article as a medical abbreviation for the apathetic response within this new town geographical area.

Membership of the action learning set fluctuated from a group of twelve beginning their involvement in the project. Similar numbers were involved when, for instance, mothers attended with their young children (not including children as active participants). In the final stages of the project, as actions wound down, numbers dwindled to include three or four people. By this time health professionals had stopped attending the action learning set.

Finding a focus

Having established ground rules to the project, the first stage of the PDSA cycle involved a brainstorming activity. Those engaged in the process aired many concerns. There were shared anxieties between the university team and those delivering the service about adding to an already heavy work load. Projects should, it was suggested, start small and not be a burden on people's work. It was possible to change the focus in six months time. The project was defined by the geographical area. The group were able to link on a common core of 'advice and information' as an aspect forming a natural linkage between the agencies.

The group quickly focused on the need to reach isolated families. A health visitor had commented on how much more young mothers communicated freely when informal home based visiting took place, and open questions were asked.

> "Keep discussing how the personal touch – not being a professional and personal. The need to attend their self esteem before they would attend group meetings."

Aim

Having identified the focus of the inquiry it was possible to establish an aim which was agreed in the notes as :
- enabling those families who are isolated;
- being able to identify need and learning more about them**.**

Identifying this aim prompted a further question from all those involved: what have I learnt about trying to give information to these families?

Learning needs for the group were generated from this:

Learning about the needs of these families.

Learning about the services.

Key questions focused on known and unknown 'isolated' families, how services were then delivered, and what would be different as a result of this

project. There was a paradox: 'how do you know if a service is not meeting the needs of 'isolated parents' if you never meet the people concerned? To answer this involved seeking individual meanings of isolation, and learning more about needs identified through this process.

Planning

The next meeting focused on the planning stage of the CQI process. There were a series of questions around definitions of 'isolated' people, or people in need, not using services. Describing these groups of people proved difficult and prompted much discussion. It was suggested that all parents of children born within an identified time frame be asked about their feelings concerning services currently offered.

The methodology was agreed. Sample size and a range of children's ages were agreed. It was suggested that groups would be made up of approximately 10 families with children aged six months, two years and three years.

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.

In the initial stages of using the PDSA cycle, group members paid great attention to technical matters. Issues such as the number of interviews to be carried out, considering the ages of young children and babies to ensure an appropriate sample size, and the use of the tape recorder preoccupied participants. In some ways an underlying anxiety to 'get it right', seemed to reflect early concerns about the project, which appeared to be taking some people to the boundaries of their individual comfort zones. To summarise, the following was planned:

- Health visitors to conduct interviews.

- Ask families identified by health visitors to tell their stories.

Doing

There appeared to be little momentum in the early stages of the project. Individuals attended meetings but there was little action. This obviously influenced some hard-pressed services in prioritising their time. Some discussion about how colleagues from social services might be brought back into the group transpired. Early steps in the initial stages of information gathering were hesitant, and did not progress as planned. Ethical committee approval was sought, but was considered unnecessary in this instance.

Having agreed that three group members would each undertake a pilot interview with one parent with a child of three months, by January 1999 pilot interviews with two mothers of five month old babies were 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. Obtaining names and addresses of a further nine mothers with six month old babies was planned.

In summary, the following was achieved:

- Pilot interviews with two mothers of babies who were five months old.

- Insight gained into understanding of what it meant to be 'well supported'.

- Slight amendments to questionnaire.

- Tentative planning for a further nine interviews.

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 assumptions, as one of the university team reported:

> "So we suddenly realised that actually these people were just as relevant as having first time with a six month old, and what they had to say was of interest. And 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 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, harder than she thought it was going to be and so a whole series of potential issues to consider…"

It was apparent, observed a Bournemouth University participant, that even a small data sample, very quickly provides rich information, and in this instance enabled groups to see things from new perspectives and be willing and motivated to accept the underlying yet 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."

In summary, the results of this meeting's reflections were:

- Small data set may provide rich information.

- Individual stories are powerful .

- Connecting with these stories enabled re-framing, seeing things from a new perspective.

- Implications for changing established practices and developing new ways of working.

Action: make a change

This information led to a further problem, an issue from which further learning could be triggered. The learning issue (or problem) concerned the practicalities of exploring and setting up a different role for health visitors. At this uncertain stage, one voice from the voluntary sector offered a solution. 'Partners' was a voluntary organisation established in the wake of locally published league tables. They aimed to establish links between home and school. Within the existing Partners* scheme, encouraging and supporting parents in their role as their children's first early education providers, opportunities were created for parents and carers to meet with others and encounter resources to meet with their individual needs. This facility was known as Stay and Play. The solution offered by Partners was that the health visitors visit the existing Partners Stay and Play scheme to offer themed advice for parents.

Partners met weekly 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 the dates of 10 June until 15 July 1999 the first cycle of health visitors joined sessions at the existing Partners scheme. There was an initial uncertainty as 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 to be common to many with whom the young parent might be in contact, whether different generations within the family or neighbours. The objective was to establish the needs of the service user and tailor services accordingly. Within the ALGs, possible evaluation strategies were explored and then, as agreed within the group, following the cycle, parents were given a questionnaire about the value of the sessions.

- A note on the voluntary organisation:

Partners was established as part of a response to address issues based on performance targets of young children within schools. As a voluntary organisation they had been established to support mothers in their role as the first educational provider for young children. The 'partnership' aspect of this community based provision, set in a school, was based on the notion that child development depends on play and the development of parenting skills. Mothers worked in partnership with the play workers for the benefit of their children. The second aspect of Partners role was based on the home visiting carried out by members of the voluntary organisation.

To summarise, the following action points were agreed:

- To explore another way of health visitors delivering their service.

- To set up another role for the health visitors.

- Change the setting - link education and health.

- Link Stay and Play with a drop in health visitor clinic and information point.

- Establish needs of service user and tailor services accordingly.

- Parent questionnaire for feedback .

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. Expectations of health visitors were considered to be low. 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. However, some health visitors wondered whether it 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.

The learning emerging from this section is presented within the section on 'learning outcomes'. It is an important stage within the PDSA cycle, or indeed within any experiential learning cycle. Talking about practice and practice related issues, is fundamental to practice development, and is the basis for what some understand as 'reflection on action'. In language, new meanings and understandings are created, and the opportunity to do this reflexively, together with others appears to construct a powerful learning context. However, it is apparent that some reported learning challenged existing professional assumptions. There were differing perceptions of needs, with parental perceptions being opposed to professional perceptions.

Practicalities were also addressed within the learning sets. Issues such as the timing of the sessions were important given the evolving and unfolding of daily routines within families.

Those involved in the ALG were learning of the need to be open minded, that

their expectations as professionals did not always match those of the group they were serving. They were also learning to respond to the needs of that group, in responding to the views expressed within the questionnaire return, even when this challenged their pre-existing beliefs.

For the university representatives there were also practicalities, which stemmed from the routines of university life, shaped by the academic year, and those in the practical contexts of service delivery. There was a long summer break.

Planning: the next stage

Add a health visitor and stir….

The last ALG meeting prior to the summer break included health professionals seemingly motivated to repeat the learning cycle. In October 1999 following the summer break, planning was underway for a further series of "Stay and Play" sessions (this entailed more than one meeting within the same month). 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 and health. As the project evolved it appeared that the issue was not merely about planning their time alongside the other members of the group and the mothers together with their children, it was about their use of this time in the new context, and planning that. This appeared to be an issue of changing practice. In the business of the activity centre mothers and babies were actively engaged in various tasks, and accustomed to delivering a service in a particular manner meant a major adaptation for the health visitors. There was no clear role evident for the health visitor, but this was inevitably going to be developing individually and interactively. Learning to work differently was initially a complex, slow and tentative process. 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 more discomfort was reported. One health visitor commented:

> "Most of the planning perhaps, was with L but the feedback that we were getting from parents actually spurred you on to think, 'oh yes it is a good idea and you know, perhaps it is worth having the health visitor involvement, because initially I don't think health visitors actually knew what they were doing there, I think they found it quite difficult, and perhaps it is just by carrying on and being seen, it's that, it's the hold back in the human nature isn't it really, something different, I am not going to be the first to try it, I'll let somebody else go up first, but once that sort of got the barriers broken down, it did it took off quite quickly really once the seeds were sown, so er, I think it was just that long drag at the beginning and I know we used to come back here and say 'I don't know where we're going with this, it doesn't seem to be leading anywhere', but what actually clicked in the end all those months ago…."

She spoke of her first visit:

> "The first time I went I thought, "well do I sit here and wait for somebody to come and talk to me or do go and talk to them, so I thought well I might as well go and talk to them, which I did and I went and sort of mucked in with the play and I think that's just a human feeling really, because I mean, yeah I knew M, and I knew L at the time, but there's always that 'well they know these people, I don't, do I initiate things or do I wait for the parents to come to me?' In the end I thought,' well I'll go', 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 because we're fairly reserved…"

The activity sessions being planned were to take place in a different part of the town. There had been a perception by some health care professionals that the school where the sessions were to meet was in a predominantly white middle class area, with a client group easily able to access information and support. Such issues were sensitive to raise and articulate. One question was to see whether this perception was accurate. 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 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 amongst those involved in the group towards the need to generate (and sometimes measure) outcomes, also a constituent part of the CQI process. There was a perception reported that:

> *"if we are going to do these changes we need to show that they make a difference somehow."*

In such environments as this 'learning set' there appeared to be an increased opportunity for those involved to discuss technical matters of professional interest, as one university facilitator observed:

> *"It was really interesting at one stage when there was some talk about how the health visitor role in Stay and Play could work together. And there was something about the tick boxes being used which implied that very **routinised** assessment, and there was a comment that was made there from Stay and Play. And I thought this is about developing measures which have **meaning**, and that is kind of crucial…"*

The facilitated format of the action learning sets used a continuous review process, with a problem based model advocated within the action learning approach. On occasions there was perceived to be a 'drift' from the main project CQI model, with an implicit CQI focus rather than the explicit one previously outlined. The group would periodically visit and re-visit the underlying aims for the team activity. In order to address this perceived 'drift' the primary project CQI facilitator periodically re-joined the group.

By the end of October the group acknowledged that energy levels had picked up, together with progress through the shared experience of the PDSA cycles. There was evidently an increasing commitment to the emergent team, with an accompanying sense of ownership. However, whilst there was a 'core group' there was a fluctuating membership. Social Services had not re-joined the team and there were further periodic absences.

It was planned to address the pre-qualification learner issue by including a maximum of two students at each weekly session.

In summary, the next ALGs concluded that:

- Health professionals were to develop a themed approach to their service delivery in new setting.
- Learning to work differently is initially a slow process.

- Value of feedback from service users.

- Their learning challenged existing professional perceptions.

- Activities at the Stay and Play generated increased sensitivity towards professional practices and outcomes.

- Planning for the next phase including off-line collaboration between health visitors and the voluntary agency .

- Planning for pre-qualification student group participation.

Doing

The 'doing' stage of the PDSA cycle was the Stay and Play activity session with health visitor input. This continued with an organised rota scheduling health visitor involvement with volunteers committing themselves to the activity. By now a system for communication between agencies had been established in case a health visitor was unable to attend on a particular occasion.

In addition to this commitment to developing pre-qualification learner placements were underway, despite the dearth of available students. This section is reported separately, within the story of learning.

- Feedback on pre-qualification learner placement.

- Learning about transferability of CQI approach across different learner groups.

- Students learning about the value of seeing children in their natural environment.

- Continuing health visitor engagement in Stay and Play activity sessions.

Study

At the December action learning set, feedback on the pre-qualification learner experience was given to the group besides reporting on the activity sessions. The results of parental and health visitor questionnaires were fed back into the group.

There was some discussion on the capacity of the group (and the involvement of the researcher) in the collection of data. One of the university team reported on attending the Stay and Play and the mothers' reaction to filling in the questionnaires:

"They were dead keen to write then, so one mother asked J to hold one of the babies and I entertained another one for a few minutes just because simply we wanted to write things because we are desperate to keep the whole thing going."

The motivation and commitment of those involved in the Stay and Play was evident in their drive, enthusiasm and commitment. These were people working and living in the community to which they were contributing. Their resolve was clear. As one of the university team observed:

"Whatever our two colleagues are saying, they are desperate to make it go."

The possibility of involving students in the planning of the next cycle was explored.

Central themes to emerge from the ALG were as follows:

- Discovering the value of the activity session to parents.

- Discovering how keen the mothers were to represent their views.

- Exploring the most appropriate way of 'capturing' important data to convey the mother's views and stories.

Planning

The action orientation of the sessions focused on planning the next cycle to be run from Monday 17th January 2000 for 11 weeks. This would take place between 10 – 11am on Mondays. There was some discussion around the number of health visitors to be involved, and the optimum commitment of health visitors. From the facilitator there was a continuing and iterative focus on thinking about future action: 'lets think about what we're going to do'.

An emphasis on maintaining a moving dialogue, focusing on the important issue, and considering what was to be done differently within the next round of activities energised the project team members. It was seen to be a positive way of moving forwards. Without necessarily making an explicit reference to the CQI model there was an emphasis on thinking and acting differently.

The service manager appeared positive towards the Project, consistently and steadily modelling a positive advocacy towards the stated aims, aware of the need for practice development to develop services:

"We need to be doing this, this is important, this is where health visiting is going."

Perhaps in the light of the volatile situation within the Trust, this individual maintained a strong advocacy for the need to respond flexibly to the public health agenda:

"This is about mental health of parents, this is about new ways of delivering service, this is about health promotion, this is about community development, this is what we are going to have to do."

There was perceived to be a continued resistance to change, with high levels of anxiety within the organisation. These were, however, justified. The Trust was both in the midst of a further re-organisation with resultant organisational uncertainty and insecurity, circumstances likely to counter necessary conditions for learning. It was known that within the group, personnel were involved in redundancy plans. Issues of status and hierarchy were intermingled with the uncertainty and anxiety of the change process. Attitudes appeared likely to become further entrenched:

"There's huge resistance, huge 'what are our jobs, what are our roles?' linked in with people getting made redundant, people leaving."

This prompted an observation on the modernisation agenda:

"Governments might keep talking about joined up thinking. The reality is it is not going to happen, whether you've got CQI, supersonic, whatever, whatever. While there's this much change going on they haven't got anything held."

Yet despite this climate shifts were apparent. Planning health visitor involvement prompted a critical moment in response to a question on how the aim was going to be achieved (how are we going to do this?). There was a voluntary commitment from one of the health visitors with the query:

"How many times have you got to do it?"

The voluntary organisation representative suggested that three sessions would be a possibility. Another permutation was offered, and finally the health visitor volunteered:

> *"Oh I'll do three then."*

One of the university team observed:

> *"And X and Y were just like a thousand and one reasons why we shouldn't do it as health visitors, and yet at the end they'll do it, I couldn't believe it. I'm still sort of staggered by it."*

That was considered to be similar to the previous occasion when suddenly:

> *"The penny just dropped and things just changed."*

However, the rapid expansion of the Stay and Play activity sessions, according to one team member, led to a perceived sense of fragility and vulnerability regarding the project.

To summarise, the planned actions driving the project forwards were as follows:

- Next Stay and Play session set up for eleven weeks.
- Support from health visitors.
- Active commitment from health visitors.

Doing

In this instance the newly planned Monday morning Stay and Play activity session, with health visitor involvement was the next stage of the action research cycle, or alternatively the 'doing' stage of the PDSA cycle. This was to take place in a different location. Small changes were gradually taking place.

Studying

The ALGs provided an opportunity to continuously study activities within the Stay and Play activity session, which was effectively the 'doing' stage of the PDSA cycle. There was a query about whether it was motivated parents who were accessing health visitors, in which case they would be likely to access them elsewhere. The continuity represented by the same health visitor attending three sessions was positively welcomed. The two health visitors involved evaluated this use of their time positively. Besides continuity of visiting personnel making a difference, practical aspects, such as not having a notice board and topics also featured.

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 play group.

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 actually 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 that people can actually follow them up and put them into action.

Once again, recurring themes included funding. There was a possibility of limited funding being available. Evaluation was also an issue. There was a concern that questionnaires were only providing a limited amount of information relating to the Stay and Play, and that much rich experience was being lost. There was a belief that interviews might help and a discussion on whether someone independent to the activity session and the health service professionals would carry out this role. The point in the cycle when interview activities would be carried out was a further discussion point. The Stay and Play staff believed that the length of time a mother had attended was a source of information to be explored.

In summary, themes arising during the ALG emerged as outlined below:

- Continuity of health visitor presence welcomed.

- Need for notice board and topics recognised as unnecessary to health visitors.

- Parents social support network extending beyond the Stay and Play.

- Health visitors learning about actively making service developments.

- Concern on questionnaires failing to capture rich data of mother's experience.

Planning

By this stage there was evidence of actions emanating from the 'doing' stage of the cycle. The bid for £500 to support the activity project at Eton Path had been successful. The funding uncertainty was continuous, but the notion of the project end seemed pliable.

The popularity of the activity sessions generated further critical questions to be addressed by the ALG. Given their success, further questions arose: where should people be moved to? How could new mums be trained to be involved in the activity session, and how could the project be grown further?

The ALG was now viewed by some as the RIPE committee meeting, and there was a suggestion from the voluntary sector representatives. This was that the mothers attending the Stay and Play be asked to see if they would like to form a mums committee and send two representatives to the RIPE committee meeting. Within the group 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. Within the year and a quarter that the project had been working together as a 'local improvement team', an increasing amount of trust had emerged between those agencies and individuals involved.

As the group facilitator observed:

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

It was agreed that the student on placement would be approached to see if she was prepared to undertake some evaluation of the parent's experience of the activity sessions.

It was also agreed that the use of the media studies department would be explored to produce a video of the activity session.

The combination of individuals and agencies engaging collaboratively in the RIPE project enabled the exploration of responses to service delivery issues. This was evident in the growing capacity of the activity session and it's place within the community.

The story continues: Involving the community

The following RIPE group meeting included mothers and users of the Stay and Play facility run at Eton Path, (their young children), besides the community paediatrician. The key questions: "What next" and "how do we keep it going?" were introduced.

Some members of the group had been to Amsterdam for the Health Improvement Collaborative. One group member observed that it had been necessary to travel to Amsterdam to find out about other Bournemouth initiatives.

Issues around students on placement were raised. The evolution and valuing of non-traditional learning frameworks and pathways, stimulated questioning around which students might be involved. One voluntary organisation worker pointed out that two future students would be herself and her latest co-worker, (formerly a user of the voluntary organisation) who were both undertaking NVQ assessor and assessor training programmes.

The recurring theme of funding issues featured as a discussion point, together with steps necessary to make the activity session self funding. The decision was to be left to the users of the Stay and Play, dependent on how they want to run the group. There was a concern that a charge would be likely to lead to a drop in the numbers of parents attending.

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 bi-lingual 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. There had been a further German national attending the group, and both found it helpful.

According to the women attending the group, the main reasons for attending the Stay and Play session were seen to be the development of play skills and 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 was a contact point, mothers would exchange telephone numbers.

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

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, and the possibility of just two or three people attending, there had been weeks when more than twenty people attended.

New mothers were not automatically and intuitively confident with their new responsibilities. This informal, session style was appreciated by the users; it was seen to be about reassurance rather than 'not wishing to trouble' health

visitors at clinics where attendance was considered an unsuitable forum for asking questions. Health visitors were seen as being 'too busy' to disturb. At the Stay and Play, approaches by health visitors, making informal personal contact with mums, was appreciated. One user explained that in the 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. A simple solution was to ask another health visitor. They were considered to be a useful resource. "Babies don't come with health manuals" one mother attending the ALG pointed out.

The paediatrician attending the meeting appreciated the value of approaching mothers at the very early stages of attachment and bonding, rather than in the later stages 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, reflected in those attending for the session on this occasion. Many of those involved referred directly to their personal experience.

Explorations were made around joining up with other agencies and other projects such as Sure Start, aiming to secure funding to set up the Stay and Play in another part of town, repeating the whole process. This issue was to be a recurring theme at subsequent meetings.

Other, incidental links were explored within the RIPE forum. For instance, whether it might be possible for the activity groups to link in with the healthy living centres, with whom one 'Partners' person had been in communication.

Subsequent meetings built on similar themes, focusing on the continuing provision for mothers and the improvements to be made around continually increasing popularity, accompanied by the need to move children on, and the need to acquire funding in order to assure the continuity of the group.

In the summer break a questionnaire (Appendix C) had been developed to obtain users feedback about the Stay and Play sessions. The questionnaire feedback was overwhelmingly positive, with mothers indicating personal benefits for themselves and their children. The popularity of the group had almost led to overcrowding, and this was shown in the feedback. Some mothers expressed concern for the safety of young babies when an increasing number of active toddlers were around.

The response was to arrange separate morning and afternoon sessions, the morning being for babies and the afternoon sessions for toddlers.

The ongoing discussion on funding had been addressed within the Primary Care Group, which had funds available within Pace of Change money. A health visitor sent on a course at the Anna Freud Centre planned to set up a clinic for 'difficult' babies, and the bid under consideration included a support worker and links into the Stay and Play. Some anxiety was expressed around labelling babies 'difficult'.

Despite the uncertainty of future funding, by the summer of 2000, the manager of the Child and Family Support Service hoped to place Stay and Play on a permanent footing, and spread it across town.

The story continues. At one stage there were five separate sessions across the town within each week. News of the good practice has spread, with visitors from other areas seeking to emulate the model. Yet the external changes to the Trust have had repercussions.

The health visitors find it more productive to visit those sessions where toddlers are the focus of the activities, than those where mothers attend with babies. Whilst both the Eton Path and Cattle Drove sessions continue, funding for the Stay and Play will cease shortly.

The action learning set currently no longer meets as such, but rather has emerged as a planning forum. The doing is out in the field.

There has been no formal closure of the sessions as yet, a 'watching brief' maintains a focus on future planning.

The regular dissemination about this project to other health visitors in the service has been reported to have influenced other individuals in their preparedness to become involved in change processes and practice development initiatives.

It has been an uncertain and unpredictable story, to which at the time of writing, there is no end. But in the manner of the best learning enterprises, the activity sessions have evolved to include a wide range of the community, emerging as a nexus point within the community setting. There appears to be a fertile environment for further development.

Outcomes

In the ensuing section categories on outcomes related to this site are outlined within three discrete sections. Firstly, as improvements in generic working practices; secondly as improvements in health and social care working practices; and, thirdly as reported outcomes for service users

Improvements in generic working practices

- *Collaborative processes – planning*

  Collaborative processes undertaken as planning for placing health visitors in the voluntary agency session reflect this aspect of project practice.

- *Collaborative process – information exchange*

  Information exchanged on the role of assessment in a natural occurring activity session, and feedback between agencies providing a new perspective on their practice was gained, providing examples of this aspect.

- *Collaborative process – developing joint funding application*

  The collaborative processes between the agencies and the university are shown within the project by the joint funding applications for the Stay and Play sessions.

- *Developing collaborative communication systems*

  The need to respond to the non-attendance of a health visitor met with the introduction of procedure designed to increase communication between agencies in such eventualities.

- *Developing a capacity for change*

  In the case of this item this occurred through the participation of the health visitors in the Stay and Play.

- *Building on and developing existing networks*

In this instance both voluntary agency and health service representatives were involved in a county wide forum, and were able to build on their contacts through this network.

- *Developing knowledge of available services*

In this project health professionals gained knowledge of voluntary sector services.

- *Developing professional knowledge*

In this instance professional knowledge regarding the needs of the service user was developed through involvement in gaining stories of service users.

- *Developing shared understandings of services*

In the project joint participation of services delivered for young mothers and their families were shared, through jointly gaining information from services provided and gaining more knowledge about existing practices.

- *Developing an individual capacity for challenging existing professional assumptions*

Within the project this was shown by the experiences reported by several health visitors involved in delivering services to young mothers and their families; their assumptions were contradicted by the experiences of the young mothers.

- *Developing a capacity to extend professional service user related knowledge*

In the project this occurred through the gathering of knowledge directly from the service user through hearing the experiences of young mothers, in order to extend and develop services and practice.

Improvements in health and social care working practices

- *Fostering interprofessional collaborative processes*

In this project interprofessional collaboration occurred through the actions of jointly developing the activity sessions with health visitor involvement.

- *Developing a user oriented focus*

Within the RIPE project this occurred through the actions of the ALG in hearing and responding to the needs of service users.

- *Developing a capacity to apply an action oriented learning approach to a service related problem*

In this project this was shown through health professionals indicating that through taking action, rather than responding negatively, change and improvement was possible.

- *Fostering a positive shift in new patterns of practice*

The need to develop established practices were shown through placing professionals in direct contact with evidence from users of their

services, thereby creating a need to shift and develop responsive practices.

- *Providing a learning environment*

  In this project an existing community based organisation provided the dynamic base for many of the subsequent RIPE developments. There were levels of a learning environment, from the framework of the ALG meeting itself, to the framework of the community based activity sessions which were a learning arena for a range of co-workers, mothers, children and the university itself.

- *Involving service users*

  In this project the voice of service users was central to the approach used in developing the service, gaining their feedback on the activity sessions, besides their participation in several ALGs.

- *Developing social capital in the community*

  In the project this was shown through the actions of the mothers in developing social networks beyond the activity sessions, and in the reduction of isolation reported by mothers.

- *Developing capability in the community*

  This is illustrated within the project through the participation of play organisation co-workers, mothers and health visitors in community settings, actively engaged in mutual support in developing the children.

- *Generating a capacity for change*

  In the RIPE project this occurred through the active involvement of the health professionals in the community, hearing the stories of the service users and acting on this information.

- *Facilitating role exploration and development*

  In this project this aspect occurred through placing health visitors in a different context (the Stay and Play) to deliver their service.

- *Generating the capacity to create actionable knowledge*

  In the RIPE project this occurred through health visitors and others involved in the ALG becoming increasingly involved in finding out about service users and family views and acting on this.

- *Generating the capability to reflexively collaborate on service change*

  In the project, this is illustrated through the members of the learning set examining the alternatives to how the service might be delivered, and being open to hearing the views of other participants, in order to jointly change services to benefit the service user, as when considering how health visitors might be placed in order to engage with mothers who might be isolated.

- *Collaborative action planning*

This occurred through the joint planning of Stay and Play activity sessions and actions such as health visitors distributing information on the new activity sessions, to mothers they encountered in their work.

- *Developing a capability for partnership practices*

In the project health professionals were acting beyond their normal range of practices and indicated that they were more prepared to 'act differently' in different contexts in future. They had gained confidence in doing this.

- *Developing improvement knowledge*

In this project this is illustrated through the continuous process of questioning within the ALG as activity sessions became increasingly successful, and further questions emerged. For instance, where mothers might be moved to as the sessions became increasingly popular.

- *Developing the capacity for service development*

Several health professionals involved in the project spoke of their involvement in the activity sessions generating a new perspective on service development.

- *Developing the capacity to understand more fully issues related to evidence based practice and developing outcomes*

In the project those involved were gaining evidence in hearing stories of mothers, thus gaining another source of evidence impacting on their practice, and considering further possible evidence based outcomes.

- *Developing a flexible response to service user needs*

In this project this occurred in a number of ways, for instance, through adapting the health visiting service to placing them in a different setting, and also, in scheduling separate activity sessions to respond to concerns on safety for babies.

- *Extending application of flexible user led services*

In the project this occurred through the increasing participation and involvement of mothers using the sessions and being increasingly involved in considering, for instance, how the project might be extended.

Reported outcomes for service users

- *Increased confidence of parents*

Mothers attending the Stay and Play sessions spoke of how their confidence had increased. Some also mentioned the loss of confidence on being a new mother.

- *Increased confidence of children*

Mothers, health visitors and play workers all spoke of the increased confidence of children involved in the activity sessions.

- *Improved communication skills*

  In the project mothers reported that their babies had improved communication skills through being involved in the activity sessions.

- *Improved social skills*

  All those involved in the activity sessions referred to the children gaining social skills through their participation.

- *Development of interactive abilities*

  In the project the modelling of play worker interactions with children enabled mothers to develop their own range of skills with their children through various play activities.

- *Development of pre-language activities*

  Musical games and rhymes are known to help children's language development and mother and child participation in singing sessions at the Stay and Play were enabled through their participation in the activity sessions.

- *Development of musical abilities*

  In the project based activity sessions a number of children and their parents were able to experience musical participation for the first time within that part of the Stay and Play activity session.

- *Opportunities to extend learning contexts for children*

  The contacts established through the social network of the Stay and Play session enabled diverse contacts beyond the session, such as swimming activities and language development possibilities for bi-lingual children.

- *Practical learning*

  In the project this occurred in a number of ways, for the mothers attending the session there were highly practical play activities encountered for the first time, together with practical skills such as simple recipes for home made play-dough.

- *Establishing social networks*

  In the project addressing the subject of possible isolation by providing activity sessions led to escalating mutual support for mothers which extended beyond these frameworks.

- *Reducing social isolation*

  The project addressed this possibility by providing activity sessions in areas where it was not considered that this was likely to be an issue; it was shown to transcend social and economic boundaries.

- *Modelling child development behaviour*

  In the project the Stay and Play environment enabled mothers to see health and social care professionals model optimum child

development environments.

- *Increased knowledge of child development*

  Through the activity sessions mothers spoke of the confidence gained in managing their own children through seeing a wider range of children; they found this reduced their anxiety.

- *Practical applications and activities resulting from increased knowledge of child's needs*

  In the project 'informed' yet 'informal' advice and counsel was available to support mothers in their new role, this was enabling rather than prescriptive.

Part 4   The Oldburgh Experience

The story of improvement

Services for people where mental health is an issue have been profoundly transformed within the last twenty years. Beginning to understand and grapple with complexities of change and evolution within this agenda for mental health has been a challenging aspect of service management and delivery within this period.

Shifts towards services delivered within the community are reflected in the crumbling fabric of the historic listed building housing the mental health team. It is not until the final site visit that the outward sign of impending changes is finally apparent. This stately, old and dilapidated building, has now been sold for 'residential development' as the architects sign indicates.

The Oldburgh experience

An embryonic community-based mental health team was the putative ALG meeting within this setting. The hospital location where the group met provided a range of in-patient facilities, and the service had been engaged in a number of changes. Not all were on schedule, the re-siting of the working base, and work location for this group of people is considerably behind.

It was intended that the interprofessional work of the ALG should fall within the broader strategic framework of the mental health directorate, particularly with a view to developing a multi disciplinary assessment tool.

Included in the learning set were a range of health and social care groups including an approved social worker, a team manager and cognitive behaviour therapy service manager, a clinical psychologist, a community psychiatric nurse and a social work assistant. The university team included a general practitioner, a community psychiatric nurse and a social work practice teacher. The CQI lead, a clinical psychologist, also joined this session to introduce the approach.

In this setting, as in each of the other sites, there were aims to develop a combined interprofessional and health improvement learning experience for pre-qualification students to parallel the experience for post qualification learners.

The first session

Positioning the lens

The RIPE project was introduced by the university, and the ownership of the project was established as being with the Oldburgh group, in the sense that the agenda was to be driven by those involved in the group and not by the university. Ground rules were identified and agreed, together with roles and responsibilities of group members, who were requested to keep personal reflective diaries. Confidentiality was assured. The need for management support was also raised.

There was a brief introduction to the CQI approach, as used by the university, contrasting the essential elements as being an externally imposed focus on a concern for meeting standards, or audit benchmarks etc., to a perspective aiming to improve the match between what the service provides and what a **person** needs.

From the outset it was perceived by members of the ALG that within the community there were particular issues around the needs of young adults with early onset psychosis, whose needs did not appear to be well met within existing service provision.

Directing the discussion towards the needs of service users, it was agreed that

the identified group with whom the ALG would work would be young people (those of less than 30 years of age) referred for the first time to the community mental health team. The general aim was to develop new ways to take the young person through the service using the range of community resources.

Action planning included the need to find out the numbers of people affected each year, and the current pathways used by this group.

Planning

Planning for the next meeting included looking closely at the service users, and viewing current pathways regarding services delivered to these clients. From this it was anticipated that it would be possible to establish how a change might be measured.

The second meeting

Meeting for the second time, the group spent some time considering desired outcomes for their target group, besides debating the definition of a "major mental illness". The general summary of aims for the group was agreed to be a consistent referral process to be addressed for all areas of an individual's life.

For example, it was agreed that a consistent referral process may need to include reference to symptoms, medication, family needs and dynamics, housing, occupation, socialisation, risk.

It was considered that once in the system the individuals and family should be educated to look out for triggers and symptoms in order to alert services. This aim focused on individuals actively engaged in their process, as empowered service users, self monitoring, demonstrating choice and involvement, rather than passive recipients of a service. Consideration was also given to carers needs, and the need to look at these needs separately and sensitively.

Using the flow chart to track the individual journey through the service, the group then looked at the current delivery systems to analyse where change needs to occur to bring about the outcome described. This proved to be difficult. During the meeting some concern was expressed about the lack of GP representation in the site meetings, given the vital role of GPs in the overall process. It was agreed that one of the team would talk with a consultant psychiatrist to update information in GP practices about the project.

'Homework' for ALG members meant finding out about stages of the hospital process for this group. It was recognised that there was a need for diverse sources of information in order to challenge the inherent orthodoxy of the status quo. Without inclusion of a range of sources there would be a possibility of a clinical dominance continuing rather than being sensitive to the service user perspective in assessment strategies.

The third meeting

Refining the focus

The Service User Development Worker joined the group. The remit of this person was the facilitation of service user involvement in planning and developing mental health services.

The group discussed assessment in relation to the overall aim for the under 30's. There was unanimous agreement on the need for clear and consistent assessment procedures, seen as vital in providing a quality service to this group, throughout their involvement with the Community Mental Health Team (CMHT). It was considered that assessment represents a crucial element of each stage of an individual's journey through the system when working on any service improvement. There was sensitivity towards the needs of this group of young people who were considered to "get a bad deal from the service at the moment". In the course of their treatment they frequently came to be perceived as "revolving door inpatients".

Three perspectives were to be the vantage point in looking at the process of an

individual's journey through the mental health system. These were:

1) the professional;
2) the carer/family;
3) the person with the condition.

The complexity of the process was apparent, with the group experiencing difficulty in making an accurate assessment of the 'sufferer's' view of the experience.

The possibility of including students in researching this part of the project was discussed. Members of the group responsible for nurse and social work student placements were to explore this aspect, with another individual discussing the involvement of medical students in the joint activity.

It was agreed that one member of the group would feed back progress to the management team. Some tension had arisen around this area. A concern had been expressed that the focus of the work being undertaken did not reflect the original specification agreed within the establishment of partnership arrangements. This conflicted with the university perception that the NHS Executive funding the project had funded time to support the site-based practitioners in their health improvement and learning. The management perspective was that they had signed up to a project looking at interprofessional assessment strategies, which had shifted towards a focus on care pathways for a specific group.

Whilst recognising that the learning was "slightly less interprofessional" than it might otherwise have been with representation of all groups – there had been no involvement of the medical profession, other than the general practitioner who was part of the university team. There appeared to be little active support of the project from the consultant within the hospital, as was stated by a member of the university team:

> "Well I think he was sort of saying, if other people want to waste their time on this sort of thing, well then that's up to them, but I'm too busy so you will have to get on without me…"

This view was corroborated by a further member of the ALG.

However, the group was becoming increasingly inclusive in another direction. There was a valuable contribution from the service user representative. It was recognised by one health professional that, from the user's perspective, the care pathway appeared quite different:

> "How (different) this process would look if you were a user rather than a professional and there were some interesting angles that you don't naturally think about if you are involved as a professional in a care team, about how the user views the professionals."

The group membership, according to one member of staff who was familiar with the site team, were all people keen to engage in dialogue and were receptive to change. This desire to progress inevitably influenced the constitution of the group.

The fourth meeting

Group membership

Membership of the group was once again emerging as an issue. The group was smaller with apologies from the psychologist and the service manager, but professional engagement was changing. One of the group, a Community Psychiatric Nurse (CPN), had acquired additional responsibilities elsewhere and was no longer to be fully involved in the RIPE project. Another CPN would be leaving the Oldburgh team. There was uncertainty about their

replacements. There was the possibility of the psychologist leaving the group.

To some extent it appeared membership issues appeared to be related to the nature of the project remaining 'virtual', remaining somewhat theoretical and divorced from practice. Making links with practice was a necessary step in embedding the approach in order for individuals to learn. It appeared that the group remained just that, and were not developing into a team. The changes in the framework continued, and it was reported that individuals were waiting for someone in a position of authority to sanction the use of an assessment tool.

All those participating in the ALG, from social work and nursing backgrounds, valued and sought the continued involvement of the Service user development worker. However, a reduction in working hours limited this possibility. The GP agreed to look at alternative ways in which this participation could be funded.

The service user journey

Re-capping on issues from the previous meeting and those parked within the 'parking lot', (a CQI strategy explained previously) the group focused on the process chart from the service user perspective. This proved to be a lengthy procedure, producing interesting and innovative ideas. Using this process helped clarify activities necessary when a young service user is to quickly and successfully engage in work with mental health services. Evidence suggested this reduced distress to sufferers and carers, and it was anticipated that this would reduce the number of incidences where help is not received until crisis point is reached. According to this evidence, earlier appropriate intervention resulted in less aggressive treatment. Time constraints limited the scope of the group's activities so that an emphasis was to be placed on the first four stages relating specifically to initial engagement with services. The group then focused on those areas felt to be potentially useful from a CQI perspective.

These four areas were:

- Accident and Emergency recognition of mental health symptoms (possibly via Mental Health liaison or RMN. trained nurse).

- Information to referrers re mental health services.

- Information to carers and sufferers re mental health services.

- Improved initial assessments.

The group spent some time considering the benefits of a multi-professional assessment team. However concern was expressed about the breadth of this remit, and the group agreed to target a smaller, more easily achievable goal as an initial start to the CQI process. This would be to produce a guide to local mental health services for the public. It would also be available for professionals to scrutinise.

The aim of this was to enable sufferers and carers to detect symptoms early on and access relevant help as soon as possible, with the intended outcome of a reduction in the number of cases where crisis point is reached before initiating contact with mental health services.

Areas for possible inclusion in the guide would be:

- Signs and symptoms of developing severe mental illness.

- Type of support available.

- Routes to accessing this support.

It was agreed that the following meeting would focus on design. Activity for the group between meeting would focus on group members gathering any available leaflets in the area, and discussing with service users what it was

considered might be useful to include.

To summarise, the group were able to agree the progress of their achievements had been as follows:

- Small achievable goal agreed.

- Group to produce a guide to local mental health services.

- Overall aim: to reduce the number of cases where crisis point is reached before initiating contact with mental health services.

The fifth meeting

Group membership

With the actual or impending departure of two group members, the current membership of the group was discussed, with the need to draw in new members high on the agenda. There were two potential participants, a consultant psychiatrist and a CPN appointment. Another medical practitioner with a potential interest in the group was also suggested. The CPN had an existing interest in working interprofessionally and would join the group when taking up his post.

The work of the group had led to an involvement in a region-wide training strategy, resulting in contact with the Head of Occupational Therapy (OT) services, who had challenged the existing group membership:

> *"She actually said: 'why are you running an interprofessional project that doesn't include Occupational Therapy?'"*

At this stage no occupational therapist had been appointed to the working group/team, and this had been the basis of the omission from the ALG. However, the question of extending the participation to gain a more appropriate disciplinary mix was acknowledged and addressed by including the OT in future meetings.

Conflicting views were reported on the nature of whether this was a working group or a team, with the background of the site selected which had proven to be an unsuitable location with renovation problems. This view was challenged by a suggestion that personnel were in place and that the absence of a physical location did not preclude collaborative working. This position was countered, by those suggesting that without a building there was no sense of identity.

There was some tension around the focus of the project, and tension also with the style of the learning model. The university team operated within a framework of an adult learning model based on participants identifying their agenda for learning. This contrasted with a management orientation with a prescribed learning task. There was a new team to be developed from the group, and it was necessary to produce a multi disciplinary assessment tool. One clinician manager within the ALG maintained that the work undertaken by the group was a necessary prelude to the larger task of developing a multi disciplinary framework.

Locating the work of the project within the wider work of the Trust was seen to be important to reducing the feeling of 'project isolation'.

Feedback

Using the PDSA (Plan-Do-Study-Act) approach the original aim was re-visited:

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

This group were those with psychotic symptoms between the ages of 18 and

29.

Discussion around possible measures to establish whether aims had been achieved included the following:

1. A reduction in emergency referrals to A & E.
2. More planned response to symptoms.
3. Less fear.
4. Shorter time of uncertainty.
5. Increased use of help-lines.
6. Better understanding of local health services.

When discussing the production of the information leaflet it became clear that existing and useful information was plentiful. However, individuals were not aware of this information and how to access it. Information is directed towards different levels and audiences. The meningitis campaign as disseminated within primary care was suggested as a model. Two major questions arose from this study:

- What information would be most useful to have at what level?
- Where should this information be distributed?

Within these questions were several more:

- What information do clients think would have been useful to have at the outset?

- What information do carers think would have been helpful to have early on?

- What information do professionals think would be useful?

- Where should this information be stored to make it easily accessible?

- What information is currently available?

Involving a student group in information gathering was seen to be a useful way of ascertaining the views of the service user. The student group would need a working protocol, and there was some debate over the relative merits of questionnaire approaches in comparison to more open ended interviews.

It was agreed that there were three levels at which information would need to be targeted:

1. low level information to be targeted at colleges, youth clubs, libraries;
2. medium level – GP surgeries, A & E, police departments, complementary medicine centres etc.;
3. professional level including GPs, teachers, colleges and hospitals.

Each level should conclude with a flow diagram, directing readers to other levels and agencies within the journey through care.

Planning next steps   The planning framework for the next phase was agreed, this included:

- Collating available information.

- Possibly designing our own information, including guidance on how to use the package.

- Going out and asking carers, patients and professionals what information they would like to have known, and views of the information collated by the group (the broad intention of student involvement in this remained).

The broader context	Issues raised within the meeting were reflected in other contexts. The Site Support meeting had met, and the issue of the multi-disciplinary assessment strategy had been addressed. The management group continued to express the desire to see the ALG address issues around the establishment of the multi-disciplinary assessment tool, which was considered to be the logical next step to address on the process chart drawn up for service users.
	The Site Support meeting was discussed at the following ALG, and the positive support from managers from Health and Social Services stressed. All were keen to ensure that project commitment was realised.
The sixth meeting **Membership issues**	Six months into the project, three new members joined the ALG, extended now to include further CPNs, and representation from Occupational Therapy services, besides the service user development worker. The new members were oriented into the CQI approach, with the introduction of the 'value compass' (see section on broad educational model) as a way of looking at patient need, and the notion of a balanced set of outcome measures. The ground rules, the need for reflective diaries and the background of the RIPE project were introduced.
Planning	The next stage of the project was to ask service users what information would be helpful at different stages. There was a reiteration of various approaches to data collection and their relative merits were discussed principally whether to use focus groups or one to one interviews. It was also agreed that exploring the views of both carers and professionals could be left to a later stage in the project.
Doing	There was action planning about preparing topic questions for use by the students, and arrangements made regarding investigations about groups of students on placement who might be engaged in the learning sets.
	Service users would be identified by each member of the group and an approach made to the relevant consultant. A database would be compiled from this for people to be interviewed by students.
	At this stage, six months into the project, there were still few outcomes and some uncertainty about whether foundations for subsequent work had been laid. It was anticipated that such work would allow the foundations for real change to come about in working processes and practices, particularly important in changing attitudes towards learning and service improvement. At this time it appeared that morale was low because of the number of changes to which people were subjected.
Meetings Seven to Ten	Following the summer meeting, the new group met to develop the arrangements for the new students on placement in October. There was a clear time frame attached to this, reflected in the need to make speedy provision for student interviews with service users. Action planning continued in accordance with this.
	The constitution of the group had changed, with the exit of the senior social worker and also the psychologist. Their reasons for leaving were different. For the senior social worker it was a question of priorities, but there were clear perceptions relating to ownership, and perceptions of management support. The client centred approach, with a basis on individual need was an established orthodoxy in social care; it has not yet emerged as the prevailing model in

health care.

Clearly, there were implications in terms of the university team's perceptions of the situation. There was some doubt about the priority attached to the project, at a time when there were dramatic changes in the external framework. There was an awareness of the underlying tension between a task driven by the management agenda, with a specific focus, and the time entailed in establishing a climate in which individuals were able to identify their own learning agenda within a framework of continuous improvement.

This pattern of continuously developing the student placements set the model for the next meetings. The group meeting in October for the eighth session was without any social work representation, and the psychologist had also moved to a new post. The core group who remained were nevertheless keen to action items and agreements.

Some anxiety was expressed by one of the new group members that the assessment tool was not being developed, since this was the belief of the Head of Social Services. It was anticipated that this would be the next task of the group following the current model, asking students to go to service users about their experiences of assessment procedures, and establishing how they thought these could be improved. The cancellation of a planned site support meeting precluded the possibility of discussion on this subject.

There were only four members present at the next ALG meeting, with two participants being university team members. The first issue to be discussed was the development of a common assessment tool within the notional community based team. The slow progress towards this goal had resulted in a separate group being set up to generate a short term solution. The RIPE group was subsequently to be involved in revising and refining this tool. One group member had been asked to participate in this group, and it was agreed to raise the issue at a planned site support meeting.

There was a further challenge to the work of the group. Few clients were willing to participate in discussions with the pre-qualifying learners. Despite this, there was agreement that valuable information was included in the information gathering process, and students welcomed the opportunity to work collaboratively.

Discussions anticipating the next group of pre-qualifying learners arriving during January and February took place; it was expected that they would begin to work on a new area of the project.

Emerging focus from the student work

The student interviews consistently suggested that issues around alcohol, illicit drugs and mental illness were common features of first onset psychosis amongst young people, and the group tentatively suggested that dual diagnosis could provide a focus for the next stage of development.

From this a plan emerged with agreements from participating individuals to address the identified actions. Contacts were to be made with the dual diagnosis network and the health promotion department. A further contact was to be made with ADAS, the drug advisory service.

A fresh start

With the advent of the new year the ALG met, and a review of actions achieved proved timely. The actions of the student group appeared to have energised the membership of the group, who in their review of actions to date, found that a number of positive learning benefits had emerged.

They had learnt from and about the students, benefiting from this experience; a core group had developed, more had been learnt around dual diagnosis, user

involvement had been sought. The messages on dual diagnosis should be disseminated more widely, for instance to groups such as key workers. The health team was finally coming together.

What had worked less well for the group was an absence of medical support for the project, the lack of early reward, changing personnel of the group, and the absence of a CQI perspective in student work.

Dissemination plans included a proposal for a newsletter outlining the background, process and progress to date. This could be disseminated beyond the group.

Planning for the student group

A number of issues relevant to the student group needed to be resolved before proceeding with the plans for the next cohort. A revised questionnaire was planned, for data collection.

Moving on

The next ALG re-introduced social work representation into the group, and external events continued in parallel with their work. The group tasked with producing a draft assessment document and portfolio of systems had done so.

There was also an update on matters regarding student placements. The amended focus of the pre-qualification learner group was brought to the attention of the group.

Instead of the original focus on early detection and prevention of mental health problems, the focus was on early detection and prevention including the role that substance abuse can play; essentially the issue was of dual diagnosis.

It emerged that the pre-qualification occupational therapy students within the last cohort had been unable to accredit their RIPE work within their portfolio, an issue which was contradicted by the occupational therapy service professional, who was also a placement supervisor.

Beyond the group

It emerged that the Service User Development worker was planning to use course materials produced within RIPE in some of the joint training with which she was involved. This was a two day event offered three times a year as part of a mental health foundation course.

Someone known to one of the university academic team produced freelance information on drugs and had offered to draw together a leaflet/beermat/sticker for the Oldburgh area. It was anticipated that this would be done in conjunction with the local college design unit.

The changes in the external framework to mental health meant that, in the pressure to comply with statutory processes, people within community mental health teams were "almost too busy to listen at the moment".

The meeting set up for June was planned as a workshop focusing on the dissemination of information on the pre-qualification student work. This was a response to the total information vacuum in the area of drug use and mental health problems.

Whilst a range of information needs had been identified, it had been accepted that to completely meet this would require a range of publications, awareness activities and training beyond the scope of the group.

It was agreed to concentrate on meeting the first identified need. The project aim was established as:

To raise awareness of the links between and appropriate responses to, mental health problems and drug use amongst the 18-30s.

The objective for the project was established as:

To increase help seeking amongst young people who are using drugs and experiencing mental health problems.

It was decided to produce a written resource for young people to draw attention to these links and advise on how to respond to mental health problems. To maximise the chance of making this campaign effective it was to be designed in conjunction with Oldburgh College. Their students were reported to be enthusiastic about a task of producing 'realia', course work based on an authentic situation.

Further work on sign-posting people to the written information would be by making this information available in written form via the world wide web.

A range of suggestions/marketing ideas included using:

> Competitions
> Beer mats
> Slogans
> Posters
> Toilet advertising
> Mental health charities
> Youth and drug services.

Key messages for the written information were identified and a production schedule was drawn up allocating responsibility and deadlines.

This workshop was in June, and from this date until the following April, the bulk of the work involving the university-based site team was related to the activities of the student group. Student involvement in driving the work forward proved productive. However the ALG was affected by the wider structure of the modernisation agenda. In the latest round of re-structuring the Trust was in the process of being dissembled and reconstructed. Individuals heading up teams were under enormous pressure to re-establish their teams in a new setting. As a result, it was considered that little priority was attached to the RIPE project.

In winding down the project, the work of the students was presented to the ALG, or those core members who remained in post. Several students joined the April group for this presentation of the work in which they had been engaged. A contact from health promotion was also present. Evidence was collected for inclusion in the continuing professional development portfolios of those involved.

Several of the ALG membership broached the issue of the regular mental health forum held in Oldburgh, suggesting that one of these meetings could be used to examine the issue of dual diagnosis and the involvement of one of the psychiatrists was requested. Links were being made, and the practitioners were also planning to include child care workers because of the perceived gap between service teams, drugs and alcohol, mental health services and young people and the target group falling in the middle. It was planned to make a joint presentation of the student work at this event.

Outcomes

The original outcome to be identified by the Oldburgh ALG was derived from a review of the evidence base, and focused on the needs of the service user, indicating the effectiveness of early intervention strategies in the case of early

onset schizophrenia. For this ALG the aim was to reduce the number of cases where crisis point is reached before initiating contact with mental health services. This entailed establishing current information systems, and identifying information needs of the user group.

The information gathering activities of the pre-qualification student group may have contributed towards achieving this outcome. Similarly the planned dissemination strategies may be seen to contribute to the realisation of this goal, but at this stage it is impossible to say whether or not the intended outcome has been attained in any way.

It may be, that increased sensitivity to, and awareness of, service user needs in relation to dual diagnosis issues have established a capacity to develop particular service user related working practices, but it is not possible to speak further of this at this stage, and anything further would be purely speculative.

Process outcomes

At the pre-qualification curriculum level it is possible to say that the educational events provided experiences of potential improvements in process related to inter-agency working practices, focusing on the needs of the service user.

However, although it is premature to consider the value of this project for users, one can also consider whether the project has any value for improving interprofessional working processes. Clearly the near absence of medical representation within the pre-qualification learning element of the project was noted and interpreted by students. Despite this some students gained real insight from gaining perspectives from other professional groups on practices such as assessment. Several students, interviewed in practice some months post qualification, reported particular awareness of multi-disciplinary issues. One particularly had advocated the CQI approach as a potential tool for team improvement.

Experiences requiring the development of collaborative inter-organisational working practices were also provided, as evidenced by involvement of the local college in developing a communication platform addressing identified information needs. Again, thinking and working flexibly and responsively beyond the existing framework was enabled through such experiences.

In this volatile and dynamic working context, given the difficulties of recruiting to a multi professional pre-qualification experience, the delivery and development of this learning experience required frequent adaptation. Fuller explication of the student learning experience is provided separately within the story of learning.

Finally, the student group have developed a communications strategy for making potential service users, and those involved with them, more aware of available services.

With the recent revalidation of the nursing and midwifery curriculum an interprofessional theme was introduced and a level 2 option unit on interprofessional working for improvement approved. This unit, which will be shared with learners from other professional backgrounds, is based on the experiences undergone by learners within the project.

Chapter Four — The Story of Learning: Post-Qualifying and Pre-Qualifying Learners

Introduction – levels of learning

The following narrative presents the learning experiences of two groups:

- Post-qualifying learners.
- Pre-qualifying learners.

The post-qualifying learners refer to the experienced professionals that made up the ALGs of each site and who pursued the improvement projects over an extended period. These themes will be presented on a site by site basis (three sites) so that the learning can be understood in relation to each specific site. The pre-qualifying learners refer to a range of students on placement who joined the projects for varying lengths of time. The themes of learning for these groups will be presented as a whole and not on a site by site basis. This is in order to articulate a level of generality about the possibilities for student learning as a whole. It does indicate some of the individual variations of this learning but this is more individualistic than site-specific.

This chapter is followed by one, which considers the lessons that can be learnt about the way the projects were organised and co-ordinated.

All identifying features have been anonymised throughout, both in terms of participating individuals, and settings.

Post-Qualifying Learners - Castlebury

Context

The interprofessional aspects of this educational project were entwined with health improvement aims. The experiences reported within this section of the project relate to the hospital based ALGs where learners were working in the delivery of care to the elderly. The first of two teams participating in the project began their involvement in October 1998, the second the following May. The meetings of those involved in the Regional Interprofessional Education Project were held in a seminar room adjacent to the ward, and occupied several hours within a demanding working schedule.

Interprofessional learning

A clinical lead for one team observed that the existing ward culture was less hierarchical than within most hospital teams, and this was considered likely to affect the learning. This situation was the case prior to the project beginning. Equally the second team approached the project as an existing multi-disciplinary team.

The principal aim of this project was to learn to collaborate to improve services; in doing so those involved would learn from and about each other. A number of respondents within the first ALG to be established indicated an increased understanding of the roles of other professionals within the team, together with an appreciation of this in a broader context:

> "I think one of the things I got from it most was actually being made aware of the part that the other disciplines played, and understanding their roles, because although we work with them every day that we are here, you only see what they do when they are here so you don't know the sort of wider extent so it was quite interesting from that, and also I think the way people think differently about maybe the same subject – they see different perspectives."

Within groups/teams individuals assumed certain understandings of their knowledge and roles from other participants. Working within the ALG ensured that assumptions were addressed as the implicit aspects of the team became more explicit.

On the whole, in the second team, it was considered that the patient focus was incidental to the learning which took place about each other's practice:

"But when we did think about it, we perhaps weren't dealing too much about the actual object of our exercise, which was dealing with the demented patient in the acute setting, but we were learning more about each other, our roles and our colleagues roles and learning about how to work together I think rather than you know the exact aim."

Nevertheless there was report of patient focused orientation when individuals were able to benefit from the perspective of other disciplines, and a perceived limitation when viewed exclusively from the respondent's own professional lens:

"The other disciplines were looking at things that could actually upset the equilibrium – it was things like the fact that they were asked to dress in a different way from which they were used to at home would actually maybe make them become aggressive or more agitated, and I don't think we, as nurses, perhaps thought about that.."

There was an expression of surprise within the professionals allied to medicine, specifically from the occupational therapists, about the lack of awareness of this professional group's core expertise, and the extent of their dual training in psychiatry and physical medicine:

"We do quite a few standardised assessments within the OT service and that seemed to come as a surprise to some folk, which surprised me as I thought that would have been known. Also, because from an OT perspective we have always been dual trained in psychiatry and physical medicine, it is a core part of our training. I sometimes felt that wasn't really understood and that we really do have quite a lot of knowledge from our training in psychiatry, even if we haven't even worked in psychiatry since. It is an integral part of our knowledge and understanding of people who have levels of confusion and motivational techniques, all of that is part of our training."

Equally individuals became more aware of more interpersonal aspects, such as other people's strengths, and began to value these as a contribution to the working practices of the team. This was reported to benefit working relationships, and is highlighted in a later section.

Subtleties of interprofessional tribalism

In some instances the learning within the interprofessional experience confirmed existing pre-conceptions regarding the relative evolution of diverse professional groups, and their position regarding interprofessional working and learning:

"Listening to other people's perspectives and also what we've done has actually confirmed for me, the problems in multi professional learning and our actual positions."

In the view of this respondent nursing as a profession had been through a cyclical learning process through diverse initiatives and in order to adapt flexibly to changes in service delivery. There was a perception that other professions would have to go through a similar process.

One respondent drew a comparison with the Irish situation, observing that whilst this was an extreme example, there were parallels in issues of negotiating sensitive political boundaries and understanding the position of other factions:

"It's often been quite interesting kind of just listening to um the debates about Ireland, because you know it's been such a slow process, and I felt yes this has got to be this way and it's got to be understanding each others perceptions. And that's been really interesting how the two sides started to tell the world in a way that they understood each others perceptions, and I felt sure once they got to that point, they made it but it took a long time to get there, and the fact they were together in a room with kind of protected time space. I know it's kind of such a different extreme from our own little group but some of the same principles are there. You know the fact that Casey had managed to respect both groups and when he was interviewed, I mean that came over really clearly, and you know I could sort of mirror that a little bit that, that was happening in the two groups although it is like kind of such an extreme position and I thought well this is right, this is good and actually it can work in really difficult situations, not just where you know it's ..."

Experiential learning

The model of learning within the project was based on principles of adult learning and broadly experiential in nature. Within such a model the learning agenda reflects participants needs and concerns. In this instance the team was generating the learning agenda based on their practice. Learning in this way was considered to be more familiar to individuals from a nursing background. There were contrasting perspectives on this, with some respondents comfortable with this method.

One respondent reported:

"I find that I find more this way than from didactic teaching or..and I think it's more interesting as well, because it's almost like learning without er, realising. Do you know what I mean, it's not like you're working hard at something, you're learning things, but it's a pleasant experience and a more relaxed atmosphere for learning I think."

Several ALG participants were less familiar with this approach, reporting it 'alien', and likening it to 'university learning'. This was perceived by some as an orientation towards nursing, therefore affording a slight advantage to nursing staff in terms of the learning process, particularly those holding positions as link lecturers with the university.

Comments were made about this learning approach, it was not only what was learned, but the process of learning, 'how we learnt it'. This was confirmed by one respondent, who alluded to her university experience:

"Because it's a joint thing and it is very much a probing nature that you tend to perhaps rack your brains a bit more, dig deeper and come up with things after that. I must admit I did a course a while ago, at university which was action learning and I find that that was a good way to learn for me, because one of the ways I remember things is relating it to something specific, like a specific patient or specific incident, then I can recall that quite easily and I can remember what I did and what the outcomes were, rather than when I was a student it was very didactic, and book learning."

In contrast the RIPE group was considered by one Profession Associated with

Medicine (PAM) to be "fairly erudite really, free floating." The preferred learning style for this person was for "a particular situation or even a hypothetical situation that you can **relate** to "perhaps indicates the contrasting interpretations of individuals within different professional groups to the same situation (in this instance the learning setting of the ALG). It is interesting to note that in this instance the participant indicated no previous experience "in any sort of discussion groups like these meeting things." At the same time this person indicated a range of self directed learning activities which were part of her learning process, and was clearly highly motivated to "pick other people's brains", or talk informally to a range of people to gain necessary information. Clearly this was an individual activity directing her learning, but the group participation was not experienced or constructed as a learning environment.

Experiential learning – PDSA and reflection

This model was related to developing practice and perceived by one respondent as being closely associated with a particular style of learning, and also PDSA reflective cycles. This was the stage which, for some, made a crucial link between being a "talking shop" (a term used pejoratively to describe frustration at a non-productive meeting) and linking the dialogue and conversations to service improvements. It was the basis in actual practice situations (in this case on the ward) which seemed to enable some participants to identify concrete actions in order to articulate and thence potentially change practice. It was about 'making the implicit explicit'. On the whole, this was considered to be of practical value rather than merely theoretically interesting.

"Small steps, hey what we really want to do and sometimes we sit there brainstorming at the beginning and we come up with some huge concepts and changes that we want to do something massive and then we realise' oh get real'. ' How are we going to go about this?' 'How is the process going to work out and how is it going to fit in with everything else that is demanding outside as well,' and Roger very skilfully facilitated and taught us one step at a time. These PDSA reflective cycles that we were using, and they work so we can take something very very small and do it one step at a time."

And you feel that structures your thinking at all?

"Yes, it does, because it is a very clear, very simple model to use but you plan – oh I can't remember the rest of it but you get around to evaluating and feeding back in again. It is useful. I mean it is not unlike Gibbs reflective cycle really but it is using it, instead of thinking about using that, in terms of reflection that you are doing in your portfolio or whatever, or critically observe this, using it for changes you are trying to make rather than reflecting on things you have gained, it is actually examining what you have done and how you are going to go about it and planning the next step."

This process of planning small steps was seen to be of great value, but there were perceived to be some constraints in terms of working under pressure to deliver a service:

"But when it comes to here, the real world, where sometimes getting through the work is as much as you can hope to achieve, then if I am thinking about models and all these big words and all this sort of stuff, it has got to feel real, it has got to be useable and of use. I haven't got time to come up with fancy concepts in my day to day work."

Some occupational groups were more familiar with the processes of reflection than others. However, there was an awareness of potential responses to the notion of reflection. One consultant commented on the difficulties associated

with this process:

"If you sit down with a group of doctors, particularly consultants, and say 'we're going to have team reflections' they could all say something very rude and walk out, because they don't see it as helping them in terms of the service they deliver."

On the whole this reflection on performance was perceived to be something positively regarded by members of the ALG. It was considered to give people confidence in their ability to improve, even if only on a very small scale, and was intrinsically integrated within the learning process. There was a theoretical underpinning to the approach being used which gradually became clearer as a supporting framework:

"But I think the other thing is that surely it's also partly a question of giving people the confidence, that it's within their power to reflect, even if on a very small scale, to reflect on what they do every day and how they might be able to improve that and not have to go to buckets of meetings before you get to the point where you can start thinking about that, and I think that R took us through that process without explaining the theory so that we got terrified that we didn't understand the theory, but took us through that process, and its easier to look back now and see how he was leading us through, even if we didn't understand what he was up to."

For some clinicians increasing involvement with the ALG led to a growing awareness of the need to communicate as a group about working processes, but this was demonstrably something which did not come naturally to one individual with an 'action orientation'.

"I feel that in order to provide the care, that we actually do need to talk about where we are going as a group, and I'm not terribly good at doing that, I just want to get on and do it, so in a way it's been a learning experience that I can do it and should do it, if I'm disciplined to do it."

The commitment to action, through group reflection and dialogue was seen by some as "the oxygen of learning", generating momentum and energy within the group. There was an inherent tension between a limited concept of reflection as a retrospective process (reflection on action) and an unfolding awareness of group decision making and future actions based on shared understandings. This was essentially action (and thus future) oriented.

Practice related learning

One aim of this project was to improve patient care, within a needs centred model. The main focus of the interviews was on significant learning within the ALGs. One team participating in the project used the CQI model to develop an assessment tool. It was suggested that the process of participating in the development of this, understanding which questions to ask in the process of delivering care, provided an understanding of various professional perspectives.

A number of respondents in senior clinical positions commented on the relationship between change and learning. Working within senior service positions within a rapidly evolving service had inevitably provided extensive involvement in change processes. Individuals had experienced and been interested in issues such as 'managing change', and the process of changing. Involvement in the ALG had yielded further insights into this area. One leading clinician commented:

"I think a lot of people perceive change as being imposed from outside, and that's part of the reason that change is so difficult to implement because they don't feel that that's something that they come up with that they see as important, and I think that what we've been able to achieve here is we've been able to agree where we want to improve, the area we're prepared to put time in to work on, and therefore it's something that is important to us and I'm sure that we'll create the time to make sure that it happens. Well I hope we'll make the time to make sure it happens, but there is some chance that that will happen because we all see it as important, if it had been imposed from outside I just think it would have been a complete non-starter."

The learning associated with this process highlighted the importance of a team holding and owning a shared aim, "what you're trying to achieve". Without this there could be no movement for the team. It was recognised that for some people this preliminary stage would in itself involve a considerable amount of work, since the initial stages would identify numerous agendas that would be unlikely to have previously been voiced.

One respondent drew a comparison between this model of improvement learning and change, contrasting it with previous experience when 'quality circles' were introduced into the service. Within the traditional 'cascade model', transfer of a new practice was predicated on participation in a half day training session followed by a return to the workplace to implement the circles in practice. This appeared to be a superficial approach in contrast to the learning associated with the improvement process, which was in itself associated with changing practice:

*"...naïve on the effort that it would take because I now can see even to make the small steps, it does take effort and it takes and that's important to realise because, I think that we're expected to just be able to just do things very quickly. You know that there is a call for using evidence based on our practice and people say 'well why can't you just read an article and then put it into practice'. And I think I have known for a long time, it is certainly not as easy as that. But this actually leads you through and so that you can **feel** a change rather than kind of just know the theory of it."*

There was agreement between these individuals that ownership of a change initiative was crucial, without ownership of change there was no real possibility of meaningful change, or merely a façade of change. One consultant commented on the importance of this notion of ownership and imposition of change in enabling a team to improve their practices:

"If the Trust was identifying a trend, if you like, of things that weren't working, if that was going to individual teams who reflected why it wasn't working in their area, why not, and how it could, rather than say 'this isn't working this is what you've got to do', you would still feel you owned it, even if the actual issue was coming from outside."

Paradoxically, the members of the ALG were only a small part of the team involved in the delivery of care. There was a consciousness that, although other members of the team had been peripherally involved in aspects of the learning group's project (the discharge letter process), these other staff had not been included in the wider process, so the ALG members may then have been culpable of imposing change on team members rather than including staff in learning about the change, and thereby creating the possibility of them changing.

In addition to the learning around the change process there was further learning related to practice. Learning about the service itself was one aspect of the learning reported by a number of participants. This included learning about dementia and managing confused patients in acute states of confusion, besides learning about different places to access literature and support. These aspects were reported, according to one individual, to raise awareness of the problems and the resources available.

Relationships

Several clinicians made the association between change and ownership, but one respondent in particular identified the learning necessary for change to occur, describing the learning within the ALG as a kind of 'hidden learning'. Individuals gained personal insights in this context, which was essentially related to the interpersonal aspects of team work, and the dynamics of relationships:

> *"Learning usually takes place for change to happen and almost kind of, for change to stick, that learning is almost internalised and learning is, in most cases or in the majority of the time in this project, has been kind of hidden learning, in a way. It's learning perhaps how to cope with people's feelings, be alert to people's feelings and just be more aware of kind of dynamics and how the dynamics can change in a group."*

This process of gaining familiarity and understanding with other members of the team was seen to enhance working relationships. The knowledge gained in terms of individual strengths and ways of working was considered to be highly relevant to the working situation on the ward. The improved liaison between staff was considered by this respondent to be a 'brilliant' spin off of the project. As a further respondent commented:

> *"We started to recognise that we work as individuals, or that we thought we worked as a team, that we hadn't clearly understood that needed to be looked at in greater detail to be able to understand each other's ways of working better and therefore be able to function more efficiently as a team. I think that's been the most striking thing in terms of learning."*

In this group people learned about and appreciated the value of talking about their work. However, there was a clear distinction between disparaging references to 'talking shops' when compared to the active and energising process of dialogue and discussion articulated by a number of respondents. The result of the process of active discussion was, on the whole, seen as being an investment of time, recognising that in the early stages of the ALG, a considerable period of time elapsed before any real changes were produced.

> "So I think perhaps the greatest thing I have learned, is that people sitting around talking about issues like this can actually produce a result. It was a very nebulous long, long time, we seemed to be putting little details to pieces but not coming out with anything tangible or measurable. It was really interesting sitting around doing the talking.
>
> ,,,But the time was worthwhile and it was worth investing that degree of time and what I have seen as a resource from this area.....and yet now it is beginning to feel this has been time worth investing that we have actually made some gains, made some changes but that takes a long, long time to feel real."

Self in relation to others

In addition to the reported improvements and changes in team practices and performance, for some individuals, there had also been other personal gains such as increased confidence. It was reported that the support of the group was

necessary to enable changes in practice for one individual, who spoke with great conviction of the necessary support of the team in enabling a shift from one mode of practice to another. This entailed, overcoming fears and becoming more assertive in order to behave contrary to the manner in which she was originally trained. The issue was in relation to writing in medical notes, and this practice had been considered to be exclusive to the medics:

> *"This is what we talked about at the group and I overcame my fears. I was always led to believe I was not to write in the notes, or we agreed that we could do that, but it was very hard in the beginning to do that, that is what I am meaning, and now I have achieved that, and got over that and I do it normally now. You know it's just mundane."*

A further respondent had been reflecting on nurse and doctor relationships, and spoke of the value of the RIPE learning experience. It had given an additional appreciation to the value of collaboration, giving respect and listening, but crucially had given strength and resolve to do so, and endeavour to increase that:

> *"I suppose that is the difference, and I feel more confident that I will get somewhere by being collaborative and giving them respect and listening, which is something that I think I would always have wanted to do anyway, but it has given me that strength and resolve to kind of do that and look at how I can do that a bit more."*

Within the action learning set a number of respondents monitored their own behaviour within the group with an awareness of their own personality style :

> *"I know that for my personality type I'm not a feeler, I'm an action person and I like to get things done, and so to sit down and er talk for two hours, doesn't come naturally to me and I knew that, so I'm very aware when I'm listening to other people, because I actually, when they're musing over something, I just want to say 'why can't you just..' whatever, but that's not how other people are going to learn, and I'm not very good if we're not keeping to the point either, which inevitably we don't always, so I know that that part of my personality can be a problem. It need not necessarily be and so I was aware of that and, in a way I suppose, I have learnt how to take on board what other people are saying and try and empathise about their position as professionals within the team that has to evolve and change".*

Informal learning (individual learning)

A number of team members commented on the high level of facilitation they had enjoyed within the ALG. Several staff facilitated groups themselves and clearly extrapolated elements of the model to use as an informal coaching framework in order to inform their own practice.

Barriers

The general issue of resources constituted a barrier. Patient care was prime, and took priority over other issues, therefore it was seen that when resources were limited, and patient dependency high, then any extra documentation, explanation and education were not addressed.

There are two dimensions to the time aspect, firstly there is the sense that there may be a slow beginning to the learning process as teams embark on their projects. Secondly there is the aspect that protected time is necessary to enable this learning process to take place.

> *"Took us through un-picking what we did, which clearly was part of his idea of helping us see what we wanted to do. That was a step we had to go through, so we felt as if we weren't making progress, but actually I think we were beginning to understand better what we do on*

the wards, how we do it, and therefore, what a potential area for improvement might be and I'm not sure that could have been short circuited."

There was broad agreement on the time taken for the project to gain momentum. In the initial phases this had generated a number of negative responses from a number of those involved.

Structural barriers

The work patterns of different professional groups posed problems for joint learning sessions. It was difficult to release nursing staff from the wards at certain times, and there were difficulties with regard to the PAMs, for whom the time within the ALG conflicted with time available for patient care.

Significance of the service user

A more patient centred perspective.

There was an orientation towards the 'patient' or 'client' or 'service user' in this project and this was an important underpinning to the learning within the ALGs. The common goal – developing a patient centred model - was considered to be an extremely important unifying factor in developing the learning.

> *"That's been really important all the way through because it's actually focused everybody, and that's why we're all here, and to find that common goal has been desperately important. I think without that it would have been more difficult and I think it's important to establish what that common goal is. We quite often end up just paying lip service to it but I think once you start to look at the patient and their goal, and not your interpretation of their goal, because that's been a problem. You know, there's been a medical model and there's been a nursing model and a physio model of what patients needs are, but once you start to get to patient's themselves, that's absolutely vital. You can't argue with it either because it is their right, why should anyone else have ownership over patients except for what their goal is and their agenda. So that's been really vital to choose that as a starter."*

This view was corroborated by a nurse, who had gleaned important information from the occupational therapist within the ALG. The view of one clinician was that within the health service culture occupational therapists, physiotherapists and social workers were considered to be patient centred. The new knowledge concerned patient preferences for dressing and personal hygiene routines such as going to the toilet. This respondent took the view that her professional group sometimes imposed their view, but considered that insight into patient preferences both enhanced care and facilitated patient management. One instance of this was the improvement in patient management sometimes achieved by preventing agitation. This had been a consequence of the work within the ALG:

> *"So we actually found that by trying to find out from the people, the carers whether they be relatives or whatever, what their norm was, if we tried to keep to that, then we weren't going to – hopefully – going to make their agitation and confusion worse because we were trying to keep things familiar to them, and we also discovered that if you actually spoke to them and if you could find out about their backgrounds, so if they did start to get agitated you could talk to them about their family or their previous work and their hobbies, then they would quite often respond to that and you could chat away to them and they would be quite settled."*

Post-Qualifying Learners - Newton

Context

In this setting members of what was originally identified as the 'post qualification learners', that is, the members of the ALG, were connected with the community based Child and Family Support Service. Whilst an initial meeting focused on the higher level management of the project, it quickly became clear to the management concerned that the need was to actively involve those delivering the service.

Participants in this ALG included a manager with responsibility for the health visiting service, and several representatives from the voluntary organisations. Social services participation was limited to initial meetings.

The early meetings were held in a community hall of the electoral ward. With few available facilities it was decided to change the venue for meetings of the ALG to seminar rooms available within the community based hospital.

Experiential
learning

The PDSA
approach: a quality
process

One aim of the project was to link together both interprofessional education and health improvement. The PDSA cycle was seen by participants to provide an underpinning for work undertaken within the project. The university CQI facilitator worked with the ALG for several introductory sessions, before leaving the pre-identified university site team to continue with their learning project. One participant (who left the project when appointed to a new post), explained how a sudden awareness of the framework had emerged:

> "... think the realisation of the PDSA cycle, I could actually review it, you actually plan something, try it out, look at it and then act on what I found out. That to me was big. All the work seemed to get at that point. Yes, that was the biggest thing I think."

Use of the PDSA cycle in the early stages also provided a tool for progress amidst professional boundary keeping. It enabled a joint focus when tensions or potentially conflicting perspectives were prevalent. Having recognised the utility of the model, one voluntary agency worker who had considered at one stage, leaving the project decided to apply this new practice to an issue encountered within the ALG.

The model, integrating the process of reflection, was already consistently used within the approach of the voluntary agency staff, but simply implicit and hitherto unnamed. However, although the approach is new within the context of the health service, it was recognised that elements of the same approach had been used within previous working experience in educational settings. The process of raising the framework to awareness, linking planning and action with review and discussion suddenly highlighted the underpinning structure, making implicit elements of the underlying framework explicit.

> "Then suddenly it did seem as if it was exactly what we were doing it without knowing that the PDSA cycle was actually what we do all the time, you know, on reflection you know the actual sort of process of reflection."

This person was aware that the 'scaffolding' was now in place for future use in a range of contexts, and led to a feeling of increased confidence. The possibility of using the PDSA model in other settings was mooted (the interviewee had recently been appointed to another post). Beyond the ALG, an analogy had been made with principles of the "Investors in People" project, and details of the process had been requested for use in a commercial environment. Along with several other group members the framework seemed

to have been a logical way of proceeding in order to achieve a particular goal.

The strong initial focus on the model as a framework was a conscious orientation towards addressing individual needs in a way which represented a shift from a health to a social model of service delivery. There was general agreement around the model and the process of change, as the service manager commented:

> "We took quite a time, didn't we, and had a lot of discussions around what the issues really were, um and focusing on those and, I think, probably, that led on to the work that we actually did, talking to clients and really listening and focusing on what they were saying and thinking about how we might be able to do something different."

This had the advantage of trying to get the professionals to think in a different way, at a time when the service was shifting from the delivery of a service driven by professional perceptions of what was required, to a 'service' attempting to empower individuals using the service.

For those within the health professions delivering the service, using this process of reflection as part of the experiential learning cycle (and the PDSA process) contributed towards making this shift towards a needs centred model, described by the manager of the service as a 'more social model':

As one participant observed: …

> "Initially when the project started, erm it was actually going out and finding what parents wanted, so you've actually worked with agencies, plus from finding what parent's needs were and trying to put that into practice, I think that's been quite a learning curve really, rather than **thinking** what the parents want as professionals you actually go out and **find** what the parents wanted, and overall the project's been very successful I would say, good feedback from clientele."

Practice related learning:

Reflective learning and thinking flexibly

The language of reflection was familiar to most participants in this ALG, although for some it was the first experience of the reflective process. These were health professionals who recognised that at the time of training, such processes had not been part of the traditional curriculum.

The process, of planning, doing, studying feedback, acting and reflecting, was familiar to those who had previously been employed within the education sector. As indicated earlier, this model had been used within previous practice, such as within the sphere of special needs, and also within educational projects such as Highscope (a project for children to improve their work).

This was described as "the educational way of thinking" by one health professional, previously unfamiliar with models of reflective practice, and perceived as giving insight into the different ways in which individuals were thinking. There was a critical self-awareness indicated within this process, which was one of active participation. The active participation experienced by one individual meant that:

> "I've actually learnt more from it, you know, self pleasing if you like, more aesthetic pleasure from being involved in it, so perhaps we ought to think about…"

The need to be reflective was recognised, but in addition to being an individual activity, there was also a collective activity as part of discussion and dialogue in order to examine previously unconsidered areas and issues. Triggers for reflection and dialogue were stimulated by the evidence gleaned from service

users in the form of interviews.

For those who had been established in their professional group the conventions of professional practice moulded their attitudes towards delivering the service. Their routine practice was dependent on the situation, and habits of practice became well established. According to one respondent it became difficult to *'break out of the professional mould'*, and this in itself required *'being brave enough to do it perhaps'*:

> *"Well I think when you're in the job for a long time, you think you're doing it right perhaps, although sometimes you think 'well perhaps I ought to think about doing something else' or perhaps you ought to think about doing that, because you've done it for so long you just get stuck in a rut really, and this has sort of broken the rut in a way but there are other ways, yeah."*

One element consistently mentioned was the time involved in allowing a project such as the RIPE model to evolve. Working groups took time to establish in order to identify an agenda and generate problem- solving solutions. For those involved in the project within this setting there was a realisation that 'learning to be patient' was an important and presumably unanticipated element of being involved in development projects. In the initial stages of the process, when participants were confronted with uncertainty of direction and focus the importance of 'waiting' rather than abandoning the group was mentioned by a number of respondents.

There is an additional dimension to this aspect of learning. Within the learning framework set up within the Stay and Play scheme, one voluntary organisation employee commented on her involvement and the way in which her own vocational qualification was being structured within the learning environment of the Stay and Play as her workplace. Her college based learning (in the FE sector) was providing the theoretical underpinning for the practice in the Stay and Play.

Subtleties of interprofessional relationships

In the initial stages of the interprofessional/interagency working sets relationships were supremely and critically important. The value of a university based external steer to the group was seen as guaranteeing an outcome, and the facilitation was valued. A number of participants came to the forum with histories of previous working relationships, as with one voluntary agency employee who had formerly worked within both education and health sectors. In one instance, one participant formerly working within the health service had been in a hierarchical relationship with another ALG member. Such matters, along with personal histories, influenced individual learning for individuals. As an illustration of this, one participant referred to this prior experience reflection on a manager's observation that 'she found it quite strange to find this individual at a meeting, and in a new role'. Despite on-going contact a new credibility had to be established, which involved new learning for others. Understanding this in itself, and the process of gaining credibility, was seen as being part of the learning process for the individual:

> *"You've almost got to prove yourself, within the environment to be accepted and I wasn't, I don't know, I suppose in a way the learning for me was that I didn't realise that they would be the case because I was able to move on I assumed, especially as they were professionals who had moved on in their own lives and professional women that they would understand."*

The 'unspoken' agenda articulated through body language was one example of this. A number of participants were sensitive to these issues. Beneath the surface of preliminary dialogue an underlying feeling was expressed of other

group members initially listening but not hearing, or merely superficially agreeing with issues. Participants were conscious of previous agendas from which they were excluded. There was an absence of trust.

Being involved in the project was perceived as recognition of skills and capabilities within the wider community. One individual commented that:

> "...it sounds silly that affected my learning."

However, this parity was considered to be important, since it was considered that:

> "...being treated as an equal in providing learning for other people but also in developing your own learning alongside the statutory relationships."

Learning about group dynamics and interactions was one area mentioned by workers within the voluntary sector, and this was seen to be useful in contributing to easing tension within earlier stages.

For voluntary sector workers there had been an initial perception that their skills were not valued by the health visitors:

> "...unfortunately, the impressions being that they are the only ones capable of doing this, and that when you ask them to help "oh that's not my job, I don't want to do that."

Thus there was a fragile base line for relationships in the early stages. This contrasted with previous experience in the sphere of special needs, where it was suggested that people were more prepared to work together because of a common concern for somebody in need.

It was suggested that as the interaction between health professionals and the Partners project staff evolved, a healthier communication developed, so that beyond the meetings there was also "a more level communication".

Requests from the health visitors to voluntary sector workers to address post natal groups of parents was another affirmative feature indicating changing attitudes towards acknowledging the value of the partnership project. Professional boundaries were suggested as one potential cause for this. Within the project the various organisations involved were compelled to work together because of the project, *"so everyone has had to learn to swallow that pill as it were"*.

| Emotion, attitude and climate | There was an emotional dimension to this learning experience. Where new partnerships were being developed old anxieties frequently appeared. These were reflected on both sides of the working relationship: |

> "..I tended to doubt what I knew I was capable of, thinking that 'why was I being included who was actually working with parents' when these people who had different qualifications to me thought that they could do it better. That was the impression that I'd received, rightly or wrongly."

A former ALG participant from the voluntary sector had expressed similar views in 'car park conversations'. Two voluntary sector workers had, in the early stages, countered this experience but 'buddying' each other, providing mutual informal support in the sessions. The view was expressed that:

> "...she'd often felt that people were trying to put her down whether or

not it was intentional, it was actually felt, which is probably a lot to do with your own self-esteem and why you, why you know, whether you're feeling dis-empowered because of your feelings of inequality or whatever, but its um difficult to quantify, to sort of pin it down so finely."

However, initial feelings of discomfort were not limited to individuals from the voluntary sector. Equally, one of the health professionals reported *"meeting once and being frightened stiff"*, wondering why she was there.

Experiential learning – personal development

One word consistently mentioned, by those delivering services and working with those using services for mothers and children within this aspect of the project was 'confidence'. Those individuals working within the voluntary sector articulated this clearly:

"I think the interest's there, and wanting to do it, wanting to learn, wanting to achieve and I think it's all a combination and like I said its actually being confident, that big word confident, and that is everything."

As an individual in one of the voluntary agencies pointed out, the situation in the learning environment provided by participating in the project, paralleled the learning environment provided by the scheme itself (Stay and Play), in that by raising a parent's confidence, learning was raised. Learning gains were accompanied by increased confidence and this cyclical process was reflected by learners participating in the project.

There was increased confidence too, according to one health visitor, in having gained the confidence to champion any innovative idea, whereas previously she would have been reluctant to be involved. Having seen a project evolve and flourish, had influenced her learning about the innovation process, and enabled thinking more flexibly about the service.

For another individual the increased confidence gained through participation in the ALG resulted in a new ability to question professional roles in a way previously unconsidered.

Significance of the service user

According to a number of health professionals an increasing awareness of the needs of those people using their services had developed, or perhaps more accurately, where the existing services were not matching needs expressed by those at whom services were targeted.

The health professional considered one area of major learning to be an initial consideration of the needs of the client group in delivering services, rather than the professional perception of service user. A significant aspect of learning was described as being the challenge of actually finding out parents needs, and putting them into practice:

*"I think that's been quite a learning curve really, rather than **thinking** what the parents want, as professionals you actually go out and **find** what the parents wanted."*

One consequence of this was the increasing awareness of isolation within the 'client group', as members of the group learned of unmet needs for social networks and support. However, the route to reduce isolation was unknown. Use of the PDSA model in alliance with the voluntary services offered an opportunity to explore options. Similarly there was a perception that given the parental need for reassurance, there was learning for parents in being able to informally access advice and information from health professionals in a range of settings, and thereby requiring health professionals to act flexibly in

delivering the service.

There was another aspect to the reassurance for new mothers. It was suggested that some young mums were themselves learning to play. All participants at the ALG had observed the behaviour of the young mums with their children at the Stay and Play. Without themselves having had play experience as children, it was suggested it was not possible for some to pass on this ability. Similarly, given a climate where consumerism was a great pressure on many families, there were opportunities within Stay and Play to develop alternative ways of playing with and developing children, without competing pressures of consumerism. Modelling was a powerful way of developing the framework.

This was a powerful learning experience for a number of reasons:

> *"...I think the parent and child relationship that's come out of the Stay and Play and reducing the isolation has probably been one of the biggest learning curves really that I've experienced perhaps in well all my time in health visiting perhaps."*

Feedback from those using the new service was experienced as strongly encouraging, and this provided the momentum for continuing with the new practice (of health visitors being involved for informal advice within the Stay and Play setting). This provided a reason for continuing with the professional challenge of transferring practice to a new setting, which was sometimes a difficult experience for those accustomed to delivering advice within a clinic setting. This was also seen to be innate conservatism of human nature, with individuals reluctant to develop.

For both agencies within the partnership (health and voluntary sectors) there was a common motivation drawn from the parents, so that one respondent described herself as 'an advocate for the parents'. Just as a health professional was "spurred on" by parental response, the process was replicated within the voluntary agency:

> *"But we knew it was reward for the parents, we knew the parents were benefiting and I think that was the momentum to keep going and I think probably, to be fair that's because we were there every week so we started to build up a rapport with the parents and were getting feedback from the parents every week, whereas I think at that time, they were perhaps coming in on one odd occasion and saying 'well none of our parents were 'their' parents, whereas we didn't start with any parents that were 'our parents', we had to work at making them 'our parents'."*

The personal / professional interface

Several of those outside the health professions drew on personal experience in contributing to current motivation with project participation, albeit unconsciously. For one, recalling personal challenges in interactions with professionals provided a compelling reason for continuing with project participation within the early stages, when there was considerable uncertainty around the project, and relationships between those involved in the ALG had not evolved. This personal experience, for one participant: *"That isolated parents mattered."* Or as another participant put it, again drawing on personal experience: *"every mother needs help at some time."*

However, awareness of such agendas did not necessarily make the initial experiences easy in any way. There was recall of the early stages when the situation in the group was tense, and there was no momentum as the group struggled with defining the questions to address in order to improve the service:

"...quite painful few sessions I thought when we were trying to define isolation. There was quite a lot of assumptions made like there has been this time of the (Eton Way) sessions, that it is not going to be..the comments, like it is not going to be needed on that side of town, the parents won't attend."

There was a need to draw on experience beyond professional assumptions, to draw on the experiences of those using the services:

"The assumption again. Who's making this assumption and what are they basing it on? We all do it, but sometimes some of us are able to look lower than that, deeper than that to see if it's our assumptions not our professional assumptions."

Informal learning

A number of action learning set participants were sensitive to the complexities and subtle nuances of learning in the work place. Working relationships were affected by power and status differentials.

Observations on the rigidity of roles and professional identities within the health sector, were articulated by one voluntary sector worker. A breadth of experience in health and education, besides other areas, was seen as contributing to a personal sense of flexibility and adaptation. This was accompanied by an acknowledgement that a career path placing individuals on a direct route from school to college into nursing or similar health professions might constrain such flexibility. Transferring practice might then become more problematic. These observations contrasted with the autonomy available within the voluntary sector organisation.

For someone with an individual responsibility for co-workers, this had also affected practice in fostering working relationships with others. This was reflected in sensitivity to a range of issues, from an appropriate title for a co-worker, but also developing involvement within the organisation based on equal partnership. This project prompted personal learning on this issue, which was described as 'facilitating them being able to do their own (development)'.

Unintended outcome

It was not just amongst post-qualification "professional" learners that learning took place. One voluntary organisation worker commented on the encouragement offered to mothers within the scheme, and also on her own powerful experiences. Her participation in the voluntary organisation reflected altered ways of working within public health and the community development model. Her experiences had led to her involvement in the stay and play facility. In time she had become an employee of the organisation, and was encouraged to pursue a vocational qualification. The NVQ course in which she was enrolled gave a theoretical underpinning to the work and supported her new emerging capabilities. Thus she was engaged in an action learning framework, although participating in a course at a level not previously considered by the university (arguably pre-qualification), and within another sector of education.

It is impossible to consider levels of learning within the context of this project setting without alluding to the learning experiences within the partnership with the Partners project – the Stay and Play – developed as part of the RIPE project action learning. Within this context there was learning for all participants, as the project developed as a community resource. The environment functioned as a facilitating environment for many of those involved, including, health professionals, those within the voluntary sector, mothers, (and on occasion fathers), and their children.

Feedback was sought from those using the facility at various times. On one occasion questionnaires were distributed to 45 of the mums using the scheme,

to explore what parents felt their child had gained through participating in the Stay and Play, and additionally what the mothers perceived themselves to have gained. 21 of these were returned, and the outcomes included a range of social, communicative and interactive skills. Mums spoke of their own practical learning, the opportunities to gain advice, and the social support.

Post-Qualifying Learners - Oldburgh

Context

Members of a newly created community based mental health team formed the service element of this university/practice partnership. Practitioners were participating at a time of great change within the service, and this was reflected within plans affecting the proposed team. One example of this was in planned accommodation, which did not materialise as envisaged.

One aim of the learning focused interviews was to explore any learning around the process of continuous quality improvement, and in this setting no allusion was made to this process by any respondent. The majority of respondents described their participation in the project as being involved 'in the meetings'. Membership was fluid, with some members joining the group at a later stage than others. The purpose of the meetings was unclear for some of these individuals. As one participant mooted:

> "...we had a project running without a subject for quite some while."

The production of a whole care pathway for a specific group of patients was seen to be the focus of this ALG from the outset. This task was reported to be the anticipated outcome from the management sanctioning the project. However, this was not the perception of the university side working within an adult learning framework, anticipating that 'learners' within the group would identify their own learning agenda. Several respondents reflected on the tensions generated through a lack of clarity and shared understandings between the management perception of the group's task, and that experienced within the group:

> "I think also what the managers, who had sort of 'okayed' the whole project, what their concept of what the group was to do and what the group's concept were, weren't quite the same, so the managers are putting real pressure on us to come up with a sort of integrated assessment package, core assessment package, and that wasn't actually what we felt our remit was. At the start we felt ours was to actually work out a whole care pathway for a specific group of patients, of which an assessment package would be one part of it, so there was a lot of frustrations and sort of negative feeling coming from the management side because we weren't coming up with the goods fast enough and, on our side, sort of frustration with the management for not understanding what the project was about."

Interprofessional working and learning

The university team at this site included a general practitioner, however the community based mental health team was without medical representation within the ALG. Nevertheless, respondents considered themselves to be working in a multi-disciplinary manner.

One clinician manager commented on the benefit of stepping out of the daily role and focusing instead for a few hours each month on how other people were working, how it developed, how individuals were working in relation to each other. The process of stepping back was suggested to be beneficial in terms of focusing on aspects of working processes. The practice learning part of this endeavour, after an initial slow start, focused on how individuals would share those core aspects with students:

> "I can go through the mechanical process of what we do, but actually how can I share with her the, the role and um and I thought it was really useful doing that with students. It sort of slowed you down and made you reflect on your own practice. As well as looking at other

people's, it, it's a good way of, I mean I learnt far more through, um..the RIPE meetings about how, for instance, social workers view the, viewed their role working within their role and these, I'm not talking about learners, I'm talking actually about the whole time professionals, and indeed Ots, about how they viewed their role within the teams etc. So it was very useful on that basis."

The ALG created a forum in which it was possible to hear the views of other disciplines, based on the needs centred model. In practice it was possible to have an awareness of the contributions and perspectives of different services, but to have the time set aside to exchange perspectives was seen to be a mutually beneficial process. Similar angles were seen as offering slightly different viewpoints and perspectives.

"And actually to meet together and hear how they had different views and experiences...well of course they do, but you know, but then until you're in that environment it, it's not entirely obvious is it? But er, to set aside that time and actually gain from their views as well as being able to offer things myself..erm.. was yeah, was a valuable experience."

However, several respondents expressed the view that multi-disciplinary, inter-professional learning did not feel particularly new, alien or difficult in this service context, because it was part of established working practices. This was particularly the case for those with occupational therapy training, where holistic, integrated approaches were fundamentally core to their capabilities.

One respondent explained:

"My background is, I was an OT, when we train in multidisciplinary environments, and as students when we go to our practice we're often bundled together with other students from other professions and so as a profession it's quite, it's part of our philosophy, and so I very much believe in that and then in my past working life, I have worked professionally with other disciplines and it's been my job to knit them together as a multidisciplinary team. One of my roles you know, I didn't need that concept selling to me, because I know how in the past we've had to train the GP trainees etc., better to understand the contribution of others to the team in order to help them to work more completely really with the patients because of the holistic approach that we use in rehabilitation."

Despite this perception on existing multi-professional practice there were comments regarding the non-participation of a particular occupational group. The lack of medical involvement in the ALG focusing on interprofessional working and learning appeared to confirm existing views regarding medical involvement in service delivery and learning about interprofessional ("integrated") issues. One respondent commented:

"I suppose just the usual frustrations, that the medics never got involved really, any sort of joint working or joint training and it always seems to be obvious by their lack of presence really, and that's always quite frustrating because they've got a lot to contribute to it and maybe my experience shows that they're actually, sometimes the people who are least able to actually do integrated learning, not so good at it."

Experiential learning

One clinician/manager spoke of existing multi disciplinary learning systems within the department, which had a *"completely open door policy to supervisory teaching across the profession"*. This practice had become increasingly popular so that he considered *"people are beating their way to our door saying, 'can you be our supervisors?'*

There was a way in which the RIPE group was seen as a form of group supervision, in the view of this respondent, in the sense that people were reflecting on and talking about their own practice:

"I think in some ways it probably was because people were reflecting on their own practice and people were talking about their own practice..er I think dependent on how you view supervision..

I see

..it wasn't supervision in the sense that, I'm gonna come along and I'm gonna discuss a client with you or a piece of practice that I'm carrying out and 'what do you think about this?'   But it was supervision in the sense of 'look I'm going to come along and I'm going to talk about how I work..'

"So that people have a shared understanding and..no..em, in some cases it was you know, er it was quite useful."

The development of the learning project for the pre-qualification learners could not have happened without the active direction of the post-qualification learners, and in the view of this respondent

"I guess it was a learning process for all of us."

The learning approach framing the RIPE project presented a distinctive process. There had been some uncertainty in the initial stages of the group, prior to the emergence of the 'learning project' (i.e., the development of the pre-qualification learner experience, with the students themselves carrying out the initial stages of the work).

Several respondents commented on the contrast between this learning experience and that undertaken in other groups, which had a task led focus within previously identified agendas.

Acknowledging that nursing was a demanding profession with many competing and potentially conflicting agendas, one respondent commented that participation in the ALG offered an alternative perspective, with the possibility of 'thinking out of the box' and that this was sanctioned as part of the learning process:

"..nursing is a demanding profession isn't it, em and I've not been side-tracked really in any other way and, er, to be given almost the permission to think along those lines is, er, was very useful to me."

This respondent continued:

"But to actually put yourself in those shoes and to, to think laterally about those things was quite enlightening really and that's where the permission bit comes in because normally it's something we just, we just don't do it..erm. So yes, I found it useful from that point of view."

A personal element

Time spent within the group offered aspects reflecting on and drawing on personal learning for several participants. Both referred to profoundly life changing aspects of life beyond the ALG, one in her role as a mother, and the other in relation to the patient experience, acknowledging the nature of such life events in profoundly changing personal viewpoints.

"...as a mum too it's quite, quite distressing hearing that children as

young as that were involved, I mean you, you hear it on the news but just, Oldburgh's quite a small place, you know, and you know it happens, but I suppose until it happens to you or someone that you know you can't really identify with that but um, yes made me more aware…mmm..

And more paranoid as a mum maybe (laughing)

Really?

Well, yeah, I mean look out for the signs or for sort of money, you know, money being spent and not being able to be accounted for, those sorts of things I think, erm yeah, 'cos as a parent you try and get things right don't you, and you can only sort of learn as you go along you don't get a handbook, life doesn't …it would be fairer on the children if you had a handbook but erm yes it was certainly interesting as a professional but also as a parent too I think I learnt a lot from it."

Significance of the service user

One social work representative involved in the early stages of the project observed, that whilst promoting service user participation in service development was being advocated as a new idea within health care, this was established practice within social work.

Refraining from making professional judgements was seen to be important, and within the involvement in the project one community psychiatric nurse considered that amongst the 'bits' of learning gleaned from the project was:

"...an understanding and an affirmation that you could talk to clients, and it was important to talk to clients about difficult and emotive issues around their involvement with the service and their personal involvement with the service."

The service user development worker appreciated the value of perspectives gained through direct involvement with this group. This person spoke with conviction of issues common to the service user, whether a person with cancer or mental health problems. This text is quoted at length, because there are a number of points relevant to core communication skills across professions, some of which are pointers to content within core professional undergraduate programmes, and around issues of service users accessing information. Another important point was made about 'the human touch', again relevant to communication skills, but also, crucially, about being open to the emotional content of the message conveyed by the person using the service.

"..I'm very appreciative of the opportunity that I had to do that, had a lot of very good discussions with people and found that although subject matter might be different a lot of the issues for service users, whether it's mental health or palliative care, cancer were very common, and some very good discussions, very stimulating.

Right

The common issues, the service user, whether they've got cancer or mental health problems what have you, erm, first off it's accessibility to information and accessibility to resources, whether that's a GP referral and/or what have you, but it's getting the referral to the appropriate person quickly

Mm hm

And getting the right kind of diagnosis and that's common, much more

common than people think, I had a conversation with a professor from NAME who was involved with cancer care who couldn't see the similarity, there's a lot of similarity even with mental health, and he didn't agree with me, but mental health destroys your life in the same way as a life threatening illness, because it destroys your persona, who you are, and it often disrupts your family and career, you can lose your home, ultimately for some people they will not only lose their quality of life but they will have it impaired significantly, but then they can actually lose their lives erm, whether they take it themselves or whatever, and they were looking at quality of life issues. There's a lot of similarity, but it's about access to information, appropriate and quick referral and support, and all of those issues are very common and I think it's something that certainly graduates need to know about very early and if we can get that at undergraduate level it's an awareness of that, quality of life issues and how to relate to, talk to people who erm, have got a quality of life threatening illness, whatever the label is.

And has your experience been that professionals do need some…

Mm, very much so, yes, they talk to the foot of the bed or the diagnosis but they don't take on board how traumatised people are, and how communication, eye contact, body language, the whole scenario, and how important they are and giving people information in a format that they can actually absorb at the time, some of it has to be written down because your input channels are severely, erm, almost closed when you get that shock of the diagnosis and people don't take in information. They can't, they're traumatised at the time, they don't think of things they have to ask until afterwards and a lot of the time with mental health, my background's been with physical illnesses, but working the last five years with mental health I was amazed by the similarity. People would turn round and say to you 'what did they tell me again?' and that doesn't matter whether you've got rheumatoid arthritis, or you've had a sub-arachnoid haemorrhage or you've got a mental illness, and then you see it written down, any statements that they can assimilate to take on board in bite size chunks, er. Not because their intelligence is impaired but because of their ability to assimilate information at that time in their lives, erm, and I think that's , it's a vastly underestimated field of work really, processing of information not diagnosis, whatever their field, but maybe that's why…

Mm

Why I got involved in mental health, erm properties of people can be impaired with mental health the same way as if they had strokes. Different cause but their awareness levels aren't that different, and they may not have a permanent disability but it's about how you phrase and deliver information and how you chunk and deliver it, that's something that students, under graduate students, need to understand. It's not to do with intelligence, it's all different scenarios and certainly I've found a lot of quite erm, grand, qualified people (clears throat) excuse me, who either have or haven't got that skill. Some high powered consultants can be very unaware, and if people come out in tears because they haven't understood, or they've missed the point and others are wonderful, they've got a very human touch. It's not just medics it's all disciplines. It's easy to say medics, but they are the brunt of all sorts of criticisms. But they are not all unaware, some of them do need their awareness raising and I think, if they can work more with other disciplines, social workers, OT's, psychologists maybe, they'd get more awareness of that approach, there's a richness there of

mixing when they're under graduates that's very important, in my work experience.."

This respondent continued to elaborate on the different perspective brought by introducing a service user perspective, and highlighted at least one of the issues in actually making this voice heard.

The earlier conversation with the consultant oncologist was once again the source of this dialogue:

"He thought cancer was special and a one off and there's nothing else like it, but the basic erm, but the basic communication with the service user, there are – the common ground doesn't matter what the label is, it's all there. He couldn't see, this cancer was a one off and special and the fact that what they were delivering, if you'd said not said to me, I was sitting in this particular presentation about a hospice and a cancer care, oncology topic. I could have been listening to <u>anything </u>else, erm, but then I used to work with rheumatoid arthritis and they used to say its like living, living a lifetime of compromise, well that could be any disease or illness because you don't know what the next day holds for you. Not all oncology is life threatening. I mean it's terrifying, but then mental health is terrifying because you lose your persona of who you are, what could be more frightening than that? You lose the control of your mind and your personality a lot of the time, and that's absolutely terrifying. Okay with a cancer or something like that you might actually, ultimately, you might lose your life and you might be very distressed and depressed and have a lot of mental anguish, but at the end of the day you're still you, and I think if you actually take away the common, and I think that's a very big learning thing – I think that students need to take on board because it helps them relate to service users and <u>listen.</u> Open their ears and listen to what they're saying, don't interpret what they hear based on text books, <u>they've got to actually hear the fear and the anxiety and let them talk, and </u>not finish their sentences for them which is what we often hear, erm in your working career (clears throat)."

Learning as insight and challenge

One participant, a representative of service users, and also trained as an occupational therapist, spoke extensively about the contribution of service users, and on aspects related to involving this group in meetings, besides the issues around working in partnership with them. There were a number of significant issues related to relationships between professionals and service users offering considerable insight into the process.

In the early stages of her involvement in the project some disquiet had been experienced as a result of seemingly profuse thanks for what was perceived to be a minimal contribution. In time, this person identified this as being part of the difference between professional perceptions and the service user perspective, when so many issues were fundamental:

"...the richness of contributing to the work, and that a lot of people who hadn't been working at the coal face with service users maybe aren't so aware of how basic the starting point is when you're relating to their needs, expressed needs."

As an illustration of this given by the respondent, was the contrast between systems, and schemes such as those, which were the focus of discussion as led by the university team, when compared with the service user orientation. Here basic questions regarded access at a number of levels:

"But first of all how does the service user find out about this? What's

important to them is that they have accessibility, that they can understand the information, that the language, terminology, the jargon is absent and it was all very basic."

This question was the guiding principle underlying the pre-qualification learner exercise.

Post Qualifying Learners

Essential Themes:
Kinds and Levels
of Learning

Understanding Roles:

- There was an increased understanding and valuing of others' roles and the different valuable perspectives that these bring.
- Participants at times had to learn to change their own and others' attitudes about the roles and histories that they had in relation to one another.
- In learning about one another's roles, a new perspective or understanding of the patient was also sometimes achieved.
- Tribalism: there was a greater appreciation of the historical barriers to interprofessional understanding and the importance of having an opportunity to address these barriers.

Stretching Boundaries:

- There was learning in which participants had to stretch their imagination beyond professional boundaries. As such, learning was transferable between personal and professional boundaries. The 'real' nature of the learning environment meant that connections were made with other situations, times and roles.

Reflective Learning using PDSA cycles:

- The importance of the PDSA cycles as a framework for learning is that the learning led to some form of action. This gave members confidence in their ability to reflect and see how this can lead to action and results.
- Learning the PDSA cycle as a way of proceeding was also considered valuable because:
    - It unified the aims of the group beyond their differences by focusing on the needs of clients and patients.
    - It became implicit to their way of working – it thus became 'tacit learning'.
    - Participants could see the transferability of the model to other contexts.
    - Seeing how the use of PDSA cycles lead to actionable improvements, resulted in an increased feeling of confidence in participants.

Practice-related, experiential learning:

- It was learnt that small steps of change and joint ownership of these changes were important.
- It was learned that practice-related learning required patience as there is a 'feedback loop' with the real world in which the need for agreements occur as well as sequential steps in time.
- There was evidence that the multiple and complex challenges of the projects called on some participants to draw on their relevant experience from the past and apply this in new ways to the present project.

Learning about the service:

- There was an increased learning about the nature of the service that they offered, the problems that they needed to address, their possible solutions, and the resources that they had at their disposal.

Personal and Interpersonal Learning:

- Through observation and participation in the interpersonal situation there was private, individual learning about interpersonal dynamics and how to cope with these, on both an emotional and behavioural level. This led to acknowledged improvements in functioning as a team.

Learning facilitation skills:

- Members learnt group facilitation skills by having a facilitator who functioned well as a high level CQI facilitator.

Learning the value of a patient/client centred perspective:

- The value of a more patient/client centred perspective was learnt through experiences in which patients'/clients' views became a credible source of evidence. In this regard, a range of learning from service users occurred such as:
    - The value of talking about difficult and emotive issues with the service user.
    - The common desire of the service user to have accessibility to resource and support.
    - Understanding how 'basic' is the starting point from the users' point of view regarding their needs.

Barriers to learning:

- Barriers to learning that needed to be addressed were the difficulty of finding protected time due to other priorities and the differing working patterns of different professional groups.

The Pre-qualifying Learners

Context

Kinds and levels of learning

In each of the three sites there were attempts to set up and deliver pre-qualification learning experiences that combined interprofessional learning and continuous quality improvement approaches. Recruiting multi-professional or multi-disciplinary mixes to each ALG proved problematic.

The hospital setting was the first site for a pre-qualification learning experience. Participating in this were six female students with professional training in physiotherapy, occupational therapy, nursing and social work. Members of the university team worked with this student group, each of whom were issued with course materials outlining the underlying theoretical framework to support their ward-based learning experience. This adopted the principles of a needs-based, patient-centred focus within the continuous quality improvement model and took place beyond the parameters of the ALG. Students returned to the ALG with their practice-based results.

In the second setting, the Stay and Play facility was physically situated within the aegis of community education. Again, as the setting for the user focused continuous quality improvement exercise, this provided the location for those pre-qualification learners within the child and family support service. Four female students were involved in the first pre-qualification ALG. Two nursing students and two NVQ students based at a nearby college were involved. The learning experience was active, and those students on each attachment were able to co-work alongside the others in the community together with the voluntary agency staff, the mothers and their children, besides the occasional health visitor. Members of the site-based university team met with the students within the seminar rooms of the local community hospital setting, following the Stay and Play sessions. Students had the opportunity of participating in several Stay and Play sessions with follow up provided by members of the university team.

Principles of experiential learning were based on identifying learner experiences as a starting point, although because of the unanticipated mix of the group (it had not originally been envisaged that NVQ students would become involved) the starting point drew on personal experiences rather than work related practice experiences. Nevertheless, working directly from the experiences of the student group it still proved possible to transfer contexts and pursue a needs-based model in order to consider how services might be improved for mothers using the services. A second group of students also pursued this path, whilst a single student undertook work within the final pre-qualification experience at the Stay and Play. In this case learner experiences were very 'hands on' with direct engagement with those using the service.

The community based mental health team provided the third setting for pre-qualification learners. Students were drawn from a range of occupational bases. It proved difficult to construct a truly interprofessional experience, and university teams were compelled to work with whichever students were able to participate. The first cohort included a medical student (who attended one session) along with nursing students and an occupational therapy student.

The second cohort included a psychologist (who attended one session), an occupational therapist, and several students undertaking an NVQ level 4 in care. The third cohort was exclusively nursing students, and the fourth group of learners included nursing and social work students.

The learning project associated with this group was progressive, each group building on previous group activities. All aimed to find ways of improving the

acute psychiatry services, particularly for younger patients with first episodes of psychotic illness. The initial group met patients recently admitted to the service and explored the user's view of the services. Information from these interviews was used by a larger group planning improvements to the services particularly for 18 – 30 year olds, presenting to the service for the first time with schizophrenia. One finding was that all those interviewed had a personal history of drug use in addition to their psychoses ("dual diagnosis").

The following student group looked at the information and services currently available for young people with such diagnosis and how this is distributed. They worked together and found little good information readily available. The student group then designed a local resource, giving information about the signs of significant mental illness and the appropriate actions to take. Local art and design students translated these ideas into eye-catching posters.

The next student resource aimed to work together to develop this resource. The task was completed following the continuous involvement of one particular nursing student, finally assisted by a social work student.

Interprofessional learning

In both the hospital and the community based setting comments were made on the absence of medical participation within the group, which was perceived by the students in the first place as being a subtle learning issue:

> *"It just highlights the problem in the first place, doesn't it? The fact that we're all willing and happy to join in and discuss these things but where's the medics and how much do they think their time's more important than we think our time is?"*

Students considered undergraduate medical training to be responsible for this attitude, with the perception that the prevailing disease centred model of medicine contrasted with increasingly holistic approaches used within other professional training. Students in working placements are absorbing information and learning from a range of intentional and unintentional learning experiences. Informal learning about the hierarchical nature of the organisation and medical involvement was not limited to the participation of medics within the RIPE ALG. One student had asked a senior house officer on the ward for an opinion on multidisciplinary education. The response had been a query on the nature of the ALG. Students interpreted the response (indicating that no problem with the 'old way' of nurses writing their medical notes,) together with a perception that there was no need for the meetings, as showing a lack of support for interprofessional working.

Again, in the community based mental health setting several students identified knowledge of the reluctance of other professional groups to be involved in interprofessional working as part of their learning outcomes.

Learning from and about each other – practice related learning

Other professionals responsibilities and roles

Communication aspects were highlighted as an essential component of working in a team, and informed individual practice.

> *"Just knowing how to work with other people, how to work with other people, and knowing what they need to know from you. Those kind of things."*

Students working on placements in the hospital setting perceived that multidisciplinary working stemmed from good communication. One aspect of this communication process was seen to be the notes maintained on the ward, and this was considered to be the most logical place to start looking for areas

for improvement. Reviewing the work also made the group aware of the amount of existing good practice, with note keeping the only area where there was room for improvement. The student-identified need for multidisciplinary notes reflected an area in which the hospital had been compelled to take action.

This awareness of team practice impacted at a personal level. One student gave an example of writing something in the notes following an action with a patient. She considered that this was something she approached systematically, but had not previously realised the importance of this process.

Information processes at another level informed activities of the mental health team participants. In this instance members of the group reported being *"shocked by the lack of information"* available.

Patients informing practice

Students considered that practices such as assessments had been improved following focused conversations with the service user. One student considered her previous practice 'naïve' when contrasted with the more holistic approach learned by considering the patient's needs in a more domestic environment, beyond the current hospital situation. She could now understand how repeated admissions might recur when such considerations were ignored. At this stage of training, students were already commenting on the fact that when assessments were carried out they wrote **their** interpretation of patient needs, but one of their first practices within the ALG was to **ask** patients their needs. Answers revealed the gap between patient and professional priorities, and contrasted strongly with anticipated answers. One student recounted an example of an elderly lady seeking hairgrips when the nurse had anticipated an answer about physical needs, even thinking that the patient might express an action that could be measured, such as wishing to get out of the chair, or to be able to get to the bathroom without getting out of breath.

> *"My lady with hairgrips. I said "is there anything you feel you need while you are here? What can we do for you? She was concerned about getting some hair grips and her appearance and looking the same in hospital as she did outside. That was her main concern.*
>
> *Were you surprised?*
>
> *Yes. At first I just laughed and then I thought "well, you do don't you. I know myself, your hair, it is a big thing to a lady, they want to get their hair washed and..it is all about their body image and things. Why should it be different in hospital? So even as you say something which looked quite small was actually a bigger thing, beneath it. Okay it was just something that the hospital doesn't cater for, or that perhaps we as nurses don't."*

Value of the service user

In the hospital context, the process of discovering the patient's own perception of their needs, offered insight into how different professional roles were perceived. Communication aspects between patients and other team members were a further source of learning.

Exploring the patient view about care outcomes was a focus for learning within one ALG. Knowledge of this also enhanced the practice of communicating with other team members to create a common goal. This process was reported to be an area of learning resulting from the ALG.

Knowledge of other services was an area in which students recognised learning gains when considering other services and professions to be involved in patient care. Combined knowledge of both patient need and available services created an awareness of optimum timing for any further referral.

Student participants in the community based setting of the Stay and Play valued another perspective based on service user needs. In this case the perspective was that of the mother's as they learned about their feelings of isolation.

There were a number of aspects to this theme, one of which impinges on aspects of professional distance. Another is related to the nature of professional work itself, since the delivery of care involves a range of people, many of whom may not historically be classified as 'professionals'.

In the hospital context students spoke of an increased awareness of other professionals giving the patient more choice to promote recovery. There was an awareness of a sense of collective responsibility towards the patient. Students articulated how important it was to maintain distinctive professional identities but to blend together, to work together, or the good of the patient.

Within the community based mental health setting, the work of the project group involved the use of a group workbook. This student group, involved in seeking out information sources, were shocked at the dearth of available information. They realised that from a service user's point of view the position was very difficult:

> *"I think as well it made me realise just how difficult it is from a student professional point of view. We all went out and expected to find information, and it was really hard to glean anything from anywhere and then, if you look at that from a service users point of view, how you don't stand a hope in hell in getting, you know what I mean…"*

From this approach insights were gained for a social work student, formerly believing that changes should happen at a structural level, but being involved in this project had led to an understanding that it was possible to make changes at a more local level.

Experiential learning

Reflection

The process of reflection was familiar to those who had been trained in social work, nursing and therapeutic disciplines. For the nurses, this had been a continuous strand within each placement and assignments on reflective practice were also required as part of their course. The value of reflection was recognised as part of this interprofessional experience. Talking to members of other professions stimulated further thoughts about working practices. This was considered to be 'reflection on practice' rather than 'after practice'.

Beyond the hospital context and in the community mental health team, reflection was again seen as being of great value in the learning experience, providing an opportunity to review the process, seeing things which might otherwise have been missed. This was seen to be part of good practice, as one participant remarked *"suddenly you've got the whole jigsaw"*. The value of joint reflection following particular actions (in this case arranging interviews) was again considered beneficial.

Part of the informal systems supporting work based learning for NVQ staff working within community based provision included a Staff Support Group, providing an arena in which to discuss effects of work based events on staff. This arena was considered to be similar to the framework provided by the ALG.

The learning experience was seen to be part of a student learning process (doing a research project) rather than a disciplinary related project.

The ALG model was considered to be good at a number of levels, providing an arena for joint discussion, sharing of views, and mutual support besides

reflection. One community-based practitioner explained that language was an issue, a view endorsed by several colleagues.

Some people found continuous quality improvement terms inaccessible, viewing it as jargon. Initially the unfamiliar language within the learning set appeared daunting to some participants. One participant made the analogy of a 'tool', as she sought meaning from unfamiliar language. In practice, actions were not necessarily named for some participants, but using the resource book and support from a facilitator had enabled practitioners to identify, and thus name their practice.

One example of this was in the community mental health learning project. Words used within the project literature were about "showing respect and consideration, these were aspects of ethical practice". One individual considered that with nineteen years experience in post, such qualities were routine part of care delivery:

> *"... and yet I'm doing it naturally, showing respect and consideration and listening to what the person wants".*

Portfolio building

In the case of the first group of learners the learning experience was considered to be highly relevant to their practice. Nursing students had been learning about managing change on the wards in their university- based training, and this was reflected in the hospital ALG process. Work from the experience was to be used for portfolio building.

Some participants in the mental health setting were able to use the work for inclusion in their portfolios, but there were anomalies in this situation.

The professional personal interface

Learning about themselves and their professional context in the hospital setting was a highlight for members of one ALG. This was in relation to their own contribution to the group and what was given to the group in terms of describing individual working contributions.

Students clarified some of their own knowledge in articulating this and sharing with the group, overcoming initial concerns about whether knowledge would be relevant to other group members.

Participation was initially challenging, with professional loyalties already strong. Students spoke of finding the experience daunting, assuming responsibility for representing all other therapists in the hospital led to feeling *"a bit threatened"*:

> *"Yes. I felt a bit threatened – a bit. I thought, "hang on a minute." You almost felt that you were trying to justify the ward. We've only been on there a few weeks and I felt like I was trying to stick up for them or our profession or whatever, at first. Funny feeling."*

A number of students across sites reported feeling more confident in their practice, whether it was in communicating with those using the service, or with other colleagues.

Barriers

Beyond those references to involvement of the medical profession previously identified, one student spoke of the principal learning as being an awareness of logistical barriers to organising across agency boundaries.

Prequalification Learners Essential Themes:

Learning the value of taking a patient/client perspective:

Students learned to value a more patient/client-centred perspective:

Kinds and Levels of Learning

- To consider patients/clients within their domestic environment; in their everyday lives and not just within the treatment situation.
- To consider the patient/client view about desired care outcomes and how resources could match this.

Seeing the larger picture:

The reflective practice model facilitated the kind of learning in which students were able to "see the whole jigsaw"- how needs are matched by resources of various kinds and levels.

Gaining confidence through seeing the practical relevance of their knowledge:

Students were able to clarify the relevance of their own knowledge base in practice and this enhanced their personal confidence.

Learning to value communication procedures between agencies and professions:

Students learnt about the importance of recording and communicating about the patient across professions and contexts and how there were often gaps in such procedures.

Learning through taking a critical perspective:

Students learnt about the negative effects of hierarchical professional relationships and developed an attitude that this needed attention.

Chapter Five   Lessons Learned from the Organisation of the Project

ORGANISATIONAL LEARNING

Changing and learning cultures

This section changes focus, presenting reflections and evaluative comments about the organisational challenges of moving towards a culture that can support educational opportunities, such as those outlined in the previous sections, as part of a potential 'learning culture', or rather an environment which supports learning *about* practice, *in* practice settings.

This project has been located within the broader policy context of the NHS, and thus serendipitously reflects aspects of the government's modernisation agenda together with influential policy thrusts affecting service delivery. Within this broad framework has also been a dramatically re-structured orientation towards learning at a number of levels; an orientation towards the service user, clinical governance, and lifelong learning amongst these. A number of controversies have bedevilled the service within this period, including what has been identified as the lack of an 'organisational memory' in a fragmented system with few shared understandings of practice.

One clinician alluded to this characteristic in explaining how project involvement had led to an increasing awareness of team practices in relation to other parts of the care delivery system:

> *"And I think that we have now recognised that one of the key things we want to do, is address the fact that we are bad as health care organisations at really providing the information that is needed to the next team of people that are going to manage an individual…as organisations we are quite good at doing our bit…"*

Moving towards a model of care that was responsive to service user needs rather than led by professional dictates was seen to be a slow move away from traditional styles of service delivery. Some resistance was initially encountered in introducing this perspective into practice settings, as one university team member recounted:

> *"And there was a consultant on that day who – I mean the best quote we had I think anywhere in the project – when C said "What we want to do is focus on patient need and the first thing we need to do is look to identify patient need", "we can't cope with the needs we already know about" and that was, as far as he was concerned, the end of his involvement with the project. He left and has never been back, so that was quite an eye opener."*

In learning to do things differently it was those people directly delivering services, rather than service managers who needed to undertake the learning projects. One manager distinguished between delivering a service rather than carrying out roles and responsibilities in an empowering manner when many individuals remained comfortable in their established roles. A considerable amount of learning was required in this uncertain area.

There was a need to make changes in a "fairly slow and subtle way". Within the RIPE project, one manager suggested:

> *"...what we are doing is actually beginning to change people's views and attitudes and gradually start to filter that through to others, that are perhaps less aware."*

This service manager made the point that specific issues viewed as problems from a consumer's point of view were often quite small and relatively simple things to change, and yet service improvements frequently focused on large changes, rather than listening to individuals and responding appropriately. The system was not designed to work in this way. Lessons from this project indicate the possibility of change.

Time for groups to become established

In all sites the need for an investment of time became apparent. This was an important aspect, because as one service manager observed, one consequence of having insufficient time to properly work through certain ideas, was an appearance of the ideas under discussion being unsustainable. There were other aspects to the issue of time, as one service manager pointed out in respect of personal experience:

> *" ... it takes time to sort out what the issues are for individuals, what the priorities are, I think for individuals and even when you focus it on something it still takes time for people to come around and say 'yes it is a good thing'. That there are still those people who are not sure about it, though they are prepared to give it a go, but they're still not sure, so they need time to actually see the results or to convince themselves that it is something that is worthwhile."*

One therapist within a community based team mentioned the time lapsing before any clear agenda appeared to emerge within the learning set. Much of this was ascribed to different ways of working between the theoretical aspects perceived as being associated with university practice, clinicians at grass root level, with an orientation to action. This reflected comments regarding the 'talking shop' mentioned at other sites. Ultimately, momentum generated energy within the ALGs, but this was not initially apparent:

> *"Yes, I think that was, I don't know, I think a lot of it was because I think possibly, people from the university within the group had a different way of working from the clinicians who are at grass root level, where I said I think, we're very much more hands on, get going, get things moving and there's a lot of theory going on, just talking going on, which I know I did and I think a few others found frustrating that they weren't moving a bit faster.."*

A group or a team

Partnership working between the university and service settings may involve working with teams. Team functioning was identified as an issue in several settings and in partnership working no assumptions should be made regarding a group of people actually having reached the stage of operating as a team.

One group participant leaving an ALG following a year's participation, considered that assumptions were being made by the university team about the nature of the team working in partnership with them. At this stage the 'virtual' multi-disciplinary team were having a day dedicated to team development, but, in the view of this respondent the university appeared to be operating on the assumption of working with an established multi-disciplinary team, which was not the case:

> *"I wouldn't consider that the teams are being – there seemed to be an idea from the university side, but you know, we were sort of established multi-disciplinary team, which we're not...."*

Asked to expand on this tension, she replied:

"Well yes, I felt, if we were being asked as a multi-disciplinary team to take part in it, we did feel that that was how – that we were in that sort of integrated state, and I thought possibly that through the project – the project might help to develop that better somehow."

Exploring this aspect (of team development) in other context, it was considered that the stage of team development was likely to affect the capacity of a team to benefit from the approach.

A common goal – improving partnerships

Learning that other occupational groups shared a similar goal was an underlying theme appearing in the data. The manager of the child and family support team and an early key player in the voluntary sector both shared similar underlying views of a service empowering service users. From the voluntary sector came the view that sometimes the only way to empower individuals was to provide some structures. This could be the beginning of a gradual process.

From the community based service manager came a view resonating with this, about future services defined by user needs in an empowering way, and those directly involved in service delivery, the learners around this fundamental change:

"They'll have to deliver the service and I am talking about delivering a service when really it should be an empowerment, so it is not necessarily about delivering a service but it's about carrying out their roles and responsibilities in a way that is empowering, and in a way that is sensitive to individual's needs and, I guess we're probably still a long way off knowing how the service should look, what we should actually be doing and how we should be structured. How we should be out there assisting and empowering people."

University/ practice partnerships

Partnerships involved varying amounts of initial preparation. In the hospital setting there had been preliminary discussions between the consultant of the first ALG and the university facilitator. In addition to this, one ALG member was also a university lecturer practitioner. Several link practitioners in practice settings performed a key role in hospital based groups. However other professional groups joining the group were not party to the same information, and *"thought it was just a meeting"*. There was a perceived advantage for those familiar with university life and participation in what was experienced as a seemingly alien mode of "discussion groups". However the discussion and dialogue formed a key part of creating shared understandings of practice.

Notes of ALG meetings were kept by members of the university team and passed onto those in practice settings. This helped the development of shared understandings and fostered relationships between practice and university settings.

Consistency of participation

Ownership of a project is an important part of 'growing' an approach to change, or generating the capacity to change. One individual spoke of learning related to this and personal experience in developing teams and the change process. Consistency of attendance was considered to be necessary when members of a core working group or working parties were working through a process. Without continuously attending ALGs, there had been no sense of project ownership:

"Therefore my learning was, it is very important to make sure everybody has a role and everybody is there all the time, otherwise it becomes disjointed and then you lose ownership. What is important is that everybody has ownership of this project and if you have somebody

just dipping in and out like myself, then I don't feel I have ownership of the project.

So you don't feel you have ownership?

No, I don't because I just dipped in and out, and that is a disadvantage.

Alright, clearly as you are saying, that would influence your learning and how you would, in your own practice, develop groups.

Yes, I mean you learn that much quicker from bad practice than from good practice. So the fact that I was operating on a bad practice sort of meant I learnt quite quickly."

This individual was nevertheless highly appreciative of the facilitator's skills, and the evident facility to pick up on key issues emerging within the group.

A number of respondents commented on learning in relation to change processes, particularly noting that imposed changes entailed very different attitudes towards changing and developing established working practices. One participant identified this as *'hidden learning'* within the project, relating this to ownership and managing change:

> *"I think if you don't own it you don't really change it. Or you don't always get true change and you can get a façade of change sometimes, and that can happen. We've got a project at the moment, with the multi-disciplinary documentation and some people have really worked with it, believe in it right from the beginning, and other people are having it foisted upon them, because not everybody can be involved in every project, and the people that have worked like to do it from the beginning, understand it, own it and can do it, and the others are finding it a lot more difficult."*

However, paradoxically, several commentators noted that the corollary of this applied to RIPE project members and the wider ward team on which the improvement endeavours were focused.

CQI expertise and group facilitation

The role of the university as an 'honest broker' in neither steering nor chairing the ALG was a consistent theme to appear in the data. In the early stages of working without a pre-determined agenda, skilled facilitation provided the key to maintaining the group. It was necessary to invest time in this process.

Ground rules underpinned by an authentic basis of mutual respect and valuing were required in order to ensure 'privileging conversations' within the ALG. Whilst these may not have been explicit in all cases, there was an implicit valuing of all participants, with a concomitant parity of status:

> *"Patrick is the real expert with facilitation and listening skills and counselling skills, and those skills are vital to the process. I mean, I think I have learned things from him. But it is something you can't just kind of copy, because it's kind of not genuine if you just kind of mimic, it has got to come from you when you facilitate and listen. But some of the techniques I think I would certainly try and use."*

Respecting and valuing all contributions to the 'group think' was shown by using techniques such as parking spaces. Initial stages are potentially problematic. One participant used the words *"on the brink of a project"* to describe the initial hesitant stages of project evolution. This had been personal

learning, but the organisational concomitant of recognising and acknowledging this process is extremely important:

> "It affects the people that are contributing, but also kind of like well valuing as well, I suppose, ourselves, and that has kept everybody going because, especially at the beginning, it seemed like we were taking a long time to get to where we were even heading, and there was a lot of work to do. I think that stage can be a very tricky stage. I think I didn't really appreciate how tricky that beginning stage was and perhaps, looking back, there are other projects that I've been involved in that have kind of, well, they started quickly but died quickly too, and thinking back, it may be that the preparation has not been as thorough, because I think that preparation is crucial to do that. So I feel that that's been important to learn for me."

The CQI paradigm is a process for structuring a user-led, activity-oriented (in this case an improvement-oriented) approach to learning in health and social care. It also allows, in the broader context of the learning environment, a recognition of the importance of informal learning, and what may be considered the 'interpersonal' aspects of team working. Whilst those within the academic team (RIPEACT) were able to either adopt, adapt, incorporate or model principles or practices associated with this approach, there was a broader benefit to the organisation in terms of the principal CQI facilitator's role, teaching within the MA IHCC (a Master's degree in Interprofessional Care). Similarly, there were principles associated with curriculum development such as planning and structuring the pre-qualification learning experience. At a broader level the opportunities for seeding this approach across organisational boundaries, within Trusts, and across the region, were important elements to contribute towards the emergence of a capacity for learning this methodology, which itself reflects a continuous learning process in a number of ways.

The opportunities for offering specific events such as the March 2001 Masterclass on health improvement (Managing Complex Services in Healthcare) may be considered part of a preliminary stage in creating conditions for learning about specific innovations, such as working with the continuous quality improvement methodology.

Inclusive

This element was particularly important when people were not accustomed to actively participating in groups. In a traditionally hierarchical system, such as the health service, this was a particularly important element, when some measure of support may be necessary. This point was illustrated across sites, including a social worker and health visitor, besides voluntary agency workers. To ensure parity and equity, the inclusion of all participants, this was a vital characteristic, privileging all contributions to the conversation:

> "Going round and asking everybody in turn so that everybody does say something, because there will be quiet people in a group, and it is vital that their voice is heard as well, because quite often they're the ones that have thought it through and come up with the solution as well. So a lot of this has reinforced what I feel is right but sometimes you can't always do it can you? (laughs)."

Conceptions of learning

Education is a socially constructed processing of experience, and access to educational opportunities has historically been deeply rooted in class and culture issues. Individuals enter educational processes with individual orientations towards learning based on personal life experiences. These differentials have been reflected within the induction into knowledge and definitions of what constitutes knowledge (and ignorance) in the process of 'becoming a professional'. With a history of learning opportunities implying a passive stance to assimilating knowledge, associated with 'training',

'education' and 'courses', it is frequently not part of established practice for many individuals to view an anticipated event, such as a meeting, as a learning opportunity. This also implies an active, dynamic concept of oneself as a learner, taking individual responsibility to direct personal learning.

The RIPE project meetings were structured as meetings, and learning opportunities may be seen to have been circumscribed by this definition, where people were not alerted to the possibility of learning.   One participant described *"learning to look for the learning".*   There are opportunities for learning around project participation, as one participant observed:

> *"And it was the process of learning and how it happened and it's kind of outside as well. I think at first, I didn't appreciate this at all. In fact although it's always been, you know, the RIPE project and we knew it was to do with education, I think at the beginning we didn't appreciate that the education was a part of it, it just seemed to be like the project and that was our focus."*

Subtleties of interprofessional working and learning: team working and leading

A number of disciplines and professional groups were represented in the action learning sets. Several comments were made about nurses and their role within the group. In one instance the ALG was seen to be primarily about nurses and doctors rather than associated professions. One nurse commented on this in relation to the collaborative aspects associated with the supposed benefits of interprofessional working:

> *"One of the things that um, is quite kind of in fashion at the moment, is nurse leadership, but I am sure also in fashion is like doctor leadership, physio leadership, but in a way if you are just concerned about leading, there's that important point that you miss about co-operation and collaboration."*

It is important to be aware of, and sensitive to. perceptions of other professional groups, particularly since highly capable and competent practitioners constitute these professional bodies. In the view of several practitioners, large levels of ignorance underpinned misconceptions relating to their actual (rather than perceived) levels of expertise, and the nature of their tasks. It is possible to be 'nurse-centric' in making assumptions, when frames of reference may be circumscribed by institutional frameworks and uni-professional silos:

> *"I mean, the whole skew I feel has been sort of nurse orientated. I mean, members of the group are involved with the university anyway, whilst other members of the groups weren't and haven't had anything to do with the university at all. So I felt as if they had a slight advantage already with the learning process I suppose."*

One nurse spoke of her experience with this aspect of the learning process, describing an increased awareness of nurses and doctors within a hierarchical relationship in relation to other professional groups, and perceiving their dominance within the group dialogue as reflecting this differential:

> *"It was nurses and doctors that did all the talking, as it is in daily working life. So perhaps it is as much what they didn't say as what they did. And there was a feeling of them and us, which surprised me, because I thought we were a good team that worked all together and I thought that they were less forthcoming with information because they didn't need to be, because in the beginning I decided that we work so well together, because there is so much tacit knowledge, that we actually can work fast because we have shared meanings, but maybe it is actually a power differential that they don't come forwards and say*

what they want for whatever reason."

Multi-professional and multi-agency teams are not limited to nurses and doctors, with their now historic quasi power games. Interprofessional working on the RIPE model fosters inclusivity and does not privilege exclusivity. It seeks to privilege the needs of those using the service.

Language

The culture specific nature of language was evident in a number of ways. Members of the university team were conscious of this element between exchanges in university and practice settings, there were several allusions to 'jargon' in different contexts. Within one interview with a clinician the timbre of the interview changed substantially when a word with a perceived management orientation (operationalise) was introduced. Another clinician suggested that the cohesion provided by using the common language of CQI within the ALG, had been instrumental in allowing them to constructively explore working relationships and processes.

It was also reflected within the language of the university team. One team member spoke of this in relation to previous experience of quality improvement. The crucial development in this model was seen to be the service user focus:

"I thought I understood quality improvement and then I realised that I didn't think I did, and then I realised that I did do it – did understand it, and it was actually, again, about language and about people using all sorts of language and just – a new series of words for a new model or a new idea, that actually wasn't that innovative at all. It was another spin on another way of doing things. But certainly – so that is kind of my history of that, and I have been involved in quality groups and quality circle groups and these sorts of – those sorts of language of things within Social Services and Social Services management before, trying to look at how we can improve services and that, in that sort of focus. I think the quality improvement models that we are trying to use here are subtly different, but importantly different, in that we are trying to take more of a user perspective and a user focus and, I think quite a few of the quality models, certainly quality circles and those sorts of things I have been involved in – I was involved in before – tended to take a more systems view, to try and look at systems and structures and try and improve those. Almost in the absence of thinking about 'well – what is the implication for the user?"

Ownership, learning and change

Comparisons were drawn between the facilitation within the RIPE project and with the introduction and implementation of other initiatives, particularly in this instance with reference to the implementation of quality circles. The depth of the learning within RIPE provided a stark contrast with the superficial manner in which earlier quality initiatives had been addressed. It was recognised that fundamentally this was a learning issue, related to complex practice development changes:

"So I try to compare what we've done between, with previous attempts and there's been other attempts with quality circles. And I think that was another one where I think I went for half a day, there were lots and lots of other people, to learn how to set up a quality circle and going back, with kind of very few skills, trying to set one up and finding it incredibly difficult and, I suppose, being very naïve on the effort that it would take, because I now can see, even to make the small steps, it does take effort and it takes, and that's important to recognise because I think that we've expected to just be able to just do things very quickly. You know that there is a call for using evidence based on our practice and people say 'well why can't you just read an article and then put it

into practice'. And I think I have known for a long time that it is certainly not as easy as that. But this actually leads you through and so that you can feel a change rather than just know the theory of it."

The Collaborative context

Part of the wider infrastructure to the project was 'the collaborative'. This had been established by the NHSE as a forum and a mechanism to enable participating universities to benefit from mutual information exchanges, and to promote relationships between the NHSE and those participating universities. Collaborative events were opportunities to share learning and also invite relevant individuals or representatives of external networks with similar interests or aims.

The collaborative was mentioned as being a wider and valuable contact point for a number of individuals. Being part of a wider initiative was valued for those who were able to participate in broader collaborative activities. A range of benefits included learning about other aspects of the RIPE project, and being exposed to numerous approaches to similar issues; one participant regarded one collaborative as *"mind blowing"*. Another regarded this collective experience as an enormous learning opportunity in contrast with the more incremental progress through the project:

> *"Yes I mean that, well there is a whole host of stuff that came out of Amsterdam that I found valuable. I think to recognise that there are lots of people who are struggling with how to actually achieve change and coming up with sensible proposals about how that can be done. I thought that was very exciting, because I had been very conscious of the fact that there has been so much talk about audit, there has been so much talk about all sorts of aspects of how you can improve the quality of health care, and the bit that tends not to happen is the actual change, so people say, 'well look we want to get from there to there, we know that we are under-performing but how do you actually implement the change?' How do you get people to change the way that they function, how do you get people who have set patterns of work to make a change? And sometimes you can achieve a modicum of change when people are still enthusiastic about the topics that they are thinking about. But then people tend to slip back into their old habits and so, to make significant change, and to make sure that it is actually sustainable, has always been a problem and it is intensely frustrating."*

Personalities

There are two aspects to those personalities within this project, one within the broader NHS context and another within site ALGs. As a civil servant the original commissioner of the project spoke of the value base underpinning his work, and also of the notion that *"it is easier to ask for forgiveness than permission"*. In the culture of the NHS the proactive model of innovation appeared novel.

Within the regional re-structuring of education and training, the appointment of a professional lead across the region positioned another creative, problem-solving innovator with a capacity for radically 'thinking out of the box', to drive forward issues relating to the re-structuring of health care and the service delivery.

Individual personalities will affect the dynamics of individual site based learning groups. These will necessarily be affected by a number of issues, including those individuals participating in the group. A number of comments were made about the optimum level of ALG participants. In one or two instances comments were made relating to people who may not necessarily have appeared to be prime contenders for participation. Nevertheless, opportunities and significant learning had been generated for these individuals.

Time for development	There are two dimensions to the issue of time to emerge from project experience. One is related to the necessary time to allow the group to begin to emerge; this has previously been addressed. For a group of people to begin to learn together requires an investment of protected time.

In the same way, time is also important for any team (including those in the university) to maximise shared understandings of experience and learn from it. In the early stages of this project, with a destination both uncertain and unknown, there were enormous stresses on various members of the university team. Partnership working requires a support system. "Off-line" activity is necessary to nurture links with practice settings.

In the early stages of the project, university members of two site teams struggled to develop a coherent practice in the practice setting, exploring roles and relationships. The 'mop up' session at the end of the experience provided a useful opportunity to reflect on, and share experiences and understandings of, what had transpired in the ALG. However, attrition from both groups meant that by the end the university team had changed, leaving in one case a CQI facilitator, and in the other case a quality steer, plus researcher. Support and time investment are necessary resources to working in this way; uncertainty and an unknown journey present their own demands. (Allowing the same amount of time for preparation and follow up as for the actual session was considered to be a useful model in factoring in necessary time).

A second team experienced difficulty in creating time for the necessary liaison prior to meetings. Although communication systems are facilitated by technology, there is a corollary of time necessary to create space for learning about what has happened in practice.

The 'organisational time' of practice settings is dictated by the service delivery, and has a momentum of its own. The structure of the academic year is an underlying framework for many within the university and neither shared with, nor relevant to, many of those working in practice settings, perhaps in partnership with university staff. This is an important element and university staff will naturally be sensitive to such aspects.

Levels of co-ordination and support

Within the university setting, the academic team (RIPEACT) was the principal mechanism for co-ordination and support of the project. Email communication facilitated activities within the group.

A Site Support group was established in each setting to assist the work of the group. Participants in each case included the appropriate and relevant organisational and service leads, such as the Trust Chief Executive and the Director of Mental Health in one instance, and the Director of Operations/Nurse Advisor in another. In the case of the hospital setting membership paralleled members of ALGs. Convergence and parallels ensured no conflict of interests.

In the case of the second setting, with the child and family support service, a period of service re-construction paralleled the activities of the ALGs, with only one Site Support meeting being held following the initial meeting.

Within the third setting, the site support group met mid way through the project, and again the service was in the midst of major developments. However, in this instance there was perceived to be some tension between the agenda of the site management team, and the agenda of the ALG. The distinction between generating an agenda for learning within the team, and carrying out a learning enterprise from an externally driven agenda was perhaps an important one.

The value of collective action	Amongst the many references to learning gathered during the process of data collection a number of references were made to involvement in learning experiences beyond the project. Contrasted with circumstances a decade ago, there were reported to be fewer opportunities for colleagues to jointly participate in courses off-site. Instead, individuals attended courses and shared information when they returned – a strategy a number of people experienced as ineffective.

In contrast, one lecturer practitioner, with a keen sensitivity to learning opportunities, spoke of the difficulties in structuring genuinely multi-professional learning enterprises, given the need to deliver the service. Despite this, it was reported that within this person's remit, participants were sent off on courses in two's wherever possible, since there appeared to be greater opportunities to capitalise on the learning.

"Learning partnerships" may be a useful term for this. In the case of voluntary sector participation in the project, early tensions were ameliorated through informal mutual support in the project between workers from several voluntary sector organisations. Project workers continued to attend the ALG. There was attrition where this did not occur.

Similarly, a service user development worker had recognised the value of combinations of two or three service users to participate with training endeavours. This was particularly important since there may be some professional resistances to messages to be heard from service users, with aspects of their stories challenging to professional ears or long established professional 'judgements'.

Climate	One important factor in facilitating practice-based learning is the underlying importance of the conversations around the work. Dialogue is an important aspect of these groups, and yet creating the climate fostering such discourse, in itself, requires skilled facilitation in order to generate the potential for creative thinking around solutions.

In a culture where officially sanctioned meetings are the norm, with an agenda strictly task focused, serendipitous learning opportunities may frequently be overlooked.

Barriers	In the early stages of project working, learning biographies were sought from members of the RIPEACT team. One respondent commented wryly that practices within the university had become increasingly uni-professional rather than multi-professional, limiting the possibility for university-based interprofessional working. Whilst there had been considerable rhetoric attached to interprofessional working from a range of professional bodies, each claimed their territory and privileged their individual perspective. It was acknowledged repeatedly that the unifying ingredient of this way of working was the user-led focus.

The technology supporting the project enabled speed of communication within the health service. However, access to computer terminals remained limited in the social services, this has implications in terms of developing and establishing links between health and social services.

In developing the pre-qualification experiences, staff became aware of the enormous logistical barriers impeding such developments. Besides this barrier to interprofessional working and learning, there were also the impediments of disparate accreditation processes, and requirements for portfolio keeping. As one team member observed:

"...like so many of the concepts that have come out of Health and Social Care Development, it is easier to talk about it than it is for them to actually do it."

The Academic Team: a supportive infrastructure

Membership of the academic team offered an opportunity for informal learning within shared project experiences. The regular meetings were seen as a forum for academic team development, with members learning together on the basis of practice experience. In addition to learning within the team, there were to be further opportunities for capitalising on knowledges and shared understandings accruing to the team. There was an underlying commitment to learning about, and from each other, paralleling the inter-professional process in site settings. Another parallel with the project framework in service settings was the combination of interprofessional working and health improvement; the two were seen to be inexorably linked. In addition to these aspects of interprofessional practice, a number of team members had been associated with delivering (and in some cases developing) a Masters course in Health and Community Care.

Particular attention was to be paid to the learning process; but, again reflecting the position in practice bases, there was an underpinning of genuine respect, and an open enquiring frame of mind. Ground rules for learning on this model were implicitly based on valuing, respecting, listening and empowering group members.

It was considered to be a 'human project', considering that there was an input *"a bit more from the heart"*, and axiomatic to this was the assumption that practitioners are connected to service users in a deep and profound way. Within this culture the maxim of "there's no blame, there's learning" obtained. The aim was to connect the learning to life, particularly in relation to the lived experience of the project.

Other concerns were the nature of the learning within the practice-based ALGs, besides exploring aspects of implicit or explicit learning. Other practice areas to be explored in the service context related to CQI and the other, learning from practice. The relationship between experienced practitioner learning and the more 'formal' learning of continuous professional development had not been established in the early stages of the project. Further learning related aspects were shifting horizons in relation to learners, it was recognised that those learners within the project were not those originally envisaged. Redefining learning in practice settings meant redefining the learner, the orientation to learning, and the learning microculture as the facilitating framework.

Shortly after the beginning of the project interviews with members of the team focused on individual learning biographies. From this it was possible to glean the *"dual aspect"* identified and reported in earlier stages of this report. For instance, one social worker within the team was a psychology graduate, whilst another social worker had previously trained as a nurse. There was an interesting dimension to the notion of 'learning identity'.

The parallel process of working and learning together was reflected in the words of one RIPEACT member:

"I suppose those two in combination are what I find interesting about this project, because working closely with social work colleagues, psychology colleagues, even C is our token doctor and that sort of opened my eyes to how differently some people see different things. And (Name) and I have been collaborating on a little bit of this project – we haven't got very far with it yet but that collaboration led me to recognise how differently social work might see certain things that I

almost take for granted as a nurse, and that is helpful in other aspects of my work to understand that."

Growing edges of change and learning

The RIPEACT team and it's work spawned a number of further subgroups; one on pre-qualification learning, another on CQI, with individuals and groups contributing both informally and formally to other aspects of the university and IHCS. Another example of this would be in the re-validation of the nursing curriculum, where members of the RIPEACT team emerged, as a resource for the Institute.

The learning history of the team, as an accumulating record of shared experiences generated within the project, culminated in the group articulating and sharing their understandings and meanings of the two major aspects of the project, continuous quality improvement and interprofessional working and learning.

An away day was dedicated to each of these core strands in the concluding stages of the project. The need to talk about issues in order to further and deepen understandings was crucial. Creating and sustaining the framework for such dialogue and learning was a core function of the project leader within the cultural change model represented by this endeavour. In seeking meaning, learning becomes incidental.

Awaydays

In addition to the regular RIPEACT meetings, there were a number of 'away days' dedicated to deepening and clarifying shared understandings of issues relevant to particular stages of project development. These occurred approximately twice in each academic year. In keeping with project philosophy, these events sought to explore the challenges of project implementation, reflecting and deepening understandings. One example of this is shown in the agenda of the Away Day for September 1999, which focused on how service user involvement might be extended to all projects. It also aimed to reconsider how more learners could be involved in interprofessional learning. A further point was to consider further how to link CQI to other student objectives.

By January 2000 it was recognised that at least within the academic team 'something had worked', *within "The Lived Experience of Meaningful Participation",* as the RIPACT experience had been structured within a previous away day. Activity learning (or experiential learning) – learning by doing, was the theme, echoing the mantra of learning from experience underpinning both project philosophy and approach.

Away Days had emerged as a forum or mini 'think-tank' to capitalise on emergent project learning. 'something' was making a difference within the team, 'something' ad worked, but isolating or even identifying the conditions contributing to this informal learning process was more difficult. One participant offered a recipe analogy with identifying 'ingredients', and gauging the 'oven temperature' being key questions governing this.

Another participant offered an experience from a previous site meeting, reported as a "significant" meeting of the ALG. One clinician (a consultant) had asked to speak last as the ALG concluded, following other ALG members. (He was normally one of the first respondents). He was surprised by what he heard, learning that the skills of two group members were not being used in the delivery of care on the ward. This information had been totally unexpected and the consequences considered to be dis-empowering to two professions. This was reported as very powerful learning.

The creation of a facilitated framework for learning was, in both instances, underpinned by the core values of this model for continuous quality

improvement, developing a practice based learning environment from which to learn about practice.

Significance of the service user

Central to both continuous quality assurance and the interprofessional moving, was a shared value base acknowledging the centrality of the service user in delivering services. This envisaged a radically re-constructed model of services with a more holistic emphasis, as articulated by the academic team within their praxis. This position reflected the external policy drivers, as outlined within documents relating to the 'modernised' NHS.

The RIPEACT team as a resource for IHCS

The experiences acquired through participation in the project enabled team members to draw on their learning as a basis for further key developments within the Institute. One example of this would be in the re-validation of the nursing curriculum, and also within key developments within the further development of pre- and post- qualification developments in social work.

In summary, the academic team engaged in significant learning of their own apart from their involvement in ALG project meetings. They learnt much through group dialogue about the nature of CQI and interprofessional learning and working. See Appendix D and E for descriptions of two away days on CQI and the values, purposes, and strategies of interprofessional working.

Concluding thoughts…

An emergent community of practice

One bedrock of the project team learning was the dialogue and reflection on action within the groups, enabling construction and development of a history of joint learning and shared understandings by participants, as they explored and developed key concepts and applications. The mutuality and situatedness of this experience resonates with participation within a 'constellation of practice' (although in this instance constructed as a 'constellation of learners') described by Wenger (1998) as a key characteristic of a community of practice. Similarly, a shared history of learning (and practice) is defined as a critical feature of this experience and is reflected within this socially situated experience of learning and practice.

Learning about educational frameworks

The implementation of this project reflected massive changes in the NHS service delivery. There were also transformations in perspectives on learning, with increasing attention to the nature of the educational experience as a socially constructed and engineered process. When informed by a specific value base the potential for transformation became clear.

The first phase of the RIPE project was the precursor to PHRIPE, a public health based model for interprofessional learning, specifically focused around identified health improvement issues from inception. This gave the opportunity of learning from many aspects of project experience. Crucially, it was based in practice settings from the outset, and provided the opportunity to create a practice pathway for professional learning at Masters Level. This became the MA in Professional Development (Practice Pathway).

Other developments, which were enabled through the project, were the interweaving of interprofessional experience within the re-writing and re-validation of the nursing curriculum.

Similarly, an increasing awareness of the barriers to the development of truly interprofessional curricula, through issues such as timing of placements in practice settings, and the difficulties of accreditation within the developments of portfolios, created a combination of aspects providing opportunities for organisational learning.

The development of academic credits for learning from practice improvement initiatives such as RIPE offers a basis for extending interpretations of practice related learning, without concomitant difficulties associated with transfer of

learning from academic courses to practice settings.

The quality framework underpinned by approaches to lifelong learning driven by consumers constituted an important element of the modernisation agenda. This presented opportunities for capitalising on introducing applications for portfolios etc., within the clinical governance mechanism, as envisaged within the structures for continuous professional development and individual learning plans.

To some extent there may have been a tension in the early stages of the project, with university staff seeking not to increase demands on an already pressed service delivery. For this reason, not all teams were involved in developing reflective diaries, although this was an integral part of the learning quality cycle (within the study phase).

By the end of the project, site staff in one setting realised that if they had been asked to maintain a reflective journal, a basis for accreditation of some type would have been available. In another setting one project participant used the project experience as a portfolio component.

Essential Themes	Lessons learned about the organisational aspects of the project: Experiences and recommendations
Learning from the way the project was organised	**The constitution of the ALGs:**

Setting up partnerships between a university and practice context is challenging. The model for forming such a collaboration still needs to be explicitly articulated. Is it a new learning/improvement team or is it an existing practice team with university facilitation?

For such an improvement project to succeed, the ALG needs to 'own' the project, and such ownership depends on consistency of participation.

The value of CQI as a trans-professional framework:

The basic framework of CQI can provide a 'language', that can transcend some of the differences in professional and disciplinary background, especially if it attempts to be jargon-free.

The importance of a skilled CQI facilitator:

A skilled 'Continuous Quality Improvement' facilitator is important. This is different from a 'steer' or 'chair' of the group. His/her role was in managing the CQI process as well as facilitating inclusive participation.

Taking time to explicitly articulate the 'learnings':

Participants need to be helped to find the 'learning' in what they are already doing. We are learning all the time but tend to take this for granted. In the CQI process it is valuable to make some time to articulate this 'taken for granted' learning.

The need to redefine 'leadership' in less hierarchical ways:

The concept and nature of 'leadership' may need to be re-framed. Traditionally, professional education has stressed one's distinct professional identity; for example, a 'nurse leader'. This sets up power relationships that may need attention within a model of encouraging less hierarchical, and more

inclusive participation.

Collaborative meetings with similar but different projects is helpful:

It is valuable to meet with others doing similar projects ('The Collaborative') in order to learn about different ways of seeing and doing things.

The importance of 'protected time':

Although a challenge to achieve, the establishment of 'protected time' for the project appears to be crucial for it's success.

The importance of political and management support:

It is useful to have various levels of support that underpin ALGs for the project, ideally meeting as a 'site support group', as well as an academic team to co-ordinate the learning experience (which needs to meet regularly).

The value of drawing on 'synergistic' developments beyond the project:

There were indications that resources and learnings from beyond the boundaries of the projects could be used synergistically to progress activities within the projects. Such 'snowballing' is a mutually enriching experience and such serendipity is unpredictable but inevitable.

The value of the project for educational developments:

The academic team benefited from the project in that it informed and paralleled their thinking when they participated in the design of a new Interprofessional Masters Course (MAPD – Practice Pathway), and the incorporation of interprofessional themes into a rewrite of a pre-qualification Nursing Curriculum.

The academic team engaged in ongoing learning in their own right apart from the ALG activity and this led to greater clarification amongst them about the nature of Interprofessional Learning and Working.

Barriers:

There was, in some situations, evidence of a lack of 'organisational memory'. This emphasises the need to provide information to the other relevant teams about the improvement team's work, which impacts on the care of the individual/patient/client.

Moving towards a patient/client needs-centred model of care, from one that is led by professional dictates, is a slow process. This is due to both logistical problems (the constitution of appropriate interprofessional groups) and attitude (different values, 'languages' and state of working).

Chapter Six   Evaluation

To what extent were the aims of the project achieved?

The general aim of the RIPE project was to assist qualified professionals and pre-qualification learners and students to learn and work together across professional boundaries and agency boundaries so as to improve services for patients/clients.

Specifically, the project sought to develop and test ways of doing, with a view to extending effective practice and embedding this into mainstream education activity.

There were interrelated subsidiary aims:

- To develop interprofessional education which has patient/client service improvement as its focus.
- To make higher education more practice-based.
- To build evidence-based decision making into the education process.
- To integrate practice-based, project focused, inter-professional education into mainstream academic activity.
- To gain an understanding of the barriers and limitations to effective inter-professional working and learning, and to ways of overcoming them.
- To develop innovative learning approaches, including open and flexible learning, and extend their application.

At the level of the general aim there was evidence of a considerable amount of very interesting learning and working together across professional and agency boundaries, but equally there were many challenges and barriers at a number of levels. These challenges ranged from those within the individual, to those associated with organisational and structural frameworks. It is possible to specify these, and they are identified at a later stage in this section. However, in general it is possible to say that, although there are variations in this, there were definite changes to working practices for the better. In one or two cases, there were one or two demonstrable changes that patients or clients would feel, and were able to identify these specifically. However, the main finding about patient centred improvement is that a long term change in culture is required to produce this level of profound change. At this level of depth it is unlikely to produce immediate or short term changes that patients and clients would feel.

The subsidiary aims of the project will be addressed individually.

To develop interprofessional education which has patient/client service improvement as its focus

This was consistently achieved across sites. The application of CQI principles intertwined within the learning process of each action learning set ensured that the core of each programme was reflecting patient/client led service improvement. The model as developed within IHCS was not to begin with the validation of such a model, the design and accreditation of a formal university curriculum in advance. Rather it wished to discover the kind of learning experiences that emerged and then use these at a later stage to inform curriculum design. The next stage would be to build this into mainstream educational opportunities. However, there are indications that parallel to this initiative in practice development, the validation of the practice pathway is consistent with this model. The next stage of this process would be to embed this emergent model.

However, the extent to which interprofessional education was fully developed within each site varied enormously. Within each site attempts were made to develop both pre and post qualifying learning experiences in interprofessional

action learning sets.

Whether focusing on pre-qualification or post-qualification learners, there are great barriers and challenges in developing this model of working and learning. However, in many respects the project anticipated current shifts in the external framework of education and training, which now address a number of these barriers and challenges to developing the model.

To make higher education more practice based	The potential of this statement reflects the interests of the educational context, privileging their interests. In practice settings historically the educational process has been to privilege the interests of particular professional groups. It ignores the fundamental and crucial element of education impacting on the 'interprofessional learning experience' that education is in itself a socially constructed process. The emphasis on 'interprofessional learning' counters this. Within each setting the work of the ALG focused on practice-related issues. Existing activity systems were addressed within the framework of the project, in a facilitated alliance between the university and the practice partners. In the instance of Newton, changes in practice were prompted by information directly from the service users; in the hospital setting (Castlebury) the changes in practice emanated from the study of the communication systems directly affecting patient care. Pre-qualification learning activities based at Oldburgh were also, in a broad sense, practice related based on experiences of their potential client group. Thus this aim was fully realised.
To build evidence-based decision making into the education process	The nature of evidence has been debated at many levels. There are two subsidiary questions here, one relating to evidence-based activities, the second to decision making. The CQI model seeks to base improvements on decision making on data (evidence) gathered from a range of sources, including those using services. The education process frames learning experiences, frequently within award bearing frameworks. In all instances across the project there was evidence that evidence based decision making was built into the learning experience, and thus constituted an integral element of the education process. Group activities led to team decision making based on evidence gleaned from a number of sources. The nature of this evidence was frequently on-the-ground evidence emerging out of the local context. Thus it may be considered that within this model, is a practice of generating and integrating an awareness of evidence based decision making.
To integrate practice-based, project focused, inter-professional education into mainstream academic activity	The model of CQI underpinning the work of the RIPE project has provided a model for practice-based, project focused learning projects. There is now a framework within which such work in practice settings may be accommodated at Master's level. Within the pre-qualification learning pathway a model for integrated teaching between social work and health care students has been validated as part of the re-validated nursing curriculum. Despite these movements towards achieving this objective, it is not yet fully realised, although considerable steps have been made towards this.
To gain an understanding of the barriers and limitations to effective inter-professional working and learning, and to develop ways of	Within the project there have been many insights into the barriers and limitations towards developing interprofessional and interagency working and learning, such as the structural and organisational impediments to working in this way. Specific examples of issues at pre-qualification level would be those of professional bodies and a range of attitudes towards portfolio content, besides the organisational constraints of time-tabling across agency boundaries. At post- qualification level the complex issues relating to social and power relationships are deeply embedded in professional practice, thereby privileging particular types of knowledge. Ways of overcoming these issues have been explored, and ways of overcoming them addressed. In the context of the pre-qualification experience various approaches towards

|	
overcoming them	the curriculum delivery were explored as part of a generic approach towards teaching a needs centred model in interprofessional sets. The range of innovative approaches, included strategies such as developing an interprofessional experience with a uni-professional student group by providing cross-professional supervision, that is, for example, by social work practitioners supervising nursing students.
	For post-qualification learners, actions within the learning sets have contributed towards a greater understanding of the barriers and limitations of inter professional and interagency learning, issues which were addressed through relating as human beings in order to jointly develop approaches addressing needs of the service user. Dialogue within groups was an enabling and empowering process, and the combination of protected time using the common language of CQI was recognised as generating subtle insights which addressed these barriers and enabled development and thus capacity.
To develop innovative learning approaches, including open and flexible learning, and extend their application	The learning approaches developed within the project, as processes focusing on specific practice elements, represent a novel approach towards 'work based learning', embodying learning principles associated with experiential and adult learning approaches.
	Open and flexible learning has been developed to a limited extent within the project. However there has been some exploration of the way in which project learning and experience may be harnessed within the newly developed Teaching and Learning Support Network.
	However, on balance the view is held that a considerable contribution has been made to enabling the university to positively contribute to developing a capacity in project related areas. Key theoretical notions underpinning this include concepts of communities of practice, activity theory and application of the broader concept of capability rather than the narrower and arguably somewhat restricted term of competence. These are considered to be crucially important aspects in the real (rather than virtual) aspects of practice development within the parameters of rapid change, reform and improvement, together with clinical governance and the need for a transformed profile of an active learner within the (lifelong) learning and development process.
	It is not possible at this stage, to indicate something which could be measured in any way. Indications were that it was an enjoyable process for participants. One key component of 'capability' is that this broad concept addresses ethical concerns.
Is there a transferable model that has emerged from the RIPE project? (of linking improvement projects with educational opportunities)	Some core characteristics of this model have been described elsewhere within this report, but there may be seen to be three core components underpinning this (Figure 1). One crucial element appears to be the potential flexibility of this model, given certain parameters.

Reflexivity   Dialogue

Service User
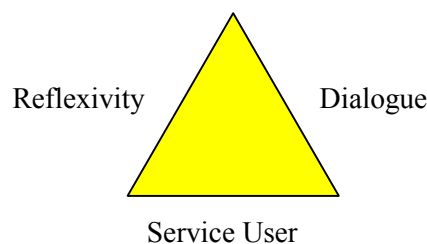
Figure 2: Core components to the model

Briefly, the interprofessional element may be considered as a transferable term to describe a process of collaborative dialogue between involved parties. This incorporates a reflexive element on the service delivered. The extended model, as developed within the RIPE project, crucially incorporates a strong valuing of the service user as central to the care process. However, essentially it is a flexible approach, which may be seen as supporting people to provide health and social care services responsive to the needs of those using the service. The educational element of this process may be seen as supporting those involved in the care process in developing an understanding of the essence of their service and seeing it as a framework for their own actions. This interactive notion is embedded within the concept of *capability*. In the same way the notion of reflexivity is linked with an orientation to actions, it is paradoxically, both anticipatory and reflexive.

Variations in the model occur from the ground up, in response to local needs, such as in Newton, where a high level group was set up initially, and it was then decided that those people that needed to be given the freedom to do the work (of identifying and developing the improvement project) were those actually at the front line delivering the service.

Did members of the ALGs learn in a meaningful way from their involvement with service users?

The service user is central to the quality approach within this initiative. Where members of ALGs did engage with service users, they were able to learn in a meaningful way.

There were varying degrees to which service users were involved in the work of the ALGs. It is important again to emphasise the divergent contexts, approaches and participants within each setting.

Post-qualification groups

In the hospital setting (Castlebury), post-qualification groups did not directly involve communication with service users, although *their experiences* were driving developments in terms of addressing improvements to communications systems. It was through adopting the perspective of the patient that a more holistic discharge summary was developed for use across institutional boundaries. In another group within the same setting, improved assessment procedures (forms) sought additional patient information; these have since been used by carers and inform the hospital care process. These have been used to a limited extent, but are considered to be of value.

In the community based mental health team there was limited involvement of service users, who were directly used as a resource in order to identify needs of an identified group. Contacts were established by a member of the post qualification learner set and interviews conducted by members of the pre-qualification learner group. The work of the group was informed by the participation of a service user development worker, and this in itself highlighted a number of issues.

The stories gathered by the pre-qualification students related the experience of service users with early onset schizophrenia. It highlighted the issue of dual diagnosis providing information for the post-qualification learner group to inform their practice.

However, evidence gathered by the pre-qualification learners also informed the activities of post-qualification learners, some of whom were also involved in supervising students on practice placements.

Learning in a meaningful way from service users is a complex issue. Professionals have been socialised into professional judgements, which may

essentially distance them from the service user. Thus the process of listening to and hearing what is said in order to act on it is both subtle and complex. There may be a tendency towards making precipitate professional judgements, as indicated by an illustration earlier; the necessity may be to 'suspend' professional judgement in order to hear the voice of the service user.

In the third setting (Newton), the community based education and health service partnership generated contacts with service users prompting challenging and fruitful insights into services, and the way they were delivered. This was, in the words of one participant, possibly *"the most powerful experience"* within which she had been engaged. It challenged professional assumptions. Participants learned from hearing how those using (or not using) the service considered the service should be delivered, rather than how professionals thought it should be delivered. On reflection, this was considered to be the appropriate way to develop services.

Pre-qualification level

The involvement of service users led to meaningful learning at a number of levels for those pre-qualification learners across all sites. In the community based mental health team, initial interviews with a number of service users were powerful catalysts to learning. This was also the case for learners participating within the hospital setting, where the user perspective challenged emerging assumptions about the nature of patient outcomes. At a general level it is possible to indicate that direct contact with service users assisted individuals in terms of their evolving learning process.

Did members of the ALGs learn in a meaningful way about what it means to improve the quality of practice?

There is a subtle difference between learning meaningfully about service improvement through use of CQI process within a group learning activity, and individuals learning about improving the quality of practice.

Within some sites there is evidence to indicate that through the CQI process individuals were learning in a meaningful way to improve the quality of their service. However, translating the need for service improvement into sustained changes in practice remains a challenge. Changes in individual practice are far deeper and bigger than addressing a collective issue of service improvement. This question may need to be addressed further in the pursuit of interprofessional (or collective) working and learning together, and individuals making the step to take action within the context of individual practice.

There is evidence to indicate that the approach improved the quality of service in certain sites, but the question about the quality of practice may or may not have happened. It is really too early to state that this has occurred, and a follow up study would be necessary at some future date to see how much these changes have become transferable into the rest of the work. One vignette indicating the potential of this approach, but also indicating challenges to be surmounted, is revealed in the case of a health care professional from a social care background being asked (as part of the team's improvement process) to write in the medical record. In her training she had learnt that the hospital record was not to be written upon, and breaking this hard won competency proved to be individually challenging. She had to overcome her fear and felt this was only achieved with the support of her group. It proved to be an extremely difficult process. Effectively this was about challenging a crucial element of her identity.

There is an awareness that this project has changed services, and there are indications that improving the quality of practice is possible but it is premature to consider the extent to which this has happened. It is evident that this project has changed services and there are indications that it could change practices, and the vignette shows this possibility, but we do not know the extent of it.

There were variations in the model of interprofessional action within teams

collaborating to improve services for patients and clients. Although there were variations, in most cases there was definite evidence of improvements to working practices. In one or two instances, there were long term changes that patients or clients would identify as improvements, such as the development of the 'Stay and Play', or the work on assessment practices in the hospital setting, but the longer term change is essentially embedded within a cultural context, and therefore change at this level is unlikely to produce immediate or short term changes that patients or clients would feel. In addition to this, there was evidence of meaningful learning attached to evolving understandings of practice development.

Did members of the ALGs benefit and learn from interprofessional interaction?	There was evidence that members of ALGs did benefit and learn from interprofessional interaction, although the extent to which this occurred varied from site to site. This learning varied from site to site, and between individuals. In several cases previous constructs were reinforced, such as a perception that, the conversation was dominated by nurses and doctors, thus reflecting one perceived reality of working life. In another setting, professional judgements were informed by understanding the perceptions of other disciplinary groups. In general, however, the time spent in learning within the ALGs, once viewed as learning, was regarded as an investment, allowing a deeper level of meaning than participants associated with educational experiences; it was recognised that this depth of learning impacted on what was learned about other individuals within the group (and also about themselves).

Participation in the ALGs led to a level of joint and shared understandings as the ALGs underlying assumptions were, when appropriate, the focus for examination. This process illuminated team actions and enhanced understanding (and thus meaning) for many involved. This occurred through the process of raising awareness and thus talking about those experiences within the team which frequently occurred at a tacit level. This may be described as a process of group reflection, an action associated with reflexivity as a process.

In the hospital setting, a number of participants considered that the time invested in this process sustained individuals through the more difficult periods of intense demands in terms of service delivery.

In some settings members of ALGs did benefit from and learn from interprofessional interaction. This was variable and depended on the nature of the group that was formed.

It appeared that the conditions for enabling this type of learning depended on a number of factors including the consistency of membership and the facilitation. Whilst facilitation is important, it is not sufficient, because allied to this is management support and promotion of the learning project (or a genuine acknowledgement of the group owning the learning project and being given freedom to learn on a self-selected learning or improvement topic). It appears that to benefit from a team learning experience that the tasks of building a team need to have occurred. It is important that this fundamental question of whether a group has reached the stage of operating as a team is addressed. Underlying this is what may be considered as a 'readiness to learn', as an emergent or developed team capacity. |
| **What was the** | There was considerable variability between sites, and not simply in terms of |

variability in the model between sites?

any perceived learning gains delivered and style, but also in the 'receiving environment' of the practice setting.

In this model the learning, as a shared history, is a product of the relationships between those engaged in the process and their common experiences of mutual understanding, based around comparative ideas of service delivery and service relevant issues. The setting in which the model is placed, whether in the hospital or the community, provides a range of subtle variations, at a superficial level.

The two teams working in the hospital setting were one example of this. They were both within the same unit, (albeit with a different service orientation) and distinctive dynamics within each team, and thus different learning outcomes emerged for each group. This was despite a facilitator common to both teams and a common learning approach (an experiential approach, using the continuous quality assurance framework), being adopted in both contexts. There was some indication that the activity of learning together, as in the process of developing an assessment sheet, or a discharge summary, was the catalyst for the interprofessional learning, but in some instances achieving this was problematic.

Essentially, the following points encapsulate the variations:

- The absence or presence of a management support structure – degrees of freedom.
- Hospital or community base .
- Contact and relationship with service user.
- Relationships of the group/team and history of group/team.
- The nature of the CQI facilitator and the way they interpret CQI.

Hospital or community?

In the community mental health team the broad framework of CQI was again used, but in this instance there was limited ownership. There was possibly also little readiness, in terms of the group understanding of the project, so that 'readiness' for learning as a team would have been difficult to achieve without preliminary intervention, in the guise of some authentic 'team development' activity. With limited management support for the learning project, there was little possibility of true interprofessional dialogue and thence learning to occur. In a management hierarchy the sanction of the management group is likely to be compelling for ALG members.

In contrast, the learning environment within the community based setting for the team with a common focus (Newton) presented a number of variations. The team was not working together, although they shared a common group to whom services were delivered. Existing relationships were those derived from a local forum for those working with young children; there were no pre-existing shared professional networks. This was, in essence, a partnership project, with partners from the voluntary sector allied with health professionals.

Following initial involvement of the CQI facilitator, the university facilitator in this setting used the process of quality improvement, yet associated with this was an orientation towards community development. This, allied with principles of action learning focused an orientation to deep learning. In this instance the work of the ALG developed the team.

Contact and relationship with the service user

The difference in emphasis between the hospital based and the community based setting appeared to be regarding the involvement of the service user (or client). Those working within the hospital context were more distanced from their contact and relationship with the service user, to the extent that one

person who actually left the ALG considered her participation had enabled her to re-connect with her original motivation for joining the profession. She then decided to leave the hospital environment and work in a community setting. One implication of the community context is about health workers being prepared to suspend, or step outside professional judgements and 'hear' more directly from the service user. In other words, in community settings, participants in action learning sets were more able to have direct access to stories of service users.

The relationship and history of the group or team	The distinction between whether a group of individuals constitute a group or a team has been mentioned previously. There appeared to be some difference between a team which had been in existence and the duration of their history as a working group, or the extent to which they had evolved as a team and had thus developed tacit understandings about their shared practices. This had implications for groups who discovered their practices had been based on assumptions which on examination, were not borne out.
	Developing shared understandings required addressing these underpinning assumptions, which were sometimes proved to be erroneous. Some teams were able to make more constructive use of their interprofessional learning projects, and the opportunity to build a team dialogue revealed aspects of underpinning assumptions which were fundamental to moving the process to a more collaborative model of learning, based on a clearer understanding of group activities. Almost incidentally, the combined processes of learning, change and ownership merge in the service of needs based improvement.
Consistency of membership	This was another aspect varying between settings. In the hospital context a 'core group' emerged within the first established team. It reflected the reality of day to day working life in any extended project, individuals left to have babies, and moved onto other appointments, yet despite these discontinuities, key core personnel remained within the ALG. The second team did not have such a fixed membership, and one key individual responsible for developing the second team project was seconded to another position within the organisation.
	There were core figures in both community-based teams. With regard to the child and family support service, these were those actively engaged in pioneering the changes they were discussing. Those involved in the community based mental health team were steering, rather than actively engaged in, the service based project. The most meaningful learning appeared to result from being more actively engaged. Within the community settings it took time for any core membership to emerge, the boundaries of the group was open to including other appropriate potential members, from a consultant paediatrician to mothers within the Newton project.
The absence or presence of management support: degrees of freedom	The variation between sites and settings indicate that there is a model with potential for flexible use between settings. It is a model, which can be owned by those involved in the action learning sets/improvement teams, on the basis of responding to local needs. That is, it marries together a top down imperative for improvement with active engagement of those actually engaged in delivering change involved in creating improvements.
	There is an important element in the degrees of freedom allowed to the team in selection of a choice of learning or improvement project. Allowing those involved in service delivery to access service users in order to identify their needs may not necessarily be part of an identified learning agenda. For those involved in some action learning sets this also meant shifting outside a prescribed model of interacting with the service user in order to hear their story directly, relating perhaps on a human level rather than as a professional to a service user. This was the essence of the communication, allowing the health

professional to access powerful information, which stimulated a re-connection with personal beliefs about practice.

The nature of the CQI facilitator and the way they interpreted CQI

Within this transferable model of learning in multiprofessional sets different styles of CQI facilitation may be tolerated. This inclusive model pays particular attention to the establishment of strong ground rules to tolerate uncertainty in the early stages of the process. Skilled facilitation should be underpinned by knowledge of quality improvement processes and principles, and incorporate the necessary 'framework holding' in the early stages of the group learning process. The most crucial element is the team finding a workable form of dialogue guided by action learning cycles, and shared aims within health improvement projects. The orientation is towards action.

CQI is a process of continuous quality improvement. Each CQI facilitator had an individual professional and practice background whether in psychology, medicine or social care, and beyond this there were variations in familiarity with the CQI from site to site. There were varying degrees of familiarity with the model of CQI being used. At the outset the model was presented within each site by the CQI facilitator, (or university 'guru' on CQI). One team facilitator had been informally 'mentored' within this approach, informally learning alongside the 'expert'. This had taken the form of using the approach towards identified improvement projects. Thus there was a shared history of learning. There had also been informal mentoring of the practice based teacher in this setting. In this instance, the collaborative learning project was the development of the pre-qualification learning experience.

In contrast, another CQI facilitator with a social care orientation and a previous interest in quality issues, also provided a facilitating environment, in the sense of holding a framework in which all speakers were equally privileged to enable active participation. The dialogue occurring within this framework was crucial, and the group's actions (in terms of health improvement projects) provided a sustaining orientation, committing all team members equally to the enterprise.

Common to all was a belief in the nature of the improvement task, the need for the service to be responsive to the needs of service users, rather than planned and driven by the needs of the service itself. The nature of this task was essentially related to the learning enterprise, the practices relating to the evolving and shared history of the learning project.

Variability in the client group

There could be no greater contrast than between the variation in a hospital based setting, housing a unit delivering care to the elderly, and a community based service, delivering services for children under five. In a similar vein, the physical setting was unique to each. The team based in the organisation of the hospital is embedded within a different matrix of relationships to that embedded within a community orientation, despite the existence of common external structures such as Trusts. It would be naïve to assume that practices were other than local, generated and constituted by those participating within the learning event. Thus, no direct comparison may be made.

Nevertheless, in spite of this, there were some factors besides the differences in setting that were important in determining the experiences of learning and improvement. The variability in client group was not found to be a crucial variable, directing service improvement in any way. Rather it was the approach used that influenced the ALG. The principles resonate with the socially embedded principles of learning articulated within Wenger's (1998) Communities of Practice.

Processes such as the facilitation, consistency of membership, engagement with those using the service, and the management privileging the perspective

of the enterprise that represented critical aspects of variation.

Variability in terms of pre-qualification or post-qualification learners

There was a range of different organisational barriers inhibiting the development of pre-qualification learner groups within and across sites. These included time-tabling, so that a range of learners from different professional groups were not in training placements within a parallel time frame. Some placements were not used as practice training placements by a range of professional groups. Part of this related to practice supervision requirements. As a consequence of this there were no possibilities of structuring an interprofessional learning set, since there was no interprofessional context as originally visualised. It was this situation, ultimately, that led to the need for a virtually uni-professional pre-qualification learner group with an interprofessional context. In this context the learners were nurses, but within the project activities cross supervision (and thence interprofessional supervision) by a social care professional took place in the practice context.

There was another aspect to the prospective mix within the pre-qualification learner groups. Approaches were made to include medical students, and post-qualification psychology students, and it appeared possible to include both. Initial training requirements for both groups included requirements for both to have multiprofessional (and thereby potentially interprofessional) experiences as part of their training. However, such is the strength of the enculturation process that it is likely that such learning activities would have to be sanctioned and advocated by supervising clinicians within their practice areas. In one instance, the practice based experience of the interprofessional ALG was sanctioned by the secretary to the consultant. The subtleties of interprofessional learning are complex.

The nature of the pre-qualification student experience proved to be extremely diverse. Although the common thread was being positioned within health and social care practices, there were enormous variations in prior educational (and thence learning) experiences, aspirations and in individual characteristics of participants (gender, age, whether undertaking placements for post-graduate professional training or a narrower framework of vocational training).

Student learning projects were site and service related, and beyond this differed in the duration of student participation, (even within settings), and the extent to which students were able to engage directly with service users. There were variations in student involvement in the activities, in the organisation of their experience, and in the opportunities for wider group de-briefing following activity. In one setting permutations included a placement of an individual student on a more extended basis, and two students involved for several weeks. However, there was potential for responding opportunistically in such instances; the individual student collected data from service users.

In another setting, one student was able to bridge the activities of several ALGs in order to provide a more longitudinal focus of project activities, adding necessary coherence (and a personal element of peer coaching). In this case actions undertaken to further the learning project crossed organisational boundaries, and resulted in briefing design staff and students, thus transcending the parameters of health and social care into collaborative health promotion activities.

Beyond the site-based activities several students became more involved in the Collaborative; presenting their work afforded a further dimension to their learning experience.

Challenges exist to setting up interprofessional learning opportunities. In the hospital placement, parallel practice placements had made it possible to design and deliver a multiprofessional learning experience on the 'ideal principles' of

CQI, action learning and service user involvement. However, this was entirely serendipitous in that the university team was able to opportunistically respond to the proximity of nursing, social work, occupational therapy and physiotherapy students within a parallel time frame.

On balance, it was the activities within the learning project, providing individual meaning for a range of students that sustained and gave particular meaning to the enterprise. The learning project was therefore a crucial element, beyond the organisation of interprofessional groups. Where the learning project involved direct contact with service users this was particularly apparent.

There are therefore, potentially two types of learning, which would be desirable outcomes, both of which are laudable, but are nonetheless slightly separate. One involves learning from users, and the other focuses learning from professional groups, and in an ideal learning experience both would be present.

Post-qualification learners

The organisational demands of service delivery affected participation in the action learning sets, just as it affects participation within any service based learning activity. Other barriers have been outlined previously, in the guise of the presence or absence of active management support for a learning enterprise.

One further variation between sites in different settings was in an initial consideration relating to whether or not the work of the ALGs would require Ethical Committee approval. This was explored in the hospital context and within the community based child focused team. In both instances it was decided that approval would not be necessary since the bulk of the work took place as a quality initiative. However, there are considerations for further exploration related to this point, particularly in relation to hospital based activities and the involvement of service users.

What are some of the 'products' of the projects that could be used elsewhere?

A number of artefacts have been produced within the life of the project:

* Pre-qualification learner booklet on CQI.
* Student produced health information posters.
* Basic interview schedule used by health visitors to guide their interview with service users (Appendix F).
* Assessment form developed by hospital based team.
* Discharge summary developed by hospital team (Appendix G).

A number of these documents are included in the Appendices, but it should be noted that each was developed with the intention of using the process in a particular service context. The act of developing the artefact was an important part of the learning process. An integral part of this approach is that it may be tailored to local needs rather than slavishly followed.

Does this model of learning in the context of an improvement project have the potential to be sustainable given the ongoing complexity and changes in health and social care provision?

The broader frameworks for learning within the human resource strategy of the NHS, and embodied within clinical governance, outlines principles for lifelong learning within professional groups, and reflects a possible application for such practice based learning approaches. The advent of such structures integrating principles of continuous professional development within individual development plans, and with the potential for aligning these within organisational learning needs are almost anticipatory, yet they position a potential for sustainability within clinical governance structures.

This project addresses these potentially sustainable features by offering a loose structure for a flexible and transferable process within which capabilities for both pre-qualification and post-qualification learners may be fostered. This flexibility is considered to be a particularly important characteristic of such a learner centred model for needs-based action oriented learning, at a time when massive changes in the health and social care spheres demand flexibility from those involved in delivering care and health services. Developing capability within staff generates organisational capacity. However the greatest strength of the model in the current context is arguably in terms of its learner centredness and user focus. The learner centred aspects may be allied with organisational needs, and more critically, needs of the service users. Learning is integrated within the evolving service transformation. A number of people in a range of service settings will have been primed through their involvement in the project and in a number of cases offer a bedrock in practice settings for future partnerships. It is in generating this capacity for action and change that, arguably, the greatest sustainability lays.

From the university perspective there is a sustainable element to this interprofessional learning project. These elements informed the Masters level practice pathway; the interprofessional strand within the nursing curriculum re-write; the quality improvement and interprofessional working element of the new nursing curriculum, together with developments in joint curriculum initiatives at pre-qualification level between health and social care.

This model of learning, predicated as it is on the social context of learning, presents a distinctive approach to learning approaches in the context of service improvement. However, the strategies for developing such an approach are subtle, complex and inter-related. It would be disingenuous in the extreme to extrapolate generalities and ignore questions of individual context in which practices are situated. A learning history is produced as a result of collective learning enterprises. The learning environment, or the learning climate is another dimension to this process, and impinges on the inter-action between learning and the learning environment implicit within the notion of capability. Learning is embedded in activities at a number of levels (individual, collective or team, and organisational) and, given the appropriate support to allow small changes to evolve into embedded practices, it is possible that the confidence and flexibility engendered within some learners may be congruent with the needs of an increasingly complex and fast moving service.

The following sub questions address this broader question:

What are the main capabilities that were facilitated by the RIPE project?	One of the principal capabilities facilitated by the RIPE project within participants of ALGs was a confidence to act. This is an important aspect not traditionally addressed within many curricula in that it incorporates aspects more related to personal development, whilst also relating to personal meanings (and understandings) generated within the work. It is for this reason that the notion of capability, rather than the narrower definition of competency, has been introduced. Thus for individuals working at different levels of the service this capability still applied. The support of the team was an integral aspect of this, but not in a dependent manner, but more as a supporting and synergistic framework. This confidence to act gave work meaning, because it made individuals feel that their actions had significance. Without this individuals became demoralised, impaired and diminished. It was also a crucial aspect of the ownership process, without ownership of initiatives there was burnout and learned helplessness, as individuals were passive recipients of imposed systems. In helping create a system individuals were energised.

A capability to change was a further dimension of this active sense of agency generated through participation in this learning process. There is a reflexive

element within this capacity and also a quality akin to humility. Direct contact with service users or access to their concerns unmediated by 'professional blinkers' engendered a sense of humility, a relatedness, sensitivity or concern about the voice of the other. This led to a realisation of alternative approaches to situations, sometimes contradicting previously held professional assumptions. Valuing the users of the service was therefore another capability to emerge.

For those within the voluntary sector, there was another aspect to this dimension. Their work did not contradict previously held assumptions, yet affirmed their concerns for service users. In this instance the challenges were to personal characteristics in order to assure the representation and hearing of the other. In either case a particular quality of courage was necessary.

Essentially the participants in the project learnt the use of a structured framework. There were three elements to this structure; a process and procedure for self reflection, frequently in conjunction with other group members, a procedure for inclusive dialogue and a procedure for moving towards needs oriented action.

These capabilities, engendered by the RIPE project, support the following vision for the kind of workplace culture that would support this kind of learning: the model of learning in improvement teams or ALGs would be an inclusive one in which learning was integrated at all levels, and modelled by all involved. Involvement and inclusivity would be key. Within such a culture it was possible for 'conversations' around current working practices and concerns to take place. Dedicated time would be ring-fenced for this inclusive activity. The dialogues focusing on team practices would be one practical conduit to maintain both working practices and staff relationships, but they would also actively promote and support learning. This type of organisation is unlikely to privilege rigid hierarchical arrangements, but rather be part of a flatter, and more open organisational style. The team would be empowered by a structure allowing a truly bottom up approach to service improvement. The culture would be characterised by non-blame practices, as well as being openly supportive to staff with a continuous commitment to learning from, and about, practice and developing the service. It would be one in which it was possible to engage in authentic working relationships privileging the service user.

Such a culture would be one in which there was a synergy operating between the wider context with activity systems (actions of teams) involved in delivering the service being the substance of on-going learning by those involved in service delivery. There would be effective communication systems, with potential for higher levels of morale stemming from a management non-intervention practice in identifying team learning goals in order that a team may generate a continuous learning process based on improving performance. Staff would be likely to experience increasing involvement within the organisation, since they would be aware of their ability to voice opinions and influence change within the organisation. In practice this would take time to establish, and the short term performance goals dictating current quality standards may appear to create tension with these longer term aspirations.

What are the implications of these capabilities for developing these experiences into mainstream,

To create these capabilities requires an experiential education process based in practice contexts. Such educationally derived capabilities as previously described arise only from experiential learning. The paradox and the tension here, emerges from the need to educationally organise the learning endeavour to maximise learning opportunities available through participation in work based learning enterprises.

Messages learned within the culture of the workplace may be subtle, yet are

accredited educational opportunities?

likely to influence the potential for ensuring that practice based learning opportunities are fully utilised. Existing possibilities supporting work based learning include systems such as supervision, mentoring, and the capabilities facilitated within this project are likely to be enhanced by working in conjunction with such frameworks. A culture supporting learning will need to assess potential learning settings to generate and realise an inter-related, socially embedded structure for learning at all levels. The importance of informal learning is one crucial message, which may no longer be ignored.

Learning has personal meaning. It is through gaining meanings within practice settings that individuals develop further deep understandings of a situation. This is not a superficial dimension, but a deep capability associated with a confidence to act. This domain of learning is one not necessarily acknowledged within frameworks for curriculum development. Yet individuals also gain personal meaning from their work, and it is this dimension of experience, which may contribute towards alleviating feelings and thus experiences of burnout.

In addition to being experiential learning, it is important that this learning takes place within the community of practice, privileging the learning of those delivering the service. Real life scenarios are the basis for the actual projects whether at pre- or post-qualification level, and it is important that individuals (and teams) see the results of their actions within the learning project. It is this aspect which is likely to engender feelings of involvement within the organisation.

It requires senior management allowing teams, at all levels of the organisation, genuine ownership of their learning (or improvement) projects. It is only then that the requirements from senior levels for real change at all levels of the organisation will be enabled. This is the nature of the commitment necessary to allow bottom up (and thence needs led from the ground) changes in service delivery to occur. This is the profound nature of learning and change within this framework. Educational stakeholders are myriad, including not merely civil servants, but include the public, the citizen, such is the nature of the modernised NHS, and the radical transformation of learning is a transformation of previous arrangements requiring imaginative and bold moves as a response.

The educational opportunities for interprofessional learning at pre-qualification level will require a political will to support. They require organisational commitment, and whilst there are schemes such as mentoring systems operating on an interprofessional basis, the model for lifelong learning envisages a continuous learning process streaming through the professional career, rather than a series of isolated pools of learning.

Confederations should give serious consideration to models such as this because it appears that this kind of educational system is very transferable, with a potential for developing the kind of characteristics and capabilities which are currently aspirations within a blue print.

The potential implications for this university are, in the first instance, conceptual, since it involves understanding, in a more meaningful way, the implications of the 'informal learning' process within the workplace environment (and this includes the university). As Eraut, Alderton, Cole and Senker (1998), point out the subtleties of developing a learner oriented focus are profound. Additionally, there are issues relating to the number of people with the capability of delivering a curriculum in this way. Capability, one message powerfully learned within the project, takes time to build.

The concept of capability, in many instances, operates largely at the level of

rhetoric. It needs addressing in a meaningful way to produce the learners and people able to collaborate, work and develop effectively in the community.

There are implications for the university in terms of developing mainstream, accredited, educational opportunities within practice settings, with an emphasis on professional development and service improvement. Professional (continuing) development programmes are placed within frameworks for clinical governance; there are potential points of connection where individual and organisational interests are likely to be congruent with the improvement of practices and development in service of those using the service.

There are opportunities for future developments working in partnership with Confederations, or perhaps Trusts, in order to establish healthier working alliances promoting community interests. Initially, there may be an educational task (or a learning opportunity) here for devising a mechanism to raise awareness and sensitivity within purchasing confederations.

The potential for this approach appears to address powerful issues relating to staff retention, and staff well-being, highly topical service issues. This is an area , which could fruitfully be further explored.

Partnership working, whether for individuals working in 'learning partnerships' across organisational boundaries, or individuals and/or groups matched or paired across disciplines within the same organisation, developing specific improvement projects, could be a highly innovative response modelled by the university based on the experience of the RIPE project. This would need to be positioned within the human resource strategy, which matches issues previously identified. Again, there may be a need for initial awareness raising prior to development around this issue, in order to create a readiness to change and learn.

Pre-qualification learners

Whilst there has been some opportunity to explore the opportunities for pre-qualification learning, organisational and structural barriers to this remain. In order to proceed with a genuinely integrated approach to practice based interprofessional learning, there is a necessity to create an awareness of the nuances of the supporting practice setting in order to shape and potentially influence supporting work based cultures. This requires a degree of political will at confederation level in order to gain support of senior management.

It is clear that it is possible to design an integrated needs based learning project based on the principles of CQI which could be framed within a pre-qualification learning framework across health and social care disciplines. This would also resonate with the need for multiprofessional experiences articulated within the competence framework of a number of professional bodies.

To a limited extent preliminary work has been undertaken in the form of positing a framework within which health and social care students may jointly undertake a learning project. The principles which are core to the model are those which focus jointly on the process of reflexivity, dialogue and the service user, delivered in a structured practice based action oriented sequence. The formative nature of the 'induction into knowledge and practice' occurring within the initial socialisation process is very important.

Post-qualification learners

Developing the experiences of the RIPE project into mainstream, accredited, educational opportunities may be pursued in ways similar to the MA Practice pathway developed at Bournemouth University. This flexible framework for health and social care practitioners offers an opportunity for individuals within statutory and voluntary organisations in the region. Close links with service

agencies mean that participants are able to shape and deliver services in a rapidly changing context. Practice based project outcomes are linked to M level units of study, and thus practitioners are able to gain credit for advanced levels of practice development.

At an organisational level the value of peer support through engaging more than one learner in the process is one lesson which appears from this project.

What are the most significant barriers and challenges that are negotiated in this model of learning and working?	There are a number of significant barriers and challenges to be surmounted in this model of working and learning, the first being the investment of time necessary to develop and establish such a system of practice based learning. This may be regarded as an organisational barrier. It is resource intensive to have an entire team involved in the learning, whilst simultaneously delivering the service. The development of an appropriate 'microculture' within the workplace, to support learning is a further critical feature to address; this is an important element of the supporting framework to learning. The role of the manager is critical in fostering capability in the work place (Eraut, Alderton, Cole & Senker, 1998).

At a delivery level the promotion of this model is contingent on facilitation skills of a high order, delivered by individuals who are aware and able to act on facilitating privileging conversations across discipline, professional or agency boundaries. This is in addition to expertise or appropriate experience within a model of CQI. It is also predicated on a model of a life-long learner (or combination of learners) who are self directed, and thereby autonomous, actively engaged in their own learning process. This contrasts with the passive learner traditionally receiving skills based training delivery. However, it is congruent with the re-defined learner actively engaged with lifelong learning. The trajectory of occupational profiles of those currently being recruited within the spheres of health and social care are significantly different from those traditionally being recruited within the spheres for instance, of medicine and nursing. Individuals will have personal 'learning autobiographies' shaped by working and learning within other areas, which may affect their approach to learning. In the broadest sense, learning may be regarded as being culturally shaped. For many it is likely that this orientation to learning will be novel; the act of seeking the learning opportunities in events such as meetings, and within the working process may not be a naturally occurring approach.

What are the resource implications of this model of learning in the context of improvement projects?	This way of learning is likely to prove costly to deliver in the initial stages. However, it may be regarded as providing added value in that the nature of the issues being addressed within teams are precisely those where problematic areas of service delivery occur, and hence the need for improvement projects to generate solutions owned by teams. Issues within working teams frequently arise from communication difficulties, and this area is crucial within team development. A supportive team will help alleviate burnout and staff stress within times of excessive service demand. It is from difficulties such as those within communication systems that problematic cases occur, which may result in litigation. When viewed from this perspective it is possible to take the view that the initially resource intensive nature of the enterprise is, in the longer term, an investment.
Does this project contribute to the debates on the meaning of the term interprofessional?	Underlying this question is a debate about the changing nature of what is meant by being a professional within the changing sphere of health and social care. The nature of the relationship between the professional, as an individual delivering a service, and the person receiving the service, as service user has fundamentally changed, to the extent that the balance of power has fundamentally been transformed. This project contributes to moving the debates forward on the meaning of working in partnership with other people and other agencies.

There is one important process dimension to this, which is that this project is primarily not focusing on the needs of sundry professional groups, but rather seeks to privilege the needs of the service user. This common focus across different occupational groups may be regarded as transcending professional boundaries. One further aspect to this is the manner in which this model has engendered a holistic approach to merging both head and heart, thus contributing importantly to addressing and integrating the emotional dimensions of the learning experience, sometimes neglected as an integral constituent of the teaching and learning process. This project has lessons to contribute to the debates about the meaning of the term 'interprofessional'.

Does this project contribute to debates on emerging policy directions and documents?

There are a number of current policy debates of relevance to this project. A First Class Service (DOH, 1998) established the framework for a modernised National Health Service predicated on principles of quality. The frameworks for delivering these principles were outlined within the structures of professional self-regulation, clinical governance and lifelong learning (interpreted as continuing professional development) as mechanisms to address the need for CQI within the service. Along with this were principles of partnership, between health professionals working in partnership with management, aiming for more involvement of 'the public' in clinical governance.

A series of interrelated strategies within clinical governance included addressing issues such as a failure to learn from organisational errors, following a series of serious failures in NHS health care. The report of an expert group on learning from adverse events in the NHS addressed the organisational failure to actively learn from serious failures in health care. Included in this was an approximate figure of 1,150 people recently in contact with mental health services who commit suicide, and nearly 28,000 written complaints about aspects of clinical treatment in hospitals.

Within the NHS an annual figure of approximately £400 million per year is paid out in settlements of clinical negligence claims within the NHS. Recognising the 'dynamic nature' of safety within the socially and technically complex delivery of health care, it was recognised that barriers to prevent active learning from taking place positioned the organisational culture centrally at every stage of the learning process. What was described as a 'safety culture', characterised by open reporting and balanced analysis, was shown to have a positive and quantifiable impact on the performance of organisations. In contrast, 'blame cultures' encouraged people to cover up errors for fear of retribution and act against the identification of underlying causes of failure, with a focus on individual actions and largely ignoring the role of underlying systems. It is considered that the type of learning facilitated within the project may have something to contribute to this, since it enables this type of systemic approach to service delivery.

Since that date there have been further strategic transformations, with a Modernisation Agency launched in April 2001 aiming to lead the NHS into a new era of *"reform and improvement"*. Underpinning this reform was a model of a service re-designed around the needs of patients, themselves in possession of more information, more influence and more power over the services they receive. The parallel notion of *"the expert patient"* is now a recognised part of the NHS agenda, positioning the patient's knowledge of their condition as a source of professional learning. The retiring president of the General Medical Council, acknowledged the reality of *"the flawed culture"* of the medical profession and the dramatic shifts in relations between patients and professionals, with patients who *"expect to be treated with courtesy and respect, and want to be more in control of their own lives."* (Editorial, The Independent, January 2001).

Thus the profession led emphasis of training, education and development does not sit well with the current health policy with its starting point as the experience of the patient or client (DoH, 2001). There is a need for specific learning to address this shift, and this is an area in which there is potential for this emerging model, melding partnership working with principles of a needs led focus based on patient/client experience.

Whilst these emphasise political, structural and organisational issues, the human resource framework outlined in A Health Service of all the Talents (DOH, 2000), has provided additional impetus to address the central strategy framing professional development, in an endeavour to ally Personal Development Plans with organisational needs, and this in itself placed within a set of inter-related Plans (for example, Regional Human Resource Strategy and Action Plan).

A range of strategies aimed to involve staff further in service delivery, improving the quality of working life for staff within the NHS thus alleviating ongoing problems such as attrition and absenteeism. The local health improvement plan integrates both education and health improvement and supports multi-disciplinary development plans.

A platform of reforms include, partnerships between local government and health services. Amongst these are moves to precipitate joint working through initiatives such as the purchase of joint education and development programmes, again positioning the project work as a potential approach for adoption.

These may be considered within the context initially of lifelong learning as established within systems of clinical governance as a mechanism to service improvement. A further dimension to this aspect is the framework for investment in lifelong learning within a locally based approach to continuing professional development, as envisaged within A First Class Service. The framework established to deliver this strategy was the NHS human resource strategy, which included ways of developing the ability of staff to contribute to the improvement of services through both organisational change and through individual development.

The NHS Plan (DOH, 2000) is perhaps the most recent vehicle for the modernisation agenda and continues the thrust of improvement reforms with a focus on the need for nurses and other staff to be able to extend their roles. An appropriate learning framework is necessary to underpin the necessary capacity to develop flexible working practices.

Final theoretical points:	Final theoretical points to be briefly introduced, address the issue of capability, and parallels from other sectors, in the context of lessons to be drawn from the experiences of school reform. Another key concept is that of 'communities of practice', which has also recently been recognised as a helpful theoretical concept within school improvement activities.
The concept of capability	The concept of capability has been used within this project, building on the work of the Royal Society for Arts and its Education for Capability Manifesto launched in 1980 (Stephenson, 1998). This manifesto asserted that "*Individuals, industry and society as a whole benefit when all of us have the capacity to be effective in our personal, social and working lives*". Key aspects from which the manifesto implies higher education should be judged, include a consideration of the extent to which students are provided with the confidence and ability to take responsibility for their own personal and professional development, and prepares students to be personally effective within the circumstances of their lives and work.

Capability, explains Stephenson, is a broader concept than competence, incorporating an anticipatory element including the realisation of potential. Capability integrates knowledge, skills, personal qualities and understanding and integrates an ethical dimension. Without fully addressing the rationale underpinning this approach, it is considered that the developmental nature of the capability approach is driven by participants actively managing their own learning, and it is for this reason that the notion of a more holistic capability approach has been advocated. In the context of the RIPE project, when attention is focused on the experience of learning, this is particularly relevant. It contrasts strongly with an approach dictated by specific course content, and this, together with its action orientation, renders it an appropriate concept for utility in educational (thereby implying potentially award bearing) frameworks based in practice settings. Underpinning this advocacy is increased awareness of the nature of the environment as an interactive context in which increasingly good performance of participating co-workers may be enabled.

Lessons from school improvement

There are parallels with school reform, with a history of educational reform within the arena of school improvement from which lessons may be learned. Extensive evaluation over a period of some twenty years has resulted in educational writers such as Michael Fullan (1991), authoring a number of influential texts drawing on lessons learned within the United States and Canada within the implementation of initiatives and an examination of *"learning as a cultural change mechanism"*. Fullan's book "The New Meaning of Educational Change" introduces another dimension to the implementation of initiatives, and within the United Kingdom school improvement reforms such as those embodied within initiatives such as "Improving the Quality of Education for All".

Whilst the service delivered is substantially different, there are nonetheless common issues. Significant educational change, maintains Fullan, may only come about through a personal development process in a social context. Fundamental to the change is the primacy of personal contact, there is a need to converse about the meaning of change. In doing so participants are involved in the implementation process, as they proceed to construct a shared reality in interaction with others. All innovations require interaction in order to proceed to implementation, and social support is necessary to sustain ambivalent feelings about the change process.

Communities of practice

Ainscow and Howes (2001), writing on their experiences of working with a local improvement team, within a local education authority draw on Wenger's notion of communities of practice. It is a useful framework in which to position learning in social contexts, and has been applied in relation to activities within the RIPE project.

Wenger's (1998) framework develops the notion of a 'community of practice' and sees learning as a 'characteristic of practice'. Essentially a community of practice has a particular meaning, a practice being the individual actions within a *"sustained pursuit of a shared enterprise"* (p48). It is more than specifically identified tasks, including elements such as commiseration, and support within a social context. Thus it may be as applicable as a framework to analyse learning within a Mexican street gang, to a health professional working within a particular organisation.

Two core concepts within the notion of a community of practice are reification and participation. Wenger states:

> *"Practices evolve as shared histories of learning. History in this sense is neither merely a personal or collective experience nor just a set of enduring artefacts and institutions, but a combination of participation and reification over time." (page 87)*

Shared meanings, engendered through active participation in a community of practice, defines and creates the experience of, for instance, learning within an ALG. This type of learning is profoundly social. In contrast, reification is the process by which communities of practice produce concrete representations of their practices, such as 'toolkits', or policy documents, assessment practices. Wenger contends that the intertwining of reification and participation, as complementary practices, is the best explanation of learning within a given community. Inter-relatedness and mutual engagement are key features of this notion which contributes much to understanding a socially complex and interrelated process of learning.

Summary and Recommendations

Summary

To some extent it may be argued that the term 'inter-professional education' no longer has currency in practice. 'Shared' or 'team' learning may be preferable terms. There is also increasing interest in the learning arising within the notion of 'communities of practice'. Whichever term is used, there is a great distance between a group of people learning together, and the synergistic processes of a developed team who have jointly choreographed their practice. Nevertheless, the aims implied within this model of working and learning together remain. There is an increasing need for multidisciplinary, multiprofessional, or multi-agency teams of people to work effectively together. Increasingly it is recognised that part of this process implicitly involves learning together, and perhaps the emergent learning represents the aspirations of those promoting the collaborative values implicit in the term 'interprofessional education'. That such learning serves the interests of service reform and improvement reinforces this mutual and reciprocal learning experience.

There is a distinction, however, between formally constructed learning experiences, and informal learning processes. This account of the RIPE project has attempted to re-present levels of learning within this complex learning, change and improvement process, both individually and collectively, in this particular experiment in education. Learning is fundamental to change (Batstone & Edwards, 1996); the two are inexorably entwined. Within the health care sector, there has been much focusing on the management of change and yet frequently those involved in the process of service delivery appear to be alienated in the process. It is learning at practitioner level, which is crucial.

It is too early to say whether the form of learning enacted within the RIPE project, 'made a difference' which was sustainable. It is clear that something made a difference for those involved in developing some ability to examine and develop their own working practices as a basis for potential improvement, and in the interests of the service user.

In this practice based learning enterprise the development of actionable knowledge, that is, knowledge based in practice for action, (Dewey, 1916) was developed in some settings. This form of knowledge is regarded as a dynamic interaction between the learner and the world of experience. Such knowledge is also the basis of Schon and Argyris' action science. It is increasingly recognised as the vital element of knowledge management for survival in 'white-water organisational conditions'.

Traditionally associated with informal learning processes, actionable knowledge is fundamentally associated with forging connections amongst individuals, and the creation of social networks. It is as old as Aristotle's praxis; the art of acting upon conditions in order to change them. Dialogue and conversation are central bridging and bonding devices; the interactions enable individuals to build communities. However, these are crucial elements for developing communication across agency and professional boundaries (partnership approaches) in the service of improvement, ultimately creating social capital. As such this needs-focused, practice-based knowledge is central within inclusive health improvement initiatives.

The project showed the potential for growing a practice-based learning environment in which actionable knowledge, knowledge arising from the practices of those involved in delivering the service, could be developed. This micro-learning environment was totally supportive, open and inclusive, the antithesis of a 'culture of blame'. Time was a major factor. Protected time was

necessary in order to ensure that any potential slow start to the project was legitimised by the involvement of leading clinicians strongly committed to the type of 'equitable conversations' which were to take place within the framework of the ALG. The element of time is an important barrier within this project, but deep learning within working teams about working practices take time. Timing and pace of sessions are factors to be addressed.

There has been much discussion about notions associated with 'reflective practice', yet whichever definition one accepts, this concept is associated with learning about practice and requires conversation about the work. This notion is central to developing practice, a core message may be that learning about the work requires talking about it. To do so in any meaningful way requires time. However, this time is an investment. There are not likely to be short term outcomes within such a profound culture change, but the limited insights generated within this project suggest that this time sustains those involved in delivering a service through intensely demanding periods. Such findings merit investigation.

Skilled facilitation is crucial in this model, where quality is more than a sense of a mechanistic series of targets to be achieved, of benchmarks to be noted, but is more associated with a continuous learning process of a particular type. It is a quality of learning. In this case the learning focused on service related issues, but it was also about personal learning. When services are delivered in teams it is inevitable that 'inter-personal elements' are part of team learning. For some individuals involved in the project this was a liberating experience, for some unaccustomed to having a voice heard within (or without) an organisation, there were stages to developing a voice. In some instances, this took considerable courage.

The project shows the potential for learning as part of a process of cultural change, a way of enabling people to think and act more flexibly. It gave permission, as one respondent said, *"to think off-track"*. Thinking about work as a legitimate (and constructive) activity. It is important not to ignore the subtle and less subtle messages learned by those within hierarchical organisations. In hierarchical organisations there are implied messages about relative importance and unimportance of individuals within the structure, about value and privilege. This is where organisational culture is important. Individuals learn that they are more or less important than others, that their views matter more or less. At many levels, no matter what position they held in the hierarchy, a number of professionals expressed frustration with the process of change, and for some the difficulties of implementing change to achieve real improvements.

Developing a capacity to work flexibly, of constructing and delivering services differently, in the field of health and social care, requires a culture, which cultivates, fosters and sustains learning. Such cultural change grows from systems and practices, which seem overtly to enhance the services to which individuals are committed. Then and only then, will people feel able to 'make a difference.'

Through participation in this project a number of individuals recognised the potential for a particular way of approaching and talking about their work in a manner enabling them to improve their service. The project built on professional aspirations to deliver the best possible service. A sense of personal commitment drove teams, who were endeavouring to improve their practices, despite the prescriptions of performance targets diverting energies and, paradoxically, dictating seemingly contrary agendas. This made project participation a significant learning experience at a number of levels. These messages are about capability and fostering capability within the workplace.

Expectations are crucial in fostering capability. Too often expectations limit and contain rather than enhance. Creating the conditions for learning is an important element of the manager's role, and there are subtle complexities to this, which may not immediately be appreciated. This is not intended to position 'managers' in a potentially adversarial position to 'professionals', praxis (theory and practice) is a central aspect of practice. In this inclusive model all are co-workers. In a learning community **all** are learners. Learning is everyone's responsibility.

The role of management in developing learning cultures is subtle and complex, beyond the kind of learning frequently implicit in mechanistic behaviourist analysis of competencies and job descriptions. Learning driven organisations require another approach to organising and enabling learning.

A process of CQI involves continuous learning. It is necessary to nurture a micro culture creating conditions in which learning can flourish. To do so requires a close scrutiny of what is being learned both formally and informally. These people were developing insights into their practice, and facilitated in such a way that the implicit indeed became explicit. They were then able to act on their own knowledge, evidence generated from their own performances.

Assumptions about individual and team practices may be deeply embedded and deep learning, which is to have any lasting impact, will be necessary to shift such assumptions. Professionally competent individuals accustomed to speedily practising routine actions individually and within a team will need protected time in which to examine their practices. For some this may be threatening at times. Whilst the learning journey may be exhilarating, within the project several people spoke of 'the oxygen of learning', it may also be uncomfortable. Yet, something sustainable had been left when the project ended, indicating that a capacity had been fostered.

In the cameo offered by this complex and inter-related project, some people have learned that they can and do make a difference. This is an important lesson. There are many steps to achieving this, and many subtle and overt barriers to overcome.

Mechanisms for continuing to develop such a learning orientation now exist within the clinical governance framework, allied to the human resource strategy.

There is considerable work to be undertaken on the nature of this learning centred approach. Whilst this interprofessional learning project focused on CQI, one hospital in the region also promoted involvement in a uni-professional 'dynamic quality improvement' network. There was neither awareness nor interface between the two clearly similar interests. Points of connection exist. Learning implicit within systems such as mentoring systems offer one further and parallel strand to realise the potential of this type of learning.

Positioning the service user at the centre of the learning model is a radical departure within health care. Involving the service user is perhaps a more complex area. In fairly recent history, doctors were still being taught about securing patient compliance in their history taking. This is a great distance from working in partnership with patients, or those using the service. Professionals may be reluctant to 'hear' service users, preferring to interpret within existing frames of reference. Such learning may be challenging. One root of this problem is that of communication, an issue reflected within communication between agencies and professional groups across the service. Identifying service user related outcomes appeared to be most simple for pre-qualification learners, who learned to value the importance of effective

communication, and gained confidence in their own communication abilities. Those professionals who were able and enabled to re-think their views, based on 'hearing' patient and service user stories, found it offered powerful lessons. Conversation and dialogue were crucial in fostering this new learning focusing on the service user.

Recommendations

A number of participants have been involved with the project during its life. Some have indicated an interest in using this work in other contexts. That capacity may be an available resource.

One indication of capacities enabled through this project is the adoption of the project principles within several different services, one hospital based and one service-based within the community, although they are no longer part of a project. However, it is important to remember the wider organisational and regional framework within which these are positioned, it would be possible to build on these. The framework exists within clinical governance (and within the human resource strategy) for developing at least some of these recommendations. There are a number of issues that need to be considered in developing 'communities of learners' across professional and agency boundaries in the promotion of service improvement.

- The context in which learners are positioned is crucial. In a learning-centred model there is a need for greater sensitivity to the wider learning environment, that element known as the 'micro-culture', which is critical in fostering learning. Preparation and support for managers is likely to be necessary as a brief for their 'hidden', but nonetheless important, role in this. (There should be no assumption that learning is exclusively a management concern).

- There may not be existing sensitivity within human resource departments to these elements of a learning environment, which may be considered to be one element of a hidden curriculum. There may be a need to raise awareness and negotiate on this together with Trusts and Confederations.

- This model of learning will operate synergistically with other learning systems (possibly such as appraisal and mentoring). It is important to envision this learner centred model as one thread of an integrated approach.

- A learner centred model for all occupational groups differs radically from many concepts of education driven provision, with hierarchies of education, training and development. The subtle messages of a learning environment may in itself be an awareness raising and educational task for many involved in the organisation (and purchasing) of learning experiences. This would be a necessary prerequisite to evolving an integrated approach to organisational development.

- Should protected time be available to whole teams? The logistical barriers to this are enormous, yet it is suggested that this would be an important and appropriate step to developing inclusive practices within and without organisations. This is a collective learning endeavour, individuals do not practice in isolation.

- This flexible model offers potential for exploration in a range of settings. It is important to recognise that the innovation (or intervention) of the learning endeavour did not occur in isolation but as part of a broader network.

- One major issue is about the personnel with the ability to facilitate in an appropriate manner. Some capacity has been generated and could be used as a 'greenhouse' for the development of further practitioners with such capabilities. This would be an area for further exploration. One initial step might be to develop a specific component within the role of interested lecturer practitioners.

- The regional health improvement plan specifically identifies a human resource strategy and action plan with a focus on training and development plans to support clinical governance. This is one area in which there is capacity for application of this approach at an individual level. It would be possible to position networks of learners collaborating across organisations on improvement projects.

- Learning arrangements within the workplace may need imaginative re-appraisal. Learning partnerships across agency or professional boundaries might be one possibility to further and broaden flexible horizons. Equally 'learning buddies' may promote developing interests.

- Protected time for shared learning is necessary. This involves a degree of political will at a regional level.

- Particular attention needs to be paid to developing learning cultures (or microcultures) within organisations. This will have strategic repercussions. It is recommended that developmental learning projects associated with this be undertaken.

- Some professional groups are required to maintain portfolios. At a regional level there could be accommodations for building needs-focused interprofessional improvement learning projects into pre-qualification learning specifications. At post-qualification level there could be a regional expectation of participation in improvement projects or partnerships within portfolios or Continuing Professional Development (CPD) plans.

- The notion of service improvement driven by needs led services is a policy aspiration yet the steps to achieving this are resource intensive.

- The potential for utilising this learning approach as a mechanism for ameliorating staff attrition, stress and thereby help create healthier workplaces, are important factors which were not explored within this project. This would merit exploration within this model.

- The learning orientation implicit in this project (an active learning model) may be novel for some learners. There may be a necessity to construct 'learning orientation programmes' to profile and develop the notion of active learning within a programme of continuing professional development embedded in the principles of experiential work based learning.

- Peer support and organisational support will involve developing and building social networks.

- Communication and dialogue is the key to new action and learning and thus builds on experiences gained in working life.

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Appendices

Appendix A: CQI in Action – The outline improvement process

A   **Assessing**   →   **Planning including discharge**   →   **Implementing**   →   **B**

- Previous mobility, present mobility, help or aids required
- Immediate assessment - ? life threatening
- Full assessment
- Meet needs
- Information gathering agencies involved
- Telephoning family / friends / residential care
- Information giving
- Involving other professionals
- Liaising with medics / information exchange
- SHO assessing - action plan
- Consultant assessing - action plan
- Reading GP referral info
- Functional ability – past/present/future
- Transferring; walking; washing; dressing; cooking
- Digesting and directing information to formulate problems, goals, plans
- Using other sources – looking, testing, listening

- Need for further physio
- Supplying with aids
- Assessing whether safe
- Liaising – family / care agencies
- Finalise problem list
- Agree which problems need interprofessional care
- Deciding common multiprofessional / patient / family goals
- Negotiating outcomes
- Providing care to meet goals
- Negotiate action plans within team (formally or informally)
- Happens all the time
- Plan discharge immediately on admission

- Allotting enough time
- Motivating
- Discussing with team
- Ordering equipment / services
- Discharge letter
- Evaluating constantly
- Co-ordinating roles ("who does what")
- Negotiating goals with patient and carers

Appendix A: CQI in Action – The outline improvement process

B   **Evaluating**   **Leaving the Ward**

- Overall evaluation of progress

- ? Fit for discharge

- What needs to be in place?

- Organising discharges jigsaw

- Arranging transport

- Checking equipment and services are going in

- Contact numbers

- Follow up e.g. day hospital / community OT / PT

- Communicating with colleagues

- Checking??

Appendix B – CQI in Action – Summary of flipchart analysing team activities
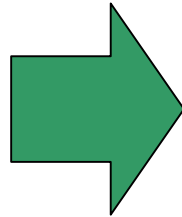
| **Referring to the Ward** | → | **Pre-admission assessing / gatekeeping** | → | **Admitting** |

Referring to the Ward
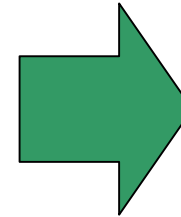
- Who by? - ("legitimate") underlying influence (i.e. relative / lay carer / professional)

- Knowledge of service - manipulative / abusive / uninformed or rational / considered ?

- GP function or initiated

- Sandra (office manager) approval*

- Nature of referral – from whom?; previous history; process of referral; ? known to service; ? recent admission

- Defining criteria for elderly care admission (ongoing)

- Unexpected admission

[25.1.99 – admission is now through the bed bureau and junior doctors]

Pre-admission assessing / gatekeeping

- ? Appropriate planning/discharge

- Assessing based on information available e.g. likely outcome (? might die).

- Gathering information – may be known (may have been on neighbouring ward)

- Reading between the lines – assumptions? Experience?

- Confidence / support

- Knowledge of referral sources / alternatives

- Informal sharing of patient details

- Suggesting alternatives to referrer, especially for internal referrals

Admitting

Information
├─ Who?
├─ What?
│   └─ Corroborated
│   ├─ People
│   └─ Documented
│   ├─ Paper
│   └─ Electronic
└─ When?

At point of acceptance rather than arrival!!

Appendix B – CQI in Action – Summary of flipchart analysing team activities

A

Assessing

→

Planning including discharge

→

Implementing

B →

Assessing

- Previous mobility, present mobility, help or aids required
- Immediate assessment - ? life threatening
- Full assessment
- Meet needs
- Information gathering agencies involved
- Telephoning family / friends / residential care
- Information giving
- Involving other professionals
- Liaising with medics / information exchange
- SHO assessing - action plan
- Consultant assessing - action plan
- Reading GP referral info
- Functional ability – past/present/future
- Transferring; walking; washing; dressing; cooking
- Digesting and directing information to formulate problems, goals, plans
- Using other sources – looking, testing, listening
- **Social worker checking if patient is known to Social Services**
- **Checking if homecare or day care is needed**
- **Checking if benefits are needed**

Planning including discharge

- Need for further physio
- Supplying with aids
- Assessing whether safe
- Liaising – family / care agencies
- Finalise problem list
- Agree which problems need interprofessional care
- Deciding common multiprofessional / patient / family goals
- Negotiating outcomes
- Providing care to meet goals
- Negotiate action plans within team (formally or informally)
- Happens all the time
- Plan discharge immediately on admission
- **Judging whether patient should be discharged to home or community hospital**
- **Home visiting by social worker**
- **Arranging homecare if needed**

Implementing

- Allotting enough time
- Motivating
- Discussing with team
- Ordering equipment / services
- Discharge letter
- Evaluating constantly
- Co-ordinating roles ("who does what")
- Negotiating goals with patient and carers
- **Setting a date for discharge**
- **Liaising with homecare**
- **Liaising with appropriate other people in the community**

B

Evaluating

Leaving the Ward

- Overall evaluation of progress

- ? Fit for discharge

- What needs to be in place?

- Organising discharges jigsaw

- **Evaluating after patient has left the ward**

- Arranging transport

- Checking equipment and services are going in

- Contact numbers

- Follow up e.g. day hospital / community OT / PT

- Communicating with colleagues

- Checking??

- **Sending discharge letter with patient as they leave**

Appendix C

STAY AND PLAY

We are interested in finding out about your experience when you attended the Stay and Play activity sessions.

Finding out whether or not you found these sessions helpful in any way will help show gaps in existing services for parents and children and future planning.

We hope you can help us by providing this information.
Please return this in the stamped enclosed addressed envelope. Thank you for your co-operation.

---

*Name of child:*_____   *Age of child:*_____

Male/Female (Please underline)   Any other children: (Please give ages)_____

How did you first hear about the "Stay and Play" sessions? (Please underline)
Health visitor/school/friend/other (please identify)_____

Do you attend any **other** clubs for mothers/carers and children?

$$\textbf{Yes} \quad \square \qquad\qquad \textbf{No} \quad \square$$

If **yes**, please give details of where they meet, and how often you attend:
_____

Age of child on first visit to Stay and Play:_____

Did you attend the Stay and Play until the end of term?

$$\textbf{Yes} \quad \square \qquad\qquad \textbf{No} \quad \square$$

If **yes**,   If **no**, why not?

                                               _____

What do you feel you have gained by attending the sessions?
_____

What (if anything) do you feel your son/daughter/other has gained from attending the Stay and Play?

_____
_____

Is there any way in which you feel it could be improved? If so, how?

_____

Please tell us about any changes in the way you behave with your child since attending the Stay and Play.

_____

Does the timing of the Stay and Play activity session fit in with your weekly routine?

        Yes   ☐**No** ☐

Best and **worst** experience at the Stay and Play

Best:
_____

Worst:
_____

Would you recommend this group to a friend?

        Yes   ☐   **No** ☐

If **yes,** what would you tell him or her about the group:
_____

Would you see any point in this or a similar group continuing in future?

        Yes   ☐   **No** ☐

Please use the space below to add any further thoughts or comments about the Stay and Play experience:

```
┌─────────────────────────────────────────────┐
│                                             │
│                                             │
│                                             │
│                                             │
│                                             │
└─────────────────────────────────────────────┘
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Thank you very much for completing this questionnaire.

The Stay and Play is part of the Regional Interprofessional Education Project - an NHSE health improvement initiative.

If you would like to know anything further please contact:
Dianne Hinds, Researcher
Regional Interprofessional Education Project
Bournemouth University
01 202 504181

Appendix D

NOTES FROM THE ACADEMIC TEAM AWAY DAY ON CQI

Consistent with the underlying philosophy of further learning built on project experience, a similar approach was adopted towards learning from the experiences gleaned within the major project themes. (That is, both CQI and interprofessional working and learning). In order to do this, in November 2000, the university's CQI lead facilitated an Away Day aiming to capitalise on the learning accrued within the project team. As within the practice settings the CQI model structured the day's events.

The day was held in November 2000, with an overall aim of gaining consensus on the "bigger picture", thus building on the collective experiences of project participants. A parallel and specific aim was of better understanding CQI and the capabilities and practicalities associated with this. Prior to the meeting, members of RIPEACT were emailed to establish their expectations for the day and to inform the facilitators planning.

The overarching aim for CQI within the context of the project was seen as being:

> To improve the way the health needs of individuals and local communities are met:

This was reiterated in the context of the RIPE aim:

> To assist qualified professionals and pre-qualifying learners and students to learn and work together across professional and agency boundaries to improve services for patients and carers.

Key elements of the CQI process:

Using the CQI model the group identified the key elements of this continuous quality improvement process:

> User's needs and ways to discover them
> Preparedness to question
> Continuous improvement
> Organic
> Flexible
> An enabling structure
> Disciplined by purpose
> Measuring and testing "trial and learning"
> Learning
> Explicit values – shared and leading to action
> Process of importance
> Insight into "development" at individual and team levels
> Common language

Collectively the team worked through the stages for a CQI project process, in this instance applying the model to pre-qualification student experience and the mainstream educational process. Integrating both these aspects were critical to the future sustainability of project principles. An aim for pre-qualification students emerged from this:

> "Students will demonstrate an appreciation of, and improve their knowledge base and skills in, health and social care improvement and interprofessional working"

Having defined the aim, the following questions applied:

> What do we know about the current situation?
> What do we need to know/learn?

There was some available evidence to answer the second question. PDSAs for the last two years could provide insight into the answer. Following the model led to the crucial key stage of identifying changes leading to an identified improvement, and incorporating them into each stage of the intended learning experience. The resultant blue print for change in the student experience envisioned key shifts in the student learning trajectory.

Towards consensus

QUINTESSENTIAL ELEMENTS OF CQI

Central to the quintessential questions relating to CQI was the explicit user/client needs focus, the emphasis on processes and people, combined with practice based learning and experimentation. An explicit values base (respecting, democratising, without blame, inclusive) was also seen to be an integral part of this.

- User/client focus nb Community/Public Health Settings
  ⇒<u>needs</u>

- A framework for thinking, learning and action, participatory with a common language and ways of being whose distinctive features are:

  - Processes and people.

  - Practice based learning/experimentation.

  - Feedback loops/PDSA cycles.

  - Explicit value base, respecting, democratising, no blaming, inclusive.

  - Ongoing, continuing.

  - A way of being – what's distinctive?

<u>Next steps:</u>

Analyse facilitation – to develop facilitation skills for others – publish.

Develop a narrative of two or three aspects related to this evolving story.

<u>Final feedback on the day</u>

The day was considered by participants to have been both enjoyable and productive. Feedback from this day included the following:

> Interesting connections, insight, and making a concrete link between theory and practice. As a positive learning experience for those involved, it had been responsible for deepening shared and individual understandings of the continuous quality improvement process.

Appendix E

<u>ACADEMIC TEAM AWAY DAY ON THE NATURE OF INTERPROFESSIONAL WORKING</u>

The second project strand to be the intended focus for an Away Day was the subject of "Interprofessional Moving". A decision had been made at a RIPEACT team Away Day to further develop the conceptual framework for this, aiming to articulate, develop and clarify a distinctive model for interprofessional working and learning. The term 'interprofessional moving' was chosen, implying a dynamic process rather than the static position frequently implied within the debates on definitions of 'interprofessional education'.

In the absence of any agreed definition or models of interprofessional working, the challenge was to reflect on team members' collective experience to generate essential features or elements of the approach being used.

The development and structuring of this day reflected the practice orientation of the prime facilitator, paralleling the manner in which the CQI model structured the proceedings within the CQI day.

The learning process

Preparatory stages preliminary to the day included the identification of key areas related to the subject. Suggested categories were emailed to team members and responses sought as an underpinning to further development as the basis of gaining consensus around identified concepts.

These categories were:

> Historical drivers
> Purpose and value
> Philosophy, language and definition
> Core skills, competencies, capabilities

There were three aspects to the day's goal:

- To jointly generate categories such as core values, rationale, philosophical skills.
- To jointly generate interesting essential statements within each category.
- To jointly consider whether the emerging categories and statements form a picture or have colours, a shape or sound, or whether they can be hierarchically arranged.

A number of questions were subsumed within the categories previously identified, in order to structure the brainstorming of ideas within the 'group think'.

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?

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?

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 – the competing discourses of care, cure and community development).
- 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?)

The day began with an iteration of the aims and an introduction to the planned structure. The shared understandings and meanings internalised by project participants in their experience of the team informed individual contributions to the process, so that ultimately a collective response was generated. Following the day there was further refinement to these stages to write final consensus statements.

Following feedback of the full group responses at a RIPEACT team meeting, the categories were progressively reduced in order to constitute a foundation to the following consensus statement on interprofessional moving.

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 is 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 whilst 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, and important aspect of participating in a dynamic process of change.

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. To participate in and be committed to inclusive dialogue, open to others.

Appendix F

Stay and Play Interview Guide
Newton Site RIPE Project
A Parent's Story

Prompting questions for use when interviewing parents:

1. Can you confirm the date of birth of your child?

2. Can you remember what you thought parenting was going to be like before you had your child? Could you please describe your memories?

3. What has it been like in reality? (prompt – check for differences if any between prior thoughts and reality!)

4. What has helped you cope the most with being a parent – especially around the time of change from midwife to health visitor?

5. What could have helped you more?

6. What has been the most difficult aspect of being a parent? Who /what could/did help you with this – who would you talk to if you felt you needed support?

7. There is support available from a variety of sources (e.g., family, neighbours, support services, community groups):

   ▪ Which ones do you know about?

   ▪ Which ones have you used?

   ▪ How helpful was the support?

8. What information or support could have improved your experience of being a parent?

9. Is there anything else you would like to tell us about your story of being a parent?

Many thanks for your help

Appendix G

<u>DISCHARGE SUMMARY</u>

ELDERLY CARE UNIT - COUNTY HOSPITAL

Transfer of care

Name	**Admission date**
GP	**Discharge date**
Hospital No.	**Discharge destination**
Date of birth	**Ward**
Address	**Consultant**
	Next of kin

<u>Problems</u> (including relevant past history)   **<u>Outcome</u>**

<u>Discharge medication</u>   (including changes and rationale)

<u>Capacity for self care</u> (ADLs, mobility, continence)

<u>Future Plan</u>

1.   Action still required by other health care/social care professionals.

2.   Planned follow up arrangements and support network.

3.   Knowledge of illness and ethical issues.

 Signature   **Date**

Name and Designation: