

The PHRIPE Project

Public Health Regional
Interprofessional Education Project

Final Report

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Executive Summary

This project was made possible by a major NHS Executive award, reflecting a regional focus on public health 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 public health improvement.

The intention of the award was to encourage educators in the region to explore and test novel ways of embedding public health 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 applied:

- Interprofessional groups in public health practice settings were constituted to form action learning groups (ALGs).
- Two models of learning were tested:
 - Professional development opportunities for experienced post-qualifying practitioners from a variety of professional backgrounds who came together to focus on a particular public health priority. In this case, the goal was to develop strategies to reduce the rate of teenage pregnancy. The university provided validated opportunities to have their learning accredited at Masters level.
 - Placements for pre-qualifying learners from a range of professional courses; students engaged in placements in selected health action areas and participated in public health improvement projects that used community development approaches.
- Both models of learning and working together were informed in different ways by the principles and strategies of Continuous Quality Improvement (CQI).
- The approaches in both settings included a strong emphasis on being informed from the 'ground' up by the needs and experiences of patients/clients/users of services.
- In addition, particular learning frameworks were put in place in order to provide a learning experience relevant to public health issues and practitioner competencies. In the case of the post-qualifying learning model, two important frameworks were the Ottawa Charter for Health

Promotion (WHO 1986) and the Verona Benchmark 1 for Investment for Health (1998). In the case of the pre-qualification placement model, perspectives and frameworks such as Bradshaw's taxonomy of social need (1985), strategies of continuous quality improvement, and various community development perspectives were used to facilitate interprofessional learning as well as to address the uniprofessional competencies required by the placement.

- In both models, inter-agency partnerships and partnerships between the academic and practice settings were forged by a number of strategies, including an inter-agency/interprofessional steering group and commitments at management level to offer support and resources in the form of staff time. In total, 17 organisations or sub-organisations were involved at different phases of the project.
- The members of the ALGs met to learn about public health 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 public health improvement. It was acknowledged early on in the project that public health improvement is a far-reaching outcome and that improvements in working processes, structures and personal competencies and expertise is a more appropriate goal within the life of the project.
- This broad educational model was also designed as a 'process' model. That is, it did not start out 'knowing in advance' the kind of learning that would occur beyond certain parameters (such as the frameworks used). The particular 'content' of the learning was discovered through engagements and interactions, particularly in the post-qualifying group where they defined their learning needs in an emergent, issue-based way.
- The design and management of the learning models was complex, as it operated within a number of professional and policy agendas as well as existing initiatives and developments in the practice areas in which the projects took place. Awareness of the community characteristics of the local environment was crucial. Awareness and co-ordination of all these developments was an important task for the project leaders.
- 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, which met regularly with the educational facilitators from Bournemouth University to learn together and pursue their 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 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 was able to:

- describe the complexities and sequences of the project;
- describe the kinds and levels of learning that took place;
- evaluate the project aims and make recommendations about using such educational approaches in future.

A case-study approach was designed and qualitative data was gathered from the following sources: questionnaires, minutes of meetings; systematic de-briefings; field notes; in-depth learning interviews; group interviews; fast feedback sheets; analysis of relevant documents; exit interviews; and records of improvement cycles.

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

The pre-qualifying placement sites: Boscombe and West Howe

The setting and the story of learning in the pre-qualifying placements

Bournemouth University students studying nursing, primary health care, health and community development, and social work were offered placements in community settings and services in practice as a voluntary opportunity to engage in working with and learning about local communities and public health issues.

The setting for the placements was mainly the Boscombe Health Action Area, one of seven in Dorset established to tackle poverty and

deprivation, reduce inequalities in health, and to enhance access to health services. The priorities set by the local community were to improve access to affordable physical activity, improve access to healthy eating, and to improve access to information advice, and support for health gain.

Placements within existing and emerging initiatives in this regard included an exercise class, a lunch club, a local family drop-in centre, the OASIS project (One-stop Access to Support and Information Service), and other initiatives such as the Springbourne Family Centre and a project called Business Partners (which aims to link businesses with voluntary organisations). There were also occasional limited placements in West Howe of a similar kind.

Action Learning Groups were set up along a 'Local Improvement Team' (LIT) model. Membership included students, practitioners, residents, and voluntary sector representatives as appropriate.

Activities of students on these placements included evaluation of previous improvement activity, direct work with clients and communities, undertaking specific project activity, or contributing to improvement planning and strategy.

The placements were designed in such a way as to provide opportunities for students to address the uniprofessional competencies set by their courses as well as to engage in interprofessional learning. This usually required both a placement supervisor within the setting (who may not be of the same profession as the student) as well as a profession-specific supervisor (who may be based at the university).

The Action Learning Groups included opportunities for students to learn and engage in a variety of activities which included awareness of ongoing initiatives; awareness of the activities of voluntary organisations; engaging in networking between different organisations, agencies and residents; knowledge of how to use Continuous Quality Improvement as a methodology for personal projects and for improving health and social care; different models of health and community assessment and profiling; particular topic areas and projects, such as the reduction of coronary heart disease or the needs of homeless men; and learning from other professions and the experiences of communities, users and residents.

There were different placement models to accommodate the requirements of different courses and professional groups. These ranged from a full public health placement involving an ongoing and intensive placement, to a public health practice experience in which students could undertake more limited visits to health action area projects. The most meaningful learning occurred in the full public health placement where students could build up relationships with residents and other professionals.

The LIT and placement model was complex as it tried at different times to accommodate other members, both pre-qualifying and post-qualifying and attempted to address multiple agendas. In total, approximately 20 students were engaged in public health projects during the life of the project (three years) and approximately 50 students engaged in a public health practice experience.

Pre-qualifying placements:
essential themes of kinds and levels of learning

Highlights of some significant student learning:

- Students were appreciative of learning CQI principles and strategies as specific steps were learnt that produced small but significant results. This was experienced as empowering, both for themselves and residents.
- Students felt that the difference from other placements was that these placements helped them become aware of the benefits of taking a more global perspective and in considering the improvement of communities as a whole (a systems rather than an individual perspective).
- Students felt that they benefited from learning how the focus of health care could be people's homes and communities rather than the health care organisation or the Social Services department.
- Students discovered how many different agencies and activities were operating in the Health Action Areas and realised the value of the synergistic working that was taking place in them.
- It was motivating for students to feel that the information they collected on their community visits would be of direct use to the communities they were working with.
- Students generally found reflective diaries a useful way of capturing what they had learnt and questioning their own initial assumptions.
- Students on placement learnt to see nurses and health visitors not in a narrowly medical role, but more broadly, as change agents within communities. They learnt about community advocacy, empowerment, and the importance of prevention and social

inclusion. They learnt about the importance of community and user-led action rather than service-led action.

- Students learnt about comparative resources and the gaps and priorities that existed in different practice settings.
- Students learnt to transcend stereotypes of other professionals, residents and communities. This had a humanising effect as they learnt about the everyday reality of residents' lives. Students learnt not to be judgemental and to empathise more with residents, and this formed an important element in the development of their anti-discriminatory practice skills.
- Students' understanding of the more 'theoretical' and global picture of deprivation was often facilitated through insight into a particular family, individual or community, whose story acted as a case study. Students developed insight into the vicious cycle that communities and residents can get into because of multiple stresses, structural/bureaucratic barriers and lack of opportunities.
- Students learnt more about the links between poverty and ill health while working on the project, and the many factors that impact on health in a community. It clarified their ideas about why some clients behaved in ways that might damage their long-term health.
- Students gained relevant and meaningful knowledge about how families fitted (or didn't fit) into their communities and how they interacted with a variety of services and resources.
- Social work students were happy to learn more about health promotion and nursing students were happy to learn more about community development approaches and anti-discriminatory practice.

Highlights of some significant general learning about the design and management of the project:

- The variety and scope of the activities that students were involved with maintained their level of interest and motivation throughout.
- Some placement supervisors noted how their own professional development was enhanced by the placements in that they were exposed to fresh perspectives from the students and that this had a beneficial knock-on effect to the residents.
- Consideration of the kind of support that is needed during placements is crucial as well as the optimum timing of the placements and the interprofessional mix. It is helpful for students to work in pairs. Different placement patterns by different professional groups makes it more challenging to engage in interprofessional

learning. There are also complex questions about the tasks that a placement needs to support in order to prepare students for collecting evidence to fulfil the competency assessment requirements of their professional bodies.

- Supervision: a split supervision model may be necessary; a supervisor within the placement who is not necessarily of the same profession as the student to provide supervision of day-to-day management, and a 'practice' supervisor who is of the same profession and who ensures that students meet their core uniprofessional competencies.
- The importance of 'signing up' and sustaining meaningful management support for the project was highlighted with an emphasis on specific agreements of engaging key personnel.
- The project served as a catalyst for interprofessional developments and activities within the academic school that was involved in the partnership (Institute of Health and Community Studies, Bournemouth University). A number of educational initiatives were encouraged by this experience, which provided a model of what it was possible to achieve.
- One of the benefits of interprofessional placements was that a re-orientation towards anti-oppressive practice could be learnt through a cross-fertilisation process between different student groups.

The post-qualifying sites: Weymouth & Portland and Swindon

The setting and the story of learning in the post-qualifying ALG

- Experienced practitioners from Weymouth & Portland and Swindon (areas chosen for their high rate of teenage pregnancy relative to surrounding areas) met together to form an action learning group with the goal of sharing ideas and experiences of best practice in order to develop strategies that would reduce the rate of teenage pregnancy.
- Perspectives, values and personal competencies were assessed with reference to the Ottawa Charter, the Verona Benchmark and principles and strategies of Continuous Quality Improvement.
- Focus groups of young people informed the learning of the ALG.
- The evidence base for teenage pregnancy work was researched. This included awareness of local initiatives and services as well as lessons learned from experts in the field, literature and research.
- Visits to Youth Advice Centres helped develop practice in Swindon.

- There were opportunities for reflecting on their interprofessional and inter-agency learning from one another.
- Time was put aside for meaningful reflection on the relationship between what they were doing in practice and the larger picture.
- It was acknowledged that the purpose was not to do a project together but to take the learning and insights back into their own contexts and projects.
- Half of the planned sessions took place. Attendance at the ALGs initially consisted of 16 practitioners from a wide variety of roles and practice contexts. This reduced over time to the degree that further meetings became non-viable. This issue is considered further in the evaluation and recommendations.

Post-qualifying ALG:
essential themes of
kinds and levels of
learning

Highlights of some significant learning by ALG participants that occurred specifically relevant to public health improvement strategies:

- Learning the tools and perspectives of qualitative research made an impact on providing crucial user-perspective strategies and ways of working.
- The Ottawa Charter was considered to have provided a useful framework for application to a variety of public health situations and which participants could usefully disseminate to colleagues and contexts beyond the ALG.

Highlights of some significant general learning about the design and management of the project:

- The university's Masters in Practice Development is a viable model for accrediting learning of post-qualifying, interprofessional groups working and learning together in practice.
- A formal mechanism for disseminating the learning of participants to colleagues and practice contexts beyond the ALG is important.
- The negotiation of protected time for attendance and involvement in the ALG is difficult but important if the experience is to be viable.
- Continuous Quality Improvement principles and strategies function best in work-based teams that are working together on joint projects, which this was not. Such work-based joint projects would, in the view of the CQI facilitator, help to create a greater 'pull' on practitioner commitments and time.
- There were too many frameworks around the project and future design would benefit by considering a more targeted and coherent learning strategy.

Recommendations

The full report makes numerous specific recommendations that would help future academic and public health practice partnerships engage in this model of learning and working. There are specific recommendations on the foci and strategies of learning, sustaining commitment, supporting students on placement, the use of Continuous Quality Improvement, and the planning and organisation of such projects in a partnership context.

Conclusion

In pursuing these models of issue-based, interprofessional learning in practice, the students benefit from 'real world' learning that is potentially transformative. For practice settings, the establishment of cross-agency, interprofessional Local Improvement Teams and Action Learning Groups constitutes one innovative way of pursuing a clinical governance agenda. The mechanisms and logistics of partnership working and cross-disciplinary professional learning requirements need further thought. There is significant transferable learning from this project that could be translated into mainstream professionally and academically accredited undergraduate and postgraduate education. These models provide one way in which practice-based, interprofessional pathways in public health improvement education could be pursued in the future.

1. Genesis of the Bournemouth Public Health Project

Introduction

This opening chapter begins with an outline of the main focus and aims of the PHRIPE project. The structures of the project, its partner organisations and management, including the steering group, are then described. The context of this interprofessional project as part of a collaborative of similar projects funded by the NHS South West Executive (NHS SWE) is considered, as well as the social, political and educational context in which the project was situated. The chapter concludes with a description and analysis of the Continuous Quality Improvement (CQI) methodology that was used in both project strands.

In July 1999, the Institute of Health and Community Studies (IHCS) at Bournemouth University, in conjunction with a number of partner organisations, submitted a successful bid to the NHSSWE entitled *Achieving Health and Social Care Improvements through Interprofessional Education*. The project took as its starting point the contention from the white paper *Saving Lives: Our Healthier Nation* (1999), that we must develop the public health workforce to include not only practitioners who are medically trained but also people from a wide range of professional backgrounds. The project would therefore be instrumental in developing this public health capacity within the Institute and the project's partner organisations.

The project had two separate strands, the first of which was concerned with combining interprofessional working and learning at pre-qualifying level through taking a community development approach to public health improvement. This work would take place in the Public Health Action Areas (HAAs) of Boscombe and West Howe. The HAAs were initiatives set up in areas of Bournemouth with high deprivation indices in order to tackle poverty and deprivation and to reduce inequalities in health. The second strand involved groups of experienced practitioners from a variety of professional backgrounds, who were based in Weymouth & Portland and Swindon. These practitioners were facilitated by the project leader to form Action Learning Groups (ALGs), which learned and worked together to develop strategies to reduce the rate of teenage pregnancy. It was

proposed that both strands of the project would use Continuous Quality Improvement (CQI) methodology to focus on the needs of the residents and the service users to guide the work of the professionals.

Project aims

The project's aims, as set out in the project proposal, were to:

- Develop ways of helping experienced practitioners from different professional backgrounds in the field of public health to work and learn together to improve public health and well-being;
- Provide pre-qualification learners with opportunities to develop the necessary knowledge and skills to work together to improve public health and well-being;
- Create new and innovative interprofessional learning sites;
- Incorporate the developed learning approaches into mainstream professionally and academically accredited undergraduate and postgraduate education and training provision, thereby creating a learning pathway in public health improvement.

This bid for support for the public health project followed the success of IHCS in securing the first wave of support and funding to be one of the three regional interprofessional education projects commencing in 1998. The RIPE project, co-ordinated at IHCS, was based at sites in Dorset, Wiltshire and Hampshire and focused on geriatric care, mental health and the needs of young children and families (Hinds and Todres 2002). The other two projects in this first wave comprised a collaboration between Avon, Somerset and Wiltshire Cancer Services and the University of the West of England to improve the care of people with cancer, and one based at the University of Plymouth aiming to improve the delivery of mental health services. The Bournemouth public health project also had a co-project based at the University of Plymouth working around the issue of coronary heart disease. The Bournemouth project became known by its acronym PHRIPE (Public Health Regional Interprofessional Education Project) and its overall aim was defined as that of developing and evaluating public health improvement learning pathways.

All the projects described above participated in collaborative events and will subsequently be referred to as Local Improvement Teams. The present report describes and evaluates the PHRIPE project as outlined in the first two paragraphs.

Project Structure

PHRIPE partner organisations

A number of organisations signed up to the project, confirming their support and a commitment to contributing resources to it in the form of staff time. Those organisations involved in supporting the work with pre-qualifying learners in Boscombe were:

- Bournemouth Central and North Primary Care Groups;
- Bournemouth Social Services;
- Dorset Community NHS Trust;
- Public Health Action Area teams;
- Single Regeneration Budget teams;
- Bournemouth Borough Council;
- Dorset Healthcare NHS Trust;
- Dorset Health Authority, who also supported the work in Weymouth & Portland.

Those organisations supporting the project work with experienced practitioners were:

Swindon:

- Swindon Primary Care Group;
- Swindon Borough Council;
- Wiltshire Health Authority;
- East Wiltshire Healthcare Trust.

Weymouth & Portland:

- Dorset Community NHS Trust;
- Dorset Youth and Community Services;
- Dorset Community Action;
- Weymouth & Portland Primary Care Group;
- West Dorset General Hospital NHS Trust.

Project management

The former Head of the Institute, who also headed the RIPE project, managed the PHRIPE project at IHCS. The project was co-ordinated through a project management group consisting of the project manager, the two project leaders, who facilitated the work with pre-qualifying learners and experienced practitioners, the research leader, research assistant, and the project's CQI facilitator. All PHRIPE team members attended the RIPE team meetings in order to learn from that experience and from the growing evidence base about interprofessional student and practitioner learning. It was also proposed that a steering group of

practitioners and representatives of the partner organisations would guide and support the PHRIPE project at a strategic level.

The steering group

The steering group's remit was to provide support to the work as appropriate and 'provide a steer' to the smaller project management group. PHRIPE managers/stakeholders considered it to be particularly important that members of this group felt that the project was developing models of learning which were relevant to the needs of all stakeholders and which could be sustained. It was recognised that the project would be successful and its outputs sustainable only as far as they were perceived to be useful to the agencies involved.

Attendance at the first steering group meeting in April 2000 was impressive, both in terms of numbers and the seniority of those present, which included the Education and Development Manager responsible for the interprofessional initiatives for NHSSWE and IHCS's Head of School. Senior representatives from all the partner organisations also attended this meeting. Social work students currently on placement in the Boscombe HAA attended this and both subsequent meetings of the steering group, indicating their interest in the project that lay behind the placements. The project leaders of the two strands reported on progress to date and the proposed evaluation strategy was disseminated by the project's research leader. It was proposed that the steering group might come to oversee some of the other community development-based educational initiatives taking place in Bournemouth to which IHCS was a partner. In an attempt to keep pace with relevant policy initiatives, the meeting discussed the recently published NHS consultation document on the review of workforce planning: *A Health Service of all the Talents: Developing the NHS Workforce (2000a)*, which it was hoped would promote the development of interprofessional working.

The meeting identified a number of important issues, such as the possible development of an academic centre and securing wider authority involvement, as well as the involvement of more agencies. These were referred to the project management group for development and prioritising.

The subsequent steering group meeting, held in July 2000, was not as well attended as the first. Most partner organisations were not represented, and for those organisations who had sent a representative, this was generally a less senior person who was unfamiliar with the

project. Most attendees were staff or students from the Institute. Project leaders again reported on the progress of the two strands and the research assistant gave a verbal summary of the evaluation findings to date.

The management group had prepared a report analysing the issues raised at the previous steering group meeting. It reported that four of the issues given below applied equally to other interprofessional development projects in which the Institute was involved and that many were being addressed through the first RIPE project.

- Changing IHCS systems to support interprofessional learning;
- Pooling academic (e.g. nursing and social work) resources;
- Integrating these approaches into mainstream education/CPD;
- Developing integrated FE/University pathways at different levels and relating these to work elsewhere in the region.

The view of the management group was that the steering group should concentrate on the overlapping areas of:

- Relating the work to agency agendas;
- Clarifying aims;
- Securing wider agency involvement;
- Capturing spin-offs;
- Making linkages;
- Sharing best practice;
- Establishing an Academic Centre for Public Health Improvement.

It was proposed that the next steering group should adopt a workshop format of discussion in small groups to address these specific issues.

The next and final meeting of the steering group took place in January 2001 and was well attended by senior academics, practitioners and students. However, it was not attended by any agencies outside the Institute apart from Bournemouth Social Services, although the PCGs jointly employed the two placement supervisors of students in the HAAs as well as the project leader. A summary of the main evaluation findings to date was given both verbally and in written form, but because of low attendance, the proposed workshops did not take place. The project leader of the pre-qualifying strand then presented a positioning paper on the recently formed academic centre to the steering group.

The work to fulfil the objective of establishing an academic centre took place largely through the ACHIEVE project (Academic Centre for Health Improvement and Evidence of Effectiveness), established by the Practice Development Unit at the Institute in conjunction with partners in practice. The first 'away day' to establish this took place in December 2000.

Realising that the lack of attendance and input from partners meant that the steering group in its current form was unviable, the project manager decided that no future meeting would be held and the project was subsequently co-ordinated through the project management group. However, since this consisted solely of project personnel from within the Institute, an important link with the partner organisations was lost.

Reasons why the project management structure was not sustained

Once the ACHIEVE project was established, it became the key body for the work in the HAAs, and the PHRIPE steering group no longer had a clearly defined separate function. The steering group might also have struggled to maintain commitment because it was attempting to operate across both strategic and operational levels, working with top management as well as practitioners and students. Staff at the most senior level in their organisations had many demands on their time and it is likely that after having signed up to the project, their role in continuing to support it was unclear.

The demise of the steering group points to some of the difficulties inherent in partnership working where there is a lead body, usually the originators of the project and also the budget holders, in this case IHCS. Other organisations that have an interest in the work are brought on board but they have projects of their own that may be more key to their strategic interests and these will naturally be given priority.

A practical difficulty with the steering group meetings was that Wiltshire and Swindon, where some of the stakeholders in the work with experienced practitioners were based, was some distance geographically from Bournemouth and so involved a considerable journey. This was the reason that the joint ALG of experienced practitioners met in Salisbury, which was midway between the two groups. A further difficulty during this time was that services were also subject to major reorganisation, with the PCGs becoming PCTs, different NHS Trusts with changed responsibilities forming in Dorset, and the reorganisation of the NHS regional management structure, which resulted in the demise of NHSSWE, the project's commissioning body. Later in the chronology of

the project, the original project manager left the Institute and the project in December 2001.

Another factor that might appear trivial but carries symbolic meaning for all concerned was the choice of venue for steering group meetings. The first meeting was held at a local hotel, an attractive venue with views across Bournemouth's East Cliff. The hotel not only provided pleasant surroundings that gave an impression of the value placed on the project by the Institute, it was also a neutral venue. Subsequent meetings were held at the Institute, which provided somewhat less attractive surroundings and also may have given the message that the project 'belonged' to Bournemouth University. Continuing to meet at a hotel, or if the budget did not permit, at the offices of stakeholders, might have been helpful in sustaining the steering group and ultimately the project. For example, if everyone involved in PHRIPE had made the effort to travel to Swindon for a steering group meeting, that might have encouraged the stakeholders in Swindon to attend that and subsequent meetings.

The critical point of securing long-term commitment may be to encourage stakeholders to attend for more than an initial meeting, when there is a large flurry of activity and excitement, and to come on board for the longer term to help deal with the challenges that will inevitably arise. Difficulties within projects often arise at a micro and practical level, relating particularly to accommodation, access to and compatibility of equipment, and the means of applying for small amounts of money that are not prohibitively bureaucratic.

Meaningful dialogue may also have been inhibited by the steering group's large size, which was one factor that made proceedings within it rather formal.

The Collaborative

All the Local Improvement Teams (LITs), initially the first three and subsequently the two second wave projects supported by NHSSWE, met together three times a year at a regional Collaborative event held at a venue in Somerset. It may be worth mentioning here that this was a 16th century country house in beautiful grounds, with tranquil surroundings that promoted reflection and, probably, continued attendance.

The purpose of the Collaborative was to provide support to each LIT, and to keep the LITs at other sites and the Programme Board updated on progress. The Programme Board acted as an expert panel offering

guidance to individual sites, and included representatives of the relevant professional bodies and medical schools in the area. This wide strategic membership represented a serious attempt to tackle some of the difficulties that were likely to arise within the projects; in the case of PHRIPE, cross-professional supervision of learners, differing requirements to accredit their learning on placement, and different placement patterns. The Board was also able to keep the LITs in touch with national developments and to inform colleagues about the initiatives taking place in the south west. Issues emerged that were common to all sites and discussion in a wider forum often proved very useful to members for the identification of common threads.

The evaluation strategy proposed was regarded as a key criterion for the original selection of projects by NHSSWE so, in addition to the Collaborative meetings, an Evaluation Advisory Group met approximately six-monthly from December 1998. This group was to provide a resource of skills and expertise to ensure effective evaluation of the projects. Each site had its own evaluation team and the added value of the Collaborative process as a whole was evaluated by Learners First (Knasel 2002).

In June 2000 and again in July 2000, learners at the various sites were invited to present their work at the Collaborative. At the June 2000 meeting, social work students based in the Boscombe HAA shared the work that they and nursing students had developed for PHRIPE, aimed at improving self-esteem for girls at a local school, and for improving men's health. They produced posters showing the PDSA (Plan-Do-Study-Act) cycles they had undertaken within a CQI framework to plan, carry out and review this work. A representative of the experienced practitioners' strand from Weymouth & Portland also spoke about the value of the ALG process. These were probably the most interesting and informative of the Collaborative meetings, although there was a large amount of information for participants to assimilate about the details of the other projects within the Collaborative.

However, the Collaborative meetings ceased with the end of the first wave of projects in the summer of 2001, before the second wave of projects, including PHRIPE, finished so this useful support did not continue for the life of the project.

Social, Political and Educational Context

Drivers towards interprofessional education

The interprofessional context in which the PHRIPE project operated comprised a number of different elements. These included a number of policy documents from Central Government and the statutory bodies that regulate the professions, as well as existing work within the Institute. Several conferences promoting both interprofessional working and CQI also took place during the lifetime of the project. NHS policy documents that promoted interprofessional working during this time included *A Health Service of all the Talents: Developing the NHS Workforce* (2000a) and *The NHS Plan* (2000b). These documents were followed by the UKCC's *Fit for Practice and Purpose*, issued in the autumn of 2001.

In addition, the Institute was running an interprofessional postgraduate qualification, the Masters in Interprofessional Health and Community Studies (MAIHCS), which began in 1995 and included a unit on CQI. There was also the first regional interprofessional education project, the important precursor to PHRIPE as described previously. A number of important conferences were organised, one jointly by NHSSWE and IHCS at Hartham Park in 1999 and another held at Bournemouth and facilitated by IHCS in November 2000. These conferences aimed to extend the learning about practice-based interprofessional education and help good practice to be built into mainstream professional education. They generated much interest, attracting both important keynote speakers and an international attendance.

Understanding of the nature of interprofessionalism was also developed through a reflective group enterprise that took place at the Institute in November 2000, involving the RIPE and PHRIPE teams, in order to make team members' assumptions about the model on which the interprofessional projects were functioning more explicit. The group attempted to tease out the essential themes of interprofessionalism and to investigate how best to construct its core components or dimensions. The exercise ranged over diverse areas of historical and personal drivers, purpose and value, and philosophy, definition and language.

The reflective day was planned, conceptualised and facilitated by the projects' research leader and has since been written up as one of a collection of occasional papers (Todres 2002) about the two projects in *Making it Better* (Todres and McDonald 2002).

The reflective group exercise was one factor in drawing attention to the importance of developing shared understanding of the language used. This was an area that was also explicitly explored by the experienced practitioners on the PHRIPE project in one of their reflective sessions, which is described in Chapter 2 of this report.

**Interprofessionalism:
definitions and
language**

It was clear from the beginning of the project that it would adopt an interprofessional rather than a multi-professional orientation. The following definitions are taken from the original NHSSWE tender document:

Multi-professional education is defined as a learning process in which people from different professional groups learn together. The content to the learning is therefore common.

Interprofessional education is defined as a learning process in which different professionals learn from and about each other in order to develop collaborative practice.

There has been continuing debate about other aspects of the language of interprofessional working and learning. Biggs (1997) refers to the semantic hinterland of meaning about interprofessionalism that lies behind policy objectives. The term interprofessional may be used to signify relations between different agencies (interagency) or between different organisations (interorganisational). Government policy has focused on these latter two but equal attention has not been paid to interprofessional relationships, in the sense of relationships between individual members of different professions. Hudson (2002) draws attention to the fact that traditional sociology regards professional groups as self-interested and self-referential groupings and notes that if this is true it may cause problems when organisations begin joint working. This is one of the factors that makes up the so-called pessimistic tradition in interprofessional working.

**The historical
context of
interprofessional
working**

The need for interprofessional or, more accurately, interagency working has become increasingly apparent over a number of years. As far back as 1942, the Beveridge report noted the interdependence of policies for full employment, social security and health care. In 1987, the UK Centre for the Advancement of Interprofessional Education (CAIPE) was established. A number of initiatives from the Department of Health during the 1980s and early 1990s promoted interprofessional working such as *Training for Community Care: a joint approach* (1991). By the end of the

1980s, a number of high-profile cases of child abuse pointed to major gaps in communication between agencies, which led to important information being missed. The Jasmine Beckford inquiry, carried out in 1985, emphasised the vital importance of communication between agencies and professional groups, and particularly between social work and community health services.

At around the same time, there was a growing awareness that adult services were also confusing to the client, particularly in community settings. In 1991, the Department of Health recommended that tailored packages of care should be developed for clients, based on an assessment of individual need rather than the provisions of a particular service. As Biggs goes on to argue, these policy initiatives assume distinctive contributions from discrete professional groups who use their complementary skills as appropriate to co-operate on an agreed objective. He believes that, despite boundary disputes, this presents a stable picture that provides little threat to the core identities of the professional groups or agencies involved.

This leads us into the optimistic tradition for interprofessional working. The following policy goals have been associated with increased interagency working, taken from Hallett and Birchall (1992, quoted in Biggs 1997):

- The achievement of greater efficiency in the use of resources and improved standards of service delivery through the avoidance of duplication and overlap in service provision;
- Reduction of gaps and discontinuities in services;
- The clarification of roles and responsibilities arising in demarcation disputes between professions and services;
- The delivery of comprehensive, holistic services;
- To this list Biggs would add the promotion of a service driven by objectives and outcomes rather than professional interests.

Biggs points out that interprofessionalism, especially in terms of service planning, can be inward looking. This can eclipse consideration of problems external to the service, such as poverty, poor housing etc. A focus on ever-greater collaboration as a solution to all ills will obscure focus on these important factors. This pitfall was avoided in PHRIPE by an explicit concentration on a radical public health agenda that recognised the importance of social factors while promoting interprofessional working for the benefit of the client and the community.

Context of the interprofessional supervision of students

An important enabling factor in the project agenda was the ability of one profession, in this case health visitors from a nursing background, to supervise students from other professional groups on placement. Within PHRIPE these were predominantly social work and community development students.

Interprofessional supervision of students began with the Joint Practice Teaching Initiative (JPTI) in 1990, as Weinstein (1997) describes. From 1990 to 1995, the Central Council for Education and Training in Social Work (CCETSW) provided funding to develop joint training for practice teachers and clinical supervisors in health and welfare (Weinstein 1997). The stated objective of the JPTI was to encourage multi-disciplinary training and to contribute to the training of other professionals. An interprofessional steering group ran the initiative and its first meeting was attended by delegates from nursing, social work and occupational therapy.

However, developing joint validation procedures proved more difficult than anticipated and there was unwillingness among the professional bodies to approve jointly validated programmes that would lead to all professions receiving the same award. Agreement was reached in 1992 to validate a core module of practice teacher education, incorporating the CCETSW practice teaching award, the English National Board for Nursing, Midwifery and Health Visiting (ENB) community practice award, and the College of Occupational Therapists' (COT) sequential approach. The core components of the module were:

- Development of self as a practice teacher/clinical supervisor;
- Exploration of adult learning theories;
- Achievement of skills in assessment.

In addition, three value-added elements were introduced to enrich the core curriculum:

- Equal opportunities and anti-racist and anti-discriminatory practice;
- Professional collaboration in community care;
- Long arm supervision – the potential for placing a student from one profession in a placement supervised by another professional but with 'long arm' supervision from a practice teacher of their own profession.

These were also important elements in the PHRIPE placements. The JPTI was a useful development that enabled interprofessional student

learning on placement, albeit one requiring students to have, in effect, two supervisors instead of one.

Weinstein reports that, despite problems implementing the new joint module, interest in interprofessional education grew after the end of the pilot. She points to the attitudinal change that took place between 1993 and 1995 and the fact that post-registration learning, with a number of interprofessional Masters programmes being set up across the country, was accepted much more easily than interprofessional learning at pre-qualifying level. As an example, joint programmes were established between nursing and social workers preparing to work with people with learning disabilities during this time. The ENB imposed a moratorium from 1991 to 1994 but when it was lifted, a number of organisations expressed interest in joint validation. CCETSW and the Social Services Inspectorate jointly sponsored a project with the Centre for the Advancement of Interprofessional Education (CAIPE 1996) to explore joint training for doctors and social workers (Weinstein 1997).

Other joint training initiatives include the SW/OT joint social work and occupational therapy training at the University of Derby between 1997 and 1998, which then proceeded to look at the feasibility of joint validation of the two programmes. Another shared learning initiative between the same two professional groups took place concurrently at the University of Wales Institute and the University of Wales College of Medicine (Connor 1998).

The public health agenda: tackling inequality

The damaging effects that deprivation and social exclusion have on the health of those affected have been increasingly documented in recent years. Variations in life expectancy between the highest and lowest social classes remain substantial. In 1997, Raleigh and Kiri (Shaw et al. 1999) reported the findings of their study comparing life expectancy in different District Health Authorities between 1984 and 1994. They found a difference in life expectancy of 6.7 years for men and 4.7 years for women between the most and least deprived areas.

Another study found that during 1999, on average 26% more people died from coronary heart disease in 20% of the most deprived Health Authorities than in the country as a whole. These disparities in health outcomes reflect the disparities in income and quality of life in those areas. Free market policies meant that income inequality grew faster in Britain between 1970 and 1990 than in any other developed country,

except New Zealand. From 1977 to the mid 1990s, the proportion of the population with less than half the average income more than trebled, from 7% to 24% (Shaw et al. 1999). The UK had been doing poorly in this regard in comparison with the rest of Europe. In 1995, the percentage of children living in households below the official US poverty line was 25% in the US and 22% in the UK and Italy, which jointly had the highest rate in Western Europe. The UK also had the highest number of live births to women aged 15-18 in the EU (Social Exclusion Unit 2001b).

However, there is now some evidence that the trend has begun to reverse with the operation of interlocking or 'cross cutting' policies co-ordinated by the Social Exclusion Unit. These include the minimum wage and the various tax credits designed to meet the Treasury target of halving the number of children living in poverty by 2010. There is also the Sure Start initiative, which is benefiting 100,000 children under four in deprived areas and involves a number of different professional groups, as well as parents themselves.

A number of recent initiatives such as those described above now recognise the links between poverty, social exclusion and poor health. These began with the white paper *The New NHS: Modern, Dependable* (DoH 1997) in which the new Labour Government set out its plans for NHS reform, which included improvements in public health as well as better quality public services. The subsequent white paper, *Saving Lives: Our Healthier Nation* (DoH 1999) included, for the first time, the commitment 'not only to increase the health of the population as a whole but also to improve the health of the worst-off in society and to narrow the health gap'. This document provided an important basis for the project work in terms of promoting a multi-skilled public health workforce as previously described, but also in the target areas it identified for improvement, such as reductions in coronary heart disease and stroke, and improvements in mental health.

Partner organisations such as the Primary Care Groups (PCGs) were also subject to new policy initiatives, moving them towards taking a more active role in public health. The beginning of the PHRIPE project coincided with the introduction of PCGs in 1999, when they were ascribed three main functions, the first of which was 'to improve the health and address health inequalities of their community' (NHS Executive 1998). GP practices previously varied in their engagement with the public health agenda. According to Levenson and Johnson (1999),

this amalgamation of all GP practices into PCGs would mean that they would all now be expected to perform a public health function.

Areas with a high number of socially excluded people are characterised by a poor quality of life, high dependence on benefits, low educational achievement, high crime and unemployment, vandalism and drug dealing. In 2001, the Social Exclusion Unit demonstrated its commitment to tackling the problem of neighbourhood decline by publishing an action plan entitled *A New Commitment to Neighbourhood Renewal*. This included the setting of new Public Service Agreement (PSA) targets for each Government department. The Department of Health's target was to develop strategies to narrow the health gap between deprived and more affluent areas. This included targets for Primary Care, the promotion of healthy lifestyles, including smoking cessation, as well as non-health strategies such as reducing unemployment and tackling crime. More recently, the Government has set targets aimed at reducing the gap in life expectancy and infant mortality between the most and least privileged areas. This agenda for change and increased social justice in areas of high deprivation has been pursued particularly in the strand of the PHRIPE project with pre-qualifying learners in the Boscombe and West Howe HAAs, but was also embodied in the work of the experienced practitioners, who realised that the roots of teenage pregnancy often lay in social exclusion.

Learning frameworks

The experienced practitioners' strand used the learning frameworks of the Ottawa Charter for Health Promotion (WHO 1986) and the Verona Benchmark 1 for Investment for Health (1998) to guide their public health and personal development learning. These are described in detail in Chapter 4. Learners in both strands of the project used CQI as a framework to help plan and improve their practice.

Continuous Quality Improvement (CQI)

The use of CQI formed an important part of the project proposals for all the interprofessional LITs, including that of PHRIPE. CQI's focus on client needs, having a clear general aim, understanding processes within a systems view and establishing improvement projects as short-term learning cycles, were therefore intended to play a significant part in the project. The Bournemouth LIT sites were particularly fortunate in that a specialist facilitator, the project manager and two members of the RIPE team had prior experience and considerable expertise in CQI.

Two members of the LIT described the use of CQI on the RIPE project in another paper (Wilcock and Campion-Smith 2002) in the collection *Making it Better*. Based on Nolan (undated), they define CQI's main driver as being:

The desire to improve the match between the services professionals provide and the needs of the people who depend on them. These ideas are based on the premise that the foundation of quality is matching service to need and quality improves as the match improves (p77).

One of the first messages that they believe should be conveyed to interprofessional teams is that CQI is not a newly developed theory they have to learn but is based on values and principles that they are already familiar with. These principles should be integrated into a framework that can be used by team members in their everyday practice to produce the sorts of improvement that they feel are most important to their clients. The model used (Nelson et al. 1998) illustrates a person with need accessing the system, and as they pass through the system they are variously assessed, diagnosed, treated and followed up. At the end of the process is the clinical value compass (Nelson et al. 1998). One aspect of a balanced set of measures as embodied in the compass is to check that an improvement in one area has not been at the expense of quality in another. The clinical value compass consists of the following elements.

Clinical outcomes

These may be considered to be direct consequences of interventions e.g. signs, symptoms and consequences.

Functional status

Measures of health status that provide insight into the impact of clinical outcomes on quality of life, for example.

Satisfaction against need

The important factor here is the integration of need with the concept of satisfaction, making it patient-referenced as well as service-focused. Thus, measures may relate to processes of care or the personal benefits realised by clients and their families.

Costs

Where costs are recognised to be an outcome of care. They may be direct service costs or indirect social costs.

The authors point out that most of the emphasis in published CQI studies has been on the middle part of the improvement model, when the person with need passes through various health and social/community care systems. This is important because it is impossible to improve care without improving the processes by which it is delivered. The process of drawing a flow chart, which is an integral part of the CQI process, is often the first opportunity that team members have to contribute their piece to the jigsaw of care. The process itself promotes discussion about the assumptions under which they all operate and how to improve the care they provide.

At the beginning of the process it is important to ensure that the service provided is meeting the needs of its client group. Wilcock and Campion-Smith (2002) describe how most previous efforts have involved measuring patient satisfaction with services through questionnaires and tick boxes. However, this does little to improve patient care because such measures can tell us little about clients and their needs. As Kahan and Goodstadt (1999) comment, 'We need to know that more is possible before we can be dissatisfied with getting less' (p86).

What is required instead is to listen to stories about the impact of illness on people's lives, a process that emphasises their humanity rather than their role as passive recipients of services.

Another key message from RIPE was the importance of creating the conditions for learning. Stories of successful improvement are stories of people learning together and then reflecting on what they have learned (Wilcock and Campion-Smith 2002). In addition, recent attention has focused on the Nolan framework (Langley et al. 1996), which poses three questions for improvement teams to address:

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

Wilcock and Campion-Smith (2002) believe that the best idea is to choose small changes that can be implemented quickly. This is highly motivating for staff and the learning begins quickly, thus maintaining their interest. Larger improvements are realised by the cumulative effects of improvement (Plan-Do-Study-Act) cycles underpinned by serial learning. The paper extensively drawn upon above, describes work on the first RIPE project, but PHRIPE set out to trial the use of CQI in a public health

setting. The use of CQI in public health and health promotion projects is less common and its adoption more recent than in healthcare organisations. Kahan and Goodstadt (1999) address key questions on the applicability of CQI to health promotion, such as whether it matters that health promotion, in contrast to more institutional health-care based approaches, does not produce goods and is not always a service.

They describe how CQI was first applied to the manufacture of goods then adapted for the provision of services. Kahan and Goodstadt (1999) document the contested nature of the concept of quality, arguing that, while there is some agreement that quality embodies notions of efficiency, effectiveness and consumer satisfaction, the fact remains that definitions of quality are subjective and depend on who is doing the defining. Criteria for quality depend further on whether the production of concrete goods is the aim or whether intangibles, such as increases in well-being or self-esteem are the desired end result. It is also important that the genuine improvements of services to meet people's needs are emphasised and that cost cutting is not seen as a central aim of CQI.

Relationship of contextual factors and frameworks to the development of the PHRIPE project

There were some differences in the way that each of these factors influenced and contributed to the development of the project. Practitioners' and, in particular, the project leaders' awareness of the evolving public health and interprofessional agendas during the project contributed to the direction and implementation of PHRIPE in line with new policy initiatives. An example of this was the developing role of the Social Exclusion Unit in tackling teenage pregnancy and the funding that became available to each area, including Weymouth & Portland and Swindon, for a rapid development of their strategic response. The two major agendas or project drivers also had a considerable influence on the formulation of the project proposal. *Saving Lives: Our Healthier Nation White Paper* (DoH 1999) was particularly important, affecting the priorities and work of both PHRIPE and the partner organisations.

CQI performed a different role in the project, providing a framework that enabled improvement work to take place to implement the public health and interprofessional agendas. Project staff thus drew on these contextual factors and learning frameworks as resources that influenced the development and implementation of the project in specific ways.

2. Methodology

An action learning framework, utilising a case study approach to each project strand was adopted for the evaluation process. This was then able to respond quickly to the many changes that took place in the project. This framework was designed to monitor the extent to which the specific project aims set out at the beginning of this chapter were being met. The research process also set out to document and analyse the following factors involved in implementing the project, paying particular attention to all aspects of the learning that took place:

- The approaches to learning and its various learning strategies;
- The breadth of the learning that occurs by looking at some of the skills and knowledge that were acquired;
- The depth of the relevant learning, by seeking to understand its main components;
- The barriers and enabling factors in achieving the outcomes;
- The use of CQI;
- The nature of interprofessional, interagency and cross boundary working and learning taking place;
- Evidence for public health improvement;
- The potential sustainability of the project and how it is embedded in mainstream education;
- Unintended outcomes.

Some changes had to be made to this initial plan, since it was originally proposed that the Plan-Do-Study-Act (PDSA) cycles produced in the learning sets would be used as part of the evaluation process, in particular in the ALG of experienced practitioners that met in Salisbury. However, the ALGs in Salisbury did not form a practice-based team and CQI was generally undertaken with the pre-qualifying learners in the HAAs on an individual basis and so neither group produced team-based PDSA cycles. This part of the evaluation of CQI was therefore not possible.

The research strategies developed involved the use of mainly qualitative methods with the exception of the fast feedback sheets and questionnaires used in both project strands. A number of distinct but complementary interview guides were developed for the semi-structured interviews to investigate emerging themes. The interview guides were used flexibly and responsively to follow up interesting perspectives from

participants. These developed during the course of the project as more was learnt about the most important elements. The interviews varied in length from half an hour to an hour and a quarter, depending on who was being interviewed, their level of confidence, and how much they had been able to reflect on their work. Interviews with practitioners therefore tended to be longer. Permission was sought to tape-record interviews, which were then transcribed at the Institute and stored without names attached.

The researcher attended ALG and learning set meetings wherever possible and took part in group exercises when appropriate. This level of involvement facilitated arranging and conducting interviews and also helped develop understanding of the complexities involved in each strand of the project.

Methods of data collection

ALG of experienced practitioners from Weymouth & Portland and Swindon

Important data for the evaluation process was generated throughout the project by the times set aside for reflective sessions that were facilitated by the project leader. Additional methods used in the evaluation process include:

- 'Fast feedback' sheets filled in after the ALG educational sessions, so that members' views of their value could be obtained.
- Semi-structured interviews with:
 - All available ALG members at the end of the project;
 - The project leader and the CQI facilitator.

Interviews generally took place at the practitioners' place of work, since this was more convenient for them than travelling some distance to the Institute in Bournemouth.

- A questionnaire based around the competencies of the Advanced Practitioner, a concept derived from the Ottawa Charter, which formed one of the theoretical frameworks around the project, was developed in conjunction with the project leader. This was designed to measure ALG members' self-perception of their expertise in five key areas of health promotion work, and was completed by them at an early stage in the project. It was envisaged that this questionnaire would be repeated at the end of the three-year period to measure any improvement that had taken place. However, since the project ended earlier than planned, this repeat administration did not happen.

- Meetings attended by the researcher:
 - Most ALG sessions (informal debriefings with the project leader took place after these meetings);
 - Inaugural meeting of students on the Masters in Professional Development (MAPD);
 - Sessions of the Teenage Pregnancy Task Group, Swindon;
 - Interagency Strategy Group on teenage pregnancy in Dorset.

- Documentary analysis of:
 - Minutes of the Teenage Pregnancy Task Group;
 - Educational materials used in sessions;
 - Background and context to the Learning Frameworks around the project;
 - Evidence base of work designed to reduce teenage pregnancy;
 - Course documentation for the Masters in Professional Development.

The Boscombe and West Howe HAAs

- Meetings attended by the researcher:
 - Student learning sets;
 - Practitioner learning sets;
 - Re-launched learning sets from January 2002 (informal debriefings with project leaders took place after these meetings);
 - ACHIEVE (Academic Centre for Health Improvement and Evidence of Effectiveness);
 - OASIS (One Stop Access to Information and Support Services);
 - HLC (Healthy Living Centre) co-ordinating committee.

- Semi-structured interviews with:
 - Pre-qualifying students on public health placements;
 - Pre-qualifying students having a public health practice experience;
 - Placement supervisors and social work practice teachers who supported the student learning;
 - Project personnel, including the project leader at intervals during the project, and the CQI facilitator.

These interviews generally took place at the Institute, as nursing students had to spend some time there attending lectures while

on placement and this was an environment that they were familiar with. Some interviews with social work students on placement took place in the HAAs, if that was more convenient for them. The visits also provided the opportunity for the researcher to attend the exercise class or visit the lunch club and thus improve understanding of those initiatives in a way that can only be gained through personal experience. A tour around West Howe HAA, facilitated by the placement supervisor, followed the interview there.

- Negotiating access to:
 - Students' reflective diaries kept while on placement;
 - The contracts drawn up between the practice teacher, the placement supervisor and the social work students;
 - The write-ups of their community visits or their action plans for nursing students.

- Documentary analysis of:
 - Relevant NHS and professional bodies' policy documents;
 - Minutes of practice educator learning sets.

- Devising a questionnaire that attempted to find out why some nursing students did not continue to attend the learning sets, by looking at their attitudes to interprofessional working.

- Fast feedback sheets filled in after the practitioner learning sets and the learning sets that began in January 2002. These included questions about participants' main learning from the meetings and any questions that they would like addressed at subsequent meetings. Questions and comments were collated and circulated to the project and CQI facilitators to help plan the next meeting and deal with any queries that students in particular had not felt able to raise in the meeting.

Epistemological orientation

A broadly interpretive reading of the data was carried out (Mason 2002) in which meaning was ascribed that sometimes went beyond what was literally there on the page of the interview transcript. This was done in order to take account of a number of different factors, some relating to the project agenda described in this chapter. It was the belief of the evaluation team that it was not possible to undertake a 'purely literal' reading of the interview data in particular, since the researchers' own

perspectives and experience will always colour the interpretations and the particular elements singled out for emphasis. It was also our understanding that an objective or value neutral viewpoint does not, and cannot, exist. A reflexive stance was therefore maintained throughout in order to be aware of individual perspectives and the effect that these have on the research process. Both interviewees' own perspectives and those of the researchers were included in the process of analysis.

However, there is a limit to how far we have trodden down the relativist path (that there is no meaning or reality outside the individual's own constructions of it). In the project report, and particularly in the chapter on evaluation, it has been necessary for the research team to synthesise these different voices and perspectives to make a whole, and to take an overview of the project in relation to fulfilling the projects aims, indicating the most significant research findings and in making recommendations to assist future, similar projects.

Analysis and reporting of data

Our case study approach was guided by a search for 'the particular in context' (Mason 2002). However, in two such large case studies we have also tried to identify common themes in the data from each project strand, across groups of students from the same discipline, practice educators or the ALG of experienced practitioners.

Thematic analysis was carried out on the interview transcripts throughout the project and the broad categories developed were broken down into smaller themes. Our approach in this report was to assess how much each element in the project, e.g. a particular learning framework, contributed to the success or otherwise of the project. 'Slicing the data' in this way meant that themes were not tackled explicitly, but they can be located as headings to the different sections. Findings were structured into broad sections according to the most important aims of the evaluation process, for example describing and analysing the learning of all those involved in the project. Other sections cover practical considerations relating to organisation of the project and barriers to implementing the project agenda. The most important themes are then highlighted in the summary of the main evaluation findings at the end of each chapter.

When describing the project and reporting project outcomes, we have also drawn upon the evaluation model developed by Coles and Grant (1985) to evaluate aspects of medical education. This model proposes

that each project, service or policy has three versions, which they illustrate as three overlapping circles: 'On paper', 'In action' and 'As experienced':

- 'On paper' is the project as intended, planned, designed and set out in the project proposal with aims and objectives, values, assumptions and beliefs of the planners.
- 'In action' is what happens when the project proposal is implemented. This means the project or service in practice and the actions and interactions of those involved.
- 'As experienced' covers the impact the policy or project has on those involved, including both internal and external users. This includes the outcomes as well as the users' experience of those outcomes.

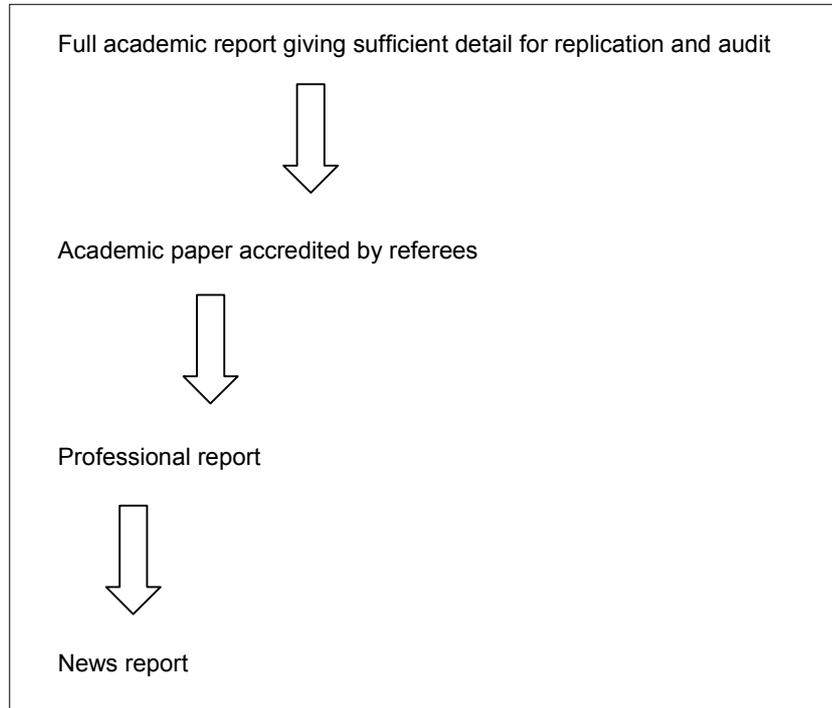
The authors emphasise that an evaluation that concentrates on only one version must recognise that others may have been ignored. Their model throws up some interesting and complex permutations. In the middle is the area of overlap, which contains the elements that were planned, implemented, and formed part of the users' significant experience. All other areas will include only one or two elements of the three project versions described earlier.

This model has been utilised in the way the evaluation findings have been structured in the chapters on each project strand, with the project 'On paper', described under the heading 'Project proposal', and the project 'In action' described under that same title in both chapters. The project 'As experienced' is contained in the sections on students and their practice educators in Chapter 3 and on the learning of experienced practitioners in Chapter 4.

Dissemination of the NHSSWE project findings

Detailed plans were also put in place at the Collaborative for dissemination of the evaluation reports, and a British Educational Research Association (BERA) (2000) document, describing a pyramid model of educational research writing, was circulated to all LITs. This proposed that the full academic report would serve as the basis for other sorts of reports designed to disseminate the results more widely and to be accessible to different audiences. The professional report would be a shorter version of the full report, more appropriate for busy practitioners and stakeholders. The news report would draw attention to the existence of the other formats of the project write-ups.

Figure 1: BERA pyramid model of educational research writing.



This structure has been adopted in writing up the PHRIPE project, with the present report representing the full academic report. The executive summary, which can be found at the beginning of the project report and is also available separately, represents the professional report. It is also planned to submit academic papers for publication in peer-reviewed journals, based on the data in this report.

3. Boscombe

Introduction

This chapter is divided into five sections, with the first section outlining the pilot project for PHRIPE, the original project proposal and the students' learning outcomes on placement. It also includes a description of the Health Action Areas (HAAs) and the main activities within them involving students. Section two describes the project in action, including its context and personnel, the different placement models adopted and the principal activities that the student learning sets engaged with. It also includes a brief overview of the main learning frameworks around the project, including Continuous Quality Improvement (CQI).

Section three moves on to consider the different aspects of student learning that occurred on placement, incorporating the perspectives of the practice educators as well as those of the students. It also looks at the interprofessional working and learning opportunities available to students on placement. Section four looks at practical considerations relating to the organisation of the project, while section five considers some of the barriers to fulfilling the project agenda. The chapter concludes with a bullet point summary of the main evaluation findings.

Piloting Interprofessional Student Learning

In response to the NHS policy initiatives described earlier, and in order to develop interprofessional practice, students at the Institute of Health & Community Studies were given an option placement in a community setting, working on issues related to public health (Payne and Ryden 1999). This pilot project, which took place during the summer of 1999, then provided the model used in PHRIPE for future interprofessional student placements in the field of public health.

Traditionally, student nurses would have been placed in acute care wards, community hospitals or care homes so, for the first time, they were offered a placement that focused on health rather than illness or disability. The students participated in project work that involved researching a potential health need within a deprived population area. Tutors felt that this approach to facilitating adult-centred health improvement learning could have major advantages for higher education

and service providers. In order to work in these new ways, it was proposed that learners and their practice educators needed to learn in new ways as well. The 'learning set' approach used in the pilot enabled two tutors to facilitate six students on placement with a high degree of mentoring and educational input, but a low degree of direct tutor mediation. The learning from the placement helped to demonstrate to stakeholders that students did not have to be a burden to over-stretched human resources.

The PHRIPE project proposal

The project proposal was for pre-qualifying learners from different disciplines to go on placement together in the Health Action Areas (HAAs) of Boscombe and West Howe and join teams taking a community development approach to public health improvement. Students on placement in the two HAAs would be encouraged to develop a preventative approach, utilising longer-term strategies of helping residents make improvements in their lives and in their health.

The project outcomes envisaged were that there would be comprehensive, evidence-based programmes of action to improve health in localities within the two HAAs. The individuals involved in the learning sets would develop their health-improvement practice skills.

Students would be drawn from the following courses within IHCS:

- BSc (Hons) Nursing
- BSc (Hons) Primary Health Care
- BSc (Hons) Health and Community Development
- BA (Hons) Social Work

The 'Local Improvement Team' (LIT) model that would be adopted was designed to facilitate interprofessional learning and encourage practice focused on improving residents' health and well being. Membership of the LIT would include students, practitioners, residents and voluntary sector representatives as appropriate. Activities undertaken might include evaluation of previous improvement activity, direct work with clients, undertaking specific project activity or contributing to improvement planning and strategy.

It was hoped that practice-based multi- and interprofessional education would enable learners to reach a new understanding about the benefits of sharing roles and responsibility for health gain among health, social care and community development students and practitioners. The aim,

therefore, was for the project to encompass the facilitation of learning, the development of practice educator skills, the development of public health improvement projects and capacity building in local communities. It was hoped that the LIT model would allow students to move away from shadowing experienced staff to engage in more adult-centred learning.

In common with the experienced practitioners' strand, it was envisaged that CQI values and methods would play a significant part in the project, this time through the facilitation of pre-qualification students to use CQI in their practice-based experience.

Project location

The two Health Action Areas (HAAs), and the many projects and initiatives taking place within them, did not merely form the background to the student learning on placement, but were the substance of it. In order to give a better understanding of the student experience, the two HAAs and the initiatives and voluntary organisations working within them are described in some detail, including the important role played by Boscombe Link in promoting community development. Information is also given on initiatives aimed at obtaining funding within the Boscombe HAA, including the major bid for the Healthy Living Centre (HLC).

Boscombe Health Action Area

The Boscombe Health Action Area is one of seven Public Health Action Areas in Dorset and is related to a national network of Health Action Zones. These areas were set up to tackle poverty and deprivation, to reduce inequalities in health and in access to health services. All these areas have high deprivation indices scores (Office of National Statistics 2001) and Boscombe West, which has a population of approximately 12,500, is one of the 52 most deprived local authority wards in the country. Crime rates are high compared to the rest of Bournemouth, particularly for burglary and violent crime; approximately three-quarters of which are thought to be drug related.

Having once been a relatively wealthy area and thriving holiday resort, Boscombe has a number of large houses, which are now Houses in Multiple Occupation (HMOs) and used as bedsits or bed and breakfast hotels. Of all the housing in the area, 48% is privately rented and, on average, 100 families are in bed and breakfast accommodation. Population turnover is relatively high and in 1998 local GPs reported a patient turnover of between 25% and 40% in their practices. Boscombe has a relatively large number of places for substance abuse in treatment centres, which attract people from outside the area.

The local population includes substance abusers, asylum seekers, a large Portuguese community, as well as families in short-term accommodation. Longer-term residents of Boscombe sometimes express hostility towards the incomers, whom they see as taking more than their fair share of resources and giving the area 'a bad name'.

Work in the HAAs was designed to:

- Co-ordinate a strategy for health improvement;
- Provide a targeted response to identified health and social care needs;
- Improve accessibility and acceptability of service provision;
- Build on working partnerships between health and social care providers;
- Create an environment for working and learning together for mutual gain;
- Establish a system of continuous quality improvement and health outcome measurement.

The Boscombe HAA therefore began its work by undertaking a series of community profiling activities and public consultation events aimed at engaging local people. Health visitors co-ordinated this work, convinced that they could be working in more effective ways within their community and be more responsive to local needs. The consultation identified residents' expressed needs (Bradshaw 1985) and their priorities for health improvement.

The work supported local and national health improvement priorities particularly in the areas of:

- Primary prevention of coronary heart disease (CHD);
- Rehabilitation of those with established CHD;
- Mental health promotion;
- Mental health treatment and rehabilitation.

The priorities set by the local community were to:

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

Students on placement had a significant involvement with initiatives designed to meet these three priorities for health improvement.

Students' learning outcomes on placement

Together with work at the Springbourne Family Centre, these initiatives provided students with their principal opportunities to meet the learning outcomes that were required by their respective courses. These were the core competencies for the social work students, and action plans or write-ups of their 25 community visits for the nursing students.

Learning outcomes were the same for all students from a particular discipline who were on placement. Social work students were given a contract when they arrived on placement, which detailed how they could meet each core competency through undertaking different aspects of the project work. This was done in order to bridge the gap between the more usual social work approach of individual work with clients and the community development approach with groups encouraged on the project. The core competencies that social work students were required to meet were:

- Communicate and engage;
- Promote and enable;
- Assess and plan;
- Intervene and provide services;
- Working in organisations;
- Develop professional competence.

The overall aim of the placement was:

To learn more about multi-professional collaborative work and to meet the health and social care needs of residents in a Public Health Action Area. This is to be done within a social work framework.

This therefore marked a departure from usual practice for social work students to be asked explicitly to consider residents' health needs and emphasised the interprofessional nature of the work they would be undertaking on placement.

The objectives the social work students were required to meet on placement were to:

- Learn more about interagency work with the public;
- Learn more about the ethos behind the HAA;
- Learn how to work with communities to facilitate health and social care improvements and ensure this is sustainable;

- Learn how financial and social deprivation can affect individuals and groups in communities and how to counter this;
- Learn to meet all the core competencies, practice and value requirements of social work.

Social work students had to complete five evidence sheets while on placement, showing how they had demonstrated each core competence and which theoretical frameworks they had drawn on to underpin the work they were undertaking.

Nursing students involved in the project were assessed through their community visits. They planned the objectives that they wanted each visit to meet, which would vary according to the nature of the provision. For the visit to the Boscombe Family Drop-In, the objectives planned by the students included finding out:

- What type of service is being provided;
- Who uses the service;
- How many staff or volunteers are employed;
- What links the organisation has with other services;
- What facilities are available;
- What health promotion initiatives the service provides;
- How the service is funded.

Students on placement with the project in Boscombe were therefore able to meet these learning outcomes through involvement with the projects described below.

The exercise class

Christened 'Bums and Tums' by the women who used it, this facility provides an aerobic exercise class several times a week, with a free crèche on the premises. It began in April 1999, with 80 women attending during the first year as it expanded from one to three classes a week. The classes cater for local the residents' need for cheap accessible exercise and was held initially at a local community centre before moving to facilities owned by a local church. During the first year the classes were taught by a fitness instructor from Healthworks, the local NHS health promotion agency. Subsequently, two local residents who had attended the classes from the beginning were supported both financially and practically to become instructors and they now teach the classes. Other residents act as volunteer administrators.

The exercise classes provide more than improvements in health and fitness, although these are important. Contacts made there lead to the formation of important friendship and support networks and often to increases in self-esteem for the women involved. As one of the instructors commented:

It's a relaxed and comfortable atmosphere and not a roomful of skinny women in leotards.

The women who had trained to become instructors reported that they were pleased to be able to give something back to the classes that they had enjoyed and benefited from. One described how much she had changed as a person through this process; gaining in confidence and learning how to communicate better with other people.

The exercise classes became well known in the community and attracted many visitors. However, the project co-ordinator would not allow anyone simply to observe the classes, arguing that the women involved should not be made to feel self-conscious through being watched by visitors. If students, researchers or practitioners wanted to know what took place in the classes or to begin work with the women, then they had to join in with them. This had the welcome side effect of rapid increases in fitness for the students, who might take part twice a week for several months. Practitioners and students were therefore made to 'practice what they preached' in terms of the role exercise plays in a healthier lifestyle.

Taking the class together provided a common bond of experience for students and residents, cemented afterwards by a visit to a local café for coffee. These informal beginnings of relationships were an important part of the placement experience for students and formed the basis of a different way of working with residents. Students came to know the resident as a person first, rather than as 'a problem with a person attached to it'. Residents were also able to overcome some of their negative perceptions of social workers through experiencing the facilitative approach taken by the social work students.

The Lunch Club

This is a food project held one day a week at a local Family Drop-In Centre. It began in October 1999 when 18 adults and 14 children attended the first lunch. It now caters for an average of 12 families a week, costing only £1 a week per family initially, rising to £1.50 in 2001. Residents help to shop for, prepare, serve and then sit down together to

eat a healthy meal. Some of the women who have attended the exercise class then come down to the lunch club for a midday meal with their families. This food project operates with the help of a cook, working initially as a volunteer but subsequently as a paid worker, and a variety of family workers, health visitors and students on placement. After starting off in difficult physical circumstances, the lunch club was greatly assisted by the Tudor Trust who paid for complete refurbishment of the kitchen in 2000. The PCT also gave £500 for much-needed equipment.

An after-lunch club for children's activities was set up at this venue, after it became apparent there was a need to engage the children in creative play in order to give their parents a break and the freedom to talk to project workers and advisors. Between four and eight children generally attended the sessions. These activities with the children provided an important opportunity for interprofessional working between students and also for the use of PDSA cycles to provide a framework for that work.

The lunch club thus encouraged healthier eating among residents and improved their skills in food shopping and food preparation, as well as increasing their knowledge about nutrition. However, not as many residents volunteered to help with the preparation and cooking of the meal as had originally been hoped, which in turn diminished the ability of the volunteer cook to teach. The state registered dietician's report suggested that the lunch club was meeting the need for a low-cost family meal but that residents were not participating or asking for advice as much as had been hoped. However, project workers felt that the lunch club provided a means of social support as well as a model of a sociable family meal. The lunch club provided students with a further means of accessing residents through chatting with them over lunch and thus provided another informal way to begin working with them.

The OASIS project (One stop Access to Support and Information Services)

The *Voluntary Service Handbook*, published by the Bournemouth Council for Voluntary Service, lists approximately 400 organisations in Dorset. However, the problem for providers is how to avoid duplicating existing services and how to inform residents of what is being provided in their area.

In November 1999, an information and advice group was set up as part of the HLC bid to concentrate specifically on investigating the information and advice needs of the local community. The project was christened 'OASIS' and aimed to provide the community with advice, information

and advocacy resources under one roof (Collings and Hemingway 2001). The following mission statement was devised with the input of students on the project.

OASIS will benefit the local community by offering resources to access information on health, the well-being of the local community and consumer advice. It will also be a focal point for presenting information on local community events.

It was proposed that OASIS would provide an electronic database of services as well as a website, which would allow access to take place at various centres including doctors' surgeries and community facilities. It would also provide new advice sessions or reshape existing ones, including those run by the Inland Revenue, local solicitors, Citizens Advice Bureau (CAB) outreach service and the Careers Service, as well as health education and financial advice, for one session a week.

The OASIS project was included, fully costed, in the Healthy Living Centre bid at the end of 2000 and work on setting up the database continued during the life of the project. Students became increasingly involved in this work, and those students on placement or having a placement experience helped develop a pro-forma for organisations to fill in with details of the service or self-help they provided. Nursing students carrying out some or all of their community visits in Boscombe were particularly involved in this aspect of the project work.

The OASIS group worked on finding suitable premises, and moved from temporary premises in the local library to Boscombe Link in March 2001. Abbey Life, a local insurance company, contributed office furniture, computer skills training and marketing expertise. PHAA funding was provided for the purchase of two computers and for the production of a quarterly newsletter, which would be another source of information for the local community. However, the proposal to produce a newsletter subsequently had to be reviewed and it was decided to include much of the information gathered for an insert in the *Boscombe Eye*, a magazine produced at Boscombe Link. This was distributed via schools, libraries and doctors' surgeries.

Other initiatives in the HAAs

The students on placement had a significant involvement in a number of projects and funding bids for major initiatives in Boscombe and to a lesser extent in West Howe. This involvement included working with the Springbourne Family Centre, which differed from the Boscombe Family

drop-in by being more structured and running courses for parents, ranging from computing to arts and crafts. There was also a crèche on a separate floor, giving parents an opportunity to have a break from their children.

Another resource available to the project work was accessed through Dorset Community Action, who manage a project called Business Partners, which aims to link businesses with voluntary organisations. This provided the link between the Boscombe project and Abbey Life, who offered facilities such as photocopying and printing as well as providing assistance to the OASIS project.

Many initiatives and funding streams were either already on stream in Boscombe or were at the development stage during the lifetime of the project. These included the bids to the Single Regeneration Budget 6 (SRB6) and to the New Opportunities Fund (NOF). However, the major bid that dominated the work in Boscombe was for the Healthy Living Centre, which was based on the three health improvement priorities identified by the local community.

Background to the Healthy Living Centre initiative

The Healthy Living Centre (HLC) initiative was set up in January 1999 by the NOF within the National Lottery Act. The initiative has a budget of £300 million from Lottery funds UK-wide. The programme aims to promote health in its broadest sense and target areas and groups that represent the most disadvantaged sectors of the population. HLCs are ultimately expected to become available to 20% of the population and to contribute to the Government's health strategy as set out in *Saving Lives: Our Healthier Nation* (1999), as well as complementing existing provision. HLCs support national and local health strategies, including Health Improvement Plans (HIMPs), and contribute to tackling inequalities in health. The bidding process is designed to encourage partnership working across the voluntary, public and private sectors.

The Bournemouth HLC bid came through the first round of the decision making process in July 2001 and in October 2002 confirmation was received that the bid had been successful. The bidding process was lengthy and it was hoped that the bid was a means to ensure the sustainability of the project initiatives at the end of the three-year projects funded by the NHS south west region through Bournemouth University.

Boscombe Link

Boscombe Link, an umbrella organisation that provides many different services to the community, has also been an important facilitator of the project work. It has provided meeting space for OASIS as well as housing the project's two computers and hosting the information sessions. The Community Development Team, which provides support for asylum seekers, is based here, and has an involvement in the SRB6 bid, the annual Arts Festival and the Boscombe Network for Change.

In spring 2001, another organisation based at Boscombe Link, the Boscombe Working Community Partnership, was set up to administer the funds obtained through the now successful bid for the SRB6 money, which amounted to £1.4 million to be spent between 2001 and 2006. The partnership included theme groups to work in the following areas: Environment, Support, Community, Enterprise and Employment. In consultation with the local community, it has set many targets in job creation, skill promotion, careers advice and new businesses. Students on placement contributed to the community consultation days round these initiatives.

Boscombe Link also houses the Council for Voluntary Service, which includes the Volunteer Bureau as well as the HQ of the credit union. This is a not-for-profit financial co-operative set up to encourage savings and provide loans to its members at reasonable rates of interest. It also provides weekly sessions at the West Howe Community Shop.

West Howe Health Action Area

West Howe had a population of approximately 13,500 at the 1991 census and in November 1999 included 1,117 children aged nought to four (Dorset Health Authority 1999). This number represents approximately one in eight of all children under four in Bournemouth. West Howe was originally set up to house travellers and their families and remains a close-knit community.

Housing is mainly low-rise, semi-detached public housing built during the 1950s and 60s, interspersed with plenty of open spaces and trees. One third of all housing is now owner-occupied as a result of the right to buy policy. The housing is of generally good quality and all properties have central heating, UPVC double-glazing and cavity wall insulation. However, the area is relatively isolated and has a negative image attached to it. Many residents feel stigmatised for living there, and few non-residents find reason to visit. The area scores highly on indices relating to poverty, child and family health, welfare and education. A

significant number of residents are either in receipt of benefits or have a low income, and eligibility for free school meals is more than double the Bournemouth average. The 1991 census indicated that 20% of children aged nought to four lived in lone parent households and a significant proportion of children have speech and language therapy or have high contact with health visitors (Sure Start Final Plan Sept 2000).

Initiatives in West Howe include:

- Developing a Community Forum;
- West Howe Investing in People (WHIPS) based in the Community Shop;
- The Sure Start project, working with parents and children under four;
- Supporting vulnerable families through the 'Young Mums' project which runs as two sessions, one for young women under 25 and the other for those under 19;
- Developing the young people's drop-in centre;
- Running holiday play schemes with opportunities for training for residents;
- Increasing exercise provision.

Initiatives here are not described in detail because students on placement in West Howe did not have the same intensive experience of working with particular initiatives as the Boscombe students did. Since the first social work student placement here had broken down a third of the way through in the spring term of 2000, no other social work students were placed at the site. The precipitating factor in the breakdown of the placement was when the bus that the student was travelling home on was stoned by local youths.

Other difficulties encountered by the student were the fact that she was on placement on her own and therefore not able to draw support from other students. She found it difficult to access community members here, possibly because, in the view of the placement supervisor, West Howe tends to be a more static and enclosed community than Boscombe. This made it more difficult for her to meet her learning outcomes, which were particularly important because she was a Year 2 student and so this was her last opportunity to meet them. A further difficulty was the fact that there was no proper project base for the students, although this applied to the students in Boscombe as well.

However, several nursing students continued to be supported here on their community placements and, in April 2002, two child-health branch nursing students undertook their option placements at this site. It had originally been proposed that six nursing students should undertake placements in West Howe and Boscombe, working alongside the social work students. However, four of the nursing students subsequently withdrew, apparently in favour of more traditional placements.

The students in West Howe visited many of the HAA initiatives and experienced many of the elements involved in the PHRIPE placements. However, there was no interprofessional student activity or cross-professional supervision at this site after the end of the first social work placement. Interprofessional working and learning for the students was restricted to observing and taking part in the interagency initiatives that were taking place, but student learning about community development and public health approaches was supported through undertaking a placement within a HAA.

The Project in Action

Context and personnel

The context for PHRIPE was complex not just because of the many initiatives taking place in the HAAs, but also in terms of existing work in which the Institute had a major stake. Money from the Practice Development Unit (PDU) at the Institute supported the two co-ordinators of the public health work in the HAAs, who also acted as placement supervisors to the students on PHRIPE. These roles were also supported by the PCT, who employed the co-ordinators as health visitors for three days a week. The PDU supported the training of instructors and the workers at the crèche for the exercise class through work that later became the ACHIEVE (Academic Centre for Health Improvement and Evidence of Effectiveness) project. The model for this academic centre followed that of PDUs in Dorset and South Wiltshire, which provide the basis for pre-qualification and postgraduate education and research, and are supported by lecturer-practitioners. The PCT was a major stakeholder in the work to develop this first known example of an Academic Centre for Public Health as part of their educational strategy and development of Teaching Trust status.

The first meeting of the ACHIEVE project, which increasingly co-ordinated the work in the HAAs as it developed, took place in December 2000. The ACHIEVE and PHRIPE projects may best be understood as

interdependent strands comprising an interprofessional and intersectoral public health learning programme. However, the two learning sets, and the students on public health placements or having a public health practice experience, continued to meet under the guidance of PHRIPE.

The PHRIPE project leader performed a number of different roles and was employed by the University as project leader and as a lecturer-practitioner in primary care and public health, and by the PCT as a health visitor. He also performed the role of nurse lead on the PCT. He had extensive knowledge of initiatives in each HAA and was able to provide a bridge in many cases between different organisations and different perspectives.

Different placement models

The model originally proposed for student involvement in PHRIPE was that of the *public health placement*, with interprofessional student working and learning and often with cross-professional supervision. However, it proved more challenging than anticipated to obtain the commitment of the different professional groups to attend the learning sets and to recruit a named person who would be responsible for driving the project agenda forward. It was also difficult to recruit sufficient numbers of students from different disciplines on to the public health placements because of the differing requirements of their professional bodies, the UKCC and CCETSW, and their different placement patterns. It was then decided that, in order for more students to benefit from exposure to the activities in the HAAs, there should also be a *public health practice experience*. The project leader therefore attended nursing ALGs at the Institute to encourage students to undertake some of their community visits in Boscombe and to attend the learning sets in order to build up a coherent picture of what was available in that community.

Public health placement

The public health placement was the 'gold standard' for student experience in the HAAs and approximately 20 students were supported on the project in this way. It was acknowledged to be a very labour intensive model, although it gave students the most thorough grounding in working with the community. Further information on how the placement supervisor prepared and worked with students on placement is given later in this chapter.

Public health practice experience

A number of nursing students volunteered to undertake some of their

community visits in the Boscombe HAA and thus have a public health practice experience. The community visits were a course requirement but students could choose to undertake them in any locality. The public health practice experience was less intensive than the public health placement and depended more on the motivation of individual students and the extent to which they could see the 'added value' of becoming involved in the project work in the HAAs. These students were not directly facilitated by the placement supervisor but attended some of the learning sets to improve their understanding of the area and the needs of residents within it. Several well-motivated nursing students were able to encourage the involvement of other members of their ALG and thus acted as 'project ambassadors' themselves. Approximately 50 students underwent this public health practice experience during the first two years of the project.

Interprofessional public health placements

Interprofessional student placements began in January 2000 when two social work students joined the project in Boscombe. During February they were joined by nursing students, and by March, other health and social care students had joined the HAA activity.

Flyers and posters advertising the PHRIPE project were displayed at the Institute in the summer of 2000 as a direct way of communicating with students and attracting them to the project for a public health practice experience. Six nursing students and two community development students responded and joined a learning set working around the reduction of Coronary Heart Disease (CHD) and strokes, smoking cessation and the needs of homeless men, as well as gathering this information for use in the OASIS database. Two first-year social work students also undertook their 50-day block placements with the project in January 2001 and in April 2002, while the learning sets of students and practitioners continued to meet throughout the project.

On arrival at their placements, students decided which projects they would prefer to work on. This decision was arrived at after discussion with the placement supervisor and after looking through the *Voluntary Services Handbook* for suitable organisations. The placement supervisor was familiar with the providers of the full range of voluntary and statutory provision in Boscombe whom she could contact to arrange student visits. Students in Boscombe usually worked with the exercise class, the lunch club and the Springbourne Family Project. The final project that students were involved with was Platform Boscombe, a support group for young

women, most of whom were single parents. Students also had the opportunity to pursue individual interests such as investigating the nature of housing provision in the area.

During the first two years of student placements in 2000 and 2001, the placement supervisor and practice teacher roles worked well, with students recognising how well they were supported in their different capacities by the people in these roles. However, supervision for the two students in the project's third phase in 2002 was more problematic. It had been agreed that they should have joint facilitation but staff shortages meant that their practice teacher was over-stretched in terms of the number of students that they were supervising, and new procedures then had to be put into place.

In December 2001, the project leader decided to re-launch the project in a different format. He did this in conjunction with a colleague from the PCT, who held the position of public health lead for that organisation and whose responsibilities included working with health visitors to modernise their role in order to make it more oriented towards public health. She was also currently involved in setting up the Townsend PHAA. This experience meant that her skills and knowledge formed an important extra resource for the PHRIPE project.

Her role in PHRIPE came about after working at the Institute for one day a week, thus providing a useful public health link between the two organisations. In this capacity, she was involved in writing a bid to the Workforce Confederation for five public health lecturer-practitioners, who would take over and expand the work in the HAAs at the end of the funding of the ACHIEVE project. This was one of the ways that staff within the Institute attempted to ensure the sustainability of the important work that supported residents and facilitated student learning.

The two facilitators sent an open invitation to IHCS staff, including lecturer practitioners, and practitioners at the signatory organisations to participate in a new series of learning sets. These learning sets would take place monthly for two-hour sessions and run from January to July 2002. They were designed to test the public health team model in practice as well as examine the roles of mentor, facilitator and pre-qualifying learner. It was emphasised that this new initiative was not an attempt to create more work for busy practitioners and students but to focus on areas of learning that were core to student curricula and

provide alternative ways for them to achieve their learning outcomes. The project leaders discussed whether there should be one focus for the public health work, that of smoking cessation, or whether different teams of practitioners and students should work on issues of their own choosing or that they were already involved with. Ultimately, the latter option was adopted. The major work carried out in this part of the project involved identifying and supporting the carers who attended or cared for patients at two linked health centres.

The CQI framework now formed a more explicit part of the project work than previously. The ways in which CQI methodology would support and provide a framework for the learning were expounded at the first session by the two project leaders and at all subsequent sessions by the project's CQI facilitator.

The first meeting was attended by more than 20 practitioners and students, including health visitors based in the HAAs, a district nurse, a senior member of the PCT, the two placement supervisors, and a community psychiatric nurse, together with their students on placement, as well as two mature students without supervisors. Subsequent learning sets were less well attended though, attracting generally about half a dozen attendees. A total of ten students had some involvement with this phase of the project.

In April 2002, uncertainties arose over the future of the public health initiatives in Boscombe, particularly the exercise class and the way in which the placement supervisor would be working in the future. Due to the severe local shortage of health visitors, reflecting a national shortage, the PCT proposed to draw the placement supervisor back into a more traditional health visiting role, leaving one day a week for the project work. The uncertainty began shortly after the last two social work students started their placements, resulting in these students generally having a more difficult time than their predecessors. However, they based themselves in the Springbourne Family Centre for one day a week where they found the social workers very helpful and supportive. They also attended the public health learning sets at the Institute, as well as other activities held there such as a Cultural Awareness seminar.

Interprofessional student group

As well as students undertaking those Bachelor degrees outlined in the project proposal, which were Nursing, Social Work and Health and Community Studies, Advanced and Postgraduate Diploma in Nursing

and Advanced Diploma in Social Work, students also took part in the project. In addition, a number of international students on the Socrates programme or undertaking the interprofessional MA (MAIHCS), as well as some Millennium Volunteers, had a public health practice experience. Volunteers who wished to gain further experience, for example in childcare by working in the crèche for the exercise class, were supported by the placement supervisor to gain NVQ Level 3. Although it was hoped to involve midwifery students to reflect their new public health role and also to involve a new public health registrar in the project work, these developments did not ultimately take place. The great majority of students on the project were social work students on placement and nursing students having a practice experience.

As described earlier, student learning was mainly restricted to the Boscombe HAA, with limited student involvement in West Howe.

Student learning sets

The student learning sets consisted of students, the project leader and, at various times and as appropriate, representatives of residents' and voluntary organisations, Bournemouth PCT, Dorset Health Care NHS Trust, community liaison officers employed by the Borough Council at Boscombe Link, members of sponsoring organisations such as Abbey Life, local churches, and library services. The learning sets adopted various structures and time frames during the project, firstly meeting every two weeks, then every week and finally every month. Nursing students were invited to attend the learning sets and to contribute the information that they had gained on their community visits towards the OASIS database. An example of how this worked in practice occurred in June 2001, when nursing students having a public health practice experience researched the number of church halls in Boscombe. They designed a questionnaire, found names and addresses and collated the information, which included availability for hire, cost and the activities that took place in each hall.

At each learning set, students would also find out about ongoing initiatives and the activity of voluntary organisations, for example in the form of a meeting with the director of the Volunteer Bureau. They would also be updated on the progress of various funding bids and have the opportunity to raise issues of interest to them.

At one of the first learning sets, a RRAP model for working with residents and others evolved, which stood for:

R = Residents

R = Researchers

A = Academic, or learning, for student learning on the project

P = Practitioners e.g. doctors and hoteliers

Early learning sets focused on provision for disabled and elderly residents. A project worker for Age Concern described how disabled service users were being involved for the first time in planning their own services. The needs of the large elderly population in the area were also considered. There was some provision for this group but the worker highlighted the problem of how to make older people aware of what was available, and then to encourage them to use the services. This emphasised the need for easier information access, which then linked to the work in building the OASIS database.

Students involved in the learning sets over three years played a part in researching many different areas. Much student activity related to finding and collating information about existing provision and attempting to link organisations undertaking similar activities together. The OASIS project and the insert in the *Boscombe Eye* were thus a valuable way of ensuring that the research carried out by the students could become a resource for the community. Students at the learning sets had an involvement in the following areas:

Information databases

- Obtaining information from existing sources, e.g. Age Concern, Help and Care, GP surgeries;
- Setting up the OASIS database;
- Obtaining and collating information for the special edition of *Boscombe Eye*;
- Investigating GIS, an IT mapping system that can map individual street and house numbers to give information about local services.

Healthy eating

- Contacting the community dietician;
- Researching *Crumbs*, a local bakery, which employs people with mental health problems and learning disabilities;
- Finding out about food co-operatives and local allotments.

Housing

- Listing housing associations and the different criteria they use;

- Researching rent deposit schemes;
- Linking with BRHAG (a housing action group) and BCHA (Bournemouth Churches Housing Association).

Physical activities

- Researching current activities, e.g. keep fit, gyms and alternatives such as Tai Chi;
- Finding out about all current providers;
- Investigating barriers to increased physical activity.

Homelessness

- Visiting soup kitchens and drop-in facilities;
- Researching the health needs of homeless men, e.g. difficulty in finding dentists, chiropodists and accessing advice.

CHD and stroke

- Discovering links between CHD, homelessness and deprivation;
- Visiting Bournemouth Heart Club;
- Visiting the Stroke Association;
- Smoking cessation – writing to Smokestop advisors.

Community provision in church halls

- Listing all local churches;
- Devising a questionnaire of existing activities and facilities;
- Collating information for future use.

In addition, students took part in community activities including the Boscombe carnival and charity fun days. They also worked with residents' associations and met with local councillors.

Practitioner learning sets

The learning set model originally proposed was for one Local Improvement Team comprising practitioners, students and other interested parties working to promote public health. However, the practice educators felt they were not yet ready to adopt this model of learning alongside their students and that they would prefer to meet separately. By autumn 2000, nominated practitioners from nursing, social work, midwifery and community development were taking part in these learning sets as well as the placement co-ordinators and representatives from Social Services, Healthworks and a number of voluntary organisations making 18 members in total. An early session took place on CQI, lead by the project's CQI facilitator. The practice

educator learning sets met monthly and then bi-monthly until January 2002 when, as described above, the project was re-launched as a single monthly learning set to include both students and practitioners.

At an early meeting, practitioners discussed various models of student learning and assessment on placement. These were:

Model 1: Family-centred

This model would involve allocation of families to students and would be negotiated between local families and students, rather than imposed. Students would consider family need in relation to service provision.

Model 2: Issue-centred

Students would identify an expressed need of the community e.g. housing. The history of the issue, and what could realistically be done now, would be investigated.

Model 3: Assessment-centred

This would involve students assessing, working and managing needs and resources. They would also design assessment tools and work with the public, e.g. on the mobile health bus.

However, the students' experience on placement was constrained to some extent by having to meet existing learning outcomes, core competencies for social work and action plans for nursing students. This meant that these different models of student involvement could not be fully trialled.

The learning
frameworks

Continuous Quality Improvement (CQI)

An explanation of CQI methodology and its application to public health is contained in the section on *Background to the learning frameworks*.

The placement supervisor in West Howe reported that CQI had been used with students there and in the health visitors' public health work. Reflection played an important part in this work, although planning and implementing improvement cycles were difficult because of role and financing constraints.

Students on the project in Boscombe were facilitated by the placement supervisor to incorporate CQI into their work with families and on improvement projects. One student was incorporating CQI using Plan-

Do-Study-Act (PDSA) cycles to frame his work with a family who wanted to buy a computer. He explained how he had worked his way through the cycle and that his first task was planning what he could do for the family and that the 'doing' was going to Dorset Reclaim. Subsequently, if they did not have anything suitable, then that would form the study part of the cycle to be followed by new action.

He also described how he was using CQI in another piece of work he was undertaking to arrange an outing to a large local park for the women who attended the exercise class. It was also possible to hand the planning process to the women involved, as he had done when making changes, and when planning and reviewing that work.

Another student reported that she found CQI very straightforward to use and felt that it helped to focus her mind on the work. She felt that it was adaptable for children, adults and work with oneself. She had used it to help with the after-lunch activity, which involved working with the children at the lunch club in order to give their parents a break. CQI provided the framework for revising her work with the children, as they had a very short attention span. She found that reading to them from a book, even one with few words and brightly coloured pictures, could not hold their attention for long. The children needed interactive activities to engage them, so she learnt to have a number of activities planned that she could switch to when necessary. This work with the after-lunch activities then formed one of her observed practices to meet her core competencies.

One social work student had used PDSA cycles when she arranged for a senior member of staff in the Media Studies department at the university to help the women design a logo for their renamed exercise class, 'Fizzical'. Unfortunately, this work was arranged soon after the residents were told that the future of the exercise classes was in doubt and so they were less enthusiastic about planning for future work, since they were unsure what future the exercise classes had.

Another nursing student, who had also attended the re-launched learning sets from January 2002, felt that CQI had been difficult to understand. However, learning to use it on a practice issue, in this case a project on carers, had helped her make more sense of the methodology.

I think as we were working you know through the project, I seemed to see where it fitted, where that would fit in that sort of framework and I thought I'm starting to understand it a bit. But I still feel now it's a bit gobbledegook.

The students were provided with a personal improvement book containing Plan-Do-Study-Act (PDSA) cycles so that they could undertake a project to improve an aspect of their own lives, such as increasing exercise. However, most students did not do this because they saw it as more work that they would have to do in their own time, although one student used CQI on a personal improvement project related to her own work. This formed the basis of the example worked through in the learning sets for the student to improve her skills in planning and writing assignments.

The CQI facilitator explained that it was important that students understood the way in which personal improvement projects should be undertaken. Students needed to understand that CQI was a very useful and important tool for improving practice and that testing it out on something in their own lives was a way of learning about the methodology and not an end in itself.

One of the placement supervisors explained how she had been introduced to CQI and came to appreciate its value. This was through attending conferences where researchers and practitioners explained how CQI was being used in different practice settings. She then realised the potential within the project for CQI methods to be applied not just to project work but used by the students on placement.

It's giving them a tool, a framework for their work because it's helped them to have a framework to hang their experiences on and it also helps them to break up their experience into little manageable bits and when they come here it can be a bit overwhelming because it's very unstructured. By using CQI and the PDSA cycles they can break off little chunks and see what they've achieved in stages rather than thinking they've got to change the world while they're here.

She also used CQI to plan new work when she might feel overwhelmed by the multiple factors involved in developing a project. She explained:

It helps me because sometimes you can be plodding away and think I haven't achieved much really but when I go back to that tool, I think, hold on, I have, look at this, look at that, and I can see how they provide little bricks if you like. You can see the wall being built up with the bricks but I think before I used that method I discounted the bricks, I wanted to see the wall and because I couldn't see the wall I didn't think I was doing anything.

She reported that several of the residents involved with the exercise class were now working for the first time and they had found CQI useful in structuring their own working lives. It had been difficult for them to come off state benefits with starting work and arranging childcare and they were keeping a diary to help them realise how much they had already achieved. CQI had helped them to structure a plan for recording and reflecting on their work.

One practice teacher spoke of the difficulty of adapting the value compass in CQI, which she felt was particularly oriented to health care settings and to social care work. It was necessary for her to look at the different arms of the model and think how that could be 'made to fit' in social care. She also felt that students using CQI were steeped in an approach in essence one could argue was CQI, but wondered in what ways their approach went beyond what a community worker would do when talking to a community about their needs.

Bradshaw's Taxonomy of Social Need (1985)

This framework was widely used by both practitioners and students as a model of using residents' expressed needs as the basis for working with them. This framework posits three levels of need:

- Normative need, which is what health professionals assume clients want and need;
- Felt need, which is what clients feel privately that they need;
- Expressed need, which is what clients say their own priorities are for improving their health.

One student came to understand the concept of expressed need through working with a family on the project who wanted to buy a second hand computer. His goal in helping the family was to use the theoretical frameworks of social need and change theory to meet the residents' expressed needs. He also wanted to maintain the change, because

making a small change of their own choosing should help to lift residents' self esteem. That in turn should encourage them to undertake and initiate more change.

Maslow's Hierarchy of Needs (1970)

This is depicted as a seven-stage pyramid with, at the base:

- Physiological needs: such as hunger and thirst;
- Safety needs: to feel secure and out of danger;
- Belongingness and love needs: to affiliate and be accepted;
- Esteem needs: to achieve and be competent;
- Cognitive needs: to know, understand and explore;
- Aesthetic needs: symmetry, order and beauty;
- Self-actualisation needs: to realise one's own potential, at the pinnacle.

This model states that needs that are low in the hierarchy must be at least partially satisfied before the psychological needs higher up become important.

One student described how he had noticed some paintings on the wall at the drop-in:

I said they're Monets, aren't they gorgeous, and the client was not remotely interested and Maslow's theory came to mind in a split second; why would they be worried about a French impressionist when they haven't got a home to live in and they don't know where their next meal's coming from. Their energy's somewhere else.

This showed how helpful the integration of theoretical perspectives into the students' understanding of residents' actions could be.

Learning within the Project

Student learning in the HAAs: the practice educator perspective

The perceptions of the practice educators are given here first because they had a wider strategic vision of the project's objectives, which they were then able to communicate to their students. One of the practice teachers, who had a prior involvement with the interprofessional agenda, described how the Boscombe placement represented a different approach to social work, one that emphasised working with the community as a whole.

The Boscombe placement was a very different experience from the average student placement in that students were encouraged to look at a more global picture, looking at the wider perspective of residents and communities and looking at how to improve things for groups rather than just for one person. A lot of social work is focused on one person or a small group, whereas this placement was looking at communities as a whole and at interacting with communities and also focused on bigger improvement. It was looking at change for large groups and why one would want to do that, rather than looking at the individual and individual development, so very different; a systems perspective rather than the individual perspective.

In addition to data from the interviews with students, the practice educators and the project leader were a valuable source of learning about the student experience, due to their mentoring relationship with the students on placement and their access to formal mechanisms of recording that learning. In interview, the project leader described the nature of the learning that he was aware had taken place for many of the students. They were learning about how to make a difference in many ways, through practical working, learning to be community advocates and gaining an understanding of the policy and political issues that underpin the resourcing of community-based projects. The fundamental question for him was how to engage that learning:

I mean obviously we want to make a difference to people's lives as well because we're involved in a public improvement project but I think the learning is so fundamental.

He emphasised that one of the most important learning points of the project for him lay in helping students to understand that the focus of health care was community and user need and not the professionals working in health care organisations or Social Services departments.

[The project]...also gets them to think about the focus of care or the focus of health. Certainly for nursing but I think potentially for social work as well because they're learning about statutory organisations, they sometimes think the focus of health or social care is the organisation, you know, the hospital, the primary care team, the social services department and I think it's actually getting them to refocus on where health and social

care really does make the biggest impact which is in, you know, people's homes and people's communities, so there's certainly been some reflection around that. It seems to be very healthy reflection.

This focus on user needs, in the context of public health improvement, was an extremely important element in the project's philosophy, and in the CQI methodology that supported it. This orientation was something that needed consistent emphasis at an early stage in the students' careers so as not to get lost in the subsequent demands of everyday practice.

Student learning in the HAAs: the student perspective

As described earlier, the depth of student involvement with the project ranged from the social work students on 50-day public health block placements to those nursing students whose involvement with the project included attending only one learning set. There was a whole gamut of experience and impressions, of the residents, different professions, organisations and theoretical perspectives, for the students to make sense of and attempt to synthesise into a coherent whole. Students engaged with the placement in their different ways, moved in varying degrees by the experience both emotionally, in terms of the development of their professional identities, and the ways in which they would work with clients in the future.

As a first year social work student explained, she knew that she had a lot to learn but when you were aware of all the hierarchies and structures that militated against change, it could bias your judgement. She articulated the value of naiveté in seeing through the layers of bureaucracy and habit, and asking why things could not be done differently.

Part of the learning experience for students was discovering how many different agencies and activities were operating in the HAAs and realising the value of the synergistic working taking place in them.

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

Finding out about all the soup kitchens that were available for homeless people – I did not realise that there were so many, and, as with the meetings, seeing how individuals from various

backgrounds [healthcare professionals, council workers, social workers and public representatives] collated their ideas and different knowledge bases towards achieving a common aim.

One of the nursing students described her impressions of the West Howe HAA:

Especially like West Howe, the amount of things that are going on there, it's really good and makes you think yes, I can bring the community together and it's good that they've got these things round them because it's definitely needed in this sort of area.

She described how she had initially reacted to being placed in the HAA:

You hear a lot about West Howe anyway and I think you know, you've got all these ideas and things in your head about what it's going to be like but I didn't find it like that at all really. I did find it is quite a community but I don't feel like they don't like outsiders.

However, another nursing student on placement here described an incident when she was sitting in her car eating her sandwiches at lunchtime, and a resident made a note of her car number plate. As well as making her feel like an outsider, and irrationally guilty, this incident highlighted the lack of a proper base for students at this locality. There was nowhere for them to work or socialise at lunchtime. Nevertheless, the nursing student thought that the placement had provided her with much that was of value:

*I just think it was a really good learning opportunity. I think West Howe's definitely a really good place to send people. Originally I was placed at **** for my community placement and that all fell through because of – I can't remember – due to sickness or something. I didn't go there, I ended up going to West Howe and I think the two experiences, I mean I don't know **** that well either but I think they would have been completely different and I think a lot of my friends found that as well of their experiences on placement, a lot of them got very, very bored very, very quickly because they were just like leg ulcers and that was all they were doing, I don't think they were seeing much else.*

This conceptualisation among nursing students that 'community meant leg ulcers,' as reported by this student, was something that arose in several of the interviews and reflected the fact that community placements were often not the most inspiring of experiences for them. It is also likely to be the case that students who are bored do not learn as well as those who are actively engaged with what they are doing. One of the strengths of the public health community placements was that the variety and scope of the activities that students were involved with maintained their level of interest throughout. This marked variation in student experience underlined the need for placements that were well thought through in advance. The different meanings of 'community' were also highlighted through this project, such as taking a community development approach and working to benefit whole groups, or placing students in health centres to work with patients on an individual basis.

Another nursing student undertaking her community visits in Boscombe described why she decided to concentrate on one area.

I've linked myself to OASIS, but I'm one of few students who's actually tied themselves into a project. [The project leader] approached our ALG early in the course and explained OASIS to us and how it would fit in well with our studies because, if you think about it, each week we do one community placement. At the end of the year we have to hand in 25 community placements, and that means we have to show 25 times six hours of work relating to different projects and placements.

She appreciated the value of using the information that students were collecting anyway for the benefit of the community and of meeting students from other disciplines.

If you think of OASIS as tying these all together, it's very helpful for us and all he's asking is that we allow him access to the information that we accrue anyway, which is kind of, not wasted, but it doesn't get taken any further, we hand it in and that's dead sort of information, then rather than it just go on our student file and be evidence of our time spent, it's much more useful for it to go on the database that he's building up. And also it brings us into contact with other students such as the social work students and we meet health visitors and I've certainly benefited from meeting these people. I went to see

one of the health visitors who came to the OASIS meeting the other day and gained further information from her about childcare provision, so it takes it further. Rather than just going to a placement and finding out about that isolated placement you find out how interdependent they are and how the funding affects all of them and things like that.

However, she explained that not all students had been able to see the potential benefits offered by the OASIS project, and were concerned that it would mean extra work for them. She did not believe this was the case:

Frankly it doesn't at all, it ties in very well with my studies and it helps me to co-ordinate my learning. But I think I found that because I'd started nursing before and done half the course and quit, and one of the problems I found before was that I didn't build up a picture of the community, so this ties in very well for me. And I think the other students, understandably, were quite worried about how much time they would be allocating to this project in addition to their nursing training, cos our nursing training is very demanding, but they do come on some of the visits that I arrange in conjunction with OASIS.

She described some of the benefits of undertaking community visits as a group, feeling that this enhanced the learning that could be gained.

We went to Platform, which is for young mums and babies, and there were three or four students came down with me, so it ties in well because they're getting a visit out of it and we get more feedback. Five people asking questions is much more productive than one person asking questions at a visit. So it works both ways. I suppose I am working as a liaison to some extent because I will be asking them for copies of their write-ups. And they may have picked up on something completely different to me visiting that placement so it's very interesting to see. And then we'll tie all the information together and use it for the OASIS project, with their permission.

One of the social work students in Boscombe described how she had seen the same families at various activities and different locations throughout the project.

It was very helpful for me to see people dipping into services because it gave me a picture of what support they were getting.

The ability to gain this knowledge of how families fitted into their communities was an advantage of the public health community-based placement, since there was a tendency to see families in isolation in other social work placements.

Another student described the change in residents' lifestyles that she had witnessed or become aware of within the project. These changes often took place quite quickly, unlike changes in CHD statistics that take many years, and so students found them particularly motivating.

I think the fitness classes are brilliant, and the lifestyles those girls might have had beforehand, it's really different. Some would say 'I like my child being able to interact with other children in the crèche before you know sort of play school age' or some say 'I like feeling much physically fitter' or whatever. For me it's nothing to do with that, it's meeting other mums in my situation; it covers such a range of mental health and physical health...

A student in the first phase summed up her experience in the HAA very positively:

And we're the first two social work students on this placement so we're guinea pigs. It's actually gone incredibly well though, we've had a very positive experience with the HAAs.

However, one of the last phase of social work students described how they had found the uncertainty over the future of some of the Boscombe work 'unnerving' since it happened early on in the placement, before they had a chance to identify which projects to work on. Although this student undoubtedly had to deal with problems within the placement that earlier cohorts had not, she summed up her experience on the project as having been valuable despite the difficulties. She went on to explain that she did not want to be artificially protected from what was happening and emphasised that learning from difficulties could take place and be as useful in its own way as learning from best practice. She appreciated that was the nature of reality.

I know it sounds all negative but we have learnt an awful lot about what is smooth running and what isn't. I've learnt that actually there is a lot in Boscombe and it's, you know, the troubles have been far from sorted out, but there are a lot of available resources in Boscombe for people to use, which I didn't realise there was quite that amount. I just think community-based placements are good, because community is something that we're not taught in the classroom, so you never know it unless you've done it, although we've probably not seen it in its best light. It's definitely been a worthwhile 50 days, even if you just see the negatives. I don't really want to be cushioned and protected, do you know what I mean, because it's not realistic.

This raises the question of what students can reasonably be expected to cope with on placement and how experience on placement equips them for what they are likely to encounter in practice, particularly at times of rapid change in organisations. Partnership working, as in the HAAs, has the potential for greatly enhanced benefits to communities but its complexity and the number of factors involved, including the different funding streams and different priorities that need to be co-ordinated, mean there is more potential for dislocation.

Supporting student learning – reflective diaries

Another requirement of the placement, although not one that was formally assessed, was that students should keep reflective diaries. Students generally found this a useful way of capturing what they had learnt and for questioning their own initial assumptions.

One student kept a diary for the first half of the placement until time pressures forced her to abandon it. She felt that it needed to be written up the same night otherwise the feelings were lost. She had hoped to use it as a back-up to show that core competencies such as *promote and enable* had been met, but she found herself writing about what she felt, such as her reaction to the behaviour at some of the meetings she attended.

Another student kept the diary continuously during his placement, trying to be 100% truthful in reflecting his thoughts and feelings. There was no requirement that the diary should be handed in, although the placement supervisor had sometimes asked to see it at the beginning of the placement. He described how he wrote down his feelings about one of

the drop-ins when he found himself wondering what people had done 'wrong' to end up somewhere like that.

Straight away it was all negative and judgmental: is she an alcoholic? Is she a drug addict? Does her husband beat her? You know, these thoughts would go through my mind all the time.

The process of keeping the diary thus enabled him to realise the ways in which he was instinctively reacting to clients, and to challenge his own assumptions.

One student who came from a background of working in an office described how she initially found it difficult to express her feelings on paper but felt she was improving.

Some days, yes, I find it therapeutic, some days I must admit it's hard. You forget those feelings unless you write them down. It needs to be done straightaway.

The 2002 students had further input from a member of the university staff who suggested that they might like to keep their diaries in the present tense in order to make the experience more vivid for them. Students reported that this technique was helpful in bringing back the feelings that they had experienced during particular incidents.

Supporting student learning – the practice educators

The project leader described how he saw the need for practice educators to develop their practice in order to support student learning.

There's a focus on pre-qualifying learning but we very quickly learnt on the project that in order to support pre-qualifying learning, you've got to develop the staff, both the practice educators and the professional staff that work with these learners, into new ways of supporting that learning. It's no good developing students who can learn in new ways if the whole learning environment around them doesn't develop with them, so that's why there's a focus on practice educators and the practitioners' involvement with interprofessional learning alongside the pre-qualifying learning.

The practitioners and practice educators who worked with the students reflected on the ways in which the students' interprofessional and public health experiences had developed their own practice skills. They learnt from service users, from and with their students, and from the challenge of organising this complex learning experience.

Student learning on placement was facilitated by the placement supervisor, who described how she had learnt to be less aggressive in her health promotion stance through the operation of a number of factors, including postgraduate study, experience of working in the HAAs and adopting change theory. She learnt to be more tolerant of residents who might not want to change, accepting their reasons for not changing and perhaps then adapting the service to meet their needs.

I'm much more able to accept people's identification of need, when they say what they've identified as their needs for health improvement and then to be a facilitator for that rather than saying this is what I think you need to improve your health, this is what tradition says, this is what the health service says. I've been much more able to say, well what do you think your health needs are and then respond to that with them and be more facilitative and that's been much more satisfying because it works. It runs much more smoothly and you don't feel so responsible but you feel as though you're achieving so much more because once they know what they need to improve their health, and once you're facilitating that, you get so much more done because they're in the driving seat.

This orientation of the placement supervisor was important because her attitudes were likely to be absorbed by the students, forming another element in their learning experience that would affect the way in which they worked with residents. She felt that she was supervising students in a different way on this project, although she was glad to have experience of supervising students in a more traditional way:

I'm glad of the background I've had in receiving and supervising students in a traditional way because there are some very basic traditional things that you do have to cover, but I think we're able to extend the experience a student has, or we're able to extend the traditional supervised placement of the students because we've learnt ourselves to work in a different way. We

can actually facilitate the student, not only to work in a different way but think in a different way and that's sometimes a bit scary for the teaching.

She acknowledged that this type of placement expected more from students, who had more freedom to choose what projects and issues to work on. The emphasis was also very much on learning with residents about their lives and what their priorities for improvement were, so students needed to accept that they were not controlling the agenda.

Because it involves risk, it involves putting your toe in the water a bit and not knowing what's underneath and it also means students probably have much more opportunity to get alongside residents and instead of learning about the residents, they're actually working with the residents and that's a little bit scary too, so we're, if you like, pushing the boundaries a little bit when it comes to students' experience of student placements, and I think you have to be very careful to monitor that so you don't push the student too far, but you also encourage the student to be in the mode where he or she's willing to take a few risks. It's getting the balance and it's not easy but because at the moment we have students out in ones and twos, I can try and make the experience on the placement very suited to their individual needs. They don't only cover everything they need to cover but it's a very individually personalised experience.

She described how she interacted with students when they first arrived on placement, needing to find a balance between being over-protective and leaving them to discover everything for themselves. Some of the value of the placement for students clearly lay in this initial relationship and the skills that she demonstrated in introducing them to different elements of the placement:

I have them here kind of under my wing a bit and I say to them I'm a bit sort of mother henish to start with. I do keep them very closely, because I think if you give them that good grounding they're more likely to feel able to go out and do things themselves so you do save time in the long run and then I gradually let them go until eventually they're working with families on their own but it is very carefully sort of supervised, rather than, you know, I'm all for letting them do their own thing

but I'm not for just pushing people in the water and saying there you are, you can swim now. I think you need to get in the water with them and swim with them for a bit.

A nursing student in West Howe described the ways that she had been facilitated on placement and how helpful professional staff had been:

The health visitors there were really, really good to me. I didn't get to spend sort of a lot of time with them because I think they were really busy at the time. I'm not sure if they had as many staff as they normally do which makes it harder but they were really good to me and they really, you know, explained everything to me. They made sure I got to do everything and I got to do the clinics with them. I got to do the home visits with them, which was really nice because you get to see everything then rather than just little bits of what they're doing. But the doctors at the surgery were really nice as well.

One of the practice teachers felt that work on the project had caused her to prepare students for placements in different ways, by asking them to think through in advance the type of roles they might play. This enabled students to question the stereotypes they might already have of other professions. Being able to make reference to a project in Boscombe where this type of interprofessional working was already taking place was helpful in this respect, and also in adopting a more inclusive view of what health workers and social workers might contribute.

Professional identities and professional roles

The question was raised on the project of what the *professional* part of *interprofessional* actually consists of. The notion of professionalism is a contested one that can skew discussion and exclude people who are vital to public health improvement work, including volunteers and residents. In the view of one student, a professional implied someone who was not only knowledgeable in his or her own field but who treated everyone they came into contact with as an equal. The project staff modelled this behaviour for him, so he was disappointed when he felt that not all the professionals he met behaved in this way. In addition, nursing and social work staff, most of whom are women, have often been considered as only semi-professionals in contrast with those practising medicine and law.

The project leader described how he had come to see the need to develop greater understanding between different groups. The interprofessional agenda on which the project was based grew out of the necessity for the large number of agencies, both voluntary and statutory, in the HAAs to work together more effectively. He believed that students' questioning of their own professional role and coming to understand those of other professions provided the most important rationale for interprofessional working:

One of the big issues is that we assume that because everybody signs up to the priorities for health within a local area, that everybody understands everybody else's roles within it and of course we know that's not really the case. And at the pre-qualifying level, if in effect what we're doing is long term work-force planning, if we're going to be developing people's professional roles to be able to support new ways of working within Health Action Areas, we need to be able to develop that understanding of interprofessional working, you know, right from when they start out so that really the ideal situation would be that every nurse and social worker and community development worker that qualifies, has a real understanding for each other's roles and then perhaps more sort of corporate responsibility for working with that community, understanding their needs and being able to develop services and responses to those needs. I think really it's about a need to find new ways of working and the only way that we're going to find those new ways of working that are going to work in a way which is truly multi-professional is to understand each other's roles better.

He shared his experience of working with students on the project and how it had caused them to question what being a member of a particular profession meant to them.

We've had students reflecting that it's actually changed the way in which they look at themselves, you know, the profession that they're trying to learn about being a professional, they've actually questioned, some of them for the first time, you know, 'why do I want to be this professional with this professional hat on, and what is my role working with other professionals'. So that's what's it all about really.

In the view of one social work practice teacher, students on the placement learnt to see nurses and health visitors not in a medical role, but as change agents within communities, and gained much through working with different professions. She felt this was a perspective that social work as a whole would do well to take on in the future. As a result of her work with the project, she also adopted a broader view of the roles that health and social workers might play in her teaching on a variety of topics, including an interprofessional working and communication module and on the National Service Frameworks for mental health. This demonstrates one effect that the project work had in influencing the wider agenda of the Institute.

This practice teacher learnt some useful approaches and models from the placement supervisor that were not generally used in social work. Learning from the perspectives of other professional groups lead her to question some of her own assumptions. She also discovered much about current provision in the community and the fact that community work seemed to be coming back into favour after having been largely abandoned since the 1970s.

Sometimes, working in new ways could cause difficulties with those colleagues who were working in more traditional ways. The challenges and benefits of these new models of working were illustrated by the placement supervisor, who described colleagues' reactions to her working within a public health and community-empowerment model rather than performing a 'typical' health visitor's role:

And that's caused some problems because there's the expectation from some people that you should still be performing a traditional role. There are those who are threatened by the way you work because you're challenging the way they work. There's also colleagues who think you don't do anything because you're not fulfilling a traditional role and they can't understand this sort of more strategic visionary role.

Social work and nursing students on placement also learnt about the value of these new roles, with a number expressing pleasant surprise at the role of health visitors within the project. Most had previously thought this was someone whose role principally involved running clinics and weighing babies, but recognised that health visitors on the project were at 'the cutting edge' of new ways of working. One social work student

described going out with a health visitor on a visit and finding that she was asking similar questions to those that a social worker would ask. A nursing student shared this changed perception of health visiting as a result of working with the project.

Especially West Howe I think that there's a lot of single mums out there, there's a lot of people out there with problems and it was good to see that the health visitors really get involved in that and they know what's going on with everybody and they do their visits and they help them out as much as they can. And because I did feel, I also just thought health visitors go out and they see the babies and if the baby's ok...you don't realise the rest of what's involved or that the under 25s group I went to and they sort of, I didn't know how much the health visitor would have to do with it, but she'd be talking to them about housing and all different things. There's a lot involved in it, it's not just babies, there's a lot more than that.

Working in the HAA made her consider becoming a health visitor, which demonstrated the impact that involvement in the project had on her:

I never wanted to be a health visitor before, and it was after doing the placement that it made me think about it. It was the many different things they did, it wasn't just, you know, the babies and all the rest of it, the placement supervisor did things like the Smokestop as well which I'm really interested in, and all the different groups that you can set up to help people. I just found that really, really interesting. I think I did learn an awful lot doing the placement.

The student thought that some residents did not want to have contact with the health visitor when they were operating in their traditional role, but described how the health visitors on the project were now working in different ways in order to overcome this. She described how some residents perceived health visitors as having a policing role, in the same way as social workers but to a lesser extent, and feared them because of it. This echoed the words of the placement supervisor in Boscombe, a health visitor herself, who explained that they realised the way they were working was not really helping local people, as the student explained:

I think they think that if they keep the health visitor out, that they won't notice that I'm not coping and I mean some people as well I think their expectation is quite high isn't it. 'I'm supposed to be doing this, I'm supposed to be doing that' and I think they're scared they're going to get a telling off that their baby wasn't doing this or the other, which I think is tough as well, but from my experience of those health visitors they weren't like that at all, they weren't going to give someone a telling-off because their baby wasn't doing something at a certain time; they were just there to support them, which was nice.

The health visitors were prepared to give advice at any time at the drop-in centres.

They did give a lot of advice as well, that was the other thing I noticed, they had a lot of knowledge about a lot of things and they were able to give a lot of information to people, because people come into the drop-in clinics they had and they'd just come in and didn't want their babies weighed or anything but they'd come in and say 'can I just ask you about this', just to get advice which I thought was a really good idea as well. They don't have to phone them up or wait for them to visit. They were able to drop in and ask questions when they wanted and get the advice.

Interprofessional and interagency working

The placement supervisor described her view of the current state of interagency working within the Boscombe HAA and how interagency work was putting the needs of the service user first. She thought this focus had driven the agenda rather than the needs of individual organisations, but also considered the difficulties involved in the joint funding of projects.

I think agencies have realised they've got to work together more because the way we were working wasn't working for local families. I think that's a huge step and it's got to be a process. I don't think we're achieving it, I think we've started the ball rolling but there's a process involved that's going to take time. Whether it's going to make funding easier is debatable. I think in some ways it will make funding harder because everyone wants to pass the buck and not take responsibility, but I think once we get to the stage where we are really working in a multi-

agency way then I think the funding will just be a natural progression. I think we're not really working in a multi-agency way yet but by looking at removing barriers I've had to work much more closely with social services and education and the voluntary agencies, so probably we're being forced to work in a multi-agency way and therefore recognise and respect each other's needs and problems, and then that will mean our way of working will change and therefore streams of funding will change. I think it will be an inevitable outcome rather than something we sort of just achieve by doing.

The project was working within a health framework but not one that was using the traditional medical model of health. The professions that the social work students were observing and working with were nurses, health visitors, community psychiatric nurses and community workers, as well as residents and service users.

Social work students perceived the Boscombe project as a different type of placement for them, i.e. a health placement within the HAA. One commented:

...taking referrals from the health visitors, so that was the interprofessional bit, we worked within health so everything we did was within health.

She had previously worked as a healthcare assistant so already had a 'health perspective' on many issues. She described the interprofessional elements in her work on the placement:

We had a placement supervisor who was nursing-based so the work we sort of discussed with her, spoke about the different theories and ways of working, so a lot of work we did was the interprofessional work with child protection, health visitors, some nursing students but not as much as we'd like to have done.

They had come across professionals from other disciplines in a number of meetings including the Housing Forum, which they cited as an example of successful interagency working.

Students learnt about the many factors that impacted on health in a community. A nursing student described how she was able to undertake visits with the project leader as well as to a variety of voluntary providers in Boscombe:

I've made a visit with the project leader, in his capacity as a health visitor, so I see how many hats he's wearing, how many roles he does, which is very interesting but I think it's early days yet because I'm still building up a picture. But I find it very interesting because it brings me into contact with so many different fields, even unqualified people. Okay, there's counsellors at places like South Wessex Addiction Centre and the Samaritans we've been to, so you see how all of these people have an impact on health in the community and that's really what the focus of our visits is, what has an impact on health in the community. And it can be anything. We've been to a supermarket, for example. Do they promote healthy eating? How do they do it? And it's these sorts of questions that we ask when we go to the visits. It's broadening our outlook on what is health promotion in the community.

Students also learnt about comparative resources and the gaps and priorities that existed in different practice settings. From observing and participating in many different interagency groups around Boscombe, another social work student concluded that there was not much social work involvement in the community. She contrasted this with the health sector, which she felt was very interprofessional.

We're very slow as a profession to take on this new way of working.

This was thought to be due to the chronic under-funding of the service and the range of statutory responsibilities that Social Services had to meet. Another student felt that the interprofessional agenda was rather optimistic, as she had noticed gaps at the meetings she attended.

I think generally there are gaps; social workers could do with knowing more about promoting health, whereas maybe, it may just be that I've been sat in on meetings where things have come out, health visitors should maybe know a bit more about housing legislation and things, as they're obviously the first port

of call seeing a young mum in a bedsit or a flat. I mean there are gaps everywhere, it's not health's fault, it's not the social worker's fault. I think there's more work to be done actually.

However, this comment raises the question of the interpretation of the term 'interprofessional'. This student understood it in terms of health visitors acquiring some of the skills of social workers, becoming almost a generic health and social care worker, rather than the creation of an interprofessional team that could draw on the different expertise of team members as appropriate. She also felt that there was much more scope for interagency working to take place:

It's quite obvious that social care and health are not working together so well as an optimistic student might think they are.

This student saw interprofessional and community development working as something of an individual choice for professionals, which not all of them wished to take up:

I've learnt that a lot of professionals are willing to work with other people whereas others aren't. I've learnt only some professionals will look community-mindedly, whereas some look straight down the line.

This raises the challenge of the best way to persuade and engage those practitioners who do not wish to take up the interprofessional agenda, as there is clearly a limit to what can be achieved on a voluntary basis.

Interprofessional student working and learning

As described earlier, the placement supervisor was a health visitor, often supervising students from other disciplines such as social work. The placement was situated within a Health Action Area, so this provided part of the interprofessional experience for social work and community development students.

In the project's second phase in 2001, one social work student worked with a nursing student and a community development student on after-lunch activities for the children at the lunch club. This was one example of how interprofessional student activity worked in practice. However, interprofessional student working on the project did not take place to the extent originally envisaged (see 'Barriers to learning' for further discussion on this point).

One of the nursing students described her experience of working with students and practitioners from other disciplines on her community visits:

I'm working with the organisers of volunteer projects, for example, who have very varied backgrounds, some of the family project workers, nursery nurse assistants and qualified nursery nurses and things like the Family Drop-In Centre. It's very interesting to see how people from very different disciplines are coming together. They use students on work experience placements as well to volunteer, doing health and social care, GNVQs and things like that, and then in the meetings there's the social work students that I've not come into contact with before, that have much more experience with things like housing and benefits. Those really are largely the people that I come into contact with and health visitors as well, which is a field I'm very interested in.

Exposure to students from other disciplines helped one social work student realise that:

I could take the blinkers off, because as a social worker you think you're the only one who's involved in this sort of work, but you're not, so you become aware of other people's input to a situation, which I think is really good.

However, she was aware that nursing as well as social work students were being taught within the Institute, and believed that there were also medical students (not the case), but that in the canteen everyone sat separately:

That's the nurses' table and that's the social workers' table and it's a bit like kids in school, oh we don't have anything to do with them, which is silly really because you know they could probably help you with your work as much as you could help them.

She developed this theme further to include the theoretical basis she had used for an assignment after the placement supervisor lent her some nursing books, which brought a different perspective to it. Usually, when researching an essay, she would go straight to the social work section in the library, never visiting the nursing practice or theory section:

It's got the right word in it, therefore that's where I'll get all my information.

Without prompting, she went on to describe how she had been considering that there were core issues or studies that could be taught to different student groups together. The advantage would be that a cross-section of nurses, social workers and health and community studies students could learn from each other while learning together, but she thought this could cause severe logistical and organisational problems.

Social work students on the project were also facilitated to look at another priority from *Saving Lives: our Healthier Nation*, which was the way in which the environment affects health. One student felt that health professionals had learnt to work in more preventative ways, such as promoting healthy eating and exercise. She had also witnessed health professionals looking at people's living conditions and other social factors but did not think that social workers were generally doing this, so for her, that was the crossover and the learning from health professionals to social workers.

However, there was one aspect of their training that the social work students felt was more thorough and better equipped them to deal with clients. As a result of working with nursing students, the social work students noted that nursing training did not place nearly as much emphasis on anti-oppressive and anti-discriminatory practice as was the case in social work training. One commented:

Anti-discriminatory attitudes going into anti-oppressive practice, it's monitored all the way through your practice, you have to address anti-discriminatory and anti-oppressive practice constantly. It's implicit in everything we do, everything we write.

She felt that with nurses increasingly involved in the community, this was an area that would need to be addressed within nursing training. However, one of the benefits of interprofessional placements such as this one was that this re-orientation could also be learnt to some extent through a cross-fertilisation process between different student groups.

Some students came to realise some of the practical benefits of interprofessional working through observing current practice. They felt that where there were different professions going in to do an assessment

on a client, public money was being wasted on these separate visits. If four or five professionals were involved with a family and were keeping separate records of the information they had gleaned, then a coherent picture was unlikely to emerge and vital information might be missed. One explained:

If they got together and shared information I think it could be very helpful to both. It will save time and resources that could be better spent on clients.

One social work student thought that work on the Boscombe project would give her the impetus to contact somebody from another profession to share information once she was in practice herself. She felt that, with the creation of more multi-professional doctors' surgeries, a more holistic view of working with families was emerging. The more integration that took place between professions, the better she thought it would be.

Learning about the everyday reality of residents' lives

Students' understanding of the global picture of deprivation in communities was often facilitated through insight into a particular family, whose story acted as a case study. This was the case with one social work student who, at a subsequent interview, continued the story of the family whose expressed needs were to buy a computer and become more proficient at using it. The father managed to secure employment and everything was looking more favourable for the family. Then it was judged that they had made themselves intentionally homeless and they were informed that the money for their bed and breakfast accommodation would be stopped in 28 days. There was no appeal apart from on a point of law.

Disturbed by the notion of intentional homelessness, the student had a supervision session when it was suggested that if he was in that situation and working in the housing allocation department, he would have to make the same difficult choices, given that there weren't enough resources to meet the level of need. This incident was one factor that sparked the student's interest in the lack of affordable accommodation in the area and the number of families in bed and breakfast accommodation. He reflected:

Housing is a major problem. I didn't realise how much until I went on placement.

He had read about the difficulties involved in making that sort of choice on his course but realised that:

When you read about it, it's not the same as when you're actually in front of it.

He described the conditions that many of the people who attended the drop-in and other activities in Boscombe were living in:

Families in bed and breakfast accommodation were often given the worst accommodation in the hotel, furthest away from a bathroom. This meant that when they wanted to use the bathroom they had to take all the children with them, since they could not leave them alone in the room. Rooms often had only a small vanity sink that parents could not fit a baby's bottle under to wash it. Residents were discouraged from eating in the restaurant but were forbidden to have takeaways in their rooms. All washing had to be taken off the line before breakfast was served in their room. Kettles were attached to the wall to prevent them being stolen. Children's beds were placed either side of a hallway to make an extra room.

He felt that 'bed and breakfast', given its poor quality and deleterious effects on residents' physical and mental health, was a very expensive option in all senses of the word. He concluded by drawing a comparison with earlier practice, which showed that, for him, little had changed for the poor:

Like we said earlier, it goes back to the old poor law, you're punished for being poor, then you were put into the workhouse, now we've got bed and breakfast and some bedsits are very, very similar and it's sad now in this age, 2001.

He also described his disappointment with the standard of the facilities on offer to families in the various projects, although he recognised that organisations and volunteers were doing their best, given the standard and state of repair of many of the buildings used and the donated furniture.

The importance of housing also made an impact on another student in this phase. She described a mother of an asthmatic child who had to

bleach the walls of her flat every night because, if she didn't, everything was ruined by mould. She realised what a devastating effect this would have on someone's life and the distress caused to the mother because she could see no end to the situation.

Learning not to judge

Learning not to judge and to empathise more with residents formed an important element in the development of the students' anti-discriminatory practice skills. Related to students' learning about residents' lives was their learning to suspend the sort of immediate judgements that might spring to mind when confronted with difference or 'otherness'. One theme that occurred frequently in interview was how students came to terms with residents whose lifestyles might be dramatically different from those they had previous experience of. One nursing student who had a public health practice experience in Boscombe described how she had become more aware of her own prejudices through working on the project:

I think my outlook has changed and I've probably become aware of perhaps personal prejudices that I wasn't aware of, which is interesting, and hopefully overcome them or begun to. I didn't deliberately bring myself into contact with certain members or groups in the community and I didn't see that I was deliberately not doing that, but you can't avoid it and you have to be quite conscious of how you appear to the people that you are bringing yourself into contact with. You can't expect people to relate to you or to communicate with you if you seem judgmental or of a completely different social class. It can affect things quite dramatically and how you communicate with people so I think that's been quite a good learning experience for me. How to communicate with people on a different level and not seem like I'm a health professional coming into the community to change something on their behalf, but that you're working with members of the community and it's as much effort and involvement from them that makes the difference as health professionals going in and sort of setting up guidelines. So that's been very interesting for me.

As a result of the project work she was beginning to understand more about the lives of the people she was working with and the problems they might have:

I think that you have to go a long way before you can actually say you empathise. I have to learn more about things like benefits and that's very important from my point of view because it affects people quite heavily in the community. How do they find out about things like these? It's information access and things like that so, as I say, it's early days and I'm building up a picture, but each time I spend a day in Boscombe making these visits I feel I'm gaining a broader understanding and being able to understand it more and empathise better.

Another nursing student described how much she had learnt about new ways of working with residents:

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

One of the social work students described how he had learnt to be less judgmental in a relatively short time on the project, taking more account of people's lifestyles and what they had been used to. He also thought more about the way in which he spoke to residents. He felt that attitudes to residents expressed by some students and staff were often inappropriate, reporting them as saying 'He looks fit enough, why can't he get a job' or 'He's got a gold watch, he should pawn it'. This student realised that not all scars were visible and that the man in question might have lost his wife or child and so might be currently unable to work.

Without knowing the history of the family you move in and attitudes and values come to your mind straight away but you've got to question them, you've got to say to yourself 'hang on, there could be other reasons why he or she is doing that'. Yet it can happen to anyone at any time, you could lose your wife, you could lose your husband, you could lose your house and you're put into a category, it's just unlucky you know, you shouldn't have done that, you've got to be punished for it now.

Another social work student had also learnt more about the links between poverty and ill health while working on the project and clarified her ideas about why clients behaved in ways that might damage their long-term health, and appear to some people to be irresponsible.

I think when people say about single mums not being able to afford this, that and the other whereas they'll, you know, sit there and spend money on cigarettes, I have the attitude that everyone is entitled to their one thing which they want to spend their money on. If that does lead to ill health that's their one luxury which they have, and I think the link between poverty and everything you know, doing well at school, if you're not fed well you can't concentrate at school and coming home to a cold, damp house and everything like that. I was aware of that before, but I think that is reinforced now.

Another explained her understanding of why a single mother living in poverty and coming into a small amount of money might choose to spend it on an evening out rather than paying the water bill for example, because that was her only source of enjoyment and she had no idea when she would ever have any spare money again. She described how her attitude in expressing empathy with the client's situation had sometimes been criticised by other students on her course, who dismissed it as 'Oh no, not the council house view again'.

Practical Considerations

Learning about the organisation of the project

In terms of influencing future student placements, the project has clearly shown the potential for placements built around improving population health. The continued increase in student numbers at the Institute and consequent shortage of traditional placements thus provided an opportunity for new types of placements and for that learning to be supported in new ways.

Although it had been the general practice within the project for students to go out on placement in pairs rather than individually, this had not happened on the student placement that broke down in West Howe. The learning from this student's difficult experience was that it was important for students to work in pairs, since it could be a daunting experience for them to be placed in the HAAs on their own. There were advantages and disadvantages in having two students from the same or from different

disciplines. Two students from the same discipline would be likely to offer each other more help and support, but two from different disciplines would clearly enhance the interprofessional nature of the learning experience. The social work students found it helpful that they were not out in Boscombe on their own. The placement supervisor did not need to be with them all the time and the students felt safer about undertaking activities, such as conducting a street survey into men's health needs.

Resourcing issues

A continuing problem during the project was the fact that there was no proper project base for students at either locality. However, towards the end of the project, good quality accommodation was found for the placement supervisor and students at premises owned by a local church in Boscombe. The fact that there was no base for students in the West Howe HAA was one factor in making this a difficult location in which to support students.

Extra administrative help would have been useful for reducing the workload of the placement supervisors. Once students were on placement, they organised half-days to spend with each agency. Prior to this, they would work with the placement supervisor to look at their own and residents' needs and use this as a basis for deciding which agencies they wanted to work with. A student placement administrator who could loosely organise this work with the students would have been useful for reducing the workload of the placement supervisors.

Different placement patterns

As described earlier, one of the main aims of the PHRIPE project was to facilitate students from different disciplines to work and learn together on placement. However, this did not happen to the extent that had been envisaged, largely due to the different placement patterns of each student group and the statutory requirements of their different professional bodies.

The different placement patterns of the student groups proved to be a major impediment to interprofessional student working on placement. Social work student placements had changed in the last five years from the side-by-side university and placement pattern still operated within nursing, to a 50-day block placement in Year 1, followed by 80 days in Year 2. Social work students felt that the block placement was probably a better model, one that enabled them to concentrate on theory, then on practice, and meant they did not have to keep 'changing hats.' Nursing students were on placement for three days a week and community

development students for one day a week over 12 weeks. Nursing students having a public health practice experience spent one day a week carrying out their community visits, as well as one day a week on their clinical placement.

One result of these different placement patterns was that when social work and nursing students planned to work together in a local school to run workshops on building self-esteem for girls, the nursing students had been unable to attend because one was doing something practice-related and another was in University that day. However, interprofessional learning on the project was facilitated by students observing and working with practitioners from different disciplines, as well as with residents and volunteers.

Interprofessional student group involvement

There was difficulty in engaging sufficient different student groups to represent different professions or practice areas, for example midwifery and community development, as well as those students who were outside the Institute but part of the wider University, such as media students. There were also no medical or PAM (professions allied to medicine) students involved with the project.

There were many more nursing students at the Institute than others, forming a ratio of approximately 30 to 1 of nursing to social work students. However, this did not mean that the learning sets were overwhelmed by nursing students because most did not choose to undertake their community visits or option placements with the project. This was either because they were concerned about a potentially increased workload or the public health placements did not seem like a 'proper nursing' experience to them.

Optimum timing of the public health placement

One of the issues that arose within the project was whether social work students should go on placement in the first or second year. Most projects involving pre-qualifying students involved those coming towards the end of their training.

Social work practice teachers felt that the issue of whether the voluntary, in this case public health, placement should take place in the student's first or second year was an area open to debate, with advantages and disadvantages on both sides. On one hand it was thought best to catch students in their formative stage while they were still developing ideas about how they should think in the field of health improvement. While

students were more confident in Year 2, they had generally made up their minds about health and what their role in it was.

The project leader reflected that, from the professional perspective of the practice teachers, it might be too challenging and negative for a student to question their professional identity before they had created it. His view was that it was healthy sometimes to question your professional identity before it was formed, but that was a challenging agenda.

The first Year 1 social work students on the placement were very enthusiastic and it had a huge impact on them, perhaps because they had been less institutionalised in their ways of thinking.

One practice teacher felt that the public health placements needed students who had confidence in themselves and a reasonable amount of ability and self-motivation. She also felt that students tended to gain confidence by the second year but they were also more likely to have closed minds by then:

I did social work on my last placement and this isn't it.

She felt that less able students might be more likely to flounder on an early community placement, feeling unsure about what they were supposed to be doing and whether it was 'social work' or not.

One difference between nursing and social work students was that social work students tended to be older, often in their 30s or 40s, while nursing students usually came straight from school. This might indicate that social work students were better placed to benefit from a less structured community placement than students from other disciplines.

Looking at the issue from the perspective of social work practice, one practice teacher felt that a Year 1 placement in this sort of project might not prepare students adequately for their statutory placements in Year 2. Some concern was expressed that social work students might not be getting sufficient formal report writing experience on the project to prepare them for the demands of the statutory placement that they would undertake later. If students undertook the statutory placement first, then they would have the statutory and legal parts 'under their belt' before they embarked on their voluntary placement. One student felt that it was more difficult to meet the core competencies in Year 2 and so the Boscombe project might not be a suitable placement for Year 2 students:

The evidence you've got to produce is a bit more in-depth.

Having supervised students in both Boscombe and West Howe, one practice teacher felt that the community in West Howe was more closed, less willing to take in outsiders and more threatened by what they perceived to be anyone in authority. As described earlier, one social work student placement at this site had broken down partly because of these factors. This student was in her second year and so this had been her last chance to meet her core competencies. Time was required to build up trust with these families before the student could work with them, probably more time than was required in Boscombe because of the different nature of the two communities. Families in Boscombe were thought likely to be more open to interventions since many had come to the area because of its reputation for drug and alcohol rehabilitation work. However, as stated earlier, students in Boscombe also found the time required to build trust with families was a barrier to meeting their learning outcomes.

Uniprofessional
versus
interprofessional
supervision

Interprofessional learning created a number of logistical issues in terms of the supervision of students. Social work students on the project had a placement supervisor who was a health visitor. Therefore they needed a 'long arm' practice teacher who was also a qualified social worker.

The practice teacher took responsibility for ensuring that students met their core competencies, discussing theoretical models and the evidence base for practice, while the placement supervisor took responsibility for their day-to-day management. One student explained:

If you're in a placement where there isn't a practice teacher you'll have a placement supervisor and practice teacher, which is really good because you get more support in a way.

The Boscombe students therefore felt that they were gaining something extra in terms of input and understanding because of this arrangement. The difficulty was the amount of human resources required to make this a sustainable model, particularly given the shortage of practice educators as described by the project leader and many of the students, from experience of this and other placements.

Considering the question of whether it was necessary to have different practice teachers for each different discipline, one practice teacher felt

that it was still necessary because students were working to different competencies. Although there were common themes that all students needed to know related to helping clients through a crisis, she felt that the specifics, such as aseptic techniques for nursing or filling in the forms around a child abuse case for social work, had to be assessed separately by someone expert in each field. Another teacher believed that there was a case for generic practice teachers, since many of the competencies, such as interpersonal skills, communication and recording information, were common to different professions. One model that might be adopted was for students to have generic practice teachers in Year 1, with more profession-specific competencies addressed by different practice teachers in Year 2.

Barriers to Fulfilling the Project Agenda

Attitudes towards
social work students:
The residents

One element complementing students' working in new ways was residents' changing attitudes to social workers and social work students. New working relationships between professionals and clients clearly need the active participation of both parties and may involve major changes in attitude for both. A common theme from the social work student interviews was that although the residents had a negative view of social workers, the students had been able to overcome this by the way in which they worked with residents; not as people displaying an individual pathology but as equal partners in improving their lives. However, the initial reaction of residents towards the social work students was usually one of hostility, apprehension and a wish to avoid dealing with them. One student described her experience at one of the drop-in centres:

I think my abiding memory of being on placement will be that I was introduced to a young mum and she physically took four steps back from me and I thought 'good grief what have I done' and it was just the words 'social worker'. She just immediately wanted to get away from me, because she was having a very a bad experience at the time with social services.

This student went on to describe how she now had a very good relationship with that person and that she had explained that she needed to know about her previous bad experiences so as not to make those same mistakes when she was in practice herself.

In a similar vein, another student described how, when visiting the West Howe community shop, she had been told:

If you really want to hear about what mistakes social workers make here's so and so.

But she added that it was not something that social workers would do nowadays. A West Howe resident summed up this attitude as follows:

People here are more scared of social services than the police.

The social work students came to be perceived in a different way to many of the qualified social workers previously encountered by residents, not just because they were students, but because of the way that they approached their work with residents. Students suggested that social workers in one of the drop-in centres were also seen in a more positive light because of their role in supporting clients, and getting to know them as people.

One student felt that it was possible to overcome residents' negative perceptions through working in different ways. Once residents came to see the student as a person then it was possible to set about building trust. However this process took a lot of time and she had found it somewhat exhausting.

Considering the differences between the way social work students operated in this public health placement and a statutory placement, another student felt:

I don't think social workers are perceived as having any positive benefits at all and I think by going out into the community we're still in a power position but not anything like it is in a statutory placement.

In her view, statutory placements and social work practice involved making serious decisions about peoples' lives, such as whether they could keep their children and who could adopt a child, thus exercising what could be described as a form of social control. Even when social workers were aware of their power and were concerned not to misuse it, in the final analysis they still had it. Undertaking this sort of voluntary public health placement made them more aware of these issues and that

it was possible to work with clients in different ways. However, since these were first year students on their first placement, it was difficult for them to make a definitive comparison between working on statutory and voluntary placements. She drew attention to the different ways in which clients often perceived social work and nursing students:

I think social workers are seen as sort of policing agents generally and I don't think nurses are seen as policing agents particularly, even though some nurses have the power to section people and child protection as well, but they are seen as sort of Florence Nightingale angels.

One student recognised the difference in ways of working within the project, explaining what happens if social workers are only called in when there is a problem, in the 'firefighting' method, which is generally considered the traditional social work approach. The client then is unlikely to be pleased to see them while in a state of turmoil and feeling fearful of the powers that Social Services have.

As in the familiar stereotype, she felt that people equate a visit from social workers with having your children taken away. She described how, as a social worker, you were:

Dammed if you do and damned if you don't.

The media reinforced popular attitudes and, in her view, promoted a very negative image of social work:

Everything in the media – if you take children away you're not good, if you don't take children away and something terrible happens then social workers are criticised for not taking them away when they should have done.

Another student felt that residents reacted to someone from the university as 'a huge academic', creating a potential gap that students had to work hard to overcome. Her opinion was that many residents would probably make better social workers than she would because they had more life experience. However, because of adverse life events, they often lacked the confidence to use this experience in positive ways.

Attitudes towards
social work students
on placement:
The professionals

Students reported a variety of different experiences of the way they were treated on placement. Several described their appreciation of the way in which the project leader, placement supervisor and other practice educators treated them as if they were a valuable team member from their first day on placement. They had fielded requests for students to help with the teas on projects, explaining that this was not what students were on placement to do. In their view, students were not just an extra pair of hands or there to perform menial tasks but to learn how communities and professionals could work together to effect change. These positive expectations of students' capabilities in turn brought a positive response from the students.

Students contrasted this approach with situations that illustrated less favourable attitudes to them. One reported an incident on their first day on placement when they had attended a meeting. The Chair went round to each person to introduce him or herself and say what they did and he skipped over the students, 'as if they did not exist'.

Gender issues

The vast majority of students and professional workers on the project were female and many activities aimed at families were primarily attended by women with their children. The only male student on placement described some of the challenges he faced in working against gender stereotypes. He found it more difficult to interact with many of the female residents because he was male. This included the sensitivities involved in working with a Muslim woman to help her learn English. He had not seen it as his particular role to work with men on the project, expressing his dismay at the physical and mental abuse that men sometimes perpetrated on their partners and children.

I found it was very hard for this placement to get in because I'm aware that I'm male and most of the work involved and the people involved are female and also I'm aware in some cases the male has been a bad influence.

He said that he felt slightly out of place but hoped that by working gradually and keeping a low profile he would begin to be trusted by the women. He recognised that undertaking the exercise class as the only male, which the placement supervisor expected all students and visitors to do, was again more problematic than it would be for a female student. Working in the crèche, he was nervous with the children at first but the staff accepted him from day one, making him feel like part of the team.

He had his own job to do, he enjoyed doing it and the children got to know him.

The first social work students on the project, who were women, expressed interest in improving provision for men in the area because, as described, most activities were aimed at women and children. Although men as parents were not formally excluded from activities, they may have found it difficult to participate if they felt outnumbered.

To address this deficiency, the students decided to design a questionnaire in which they stopped men in the street to ask them their views about provision in the area specifically for them. The survey identified the need for more leisure and sport provision since the only gym in Boscombe was expensive. This tied in with earlier research and the results of this exercise went to interested parties as well as the PCG so they could take it forward.

Meeting their learning outcomes

Some of the social work students reported difficulties with meeting their learning outcomes, which were the core competencies described earlier, assessed through three observed practices and five evidence sheets. Two of these observed practices were supervised by the practice teacher while the third was observed, taped and written up later by the student. The evidence sheets contained questions such as 'What law governs your practice?' after which students would write 'The Children's Act,' or 'The Housing Act' as appropriate. They would then describe the ways in which they had acted in an anti-discriminatory and anti-oppressive manner, what communication skills they had used and which theories they had put into practice. An example of an interview which formed one of the observed practices for a student was with a resident who had recently been supported to train as a fitness instructor with the exercise class within the project (Bums and Tums) through the concurrently running ACHIEVE project.

The public health placements did not provide students with standardised opportunities to meet their learning outcomes. This was reflected in the Boscombe HAA placement, which did not give students access to families on a regular basis and thus easily facilitate the sort of individual work assumed by the assessment process. Attempts in their contracts to map how students on community placements could meet their learning outcomes were not entirely successful. Students therefore used the lunch club at one of the drop-in centres in order to access families. One problem with this approach was that several students wished to use the

same clients for an observed practice. In addition to the two students based in the HAA, another social work student had been placed at the drop-in centre as a full-time base. As one student explained:

You're naturally going to go for those people who you think are going to give you the sort of interviews that are going to be useful to you and the sorts of families that are going to give you what you can actually work with.

This meant that students often wanted to use the same families in order to meet their learning outcomes. Reflecting on the issue of multiple student access to families, the student recognised that:

In the real world families are seeing lots of other professionals. I mean they are seeing the health visitor, there may be a social worker involved, there may be a doctor involved and maybe a practice nurse involved so you've got lots of professionals working there and the thing you've got to learn as students is to say well fine, if the client's happy to repeat what has been said to somebody else that's fine. In life that's what happens.

An additional factor that made meeting their learning outcomes more difficult was that this particular drop-in centre was unstructured and informal, so students were never sure who was going to turn up each week. Appointments made by students with clients to bring in other professionals were often not kept.

Another social work student felt that the learning outcomes and observed practices required were not designed for a community placement.

I think the sheets the University give out are very set around an interview, which isn't really easy for students out on a community placement because you don't really get the one-on-one sort of working because you're supposed to be showing you can work with the community. So, other than doing group work things, they do always like you to still have a one-on-one to show you can interact with one person...it's like how did you communicate with the individual and you have to literally just change the questions...So I have managed to squeeze one of them out, just about, but the other two have been group work.

Important issues of ethics and trust also arose for the students in attempting to meet their learning outcomes. They felt that shortage of time was a problem in terms of building up trust with residents and in submitting the observed practice and evidence sheets.

The ideal is sort of a statutory placement or residential where you have intensive sessions with the same people every day so you do get to know them, so you can get their trust enough to do an interview with you. Something about, you know, their lifestyle they're not going to say yes fine, in your first two or three weeks.

She had been told that the Institute were considering making changes to the evidence sheets for community placements in order to address these concerns. One of the practice teachers agreed that creative thinking had sometimes been required to meet students' core competencies but pointed out that this happened on other types of placement as well.

The question of the ethical issues involved in choosing a family for an observed practice was also raised. One student voiced her concerns:

I don't want to have to look at a family and think 'oh they'll make a good evidence sheet' or 'that'll make a good observed practice'. That was something that I struggled with, I didn't like the idea of 'am I using this family for my own ends', 'am I manipulating the situation to my own ends to produce these evidence sheets and things?'

A talk with the placement supervisor had helped her to resolve these issues, reassuring her that awareness of the issues was significant in itself and would then naturally form part of her approach to the families.

A nursing student on a community placement in West Howe described how her action plans formed the learning outcomes for her placement:

We had, it's like an evaluation, and we had to have, when we first started, a middle and an end summary, which we had to sit down and write with our supervisor. There was also a space where I had to write everything I'd done, all the visits I had made, all the learning opportunities I'd had on the placement. Other than that, that's the one thing I don't think is very good

about the Uni is that you don't really get assessed on anything in particular when you do that sort of thing, there's no real feedback, you write these evaluations but if anyone ever takes any notice I don't know.

She felt that students did not receive enough feedback on their experience on placement:

The academic side of the course you get marked on, you get feedback all the time but the practical side you don't. You get your feedback from your supervisors from your placements but I think as well as the tutors they don't really get involved unless you say look I've got a problem...

Another difficulty for her on this placement was that nursing students were required to undertake 75 hours of midwifery practice on their course, which other students had been able to carry out on their community placements, while she had not. Arranging home visits with the midwife appeared to be more complex on the public health placements than on one based with a Primary Care Team for example.

Some of the learning from placements was shared through two 'link days' at the University, where students compared notes about their experiences and they reported finding these helpful and informative. Learning about other types of student placements helped to put their own experience into context. Practitioners reported that there had been a certain amount of jealousy among the peers of the first social work students on the project for being part of a high profile initiative who were invited to present their experience at conferences, but that this had lessened with subsequent placements.

One student reported that initially she had been concerned that there would not be enough work to do within the placement to meet her core competencies and that this resulted in the two students taking on a lot of work that they then did not have time to complete fully. In fact, there was enough work but it took longer to locate and understand the complexities involved than might be the case on other placements.

Difficulties in sustaining the learning sets

One reason that students gave for not wanting to become involved with the learning sets was concern about increased workload. Lack of time and the demands of existing workload were also cited by some students as reasons for ceasing to attend after one or two learning sets. One

nursing student described the reaction of many of her peers on being invited to carry out their community visits in the Boscombe HAA:

Everybody backed off, a few people showed enthusiasm but the more that they became aware that they would have to go to a meeting on a regular basis and they weren't quite sure what he meant by, 'it wouldn't take too much out of your time'.

A nursing student who attended the re-launched learning sets from January 2002 had a similar initial reaction:

*To be honest my first thought was Jesus more work, when *** was talking about it and I thought oh no I can't take anymore, I've got so much it's coming out of everywhere now. But when we sort of sat down and discussed it all and what *** would like each of us to do and what have you, it didn't seem as much work as I had expected.*

These comments illustrate that if it was possible to get students to attend an initial meeting of the learning sets, then the enthusiasm of the project leader and facilitators and the fact that they would be doing useful work and learning useful frameworks for structuring their work, such as CQI, could motivate them to carry on attending.

Use of CQI within the project

The CQI facilitator who worked with the learning sets had considerable experience of working with different groups and the various ways in which CQI could be introduced and utilised. Through this experience he had learnt the importance of practitioners coming to sessions with a practice issue that they needed help with, rather than learning CQI almost as an academic discipline.

It had not been possible to use CQI in the re-launched learning sets, which ran from January–June 2002, in this optimum way for various reasons, the first of which was that all students and practitioners involved were at different stages in their various projects. CQI needs to be used at the beginning of projects, in the planning stage, so that practitioners can derive maximum benefit from it. It was therefore not possible for CQI to have an influence on their work at this important early stage. CQI also appears to be most successful with groups based in practice who are working to improve the same issue which is of importance to them all. Here, practitioners and students were working together on projects, but

only in small groups of two or three, and so a number of different projects were being worked on concurrently. A further difficulty in terms of advancing the aims of PHRIPE was that these projects were not particularly aimed at public health improvement because of the different backgrounds and disciplines of the practitioners involved.

Students who attended the learning sets from their own interest and motivation did not find that it was possible to successfully identify and carry through a project of their own, because this would have added to their already considerable workload, and because of a lack of supervision and mentorship. The two students who attended on this basis were both mature students and, although one had planned to facilitate a group of older women to develop their understanding of osteoporosis and how to help avoid it, she was not able to put her ideas into practice for the reasons given above.

The CQI facilitator described the four principal reasons why he believed these learning sets had struggled to keep people's commitment, which reflect some of the challenges outlined above.

The first related to the common problem of removing practitioners and students from practice to attend a meeting:

I think it's a combination of things, there isn't a simple answer; it will be different for different people. I think partly it's the problem that we all have getting anybody out of a busy working environment.

The second factor was that practitioners and students had been expected to advance some aspect of their work with the project and this expectation that they would report on progress could be intimidating:

I think it's to do with the fact that when they came to a meeting they were, it was anticipated they would talk about something they had done since the last meeting and they probably hadn't had time to do it. So rather than face any embarrassment on coming, I suspect they found themselves too busy to come and report no progress.

The third was a lack of support in practice:

I think that's one of the problems, when we were first talking about setting this up, we did talk about practice support, it was something that I've felt quite strongly about again from my own experience and when people go out of the room, no matter how good an experience they've had in the room, the world is very different out there, and it takes over. And one of the things I've learnt through, say, working on the RIPE project is you need champions in practice to help keep your eye on the ball. And that is, I thought something that the project facilitators were going to do, that was to go out and make contact with people. We talked about it a couple of times, and see how they were doing and put a little pressure on them as it were, but be supportive and that didn't happen because again the project facilitators were just too busy, so I suspect there was nothing to keep people's minds on it.

However, the facilitator from the PCT described what had happened when she planned to visit students in practice. She offered several times to visit students who were on the programme but either their supervisors could not spare them or they were not in the right place at the right time. Other students apparently did not feel that they needed a visit:

Some of them just felt that they were doing okay, that they didn't want a visit in practice. Which was fine but maybe with hindsight, maybe that was something we could have been a bit more – not forceful about – but just written it into the programme that that was an expectation, that that was going to happen.

The project facilitator felt that a visit from her might have kept up the momentum for some of the students and also made it more real for them, underlining the link between the project at university and practice somewhere else.

The fourth aspect that the CQI facilitator believed had affected commitment to PHRIPE was the extent to which using CQI and PDSA cycles to structure a practice issue was actually helping practitioners and students with their work:

I think there's an issue sometimes about if you want these people to get involved in things, it has to contribute to what

they're currently doing, and they have to see that it's helping them with their busy lives. And I don't know whether we achieved that or whether it was a burden in some way, or it was adding something to people's lives.

This illustrated a recurring and important difficulty in the project work, in that involvement was voluntary for many students and practitioners. This did not apply to students on placement in the HAAs, but to the partner organisations, the nursing students undertaking their community visits and on option placements with the project, and to many of the practitioners who attended the learning sets. PHRIPE therefore had to compete for people's time against work for which individuals were directly accountable.

The partner organisations

The project leader felt that certain aspects of the original partnership had not, for a variety of reasons, engaged with the project work as fully as they might have done. This view was particularly pertinent because his employment by the PCT as well as the Institute simultaneously gave him the perspective of the insider and outsider. This included the amount of time organisations allocated to practitioners to support the project work. He tried to overcome this by:

- Engaging practitioners from other organisations in the practitioner learning sets held at the Institute;
- Encouraging members of the PHRIPE project team to attend meetings of the interagency groups engaged in public health improvement work.

Difficulties in ensuring the sustainability of the partnership and the project included:

- PHRIPE not being high enough on the list of priorities for the partner organisations;
- Translating an organisation's commitment to PHRIPE from the strategic to the operational level;
- PHRIPE not being core business for partner organisations whose performance was often measured by meeting targets. Explicit targets were often set around morbidity for health organisations and crisis intervention for social services, e.g. looking after the children on the child protection register;
- 'When push comes to shove', organisations have to work with the most vulnerable. Public health professionals work 'upstream' to prevent chronic disease, and relieve the sort of stress for families

that could lead to children subsequently being placed on the child protection register, and so did not produce results quickly enough;

- Health and social care organisations being too engaged with their current responsibilities to sufficiently plan how to integrate their workforces.

It would therefore have been very helpful to:

- Have a named person from each partner organisation who would be responsible for developing interprofessional public health learning in practice. When that person left the organisation or changed their role within it then another named practitioner should replace them;
- Make the nature of organisations' expected involvement more explicit by asking them to provide a specified amount of protected time a year for their named person;
- Have regular stakeholder meetings during the first year because the steering group set up to fulfil that function was not sufficiently influential;
- Develop shared outcome measures that would be helpful in promoting change.

Involvement within the Institute

One of the other main barriers to learning was the lack of practice educator time that was available to the project. The project leader described some of the difficulties the project encountered:

I think one of the other barriers has been a lack of practice education resource from the different professional groups. I think it's true within nursing, social work and community development because one of the real barriers to developing the project further than we have come today really is the amount of practice educator time that we've got to actually support the students in practice and I think having given perhaps more resources up front for that practice education work, you know, with hindsight, that might have underpinned more development, so that has been a barrier. It's been a national issue but it's certainly one that we've identified a need to further develop the practice education resources to support interprofessional learning.

He felt that PHRIPE had encouraged debate within the Institute and helped move the agenda forward from abstract discussion by providing a model of what it was possible to achieve. There was now a groundswell

of people who thought that interprofessional working and learning were the way forward. He pointed out that although three years might sound a long time, PHRIPE had formed only a small percentage of the working week for the people involved in it. The project had to work with limited resources and, as a consequence, its impact was limited. It provided some of the building blocks that would be needed for sustainable change but the challenge now, as recognised throughout the project, was how to pull this sort of work into the mainstream.

Pressures on project workers

A large amount of responsibility for all levels of the project rested with the project leader. His working week was usually around 55 hours, including approximately 10 hours at home. This time was spent doing the tasks that there was not sufficient time to do during the working day, such as preparing for the learning sets.

He described his frustration at thinking he had secured commitment and feeling elated if the meeting or learning set was well attended but somewhat deflated if it was not. He would often have to undertake all tasks relating to running and facilitating the learning sets, including some administrative tasks. The amount of physical and emotional stamina required to sustain that workload and responsibility in the long term is obviously considerable. It is therefore problematic to put much of the onus for the project's success on project leaders when many of the barriers to implementing the project agenda are beyond their control.

Summary of Main Evaluation Findings

Planning the project

- An important challenge in the project work was that involvement was voluntary for many students and practitioners. This applied to the partner organisations, the nursing students undertaking their community visits and on option placements with the project, and to many of the practitioners who attended the learning sets.
- The Boscombe and West Howe strand of the project did not have a single focus in the same way that the Weymouth and Swindon strand focused on reducing teenage pregnancy. This may have made it more difficult for practitioners to identify with its aims.
- The project had two main drivers: interprofessional education and public health improvement. Some of the most useful learning came from the difficulty of having two major focuses driving one project.

Learning frameworks: Use of CQI

- CQI needs to be used at the beginning of projects, in the planning stage, so that practitioners can derive maximum benefit from it.
- It was important for practitioners and students to come to sessions with a practice issue that they needed help with, rather than learning CQI as an academic discipline.
- Practitioners and students were working together on projects in small groups of two or three, and so a number of different projects were being worked on concurrently.
- CQI appears to be most successful with groups based in practice that are working to improve the same issue, which is of importance to them all.
- The extent to which using CQI and PDSA cycles to structure a practice issue actually helps practitioners and students with their work, needs to be considered.

Student learning

- Student placements in the Boscombe and West Howe HAAs emphasised working with the community as a whole, taking a systems rather than an individual perspective.
- Students learnt that the focus of health care should be peoples' homes and communities rather than the health care organisation or the social services department.
- The 'naiveté' of first year students could be valuable in seeing through the layers of bureaucracy and habit, and asking how things could be done differently.
- Students discovered how many different agencies and activities were operating in the HAAs and realised the value of the synergistic working that was taking place in them.
- One of the strengths of the public health community placements was that the variety and scope of the activities that students were involved with maintained their level of interest throughout.
- It was motivating for students to feel that the information they collected on their community visits would be of direct use to the communities they were working with.
- Students realised that learning from difficulties in practice could take place and be as useful in its own way as learning from best practice.
- Students learnt about the many factors that impacted on health in a community, including supermarket policies and healthy eating, exercise, and housing.
- Students also learnt about comparative resources and the gaps and priorities that existed in different practice settings.

- Students generally found reflective diaries a useful way of capturing what they had learnt and questioning their own initial assumptions.
- The emphasis for students on placement was on learning with residents about their lives and what their priorities for improvement were, so students needed to accept that they were not controlling the agenda.
- Students' questioning of their own professional role and coming to an understanding of those of other professions provided the most important rationale for interprofessional working on the project.
- Students on placement learnt to see nurses and health visitors not in a medical role, but as change agents within communities, and gained much through working with different professions.
- Social work and nursing students on placement learnt about the value of the new public health and community-empowerment models of working, with a number expressing pleasant surprise at the role of health visitors within the project.
- Students learning not to judge and to empathise more with residents formed an important element in the development of their anti-discriminatory practice skills.
- The social work students noted that nursing training did not place as much emphasis on anti-oppressive and anti-discriminatory practice as was the case in social work training.
- Students' understanding of the global picture of deprivation in communities was often facilitated through insight into a particular family, whose story acted as a case study.
- Students learnt more about the links between poverty and ill health while working on the project, and clarified their ideas about why some clients behaved in ways that might damage their long-term health.

Organisational learning

- The practitioners and practice educators who worked with the students reflected on the ways in which the students' interprofessional and public health experience developed their own practice skills. They learnt from service users, from and with their students, and from the challenge of organising this complex learning experience.
- The placement supervisor described how she interacted with students when they first arrived on placement, as she needed to find a balance between being over-protective and leaving them to discover everything for themselves.
- The challenges and benefits of these new models of working were

illustrated by the placement supervisor, who described colleagues' negative reactions to her working within a public health and community-empowerment model, rather than performing a 'typical' health visitor's role.

- The amount of physical and emotional stamina required to sustain the necessary workload and responsibility in the long term is considerable and it is problematic to put much of the onus for the project's success on to project leaders, when much remains beyond their control.
- A focus on the needs of the service user drove the agenda rather than the needs of individual organisations, but there were also difficulties involved in the joint funding of projects.
- One of the benefits of interprofessional placements was that a re-orientation towards anti-oppressive practice could be learnt through a cross-fertilisation process between different student groups.
- The public health work appeared to be stronger where different professional groups were involved.

PHRIPE encouraged debate within the Institute and helped move the agenda forward from abstract discussion by providing a model of what it was possible to achieve. There is now a groundswell of people who think that interprofessional working and learning is the way forward.

Barriers to fulfilling the project agenda

- Students from different disciplines working and learning together on placement did not happen to the extent that had been envisaged, largely due to the different placement patterns of each student group and the statutory requirements of their different professional bodies.
- It was difficult to engage sufficient student groups representing different professions or practice areas, for example midwifery and community development, as well as media students. There were also no medical or PAM (professions allied to medicine) students involved with the project.
- Social work students were aware of the negative perception that residents had of social workers but they were able to overcome these challenging views by the way they worked with residents as equal partners in improving their lives.
- Some of the social work students reported difficulties with meeting their learning outcomes, the core competencies, which were assessed through observed practices and evidence sheets.
- The public health placements did not provide students with standardised opportunities to meet their learning outcomes. This

was reflected in the Boscombe HAA placement, whereby students were unable to access families on a regular basis and thus easily facilitate the sort of individual work assumed by the assessment process.

- One of the reasons that students gave for not wanting to become involved with the learning sets was concern about increased workload. Lack of time and the demands of existing workload were also cited as reasons for ceasing to attend after one or two learning sets.
- There was a lack of practice educator time available to support students on the project.
- PHRIPE had to compete for practitioners' and students' time with work that they were directly accountable for.
- It was difficult to translate partner organisations' commitment to PHRIPE from the strategic to the operational level.
- PHRIPE did not appear to be high enough on the list of priorities for its partner organisations to make the project sustainable.

The CQI facilitator described the three principal reasons why he believed the re-launched learning sets had struggled to keep people's commitment:

- The first related to the common problem of removing practitioners and students from practice to attend a meeting.
- The second was that practitioners and students were expected to advance some aspect of their work with the project. This expectation that they would report on progress could be intimidating.
- The third was a lack of support when practitioners returned to their workplaces.

4. Weymouth & Portland and Swindon

Introduction

This chapter is divided into five sections, with the first section outlining the original project proposal and the background to the learning frameworks used within the project. The project proposal and the project in action are written up separately in order to emphasise the fact that what was proposed was not necessarily the same as what took place. The first section also includes practice designed to reduce teenage pregnancy within Dorset and the evidence base for the strategies adopted. Section two provides a brief overview of the project in action and examines the interprofessional composition of the Action Learning Group (ALG). Section three describes some of the learning that ALG members felt they gained from the various educational sessions and from the learning frameworks. It also reflects on how the ALG viewed the interprofessional and interagency implications of their work. Section four describes and analyses the learning about some of the more practical and logistical aspects of the project, while section five considers the relationship between the ALG as an educational group and the work taking place in practice. The chapter concludes with a bullet point summary of the main evaluation findings.

Project Proposal

As described in Chapter 1, the PHRIPE project aimed to provide a major vehicle for interprofessional working and learning initiatives to support public health improvement programmes and to develop learning pathways in public health improvement. This strand of the project would involve experienced practitioners working and learning together with the initial aim of developing strategies that would reduce the rate of teenage pregnancy in their area. It was envisaged, however, that this focus might change during the lifetime of the project, possibly to that of smoking cessation. The impetus behind the project was an attempt to add depth and purpose to the practical work that practitioners were engaged in by putting some formal learning frameworks around it. The first of these frameworks was the Ottawa Charter for Health Promotion (WHO 1986), the second, the Verona Benchmark 1 for Investment for Health (1998) and the third, Continuous Quality Improvement (CQI) methodology.

Experienced practitioners from Weymouth & Portland and Swindon (areas chosen for their high rate of teenage pregnancy relative to surrounding areas) planned to meet together for 30 days over a three-year period. The chief executives of each sponsoring organisation signed up to matched funding with Bournemouth University in the form of staff time. The two groups of practitioners would form an Action Learning Group (ALG) for educational sessions and to share ideas and experience of best practice. In addition to the learning frameworks, it was proposed that a major emphasis throughout the project would be on interprofessional learning and working, and interagency co-operation. Sessions would be day-long and held at a venue situated midway between the two areas.

It was also proposed that participants should identify and visit examples of excellent practice ('beacon' sites) in pairs, one from each geographical location, using the Ottawa Charter and the Verona Benchmark to examine the project's development. Up to £800 was available to support each visit. Further, they would be encouraged to identify and use a mentor for their work, in order to develop their skills in reflective practice.

Finally, the project would link to the development of a postgraduate programme in professional development: the MAPD. It was envisaged that as many PHRIPE practitioners as possible would undertake this route of accrediting their learning. The MAPD has profession-specific pathways in nursing and midwifery and also a generic practice pathway that enables practitioners to gain academic credit for the work that they are engaged in while in practice. This could include work such as formulating proposals to funding bodies and writing for publication.

Core units

Core units for the practice pathway would include:

- Two portfolio units;
- A research or project dissertation;
- Practice development through group supervision;
- Critical analysis of a project or practice issue;
- A practice development proposal.

There would be no charge for undertaking the MAPD for PHRIPE participants, as it was seen as part of the piloting of experiential learning pathways within the Institute. The MAPD was regarded as a significant development which it was hoped would make postgraduate study less onerous for busy practitioners by limiting the amount of extra time and

work required to undertake it. It would also have the advantage of ensuring that practice was consistently informed by academic input.

Background to the Learning Frameworks

The Ottawa Charter

The type of radical public health agenda embodied in the Ottawa Charter is widely acknowledged to have begun in Canada in 1974 (Mittelmark 1999). This was the year in which the Canadian Department of Health and Welfare issued the report *A new perspective on the health of Canadians*. This report made the innovative proposal that improving the health of populations had more to do with improving social and environmental conditions than with advances in medical science and access to medical care (Mittelmark 1999). In 1977, the World Health Organisation (WHO), inspired by this Canadian model, declared that its main social targets should be the attainment of a level of health that would permit all citizens to lead a socially and economically productive life by the year 2000. This marked the beginning of the campaign that became known as 'Health for All by the Year 2000'. During the mid-1980s, the power of these new ideas culminated in many new initiatives such as the 'Healthy Cities' project, which was conceived at a workshop in Canada entitled *Healthy Toronto 2000*. This brought together many different organisations and community interests to explore ways of making Toronto a healthier city. In addition, at this time, European WHO adopted 38 regional targets and progress was being monitored towards the 'Health for All' targets.

This work culminated in 1986 when the first International Conference for Health Promotion was held in Ottawa, culminating in the Ottawa Charter for Health Promotion. The key contention of this document is that health is not an end in itself but a resource for everyday life. The Charter identifies the conditions necessary for health, including peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equality. It also identifies three main health promotion strategies, which are political advocacy, action to reduce inequity and help people to reach their health potential, and co-ordinated action involving all sectors of society, rather than just the health care sector (Mittelmark 1999.) (See Appendix 1, or full text available at www.who.dk/policy/ottawa.htm.)

The Ottawa Charter has been influential in many countries and has resulted in the expansion of the 'Healthy Cities' programme, which now

utilises the Charter on a community level. The cities chosen have developed action-based health plans based on the Charter, the 'Health for All' framework and the 38 European 'Targets for Health'. 'Healthy Cities' has proved to be a hugely popular initiative with 1000 cities involved by 1999 (www.who.ch/peh/hlthcit/index.htm).

The Verona Benchmark

The second framework used in this part of the project was the Verona Benchmark 1 for Investment for Health. This document places a similar emphasis to the Ottawa Charter on the social and economic determinants of health:

The greatest improvements in people's health have resulted not from health services but from social changes, and there remain huge opportunities to do even better...Poor health cannot be explained simply by germs and genes. It is rooted in how societies are organised and work. Health can be sustained or broken by how we live and work and feel about our lives. Actions that bring about health also bring wider, social, economic and environmental benefits for the whole community. (Extract from project bid.)

Its core principles are:

- A focus on health;
- Full public participation;
- Genuine intersectoral working;
- Equity;
- Sustainability;
- A broad knowledge base.

The Benchmark was drawn up by an international team from many different disciplines, including epidemiology, social science, education, planning and national development, and was the outcome of the first of the three Verona Conferences held from 1998 to 2000. The initiative built on the new 'Health for All' policy entitled '*Health 21 – 21 objectives for the 21st century*' agreed in 1998 by the WHO's European region. It stated that, as the origins of most health problems lie deep in society, they must be tackled through a broadly based strategy, of which the Verona Benchmark would form part. The aim was to develop an understanding of how to invest to improve health at all levels of society, and the first Verona Benchmark is a schedule of the main characteristics that should be present if the 'Investment for Health' approach is implemented in

practice. The Benchmark focuses on system characteristics to answer the question: if an administrative area were to try to implement the 'Investment for Health' approach on a national, regional and local level, what systems would it need to put in place?

Evidence Base for Teenage Pregnancy Work

Reducing teenage pregnancy in Dorset

There are ten Youth Advice Centres (YACs) in West Dorset, which provide advice on any issues brought to them by young people, such as housing, benefits and substance abuse. They are also able to dispense contraceptive advice and emergency contraception through a nurse practitioner 'according to protocol'. ALG members perceived nurse prescribing to have many advantages, including lower costs and a greater willingness by young people to confide in a nurse they know well and feel comfortable with.

ALG members stressed the importance of the fact that the YACs began as a voluntary and charitable sector initiative. The economic importance of this sector in the south west region is reflected in its estimated £500 million contribution to the local economy. The voluntary sector employs 120,000 people in either a full- or part-time capacity, and more than 500,000 people make a regular volunteering commitment. In total, this contribution has been valued at more than 4% of the south west's GDP (Southwest Forum 2002).

The work of Professor Ian Diamond and others (Clements et al. 1996) demonstrates that, in West Dorset, the Youth Advice Centres contributed to cutting the rate of increase in under-16 pregnancy in the period studied. Practitioners suggested that, while good practice may only succeed in delaying a teenage pregnancy by a year or so, that extra year of maturity might still be worthwhile. However, this delay would not necessarily be reflected in lower teenage pregnancy rates.

Practitioners suggested that the young men involved in teenage pregnancy might see sexual experience and early fatherhood as a rite of passage, or a life transition, when other transitions such as permanent employment may have been denied them. Since teenage pregnancy is known to be associated with factors such as low self esteem and low educational achievement as well as high deprivation indices, any interventions that can begin to address low self esteem in young people are likely to be helpful in reducing teenage pregnancy rates. This is the

sort of work that has often been overlooked in the drive to expand the conventional sources of family planning advice that have been shown to be less effective at reducing teenage pregnancy.

Practical responses and interventions designed to reduce the rate of teenage pregnancy, which were already being implemented or planned in the area, include:

- going into schools with well researched sex education programmes;
- using theatre groups in school;
- using male sex educators to engage with boys;
- developing One Stop Advice Centres;
- developing youth work programmes;
- engaging with the various interagency strategy groups.

Teenage pregnancy work during the project

Many different projects and funding streams, including money from the Teenage Pregnancy Unit and local authority 'small innovations' fund, influenced the teenage pregnancy agenda. A key ALG member described the way in which some of the funding for reducing the rate of teenage pregnancy that was available during the lifetime of the project had been used to do 'pre and post' evaluations of interventions. The schools-based work in Dorset had succeeded in having lesson plans agreed with all secondary schools and the process was beginning in middle schools. There was agreement in some schools for the school nurse to provide contraception to the sixth form. The YACs in West Dorset continued to be successful and the number in the east of the county was increasing. As the centres were set up, they were rigorously evaluated in terms of age and sex attendance and, if unsuccessful, were closed down and re-opened in another location.

Another ALG member had a different interpretation of the work being undertaken in one part of the project area that had proved difficult in both a geographical and social sense. He felt that there was little going on in his local area that was experimental in trying to solve the problem of teenage pregnancy. There was one piece of innovative work that had taken place on Portland but unfortunately no PHRIPE practitioners had been involved in it. The work was a personal development course for young people judged to be at risk of teenage pregnancy, in which a variety of strategies had been used. These included reward systems and the use of doll 'babies' that had to be cared for over 72 hours. The timeframe of 72 hours was chosen because that is the length of time that girls have in which to access emergency contraception after having

unprotected sex. Teenage mothers also came in to talk to the group about the reality of teenage parenthood. He felt that this sort of project would lend itself well to the Plan-Do-Study-Act (PDSA) cycles in CQI methodology because the practitioners involved were undertaking small-scale cycles and learning quickly from the feedback.

In discussion on the targets, one ALG member felt that the Government's aim to cut the number of teenage pregnancies in half by 2010 was unrealistic and that it would take 25 years to reduce the social exclusion that lay behind the UK's high rates of teenage pregnancy. However, figures for conceptions per 1000 girls aged 15-17 in Weymouth & Portland showed a reduction from 53.3% for the aggregate of the three years 1995-97, to 47.4% for the years 1998-2000. Figures for North Wiltshire indicated a rise from 26.9% in 1995-97 to 31.8% in 1998-2000 (Office of National Statistics 2002). Between two and three times as many terminations were carried out in fee paying, not-for-profit facilities in Dorset each year than under the NHS, indicating that the NHS is not fully able to meet the needs of those teenage girls who wish to terminate their pregnancy.

Evidence base for the teenage pregnancy work

Articles, academic papers and web page addresses that were provided to the ALG by the project leader constituted part of the evidence base for the project. Other important elements contributing to this evidence base were the research findings promulgated by Professor Ian Diamond at a number of local conferences attended by PHRIPE practitioners, summarised as follows (Clements et al. 1996):

- There is high association between higher rates of teenage pregnancy and more maternities with areas of high socio-economic deprivation.
- Significant differences remain between areas even when all other significant factors such as deprivation indices are accounted for.
- An association has been shown between proximity to youth-oriented services and reduced rates of under-16 pregnancy, which increased for this age group by 3% between 1993 and 1996, but by 25% where no youth-oriented centre existed.
- Deprivation is an important predictor of conception outcomes in urban areas. Wards with a higher number of 17-year-olds not in education and children in lower earning households had higher odds of the outcome being a maternity as opposed to a termination.
- Those aged 18-19 were ten times more likely to conceive during 1993-1996 than those aged 13 to 15 and these conceptions among

18-19 year olds were 2.61 times more likely to continue to a maternity.

The Project in Action

The introductory session of the ALG was held in November 1999 and early sessions concentrated on introducing the two groups of practitioners from the different geographical areas to each other and to the programme. The Ottawa Charter was used as a basis for deciding the input that participants needed in order to improve their skills. This resulted in the following educational sessions, which utilised the skills of both the project leader and the external and internal facilitators:

- Assessing qualitative evidence;
- Evaluation of projects;
- Community development skills;
- Writing for publication;
- Media advocacy.

The second of the learning frameworks to be introduced to the ALG was the Verona Benchmark. Several ALG sessions were devoted to small group work (based on the geographical area where practitioners worked), in which the first two Verona Benchmark themes, 'A high priority for health' and 'Building social capital for health', were linked with the practical work being carried out. This was an attempt to bridge the well-documented theory/practice gap. ALG members filled in an action grid for the two themes described above, in order to promote thought and discussion about the next steps that could be taken to bring about changes in practice in the direction indicated by the Benchmark themes. There was also a session in which participants reflected on how useful they found the Benchmark to be.

The project leader, who also held the post of teenage pregnancy co-ordinator for Dorset, provided the ALG with access to a wide range of research on teenage pregnancy. This material described projects in Europe and the United States and the success or otherwise of particular approaches to tackling teenage pregnancy. Participants were given an opportunity to look at this research during the education days, and to take down relevant web addresses and download them later if they wished. Many ALG members also attended local conferences at which Professor Ian Diamond of the Sexual Health Research Centre, Southampton University, presented research findings around factors that account for

variations in the rate of teenage conceptions and maternities. This research, together with the academic papers referred to above, then formed part of the evidence base used in developing the teenage pregnancy work.

The third theoretical framework used within the project was Continuous Quality Improvement (CQI). Further information on this framework may be found in the general introduction to the project.

Work on CQI within both strands of the project was informed by a one-day session on CQI held jointly with the first RIPE (Regional Inter Professional Education) project co-ordinated by Bournemouth University. In the course of this day, which was lead by the project's CQI facilitator, work was undertaken to deepen the understanding of project leaders, academics and researchers on CQI. The main aim of CQI, as defined at this day, was 'to improve the way the health needs of individual and local communities are met'. An example project was worked through and participants began to appreciate the difficulty of thinking practically about action rather than theoretically about concepts.

There was an early initial session on CQI within the project but feedback from the group indicated that this was not sufficient input for practitioners to feel confident about understanding and applying the methodology. Given the importance of this framework to interprofessional working, a decision was made that there should be increased CQI input during the second year of the project. The CQI facilitator at Bournemouth University therefore began a series of sessions running in January, April and May 2001. The sessions offered were adapted from the unit available to postgraduate students registered at Bournemouth University on a number of postgraduate frameworks.

Continuing space and time were allocated for reflection within the ALG. A whole day session was held in July 2000 reflecting on the teenage pregnancy agenda and the issues involved in practitioners working together to effect change, both on a personal and organisational level. However, attendance at the ALGs, which initially consisted of 16 practitioners, gradually diminished during the lifetime of the project. With proposed attendance at the session in June 2001 reduced to only two, the project leader reluctantly decided the project was no longer viable in its current form and called it to a halt. The result of this curtailment was that only about half of the planned sessions actually took place.

Interprofessional group

When the ALG first met in November 1999, its membership consisted of the following practitioners. Their professional roles are followed by the discipline in which they originally trained (if known).

Weymouth & Portland

- Public health consultant (medical training);
- Family planning team leader (nurse training);
- Director of youth & community services;
- Health promotion co-ordinator (MA in health promotion);
- School nurse team leader (nurse training);
- Sexual health promotion officer (nurse training);
- Social services policy manager (social work training);
- Community development worker.

Swindon

- Health visitor/primary care group board member (nurse and health visitor training);
- Family planning team leader (nurse and health visitor training);
- Public health specialist;
- Youth worker (youth work);
- Social services team leader (social worker);
- Deputy head teacher running a mother & baby unit (teacher training);
- Sexual health promotion officer (nurse and health visitor training).

By early 2001, the active participants (not all of whom were regular attendees) were:

Weymouth & Portland

- Public health consultant;
- Family planning team leader;
- Health promotion co-ordinator;
- Sexual health promotion officer.

Swindon

- Health visitor/primary care group board member;
- Family planning team leader;
- Sexual health promotion officer.

A GP involved in giving contraceptive advice to young people and a youth worker, both of whom were new to the project, attended what turned out to be the final session at Sarum College.

Interprofessional balance

The ALG consisted predominantly of practitioners with a background in health, although, as is evident from the attendance list above, it also included youth and social workers and a health promotion consultant who did not come from a profession-specific background. Unlike most interprofessional initiatives, the project did include someone who was medically trained, although this practitioner was working as a consultant in the field of public and sexual health. However, this interprofessional mix was not continuous throughout the life of the project, as ALG members from outside 'health' had not, for a variety of reasons, been able to sustain their involvement. These practitioners explained in interview that teenage pregnancy was just one issue among many that they dealt with in their working lives, and that it was therefore difficult for them to justify the time away from practice that involvement in PHRIPE represented. In contrast, for most of the practitioners that continued to attend, teenage pregnancy was 'core business'.

Since the project was a public health initiative, practitioners' roles and their professional identifications were more complex and varied than they might have been in a hospital setting. Many practitioners had already moved some distance from their training, since working as health visitors in areas of high deprivation had already convinced them of the effects of poor housing, inadequate income and lack of security on their client's health status. The descriptor 'health background' therefore included a wide spectrum of practitioners and roles.

As one (non-health) ALG member jocularly said of her colleague:

She's half-and-half, she could get away with not being health, it wouldn't be obvious, she hasn't got the markings.

Data from the interviews suggested that other practitioners who had trained as nurses had already largely lost their stereotypical 'health markings' and come to see the importance of the socio-environmental determinants of health.

One ALG member expressed the view that there was a struggle in practice between the formalised nature of health service provision and the informal nature of working with young people, and that she was already working across cultures and across disciplines in the ways promoted within the ALG. Other practitioners largely agreed, suggesting that since they were already working on several interagency boards and

initiatives, they had learned more from these than from exposure to the views of other professions within PHRIPE.

This participant was described by a colleague as being:

The one most missed when you weren't there because you had a different viewpoint, not medical or pseudo medical.

However, the participant felt that:

It's not actually easy to be different. I think it's assumed it is, it isn't, it's like being a lone voice.

This feeling of being 'a lone voice' contributed to the falling off in attendance of those who did not have a health background, as one ALG member recognised:

I sort of think that they found it overwhelming because there was a strong health focus. It's always problematic, it's problematic with teenage pregnancy partnership boards that you know, you can easily end up with it being all health visiting, school nursing, family planning, health promotion, we could go on, so the social workers didn't really feel that it was multi-agency focused.

Despite these reservations, most ALG members believed they benefited to some extent from the interprofessional learning within the project:

Generally we were there from different backgrounds and we did exchange ideas.

One ALG member indicated that when engaged in interprofessional or interagency work in practice, the working and learning could not easily be separated from one another:

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

really doing it in a professional way at all, you are just meeting together.

The importance of the relationship between interprofessional learning and interprofessional working proved to be a key theme of the evaluation and one which is examined further later in the report. However, the endorsement of interprofessional learning within the ALG was generally lukewarm, with practitioners struggling to recall particular instances. However, what PHRIPE had provided them with was a forum for reflection on the interagency and interprofessional work with which they were already involved and this had proved valuable.

Reflections on interprofessional and interagency language

A day-long reflective session (July 2000) was held to capture ALG members' views on how well the interprofessional elements were working within the project and to build theory around the use of descriptive terms such as interprofessional/interagency/multiprofessional. Discussion also took place around the provision of services designed to reduce teenage pregnancy, particularly initiatives taking place in Dorset.

Participants considered the different terms, which are currently used almost interchangeably, such as *interagency*, *intersectoral*, *interprofessional*, *interdisciplinary* and their 'multi'-variants to consider what the differences might be between them. The use of the term *interprofessional* itself was considered problematic and some practitioners were concerned that it might exclude people who do not see themselves as professionals, in which case *interdisciplinary* might be a better option, 'because if you've done something once then it's a discipline,' as one ALG member suggested.

For further details on ALG members' views on the different implications of the language used, and the advantages and disadvantages of interprofessional learning, see Appendix 2.

Interagency & cross boundary working

This work provided an articulation and clarification of some of the issues involved in interagency work and thus facilitated the interagency work that took place outside the project.

Issues in successful interagency working

- The size and relative importance of the organisations involved was felt by the practitioners to be an important factor in interagency working.

- Practitioners considered whether it was more important to have all agencies represented or to have good people, even though all the agencies may not be represented.
- Practitioners have found that when working with other professionals they may be working to the same ground rules, but with voluntary agencies it may be different because those agencies expect a voluntary contribution of time e.g. running a stall on a Saturday morning. So there are issues of how much to 'check into' the prevailing culture.
- There needs to be someone to keep the vision through difficult times, someone who feels an individual passion for their chosen cause and who can communicate that passion to other people.
- Multi-agency work requires clear lines of accountability and job designation; when groups are conceived of as multi-agency ventures from the beginning, then all the agencies will go through the same learning process.
- Good administrative structures and at least one identified individual who helps to pull it all together are required.
- Sharing of information and skills can happen at various points in organisations, including steering group level.
- Agreement over resources: Who has them? How are they to be shared? Practitioners may view resources as a battleground where they have to fight to get enough to meet the needs they have identified. One participant felt, 'To me it is a frustration because you can see what needs to be done but you don't have enough influence up to actually get more money down'.

The project leader and a number of practitioners expressed the view that the reflective work within the project, and this session in particular, had been its most useful and valuable feature. Time for reflection on, and the synthesis of, existing work practices were in particularly short supply for the practitioners in the course of a normal working day. Although it is often assumed that education must involve a specific input of information, the use of appropriately guided reflection and interpretation were of particular benefit within the ALG.

Learning within the Project

Learning at the ALGs

The theoretical work on learning that took place at one of the sessions revealed that ALG members believed learning is most meaningful when:

- I'm interested in the first place;

- It's relevant to me;
- I can practise what I'm learning;
- I care about the issue;
- There is good quality debate;
- I leave with fire in my belly.

The most effective learning methods were thought to be:

- Getting new ideas, having time to share and discuss;
- Clear objectives in group work;
- Open friendly atmosphere;
- Able to say I don't understand or I don't agree;
- Supportive trusting group – sensitive facilitator to guide this;
- Everyone participates – enthusiastic tutor draws everybody in;
- Use different methods of active learning, not like school;
- No note taking;
- Experiential learning, drawing ideas from the group.

The interview data indicated that these expectations of the learning environment, the course content and group dynamics had largely been met within the ALG. Members felt that the project leader and CQI facilitator were both interested in learning with and from the group and had negotiated rather than imposed a structure on them. This approach was much appreciated by all the ALG members interviewed. However, for one ALG member, the difficulty in looking back and recognising what had been learned lay in how easily the new learning became integrated with the old:

Once you begin to think in new ways, you can't remember how you used to think and then you can't remember where the knowledge came from.

This practitioner felt that the project had been a powerful learning experience and now used it as the basis for giving advice:

Nobody put himself or herself up as the professional. Everyone was in the role of accepting that they were in a learning situation. The project leader gave us permission to think as though we were students.

Another ALG member described her personal values as being centred on learning so this was one factor that made involvement in the project

valuable to her. She had seen the potential value of the project at an early stage, leading her to identify her own place on the project from within her own organisation.

Learning from the Individual Sessions

The academic papers and articles utilised during the sessions or given as post-session reading can be found in Appendix 3.

Evaluation of projects

This session adopted a workshop format and involved practitioners reflecting on a project they had been involved in and how it might best have been evaluated, together with group work around the categorisation of project processes and outcomes.

Asked whether this session resulted in a change in their thinking and how they thought this might impact on their practice, ALG members emphasised the value of being able to express themselves fully in the sessions:

Being allowed to think freely about evaluation without being pointed towards some textbook or another is very refreshing. Sessions like this give one the confidence to think for oneself and value those thoughts.

This will change the way I work and teach. I'll spend more time evaluating whether evaluations should actually be done and if they are done, ensuring that they are based on sound principles. I have gained greater insight into some of the common cultural issues that are shared by health and social services.

Increased understanding of other disciplines' starting points. Useful to work at devising action theory rather than have the theory first.

The nature of these responses indicated that, not only were the practitioners learning about the particular topic, the ALG process also provided the 'added value' of learning about and respecting the perspectives of other professions.

Qualitative research

There was a variety of responses to the session on qualitative research and, for some ALG members already familiar with this type of research, it

served primarily to reinforce earlier learning. For others, the newness and power of this method of discerning what service users felt about a range of issues and services had a major impact. One participant described how the use of more qualitative approaches influenced not just the teenage pregnancy agenda but cascaded over into commissioned work on needs assessment in prisons and the eliciting of prisoners' views on primary care and dentistry.

I went to the one on qualitative research and I didn't know anything about that. That has influenced very much some of the teenage pregnancy initiatives locally that we've used qualitative research when previously we wouldn't have done. There's been a lot more focus group work done with young people, particularly the highly excluded ends, and people like looked-after young prisoners is another one.

Writing for publication

A senior commissioning editor from Oxford University Press was scheduled to give a two-stage workshop on writing for publication. ALG members were invited to submit a 250-word abstract of a piece of work that they wished to write up. At the first session, the editor discussed the principles of writing for publication and the sort of journals that might be appropriate. It was proposed that the editor would return to discuss the finished piece on the second occasion. Academic credit would be available for this finished piece within the MAPD, whether or not it was published. Unfortunately, since the project ended prematurely, the editor's return visit did not take place. Despite this, this session was identified by all ALG members interviewed as being particularly useful, because this was not the sort of expertise and advice they could access in the normal course of their work. They spoke of an increasing expectation from their management that they should write up project work in which they had been involved. However, it is not known whether ALG members were able to submit any articles as a result of the session.

Community development

This session, looking at the historical and evolving use of the term 'community', was held in Dorchester, Dorset and involved a facilitator from Bournemouth University. The co-facilitator was an ALG member working as a community development worker for a community organisation. The location enabled practitioners from Swindon to visit some of the YACs after the session and the following day, guided by Dorset practitioners. This visit strongly motivated them and resulted in new initiatives being undertaken in Swindon. Meetings had taken place

that attempted to involve the voluntary sector in teenage pregnancy work, following the model used at the YACs in Dorset.

Learning from the Theoretical Frameworks

Generally, ALG members' views were that the learning frameworks had been helpful, even though the approach embodied in them, which emphasised the social and economic determinants of health, was not new to most of them. However, the use of the frameworks served to reinforce earlier learning, which ALG members felt needed constant revisiting to avoid being overwhelmed by the demands of everyday practice.

Those participants who defined themselves as less academic than their peers, perhaps seeing themselves as more practically oriented and not involved in their organisations at the level of strategy, thought:

The frameworks were interesting but not relevant to me where I was in terms of my workplace.

This highlighted a difficulty within the project structure since, if practitioners were not fully engaged by the frameworks or by the teenage pregnancy agenda, there was little incentive for them to continue to attend.

Regarding the use of the frameworks, the project leader suggested that:

...In fact one of the things with that project as a whole, well two things (a) it was over ambitious in terms of the number of frameworks that it was looking to introduce and to work with and (b) it was too long.

The project leader reflected that the Ottawa Charter and Verona Benchmark implied each other, so there was perhaps no need to use both.

I would probably have gone for one framework and looked to explore the parameters of those, because some of the other stuff, whichever of the other frameworks you picked up, certainly Ottawa Charter and Verona Benchmark would kind of imply the others. CQI is I think a little more difficult in that context because

it's more service specific and we weren't all the time talking about service delivery, maybe we weren't even often talking about service delivery. Perhaps a criticism is that we ought to have been. But intervening at the level of population isn't primarily about delivering services to populations.

He suggested that one option would have been to reduce the number of frameworks and another to have modularised the delivery of each framework. While this may have had advantages in terms of maintaining commitment, it would have had the disadvantage of forming a more pedagogic model and much of the time for reflection might have been lost. Some sense of the equality between facilitators and participants might also have been compromised if work had been formally assessed, as on a Masters unit.

Learning framework:
CQI

By the time detailed CQI input began in January 2001, regular attendance at the ALGs had somewhat fallen away. Despite this drawback, one ALG member was very impressed by the papers on CQI, particularly the material on the 'Learning Organisation' (Senge 1992) and found the discussions around this stimulating. It had informed his thinking about how people learn and made learning central. He felt, however, that the principles espoused in the Learning Organisation paper did not happen in most organisations. Many practitioners put so much investment into what they were doing, they could not conceive that it might be done in a better way. There had to be a decision to use the framework and value those principles within it:

There is a bit of a conspiracy going on whereby you're doing the work you think is important but are also producing statistics for the health authority to reassure them their agenda is being met as well.

He felt that CQI was akin to the Total Quality Management (TQM) he learned on his degree, although without the unrealistic aim of the complete eradication of all mistakes. This demonstrates that methodologies used as learning frameworks need to have realistic aims in order to engage practitioners. Although similar to CQI in some respects, TQM is generally considered to have a more managerial emphasis.

One problem arising from the curtailment of the CQI input was that participants had not been able to use it on a practice issue. This was also due to the fact that the ALG at Salisbury was an educational group rather than a team based within an organisation that was working together on initiatives to improve practice. This proved to be a vitally important distinction, the implications of which are discussed later in this report. The challenge involved in working with educational groups is managed on the CQI unit of the Masters framework, by each participant undertaking a Plan-Do-Study-Act (PDSA) cycle within their own organisation or practice.

One practitioner struggled with the use of PDSAs in practice until she had further exposure to CQI on the unit within the MAPD. This helped her realise that she had not broken the work into small enough sections but had tried to approach issues on too grand a scale.

Another ALG member had since been involved in setting up projects using CQI methodology when working with looked after children and sex workers. She liked the case study approach adopted in the CQI literature, which looked, for example, at reducing the rate of car accidents and at improving the information given to, and treatment of, women with breast cancer (McKinley et al. 2000). She would have liked longer on the CQI sessions (as had originally been planned) and the opportunity to plan some work as a group using the methodology.

**Learning framework:
The Ottawa Charter**

Competencies of the Advanced Practitioner (AP)

The Ottawa Charter for Health Promotion (WHO 1986) was used as the basis for designing a grid that could articulate the sort of competencies that an Advanced Practitioner (AP) in public health would need. This grid then formed an important tool with which members of the ALG could begin to evaluate their own practice.

The framework consists of the following five areas of expertise in health promotion work:

- Developing healthy public policy;
- Creating a supportive environment;
- Strengthening community action;
- Developing personal skills;
- Re-orienting the health services.

This grid framework was used as a basis for deciding what further input ALG members needed in order to improve their skills in those areas in which they felt they were lacking. Another use of the concept of the AP was as part of the evaluation process, when ALG members completed a questionnaire around it. They were asked to indicate the extent to which they felt that the statements of competence in the five key areas given above applied to them.

There was a 70% response rate and analysis of the returned questionnaires indicated that respondents felt that approximately:

- 45% of all statements of expertise applied to them to a considerable extent;
- 40% to a moderate extent;
- 15% to a slight extent.

Some of the 'to a slight extent' responses relate to areas where different ALG members would respond differentially because of their profession, e.g. it would be more difficult for some members than others 'to work towards re-orienting the health services'. The results of the questionnaire demonstrated that practitioners were already working at a high level across many diverse areas of practice.

Learning from the Ottawa Charter

Generally, ALG members found this framework particularly helpful, since it formed the theoretical and practical basis for much of the later work that went on within the project. One of the strengths of the Ottawa Charter is that its principles can be applied to many possible interventions. One participant, who was working at a strategic level, felt that it could be applied to drugs and suicide prevention as well as the teenage pregnancy agenda. Another ALG member felt that the Ottawa Charter had been used in a very interesting way within the project when the group filled in the grid of the competencies of the AP. This practitioner liked the way this process invited him to consider his own skills and competencies but he found it difficult actually doing this, because he would inevitably think of aspects of his work at the time:

The quality of my work depends on the relationships I forge and therefore, if I have a good working relationship with colleagues from other organisations, I think I can be quite good at changing the internal dynamic of an organisation or suggesting ways of doing that and other things around the Ottawa Charter

competencies, but if those relationships aren't there it's very much more difficult.

He found it difficult to map competencies over a time period and consider what he may have learned or how he might have improved, because he was applying the criteria to different projects. His perception was that the Ottawa Charter had a strong theoretical basis but, in practice, practitioners often went back to the 'old fashioned' role of lifestyle-type input, the theoretical basis of which usually remains unarticulated. If social entrepreneurs or champions were identified in the community, he was unsure how that work could be written up and valued within a strategic overview. He felt that, unfortunately, not enough people knew about the Ottawa Charter or valued it as a different way of looking at issues.

Another ALG member described how, through her involvement with the project, and the Critical Analysis for Practice unit within the MAPD, she had been able to reflect on the learning involved in writing the teenage pregnancy strategy for her area:

I knew I had learned enormously through all of that process but I didn't know what I had learnt. Then when I had finished that assignment, done all the work then the Ottawa Charter made, I understood all the things I had looked at that were about relating to the Ottawa Charter.

This shows the important role the frameworks played in distilling the learning that took place outside the project and making it explicit for practitioners.

Learning framework:
The Verona
Benchmark

Most ALG members did not remember this framework as clearly as the Ottawa Charter when interviewed, but their earlier reflections within an ALG session are outlined below.

They felt that the main benefits of using the Verona Benchmark lay in its:

- Simple language;
- Identification of who needs to do what;
- Ability to take you under the surface of issues.

They felt its disadvantages were that:

- Action needs to be taken at a strategic level, which is higher than that of the practitioners involved;
- It was perhaps too top down;
- It was too detailed for fast moving agendas.

The Verona Benchmark's grid layout seemed 'overwhelming' to some ALG members. Some practitioners felt this was a 'framework too far' and that by the time the ALG began doing some detailed work around it, they would prefer to have been discussing the work that they were actually doing in practice.

Learning framework: MAPD

The Masters framework in Professional Development (MAPD) was accredited on July 3rd 2000 and the Practice Development pathway has been available since April 2001.

Although eight members of the ALG originally expressed an interest in undertaking the Practice Development pathway, only two enrolled, one from each area, although a third participant had to withdraw due to illness. In interview, the practitioners who did not enrol on the MAPD explained that they did not feel they would have enough time to undertake a postgraduate degree. As one ALG member observed:

Although I would like to, it would be really, really hard work for me and I'm not prepared to be up at four o'clock in the morning, I just feel that has passed me by really.

Most ALG members believed that, had the MAPD framework been available earlier, at the same time as the project began, more of them would have undertaken it. The concurrent running of the MAPD and the PHRIPE project would have strengthened PHRIPE and provided additional motivation for ALG members to fulfil the invitation to write for publication or to visit a beacon site, since academic credit would have been available for these activities. It might have had the corresponding effect of sustaining attendance levels at the ALG. The project leader's view was that PHRIPE had an influence on the development of some aspects of the MAPD, and helped to shape thinking around it, indicating that the relationship had been of mutual benefit.

Another reported gain from participating and learning within the project was improved self-confidence. One ALG member reflected that she

would never have had the confidence to undertake the MAPD, which she was now doing, without having participated in the ALG. The Masters framework seemed less intimidating to her now because she knew other people on it and had been re-introduced to academic processes through the project work.

**Learning framework:
the evidence base**

Discussion around the development of the YACs revealed that they began in Dorset with a Church-led initiative, which other communities were then able to use as a model for provision in their own areas. The significance of involving the voluntary sector was emphasised, partly because voluntary agencies have access to Lottery funding and charitable trusts that statutory agencies do not. Consequently, practice in Dorset formed a learning model for the practitioners from Swindon, although they then had to make the judgement of how applicable that model would be in an area where the voluntary sector did not have such a strong presence.

In discussion about the YACs, the concept of a champion emerged, as champions were instrumental in setting up many of them. Champions were seen as key to the success of voluntary sector enterprise, as an individual who could demand funds and keep applying pressure until the money was forthcoming. Retired professional women 'with connections' appeared to be the most formidable champions. These reflections were supported by the theoretical input of the Ottawa Charter theme of identifying and working with 'zealots' or change agents in the community. Some of the practitioners then realised that they had acted as champions themselves, for example in co-ordinating small groups with poor short term funding so that they could apply to the Lottery, which now looks more favourably on applications from partnerships.

Articles that the project leader downloaded from the internet about sites of good practice informed research with focus groups of teenagers carried out by practitioners from Dorset, which included several ALG members. These focus groups were run separately for boys and girls using a structured interview guide, and looked at their attitudes to sex, relationships and teenage pregnancy. PHRIPE members formed part of the team that has written up this work separately.

In interview, an ALG member pointed out that, while it was valuable to look at research material and plan interventions with them in mind, caution should be exercised in the ways in which research findings and

project evaluations were sometimes used. These remarks related to the use of evidence without sufficient consideration of how a project carried out elsewhere might accomplish what an organisation wished to achieve.

*I'm very aware that people often, when they're trying to develop a project or a number of projects within a strategy they just want to find out what's going on in other areas and what in some way works in other areas. Today in a meeting we were talking about **** what is it we're trying to achieve and they had a little model of doing that in **** and our immediate response to that was, oh great that sounds lovely, we'll nick that idea, so there's this whole thing of don't repeat, try not to reinvent the wheel, and I think that there's a danger with that approach because you stop learning, you start thinking, oh well that obviously worked there somehow, therefore we ought to do that here, that'll tick all the right boxes with our funding bodies etc., great we'll just do that and the learning bit's switched off, you think, oh great yeah, well that's going to work here, and you don't engage with what is the aim, what are your client groups, client focused, all that sort of stuff, you're actually just importing a ready made model from somewhere and I think that's really dangerous.*

These comments demonstrate the practitioners' awareness of the pitfalls of uncritical use of the evidence base. The learning is more likely to stop if, as the ALG member interviewed indicated, practitioners do not have access to reflective sessions and other educational sessions in projects such as PHRIPE.

Disseminating the Learning Beyond the ALG

Generally, ALG members felt that, because of lack of time and opportunity, it had been difficult for them to disseminate the learning beyond the PHRIPE group. No formal mechanisms were set up in practitioners' organisations for this to take place. Although in broad agreement with this perspective, another ALG member was proactive about disseminating the learning more widely, having photocopied the paper *The Learning Organisation* (Senge 1992) and sent it to the manager of the local housing company. He also sent the *Bad Apple* article to another colleague. When meeting with colleagues, he tries to have meaningful conversations and think more about the social determinants of health:

One of the ways in which I am increasingly working is with colleagues. I realise that I'm now actively trying to challenge their way of looking at the things and asking these flipping annoying questions which actually try and break up your concept of what health promotion is.

This ALG member again drew attention to the importance of the frameworks in planning the work in practice:

This whole thing about if you've got a new way of looking at things how to convert other people if they don't come on the course. You need to have a discussion about work within a framework otherwise they zoom all over the place. All good ideas have a theoretical basis so I don't think it's possible to overlay the theory as long as it's in the context of real work, which we were doing.

Other practitioners expressed concern that 'those who need it most don't come to the meetings', meaning those practitioners who relied heavily on the medical model for understanding and attempting to deal with issues around teenage pregnancy. They felt that the project leader could have come down to each area to 'fill in' their doctors and nurses. A GP joined PHRIPE for the last session, but some participants felt that her voluntary attendance at the interprofessional learning sessions implied that she was someone who did not particularly need to be there in the first place. They suggested that postgraduate seminars at the hospital, involving doctors from different specialities attending sessions with a radical public health agenda, would be useful in redressing this balance.

Practical Considerations

Informal benefits of attending the ALGs

Participants recognised the importance of the venue chosen for the educational sessions and the subtle message that this conveyed to them about how much they and the project were valued. This venue was an ecclesiastical college in the cathedral close, where the absence of traffic and peaceful atmosphere added to its attractiveness for participants.

Going to Salisbury is like going to a time warp and it's wonderful to actually go somewhere else. The venue was fantastic, absolutely wonderful.

They particularly enjoyed:

- Going as a group (because someone would phone round to make sure that everyone was going);
- The opportunity to have lunch together and get to know each other;
- The time spent travelling together in the car;
- The whole day formats (because a half-day would have been unrealistic with the travelling);
- Developing a degree of enthusiasm for what went on in other areas;
- Time in which they were permitted to go away and think about issues, using different tools in a safe environment;
- A peaceful day away from the demands of practice.

Practitioners stated that, at coffee and lunch breaks, rather than acting as an exclusive clique, they made a particular effort to get to know people from the other area and to find out what was happening there that was of relevance to the project work. It is therefore important to understand the learning that took place within the ALG in a holistic way and not as a process that took place only within the designated sessions. Practitioners' enjoyment of the informal aspects of the project, together with a certain 'luxuriousness' in the project format (the whole days, the venue, lunch together) helped motivate them to continue attending the ALGs. This is particularly important in a project in which, leaving aside the Masters framework, there was no direct academic credit or qualification available.

Recruitment & introduction of practitioners

Some ALG members suggested that more attention could have been paid to building personal relationships at the beginning of the project, while others thought that this aspect of the project had been adequately addressed. Personal relationships that were forged on the project had assisted the development of the practical work outside it. Friendships were initiated that fed through into working relationships, which in turn strengthened the personal contact. These contacts between organisations continued, in some cases, even after the original post holder had moved on.

The project leader, interviewed after the end of the project, believed that it would have been useful to have more input at the beginning of the project, such as a weekend away or consecutive day sessions in order to 'bed in' the project and strengthen the personal bonds between participants.

ALG members' views on how the project could have been improved centred on the initial setting up of the project, the nature of the commitment of the sponsoring organisations, and their own understanding of the commitment that their involvement in the project would bring. Some felt that the implications and the commitment were not sufficiently spelled out at the beginning e.g. meeting on ten occasions a year, the attendant reading, and the time needed for disseminating the learning to others.

One ALG member's reflection on how she might have fitted in the readings with her workload was, 'I could have read them at bedtime', which illustrates the difficulties involved.

Some participants were critical of what they perceived to be a lack of strategic planning within their management structure. They felt there had been a difficulty in seeing clearly what the benefits of the project would be for certain key workers and in planning effectively for those workers to attend. Practitioners' attendance at PHRIPE needed to be integrated into a strategic vision of where services wanted to go and how they were going to get there. However, some organisations were particularly supportive of people's involvement in PHRIPE and changes in other organisations might mean that they would be more supportive of such initiatives in the future.

Demands on time and the issue of 'protected' time

Most, but not all, of the participants thought the three-year timescale was too long in the current climate. ALG members did not generally have to account in detail to senior managers for their time but were accustomed to managing their own workloads. This meant that they were able to take on additional commitments and choose which meetings to attend, the constraining factors being workload and the allocation of their time to best effect. Thus, most participants slotted their attendance and PHRIPE-related work into their usual work schedule.

In interview, ALG members raised the question of protected time for ALG attendance and how that concept worked in practice. The process gone through at the beginning of the project, in which chief executives signed up to protected time for staff to attend the ALGs, did not appear to have made attendance easier for most practitioners. However, it must still be regarded as good practice, as well as elementary courtesy, that this commitment should be sought. One practitioner commented:

There's a perception that if you're working at strategic top level then actually everything can be fitted in, and there's a lack of understanding of anything detailed and operational.

This ALG member had to catch up with routine work at the weekends if she took time out to attend a meeting. Other practitioners attended the ALGs on their days off in order to fit them in.

Clearly, at the level the participants were in within their respective organisations, it would be difficult for another practitioner to go to a meeting in their place or to carry out their other duties. One ALG member suggested that administrative support would have been a useful aid and a way of gaining some extra time for the project work. It was acknowledged, however, that the extra resources needed to properly support their involvement in the project were very scarce.

Continuity between the sessions

Readings given at the end of the session were not usually followed up at the next session, which then moved on to a different topic. This lessened the incentive for ALG members to read them.

I think we all said if we knew we were going to do it on the next time we would have done the reading. I mean if it was just – you can go and find these websites and you can go and look at it – you'll always say, well I never had time.

An alternative suggestion, originating in the feedback forms completed after each educational session, indicated that ALG members would have preferred to have the reading for each session beforehand, in order to help them prepare for the session and to have any questions answered. This was the format used in the CQI sessions at the end of the project, when reading was given in advance and discussed at the next session.

Visits to beacon sites

As stated in the project proposal, there was the opportunity for ALG members to obtain financial support for a visit to a site of good practice, either in this country or abroad. Only one ALG member undertook such a visit, travelling to the USA to look at initiatives designed to reduce teenage pregnancy. It was a source of particular regret for the practitioners interviewed that they did not avail themselves of this opportunity to experience innovative work taking place elsewhere. A lack of time to plan and research where they might go was cited as one reason for this. Additional factors were that the offer was not time-limited,

and participants did not have to report back to the group on their progress in locating a site or planning their visit.

Generally, the practitioners felt that more help and suggestions on where they might go would have made it easier for them to undertake the visits. Time for researching and planning the visits could have been made available within the sessions. Some felt that the emphasis had been on going as individuals to different projects, but if the aim was to alter practice locally, it might have been better for them to go as a group. The trip to the YACs in Dorset was cited as an example of a successful group visit.

However, another ALG member felt that it was a point of learning in her personal development that she did not organise her own visit, and that arranging your own work was just part of being a professional.

Linking groups of practitioners from different areas

Members of both groups felt that the joint sessions were a good idea and generally worked well. There were some issues arising for the practitioners from Swindon as they generally felt they did not have the services for young people that Dorset provided, and that services that worked together there did not do so in Swindon.

We haven't got so many things in place. We are looking to be guided or supported – I hadn't recognised that before – in saying that, if you work collaboratively there is always going to be someone who has more or less experience than you. There's always that dynamic.

However, it was recognised that the nature of the different provision available in both geographical areas was based on decisions that might have been taken 10 or 20 years ago, and that the work in Swindon was now progressing rapidly. 'The baseline was beyond our control,' as one ALG member commented.

Work around teenage pregnancy initiatives was thought to be more organised in Swindon since it was a unitary authority. The boundaries were therefore simpler and there was already multi-agency representation and a partnership board in place.

As described earlier, practitioners from Swindon took part in an all day community development session in Dorchester, followed by a visit to

some of the YACs in Dorset. The interesting point about the YACs for the members from Swindon was that there was a charity at the heart of them, giving flexibility and the ability to apply for extra funding. Social Services money was available in large amounts, unlike the situation in Swindon. Thus, the visit served as a useful reminder to them that it was possible for initiatives to obtain money from statutory services to be successful. However, other practitioners felt that the voluntary sector model was not one that could easily be emulated in Swindon.

It wouldn't have been appropriate for us to say, oh we'll set up this model in Swindon because we haven't got that sort of voluntary sector so there would be no point, but it's getting the learning from how that worked and what was, what the young people liked about how the centres were organised. They were organised as a youth club with some health services going in very discreetly, rather than being organised as a health service where you might put a token pool table in the corner.

ALG members from both sites expressed the view that the visit to Dorset should have been reciprocated, with Dorset practitioners visiting facilities in Swindon.

It always felt a bit of a shame that we didn't feel we had anything good enough to show them in Swindon, but actually I think we should have, in a way, had a reciprocal visit regardless. Even if it was they just came and saw, because the focus was on teenage pregnancy but there's plenty we could have shown them, the walk-in centre and the well woman centre.

The centres of excellence in Swindon differed from those in Dorset by not specifically targeting teenagers, but offering free counselling, drop-in services and nurse-led clinics on a variety of issues relevant to women's health.

Diminishing numbers at the ALG

Some of the ALG members who withdrew before the end of the first phase of the project did so due to lack of time and feeling unable to justify the day a month that was taken out of their usual working schedule. Other practitioners' roles changed during the life of the project and this made it less appropriate for them to continue to attend. Also, two regular attendees took long-term sick leave in the spring and summer of 2001.

Many practitioners were involved in services that were subject to change and re-organisation. Some felt seriously overloaded, and work to develop the teenage pregnancy agenda itself was often carried out during evenings and weekends. One ALG member was regularly working a 60-hour week, and this is the context in which competing demands on people's time needs to be understood. ALG members' monthly attendance at PHRIPE, which did not produce results that were easy to quantify, had to compete with work that they were accountable for and which usually could not be carried out by anyone else in their absence.

Some ALG members expressed the view that it had been detrimental to the project that practitioners joined the group and were then not able to sustain their involvement. They felt that this indicated a lack of commitment on the part of those who had withdrawn and that this 'falling by the wayside' of some of the original participants made those who were left feel less committed to the group and to the project. ALG members also suggested that a structure or procedure for bringing in new members would have been useful in sustaining the project, given that people would inevitably change jobs and leave the project.

However, no participants who left the project said in interview that they did so because of a lack of commitment, but due to changing roles, becoming part-time, or long-term sickness. As discussed in the section on interprofessional balance, it tended to be practitioners from outside 'health' who left the project early since, for them, teenage pregnancy was just one issue among many. An alternative explanation for a perceived 'lack of commitment' on the part of those who withdrew was that organisations might initially have signed up for practitioners to attend, and then not given them the support they needed to continue to do so. Practitioners also regretted the way in which the ALG just 'faded out' due to dwindling numbers, rather than coming to a planned end, when ways of taking some of the work forward might have been discussed.

The ALG and Practice

Relationship
between ALG and
teenage pregnancy
task/interagency
groups: time frames

As discussed earlier, ALG members generally felt that it was difficult to share what was learned at the ALGs in Salisbury with the groups that were planning and carrying out the work on the ground. This was due largely to the pressures of the time frames within which various parts of the teenage pregnancy strategy had to be completed in order to secure funding. Some ALG members believed that the teenage pregnancy work in their area had been rushed, and that the practitioners involved had not

had time to think laterally and to broaden their view of what might work. There was a fear that this would result in tinkering at the surface rather than being able to take a step back and really change things. One member of both the ALG and one of the teenage pregnancy strategy groups remarked:

The Government wants everything by tomorrow.

The short time frames in which work had to be conducted tended to support this interpretation. The timing of the first meetings of the project coincided with the Teenage Pregnancy Unit giving every Health Authority £15,000 to map problems and services and develop outline bids against a £6 million national fund. The Unit also proposed to give Wiltshire and Dorset health authorities £50,000 if they presented a plan to use it wisely. The time scale for both these bids was short and had the understandable effect of focusing ALG members on this task, particularly the groups meeting in the localities, which became entirely work-focused.

By the end of March 2001, local authorities were required to produce both a ten-year strategy and three-year plan for reducing teenage pregnancy and this again took up most of the work-based groups' time, as well as that of practitioners who were working at home well into the night. Had the teenage pregnancy agenda exerted less pressure to develop a strategy quickly, then the groups in the localities might have been able to work more closely with the PHRIPE ALGs and integrate more of the theoretical perspectives learned there into their work.

Optimum structures and membership of the ALG

It must be emphasised that membership of the PHRIPE ALG and the teenage pregnancy task groups were not identical, although some PHRIPE members did attend both. The structural and logistical problems created by different groups performing different functions, together with the short time frames available for planning the teenage pregnancy agenda, created considerable difficulty in implementing change in line with the project frameworks.

The PHRIPE ALG was conceptualised primarily as a group that would be able to influence thinking at the level of strategy and planning. However, membership of the ALGs included many practitioners who were managing services at a more local level, and who therefore had a more practical orientation. This raises the question discussed earlier concerning the optimum format for project initiatives such as this.

An alternative formulation in support of the educational model would be that, as an educational group, the ALG would be better placed to produce 'change agents' in many different organisations, and thus theoretically result in a situation in which change could be effected across a wide spectrum of practice. In reality, the role of change agent, as identified in the Ottawa Charter, is a difficult one to play if the expectation is that one practitioner is able to change a whole organisation.

Role of CQI in practice

The CQI facilitator believed that projects using CQI functioned best as work-based teams, rather than educational groups, since these teams were able to exert a greater 'pull' on the practitioners' commitment and time. He reflected in interview:

That's an interesting question, because it's about, what's the focus of this. I think it might have had a big difference actually, in all the work that I'm involved in setting up, or has been set up recently, we've come together as work teams and built the educational learning into that and then the academic centre was based entirely on that premise. You see this is from my point of view, but I think that if it's work-based it stands a better chance of success because you can keep more relevant, with education you can always think I want to go, but I'm a bit busy, so I won't, and it won't affect my work.

Another possible model, which would address the challenge of working with the two different groups, was specific educational input with the work-based teams in addition to that with the ALG. Some ALG members recognised that those practitioners involved in the teenage pregnancy work but not in the ALG were not going to change their values or customary ways of working overnight. Therefore, it might have been advantageous to have some of the educational input in the form of individual sessions for the groups actually planning the work. However, there was an occasion where the CQI facilitator came to a meeting of one such group that had so much business to get through that he did not have time to run the session on CQI, and so they recognised that this approach was not without its problems. The CQI facilitator explained what he had hoped to achieve at this meeting:

I could see as I was listening to them talk about what they were doing, I wrote up a little scheme. I was asked to do a talk about exactly how we could set up a project based entirely around

what they were talking about using principles and ideas from CQI which they could have used and applied to what they were trying to do with no framework.

Although CQI may have appeared to the task group as one more element to incorporate into its busy schedule, its use might have assisted the work of the groups in practice by providing a structure for planning, measuring and reviewing the changes they were putting in place.

Effects on practice

One positive effect of the relationship between the ALG and practice was articulated by a participant in a strategic role, who felt that the project had improved the relationship between the two services that the two recently appointed teenage pregnancy co-ordinators represented, which had been difficult in the past. In her view, the project helped to provide these two people with the public health skills they needed to do the job successfully and further strengthened the network of people and organisations supporting the work.

Interestingly, both the project leader and the CQI facilitator had a more pessimistic view of what the project had been able to achieve than most of the participants. The project leader felt that the project had not been able to fulfil its promise:

No, we didn't get there.

This disappointment was due largely to the premature end of the project due to low numbers attending.

Due to the difficulties outlined in this section, it appeared likely, as one ALG member observed, that within the project, 'more change went on in people's brains than on the ground, maybe that's to come'. However, the importance of 'changing people's brains' should not be underestimated, as that change could influence practitioners' attitudes and understanding, as well as work carried out in the future, which lie beyond the scope of this project evaluation.

Summary of the Main Evaluation Findings

Planning the project

- The PHRIPE ALGs constituted an ambitious model in terms of proposed top-level attendance, timescale and number of frameworks.

The learning frameworks

- There are many challenges involved in sustaining and managing a three-year project with busy practitioners, particularly at a time of rapid change and re-organisation within the NHS.
- Sustaining the interprofessional mix will be problematic if the project focus, in this case teenage pregnancy, appears dominated by health service input.
- Two of the learning frameworks used, the Ottawa Charter and the Verona Benchmark, were based on the premise that improving the health of populations has more to do with improving social and environmental conditions than with advances in medical science and access to medical care.
- The radical public health agenda utilised within the project was not new to most practitioners but needed constant revisiting so as not to be overwhelmed by the demands of everyday practice.
- The Ottawa Charter was a more useful learning framework than the Verona Benchmark.
- The results of the questionnaire, based on the skills of the Advanced Practitioner described in the Ottawa Charter, showed that practitioners were already working at a high level across diverse areas of practice.
- The individual educational sessions, identified through work on the Ottawa Charter, helped to improve practitioners' skills and understanding of those areas.
- The CQI sessions were a powerful learning experience and ALG members regretted that not all the planned sessions took place.
- There were too many frameworks around the project and, with hindsight, the Verona Benchmark did not contribute much extra to participants' understanding of the issues.
- The evidence base utilised in planning interventions is important, provided it is used in a way that enhances learning.

Practitioner learning in the ALGs

- The evaluation revealed that, not only were the practitioners learning about the particular educational topic, the ALG process also provided the 'added value' of learning about and respecting the perspectives of other professions.
- Practitioners recognised the importance of the time allocated for reflection within the ALG.
- It is important for practitioners to come to an understanding of the different terms and language used around interprofessional and interagency work.

- Practitioners, including those who withdrew before the end of the project, valued their involvement and learning within the ALG highly.
 - The importance of the capacity building that went on in the project needs to be recognised. 'More change went on in people's brains than on the ground – maybe that's to come.'
- Organisational learning
- The joint sessions between Swindon and Weymouth & Portland worked well, even though practice in Dorset was thought by both groups to be more advanced than that in Swindon.
 - ALG members would have preferred to have the reading for each session beforehand, in order to help them prepare for the session and to have any questions answered.
 - Practitioners who left the project early explained that they had done so not because of a lack of commitment, but due to changing roles, becoming part-time or long-term sickness.
- Barriers to fulfilling the project agenda
- ALG members felt that the implications and the commitment that their involvement in the project would bring were not sufficiently spelled out at the beginning e.g. meeting for ten days a year together with the attendant reading.
 - The concept of protected time to attend ALGs is not particularly meaningful if practitioners' workloads remain the same.
 - The MAPD practice pathway could have helped sustain the ALG and recruit more practitioners, if it had been available earlier.
 - ALG members suggested that due to lack of time and opportunity it was difficult for them to disseminate the learning beyond the PHRIPE group.
- Choosing the educational model
- The format and membership of ALGs, and whether they are to be education or practice-based, needs careful consideration.
 - As an educational group, an ALG is better placed to produce 'change agents' in many different organisations and thus effect change across a wide spectrum of practice.
 - The CQI facilitator believed that projects using CQI function best as work-based teams, rather than educational groups, since these teams are able to exert a greater 'pull' on practitioners' commitment and time.
 - The project was not able to achieve its full potential but participants nevertheless considered that its innovative approach was extremely worthwhile.

5. EVALUATION

In this final chapter, the research team will examine the extent to which the PHRIPE project met its aims, recognising that this is likely to lie along a continuum rather than elicit a 'yes or no' response. The findings of some key strands of the research process will be reported on, and an assessment will be made of the importance of other factors that could not be foreseen at the time the project proposal and the evaluation strategy were developed. These include a consideration of how far the two different strands of PHRIPE cohered into one project and a discussion of the effect of the number of learning frameworks around the project. Issues of transferability and sustainability are also addressed. The chapter ends with a list of recommendations that it is hoped may assist those planning similar projects in the future.

Evaluating the Project Aims

Project aim one

- Develop ways of helping experienced practitioners from different professional backgrounds in the field of public health to work and learn together to improve public health and well-being.

This project aim was met with regard to the experienced practitioners learning together. The project was not directly able to develop ways of helping practitioners work together, due to the structure of the ALGs as an educational group rather than one based in practice. However, PHRIPE was able to influence practice through the use of learning frameworks that developed practitioners' understanding of the social and environmental determinants of health and their own professional development as public health practitioners.

Practitioners' descriptions of their ideal learning environment included the following elements: an open, friendly atmosphere, feeling free to express a lack of understanding or disagreement with what was being said, and being part of a supportive, trusting group that was able to draw in contributions from all its members. The ALG model adopted in this strand of the project was able to provide participants with these important elements. In addition to learning about a particular topic, the ALGs provided participants with insights into the perspectives and skills of other professions. Participants generally valued their learning highly, and felt that their views of the most important factors that influenced

health had become clearer. Although it is too early to say whether public health outcomes were improved due to the capacity building within the project, there is evidence that processes were improved.

One example of the way in which learning influenced practice directly is illustrated by the individual educational session on qualitative research. As a direct result of this session, qualitative methods such as focus groups were now being used with young people to inform the development of practice designed to reduce teenage pregnancy. On the practice level generally, links between different agencies working to reduce teenage pregnancy were forged and working relationships improved as a direct result of the project.

Another important factor in the success of the learning that took place at the ALGs was the way in which they were lead. The leadership style adopted in the experienced practitioners' strand was to 'lead from behind' and facilitate learning in the ALGs without directing it. The leader's style was embodied in one of his favourite aphorisms:

When the best leaders have done their job, the people say 'we did it ourselves'.

Members felt that the project leader and the CQI facilitator were interested in learning from and with the group and had negotiated rather than imposed a structure on them. This was clearly appropriate to the advanced level of the practitioners themselves, as well as the level at which they were working, and was an approach that was appreciated by ALG members.

There are therefore many successful elements in the ALG model that could be taken up and used by other projects. The transferable elements in this strand of the project include:

- Giving academic credit based on work undertaken in practice;
- Focusing on a single public health priority;
- Educational sessions chosen to address practitioners' own assessment of the gaps in their skills;
- Use of guiding frameworks, such as the Ottawa Charter, encompassing a global conceptualisation of health and one to improve practice, such as CQI;
- Use of research evidence to guide practice;

- Individual exposition and group discussions of relevant academic papers and reports;
- Building reflection on learning and practice into projects. PHRIPE included a whole-day session;
- Visits to beacon sites of good practice, subject to appropriate support and encouragement being given to practitioners to undertake them;
- Choosing an attractive and peaceful venue at which to meet.

However, despite its many successes, this strand of the project ended prematurely, and questions therefore arise as to the factors that resulted in the ALGs not being sustained. The evaluation revealed that one of the barriers to sustainability was a lack of protected time for practitioners to attend meetings, a factor that was also highlighted by the other LITs at the Collaborative. Other barriers included the extended length of time that the ALGs were projected to run for, the number of learning frameworks and the lack of direct 'accountable' relevance of the teenage pregnancy agenda for those practitioners outside health.

Members from outside the health professions, with the exception of the public health consultant, ceased to attend before the end of the project because, for them, reducing teenage pregnancy was not 'core business'. A related factor was that, as the ALGs became more dominated by 'health', the few non-health practitioners felt more marginalised. This happened even though the determinants of health in the ALG, particularly as the project developed, were acknowledged to be social, environmental and psychological, rather than the provision of treatment services. An additional factor that would have been likely to aid the continuation of the ALGs was for practitioners to visit a 'beacon site' of good practice in reducing teenage pregnancy, particularly if they had attended with a colleague from a different locality. Most participants did not take up the opportunity offered within the project to obtain funding to undertake such a visit, thus missing a valuable learning opportunity, as many of them later acknowledged.

The difficulty of meeting the project aim of helping practitioners to work together as well as learn together raised questions over the links between learning and practice and whether it would have been better for PHRIPE to work with a team in practice. This is difficult in the public health arena because such teams do not usually exist on a permanent basis. Practitioners come together in different groups or multi-agency

partnerships in order to tackle particular issues, in this case teenage pregnancy. However, the fact that the ALGs were not teams working together on a practice issue made the use of CQI in the project more difficult to sustain. A challenge for similar projects is therefore deciding the best way to build CQI into work early on, with an educational team that is not a team in practice.

In conclusion, despite the challenges identified above, this strand of the project contained many elements and experiences that those planning similar projects should find valuable. Most participants left the ALGs with important and valuable learning, incorporating a broader view of what constituted health, or at least having their earlier learning in this field reinvigorated. We cannot know definitively how the learning will impact 'down the line' on practice but believe that it is likely to lead to a change in practice through the change in attitudes that took place.

Project aim two

- Provide pre-qualification learners with opportunities to develop the necessary knowledge and skills to work together to improve public health and well-being.

This aim was met through students' involvement with the project, either on public health placements or through having a practice experience. PHRIPE was a valuable experience for students because they were given opportunities to learn first hand about the reality of residents' lives and how health visitors were adopting new models of working with community needs, as well as observing interagency planning and working. Indeed, student learning often went beyond the acquisition of knowledge and skills to encompass an emotional dimension, which ensured that what they had learned was unlikely to be forgotten. Student experiences on placement also affected the development of their perceptions of their professional identity. Their understanding of the potential development of their roles and those of other professionals ensured that they realised commonalities in their approach to clients.

These points highlight similarities and differences between the public health and the other interprofessional projects represented at the Collaborative. The public health placements expanded the idea of the nature of the work that was relevant to students' core curriculum, i.e. community-based approaches to social work, which involved taking a systems rather than an individual perspective. One of the aims of this and the ACHIEVE project was to change the way in which nurses and

health visitors worked, and to bring an understanding that members of all professions and of none can make a significant contribution to community development. Students' research in the Boscombe HAA was used to build the OASIS database as well as produce leaflets containing details of useful self-help and voluntary groups that residents could contact. Students reported finding this motivating.

Some individual students clearly benefited to a great extent from their learning on the public health placements. The caveats here are that this depth of learning only occurred for a small number of students and was dependent on the closely facilitative relationship between an excellent placement supervisor, who was already working in the area, and her students. This depth of learning in those students not on placement, but having a public health practice experience, was restricted to an even smaller number of mature, well-motivated students who were able to appreciate the benefits of this learning opportunity.

When the individual facilitation is added to the requirement that social work students should have a 'long-arm' social work practice teacher, it is apparent that PHRIPE formed an effective but resource-hungry model of interprofessional student facilitation. The other limitation was that interprofessional student involvement was largely restricted to nurses and social workers, although students did interact with a variety of other professionals in the HAAs. The interprofessional placements, because of the factors mentioned, were initially time consuming and labour intensive to set up, and it was argued by some practitioners that the money involved would have been better spent directly on the service user. However, the aim of projects such as PHRIPE is that greater interprofessional co-ordination will eventually benefit the service user in a systematic and sustained way.

Complete fulfilment of this aim would have required the involvement of a greater number of practice educators from the different professional groups within the Institute, with more time available for the project work. It would also require greater harmonisation of placement patterns and learning outcomes, much of which can only be sanctioned at the level of the relevant professional bodies. However, the complexity of co-ordinating the various organisational factors should not obscure the fact that valuable learning took place for students, who were also able to make a valuable contribution towards improving the lives of the residents they worked with.

Project aim three

- Create new and innovative interprofessional learning sites.

This aim is related to the preceding one but proved more challenging to meet, since it required changes in organisational practice, which are among the most difficult to achieve, to make the learning sites sustainable. On a practical level it involved constant efforts by project personnel to secure suitable accommodation and equipment for the pre-qualifying students. This did not happen in one of the HAAs and happened only towards the end of the project in the other. It also required the involvement of a number of different student and professional groups which, as previously described, did not happen to the extent envisaged. A further difficulty was the lack of sufficient practice teacher time and involvement.

However, the elements that were new and innovative in the PHRIPE learning sites are also those that should transfer to other pre-qualifying projects, such as:

- Forming learning sets from all the students from different disciplines on placement in an HAA or similar area;
- Cross-professional supervision of students;
- Engaging students on placement early in their professional careers;
- Students undertaking individual CQI cycles for work undertaken on the project;
- Students going on placement in pairs;
- Involving practitioners with dual posts in universities and partner organisations as key players in projects;
- Students' ability to meet their course learning outcomes through working on a placement that also promoted community development;
- For the re-launched learning sets, using the model of 'buddy pairs', with practitioners and students learning together.

In conclusion, this project aim was met with regard to the transferable elements listed above. Meeting this aim in full would require the integration of many different factors, as well as a willingness of the partner and voluntary organisations to commit increased financial and human resources to the policy aim of increasing interprofessional and multi-agency working. It would also require a management strategy that could successfully integrate all these different elements and was flexible enough to cope with a process of continuous change in personnel, priorities and organisational structures.

Project aim four

- Incorporate the developed learning approaches into mainstream professionally and academically accredited undergraduate and postgraduate education and training provision, thereby creating a learning pathway in public health improvement.

An interprofessional Continuous Quality Improvement module was approved within the Institute at the pre-qualifying level, influenced in particular by RIPE, the first major interprofessional initiative. The opportunity to do this arose from the re-writing of the nursing curriculum that takes place every five years. The unit rationale was:

To assist qualified and pre-qualifying learners and students to learn and work together across professional and agency boundaries so as to improve services for patients, clients and service users.

This learning programme is a Level Two option unit for all nursing pathways, which carries 20 credits and offers students the opportunity to participate in practice-based learning as part of an interprofessional team. It is hoped that completing the unit will enable students to understand the importance of placing user needs at the focus of professional activity and service design, and allow them to demonstrate how they will place user needs at the base of their work for improving the quality of care and for interprofessional working.

A number of postgraduate frameworks within the Institute now support both the interprofessional and public health agendas. The MA in Professional Development (MAPD) was developed at postgraduate level, incorporating a practice pathway accessible to all practitioners, including those working in public health, which was subsequently undertaken by two ALG members. This programme became the MA in Practice Development to reflect the importance attached to the development of practice and the success of accrediting the work undertaken in practice. A postgraduate framework, the MSc/PG Dip/PG Cert in Public Health, has also been available since October 2001. This is designed to help prepare the workforce in line with the requirement that Primary Care Trusts (PCTs) and local authorities work to improve public health and reduce health inequalities. In addition, a PG Diploma in Public Health with community specialist nursing is offered, leading to employment as a specialist community nurse. These new programmes joined the Interprofessional Masters, the MAIHCC, in the Institute's portfolio of

interprofessional and public health provision at post-qualifying level, with PHRIPE personnel undertaking teaching on units within these programmes.

Rather than claiming that PHRIPE directly influenced these developments, it would be more accurate to view PHRIPE and the development of the different frameworks within the Institute as growing from the same roots. These included the policy initiatives already described, such as *Saving Lives: Our Healthier Nation* (1999) and *Shifting the Balance of Power within the NHS* (2001) which pointed towards the development of a multi-disciplinary public health workforce in order to help narrow the health gap between affluent and deprived areas. The Institute responded to this agenda by providing appropriate courses to help practice organisations meet those aims.

Project Frameworks

It became apparent during the PHRIPE project that there were complex interrelationships between the different agendas and frameworks driving the project. The project had two main drivers: interprofessional learning and public health improvement. Clearly both of these have very large agendas and theoretical bases. In addition, CQI methodology constituted an important element in the project, although it did not play the major role originally intended.

One view on how the frameworks fitted together came from the CQI facilitator during interview, who analysed the relationship between CQI and public health, describing how they could work together in a complementary way. In his view, public health was concerned with identifying priorities for improving health, and when practitioners wanted to improve an aspect of their practice, then CQI methodology provided an ideal framework for making a series of small-scale changes. Another level of integration was that both public health and CQI were about matching services to needs. The CQI facilitator recognised, however, that public health was much more complex, more political and more diffuse than CQI.

Another factor that indirectly promoted interprofessional working was that public health improvement and community development work require different agencies, volunteers, students and residents to work together in an area. The public health work within the project appeared stronger

where different professional groups had been involved. The project focus was on user and community need and interprofessional working was part of the means of meeting those needs and not something to be pursued for its own sake.

Although all frameworks and agendas were broadly complementary, some 'implied' others i.e. contained the same or similar ideas in a different format. An example of this was that CQI implied the necessity for interprofessional and interagency co-operation, as did the public health agenda. Within the experienced practitioners' strand, the Ottawa Charter 'implied' the Verona Benchmark.

Analysing the way that the agendas and frameworks worked together, the evaluation team concluded that the interprofessional agenda of the project had been comprehensively eclipsed by the public health agenda. The project leader of the pre-qualifying students recognised the conflict:

If the driver is public health then the driver is not inter-professional working.

It was difficult to predict at the time of the project proposal how the many agendas or drivers, with the addition of CQI as a framework for shaping practice, would work together and it was tacitly assumed that the effect of these would be synergistic. However, in practice the number of drivers and frameworks overloaded the participants with methodologies and created some tension over which ones to concentrate on. Somewhat ironically then, a barrier to learning and to the sustainability of the project proved to be the number of frameworks, agendas and drivers around it.

Integration and comparison of the two project strands

Another important question that needs to be considered is how far the two different strands of PHRIPE constituted one project and what the added value was of combining those two levels of learning, from pre-qualifying students through to experienced practitioners, in one project. One of the aims of the evaluation process was to assess the benefits of undertaking the project at two different sites, and what the similarities and differences were between them. The differences proved to be more numerous than the similarities, due to a number of factors, including the different educational level of the personnel involved.

Another important factor was the use of learning frameworks in the experienced practitioners' strand that would not have been appropriate

to guide student learning, e.g. the concept of the Advanced Practitioner embodied in the Ottawa Charter, and the ability to have an influence on the development of policy at a strategic level assumed in the Verona Benchmark 1.

Unless practitioners involved in PHRIPE attended a steering group meeting, they were not generally aware that they were part of a project with another strand relating to a different level of learning. There was little crossover between the two strands, although the project leader of the experienced practitioners ran four sessions with Sure Start practitioners at West Howe in order to facilitate the building of their interprofessional team. More cross-fertilisation between the two strands, such as arranging some joint meetings between the practitioner learning sets in the HAAs and the ALG in Salisbury, might have been useful in widening the learning and helping to develop a pathway that accommodated learning at both pre- and post-qualifying level. The ALG might have included practice educators as well in order to be able to pass on some of the learning to new practitioners. However, it is also possible that the sites, levels and approaches were too different for one to gain much from the other and greater integration would have added another layer of complexity to an already complex project.

An examination of the main evaluation points from each strand of the project illustrates that more barriers to learning were encountered with the pre-qualifying learners. This is in keeping with the literature (Reeves and Freeth 2002) which describes the well known factors in this area, such as the difficulties of obtaining equal student numbers from each profession and of securing joint validation and accreditation for new interprofessional courses. The main challenges for the experienced practitioners were the demands of practice and heavy workload, which made it difficult for them to continue to attend the ALGs. However, this strand was organisationally less complex and as Weinstein (1997) described, post-qualifying interprofessional learning has become much more accepted in recent years.

A more structured and top down approach was utilised in the experienced practitioners' strand, as opposed to a more responsive and bottom up approach adopted with the students in the HAAs. We learned that some of the benefits of the structured approach were that it gave practitioners the opportunity to benefit from the best thinking in public health on an international level, e.g. from the WHO through the Ottawa

Charter. This Charter is becoming more widely used in the UK to develop good practice, as well as the Verona Benchmark 1, which was the first initiative in a series of innovative international meetings.

One difficulty encountered by the pre-qualifying strand in responding to local priorities and agendas in the HAAs was that it made the project focus somewhat diffuse, as well as requiring a great deal of energy to keep up with the different initiatives born of new funding streams. Considerable time was taken in helping to develop major bids for funding, such as the Healthy Living Centre (HLC) in Boscombe. This bid has now come to fruition and the HLC is developing some of the projects previously supported by the ACHIEVE project at the Institute. However, involvement in these bids was a useful learning experience for students, who were preparing to adopt a more community-focused approach to social work and nursing when in practice themselves. Another difference between the two strands was that the ALG of experienced practitioners was not based in a geographically discrete area as the pre-qualifying students were; they had a much bigger 'patch' as befitted their more strategic role.

Another important aspect of trialling two different models was having a single public health focus in the experienced practitioners' strand e.g. developing the teenage pregnancy agenda at a strategic level, while the priorities of the local community were adopted in the pre-qualifying strand. We have learnt more through PHRIPE about the benefits of the more structured versus more responsive approaches, and about when each was most appropriate. We therefore believe that by undertaking the range of activities and approaches embodied in both project strands, we have been able to test a model that has significant benefits and contains substantial elements that are transferable to other sites.

Overview of how far the PHRIPE Project met its aims

As has been described, the full implementation of the PHRIPE project's aims would have required changes that were beyond its power to instigate. However, the project was more successful in meeting its practice-based aims and outcomes than in changing practice within the Institute and building substantial interprofessional learning into the pre-qualifying curriculum. This resonates with much of the existing literature,

e.g. Baker et al. (1998). The authors describe how the organisational obstacles that faced an interprofessional educational project stemmed from the characteristics of universities as being:

...highly organic structures with loose rules and regulations, decentralised decision making and a disjointed hierarchy of authority. Such structures create excellent contexts for creative work but they prove highly immune to change themselves. Those attempting change in such organisations often face difficulties in formulating goals, recruiting those whose actions are necessary to achieve those goals and developing a clear understanding of how to change the teaching and learning processes (p3).

These are significant points and reflect the experience of PHRIPE at the pre-qualifying level. Despite a huge effort by the project leader and a major commitment to practice development in the direction of increased social justice within the Institute, it proved difficult to gain sustained commitment and to effect lasting change. However, despite these difficulties in ensuring sustainability, as demonstrated earlier, the PHRIPE project was largely able to meet its aims. Project personnel developed a model that delivered significant learning for its participants, as well as enabling them to play a part in work that helped to improve services for teenagers and for the residents of the HAAs.

Sustainability and Transferability of the Project

Lessons for similar projects

We would like to begin this section with some thoughts on transferable learning to clarify what we mean by this concept. These include some insights from the CQI facilitator, who had experience of working with improvement projects in many different settings:

When people talk about spread they usually talk about how do we take this idea and make sure people will use it and I think spread is quite different to that. I think spread is about how we actually help people over here ask questions to which there is an experience there that will help them address their questions. Much of spread is talking about sort of we've done this round here, let's go and persuade the people over there to do it. I don't think it works like that and you may have a short-term success but it won't sustain.

The issue of the sustainability of all aspects of PHRIPE remained at the forefront of planning and management of the project. Although it was initially suggested that the answer to securing commitment lay in ensuring that managers of the partner organisations signed up to the project at the beginning, it transpired that this was not enough. It appears that the secret of sustainability lies in securing real commitment from managers and practitioners through convincing them of the intrinsic value of what is taking place in the ALGs or the learning sets. For practitioners, this could be the use of CQI, the time for reflection or discovering what other services provide, or whatever will help them in a meaningful way with the work they have left to attend the meeting. For managers, it would involve the belief that the project work will assist their organisation in meeting its strategic aims and targets.

In terms of embedding interprofessional working, the PHRIPE project leader expressed his understanding that change needed to happen simultaneously at all levels in organisations, including the strategic and the operational. It became apparent during the project that many of the changes needed to ensure the success of this and future interprofessional projects could only take place through a change in emphasis in Government policy – joint working between agencies should be mandatory rather than just desirable. Making funding dependent on it is probably the only way to ensure that this happens. Until then, interprofessional working is unlikely to become mainstream and projects such as PHRIPE will unfortunately continue to be just a bolt-on to existing practice.

The granting of academic credit is also a large incentive to continue attending learning sets and it does appear that this, together with the ALG model used with the experienced practitioners, will transfer successfully to other settings. This is subject to enabling a longer lead-in time to allow for validation of, and recruitment to, new academic modules, which should mean that the academic credit is available concurrently with the beginning of the ALG.

A similar but smaller scale project has recently been launched at the Institute. Research findings from PHRIPE have been used to assist in the planning of this year-long project, a timeframe that should make it easier to sustain practitioners' commitment. The public health practice development fellow at the Institute is facilitating the project with public health practitioners working in deprived areas of Dorset and Somerset.

The initiative has the aim of setting up public health teams that will continue after the end of the facilitation process.

In conclusion, the learning methodologies employed in PHRIPE proved flexible and responsive enough to adapt to changing local conditions and to facilitate significant learning in both strands. However, similar projects will require significant support in order to circumvent the challenges that have already been described in this section.

PHRIPE Recommendations

It is hoped that the following recommendations may help partnerships contemplating similar projects.

Implications for practice

- To change practice most effectively, projects should work with existing teams that are in a position to influence local policy and practice;
- Organisations need to give some thought to how protected time for staff to attend ALGs will work in practice. Shared administrative help is a viable option for lessening practitioners' workload, particularly for those at strategic level;
- To sustain interprofessional involvement, the project focus should be on a practice area that all professions can contribute to, and not one that will be dominated by health services input. This may be difficult because of the large number of health professionals and the continued influence of a medical model of health.

In partnership working it would be helpful:

- For the funding and commissioning body to distribute funding to the different partner organisations according to the contribution they are expected to make;
- To have a named person from each partner organisation who is responsible for developing interprofessional and/or public health learning in practice. When that person leaves the organisation or changes their role within it, then another named practitioner should replace them;
- To make the nature of organisations' expected involvement more explicit by asking them to provide a specified amount of protected time a year for their named person;
- To have regular stakeholder meetings during the first year (defining stakeholder as widely as possible);

Sustaining commitment

- To develop shared outcome measures that will drive organisational priorities in the direction of more interagency and interprofessional work.
- Ensure that there is a common understanding of the different terms used in what may be a new theoretical area for some practitioners.
- Rewards for involvement need to be given so that projects can compete for people's time with existing workloads. These can include academic credit for work in practice and a lessening of assignment requirements for pre-qualifying learners who become involved in project work.
- It is important to allow time for reflection in the ALGs and learning sets, as well as educational input. The busier that practitioners are in their everyday working lives, the more important it becomes for projects to provide them with a 'space to think'.
- Ground rules need to be established so that practitioners feel safe in doing this.
- Important project meetings should be rotated around the different partner organisations or held at a neutral venue in order to promote equal ownership of the project by everyone involved.
- Projects such as PHRIPE can place heavy practical and emotional demands on their most important personnel. It is therefore important to try to protect such staff from 'burnout' and from becoming lost to their organisation.
- Sufficient time should be allowed for the validation of new academic modules designed to accredit learning on projects. This will support the learning, and practitioners gaining academic credit for work in practice will act as additional motivation for them to continue. These validated units and courses need to be in place before such educational experiences begin.

Supporting students on placement

- Students should go on placement in pairs, since it can be a daunting experience for them to be placed in the HAAs on their own. Two students from the same discipline will be likely to offer each other more help and support but two from different disciplines will clearly enhance the interprofessional nature of the learning experience.
- Every effort should be made to obtain proper bases for students on placement with access to necessary facilities such as telephones, computers and the internet. The fact that there was no base for students in the West Howe HAA was one factor in making this a difficult location in which to support students.

- Good administrative help is important. A student placement administrator who can loosely organise preparatory work with the students at the beginning of their placements and be responsible for making other practical arrangements will be useful in reducing the workload of the placement supervisors.
- The issue of whether public health placements should take place in a student's first or second year is one that needs careful consideration. On balance it appears best to catch students in their formative stage, while they are still developing their ideas about how they should think in the field of health improvement.
- Students should be provided with a sufficient variety of tasks to undertake on placement so that their interest is maintained throughout. Placements that emphasise community empowerment are particularly likely to meet these requirements.
- Students should be encouraged to keep reflective diaries to record their learning and as a mechanism for questioning their own initial assumptions.
- Placement supervisors need to find a suitable compromise between being overprotective and leaving their students to 'sink or swim'.
- Practitioners who work in new ways need to be prepared for the reactions of colleagues who feel this threatens their own professional identity.
- Support should be provided for practitioners and students undertaking project work in their individual workplaces, otherwise it is likely to be 'swallowed up' by the demands of everyday practice.

The use of CQI

- CQI methodology should be built in at the beginning of projects to shape the improvement work that takes place.
- Practitioners should come to sessions with a practice issue that they want to analyse and work on improving in a systematic way.
- CQI is most successfully undertaken with groups in practice who are working to improve the same issue.

Planning and organisation of projects

- Projects should set modest and attainable aims and objectives, and preferably fewer of them. There is a danger that projects with a large number of closely determined specific aims and objectives form a top down model that can feel disempowering to those involved.
- Project planners should be wary of setting too many frameworks and more than one policy driver. The hope within PHRIPE was that these would operate synergistically. However, if there are many different drivers and frameworks, this may have the effect of

detracting from what gets done, because it is not clear which should be given priority. It is not usually possible to pursue all of them equally. Careful consideration is therefore required of how a complex mix of frameworks can be moulded successfully into a seamless whole.

- Sufficient time should also be allowed for planning, recruitment and disseminating information on what participation in projects will involve for both managers and practitioners.
- An alternative to the steering group model of top-level representatives of the partner organisations would be to include placement supervisors, interested students, and practice educators, as well as anyone else who might want to become involved. This will form a more democratic and participative model, and help practitioners to feel more involved.
- A single focus, such as the reduction in teenage pregnancy targeted in the ALGs, will be useful in reducing the complexity and increasing the visibility of public health projects and the ability of practitioners and service users to identify with their aims.

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APPENDIX 1

Competencies of the Ottawa Charter

Developing healthy public policy

Be comfortable articulating a socio-environmental model of health

'It is important for the development of appropriate policies that health is seen in both its positive (well being, quality of life) as well as negative (death, disease, disability) dimensions. The Advanced Practitioner (AP) is able to articulate a coherent comprehensive model of the determinants of health and to demonstrate how a policy is likely to improve health.'

Creating a supportive environment

Identify and support effective change agents, including zealots

'Within organisations and communities there will be individuals and groups that are or can be energised around particular issues in ways that can promote change. The AP is able to utilise the passion of the zealot to create momentum for change and to offer appropriate support for action.'

Strengthening community action

Inform and advise on health issues in a way that enables self help

'The AP recognises when communities need information and advice in order to progress. S/he is able to lead from behind in assisting the communities to access that information. The AP has well-developed knowledge and understanding of community development processes. S/he is able to recognise opportunities for development to occur and to act to facilitate that development.'

Developing personal skills

Act in such a way with individuals and communities that they feel enabled by his/her involvement

'The AP will act in such a way that her/his actions are congruent with best practice. This requires that individuals and communities will experience the AP's presence as enabling rather than controlling, consultative rather than imposing and fostering co-operation rather than competition.'

The AP is able to act as a mentor to others who are involved in facilitating health-promoting processes, and to effectively pass on his/her knowledge and skills.'

Re-orienting the health services

Articulate the need for re-orientation

'The AP knows and can articulate the broad economic and social arguments for investing in health promotion and disease prevention rather than the treatment services.'

APPENDIX 2

Issues in Interprofessional Learning

These reflections are taken from the one-day ALG session held on interprofessional learning.

Different implications of the language used

- Multi-agency implies practitioners coming round a table to agree an agenda and each agency taking a piece of work away to develop or implement, but not to share resources.
- Interagency implies putting resources on the table and collectively agreeing the use of those resources.
- Interprofessional work implies learning as well as working together, whereas interagency work does not have these same implications.
- Working in partnership may be a better and more inclusive term. Some funding initiatives may encourage different kinds of working together. European Social Fund bids may encourage multi-agency as opposed to interagency working.

Advantages of interprofessional learning

- It enlightens the participants more because they are open to other perspectives, rather than a purely narrow professional view.
- It helps with networking when not in the learning environment.
- It helps practitioners to understand other organisations' value bases so that communication between them can be enhanced.
- Coming together in a learning environment may help break down prejudice in long-established multi-agency teams.
- Interprofessional learning is active while interprofessional working is often reactive.
- It brings a focus on to the client's needs rather than the needs of the different professional groups.
- The realisation that more may be 'shareable' than previously thought can result in the understanding that there are generic competencies such as interviewing, communication skills and active listening.

Disadvantages of interprofessional learning

- It requires constant energy because there are lots of people to form relationships with.
- It requires the honesty to ask questions and to admit when practitioners do not know or understand something.

- It means using different language and acronyms. Language was sometimes perceived as a form of professional protectionism.
- It can engender anxiety because some practitioners may feel that other professions have higher-level knowledge in some areas. Conversely, it may be more threatening if practitioners do not understand something in their own field.

APPENDIX 3

Learning Materials Used at Each Session

Evaluation	Extract from: <i>Practical Guidance on Evaluating Health Promotion</i> by Jane Spriggett, Professor of Health Promotion and Public Health at Liverpool John Moores University, on behalf of the WHO-Euro Working Group on the Evaluation of Health Promotion.
Qualitative research	COBB, AK & HAGEMASTER, JN. (1987) Ten criteria of evaluating qualitative research proposals. <i>Journal of Nursing Education</i> 26 (4), 138-141. MAYS, N & POPE, C. (2000) Assessing quality in qualitative research. <i>British Medical Journal</i> 320, 50-52. POPAY, J, ROGERS, A & WILLIAMS, W. (1998) Rationale and standards for the systematic review of qualitative literature in health services research. <i>Qualitative Health Research</i> 8 (3), 341-351.
Continuous Quality Improvement (CQI)	BERWICK, D, (1989) Continuous Improvement as an Ideal in Health Care. <i>New England Journal of Medicine</i> 320, 53-56. BOISVERT, L, (1995) Improving Community Health: Staying on the Path. <i>Quality Connection</i> 4 (4), 6-8. EDWARDS, D. (1993) <i>The New Economics for Industry, Government, Education</i> . MIT Centre for Advanced Engineering Study. KNAPP, ML, BENNETT, NM, PLUMB, JD & ROBINSON JL. (2000) Community based quality improvement education for the health professions – balancing benefits for communities and students. <i>Journal of Interprofessional Care</i> 14 (2), 119-130. MCKINLEY, et al. (2000) <i>Transition points: changing needs for information and support during breast cancer diagnosis, treatment and survivorship</i> . Unpublished paper presented to the 7 th Annual Scientific Symposium on Improving Health Care in San Francisco, December. REISER, SJ. (1993) The Era of the Patient: Using the Experience of Illness in Shaping the Missions of Health Care. <i>JAMA</i> , 269 (8), 1012-1017.
Community development	Extracts from: <i>Monitoring and Evaluation of Community Development in Northern Ireland</i> . Voluntary Activity Unit.