Evaluation Report

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Salisbury Health Care NHS Trust crest

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Forston Clinic, North Dorset Primary Care Trust

Contents

Aim and Scope of Document

This document aims to deliver an extensive account of the evaluation of the Academic Centres in Practice (ACPs) initiatives between healthcare trusts and the Institute of Health and Community Studies at Bournemouth University. Two ACPs were initially developed: the Academic Centre for Mental Health and Primary Care is a collaborative initiative established by Bournemouth University and North and South West Dorset Primary Care Trusts. The Academic Centre for Healthcare Improvement is a collaborative venture established by Bournemouth University and Salisbury Health Care NHS Trust.

The report begins by considering the changing higher education terrain with the emphasis on knowledge exchange through partnership working, highlighting the importance, benefits and pitfalls to working in partnership with other large organisations. Through knowledge exchange partnerships, higher education is transforming work, which the introductory chapter offers an insight into, in addition to work-based learning. Finally, three different examples of higher education and health partnerships are shown as case studies, addressing a work-based learning collaboration, a strategic partnership and a research-based network. Chapter 2 outlines and justifies the qualitative methodology undertaken throughout the evaluation.

The document continues with Chapter 3 uncovering the story behind the genesis and development of each ACP, from the initial vision of Professor Iain Graham from Bournemouth University and the pioneering work of Mary Monnington from Salisbury Healthcare Trust and Jill Pooley from Dorset Community Trust. The anticipated benefits for Salisbury ACP and Dorset ACP are highlighted. In addition, the targets for the Dorset ACP are noted.

Chapter 4 shows the achievement and successes of each ACP. In particular, the Salisbury ACP has left lasting legacies through work with the Burns Unit Quality Improvement Team, its contribution to the Foundation Programme of the Modernising Medical Careers initiative and in underpinning the development and design of the South Wiltshire Academy. With regard to the Dorset ACP, the focus of many of the workshops and the support with regards to audit appears to have been extremely successful in changing culture, the lasting legacy of which could have real benefits to practice improvement and patient care. The Dorset ACP has also been successful in helping to establish a research culture throughout the Trust; specifically it has initiated a research and publication database, setting up a resource room for research active

staff and running workshops addressing presentation skills, literature searching, writing, evidence-based practice, research appraisals and proposal and report writing.

The next section of the report presents six case studies of practitioners who have worked closely with their ACP, highlighting how each ACP has enabled the practitioners to develop their practice through reflective learning models, bridging the theory-practice gap and overcoming the distance between audit, quality, clinical governance and practice.

The subsequent chapter addresses key learning points surrounding the strategy of the ACPs. These show the learning that came from analysis of the interviews with key individuals. This generated six categories: the vision, implementing the vision, barriers, roles, resources and monitoring.

The ACP model has certainly created the beginnings of a cultural shift in education and learning in the NHS. An increase in higher-level learning through work-based learning initiatives, including action learning sets and reflective practice in particular, has helped to close the theory-practice gaps and bridge the audit, quality, governance and practice divides. Such learning has undoubtedly helped practice development and improvement among those the ACPs have reached and engaged with. However, there has been a great deal of angst in both settings, much of it surrounding the strategic nature of the collaboration. The discussion, found in Chapter 6, examines the successes and the challenges in light of previous research, locating the evaluation within a wider context. The report ends with a series of recommendations that aim to build on and help others learn from the experiences had during this model of education and development.

Executive Summary

Background

The Academic Centres in Practice (ACPs) are collaborative initiatives set up between Bournemouth University and NHS trusts: the Academic Centre for Mental Health and Primary Care was established by Bournemouth University and North and South West Dorset Primary Care Trusts; the Academic Centre for Healthcare Improvement was established by Bournemouth University and Salisbury Health Care NHS Trust. Each ACP builds on the strengths of the Institute of Health and Community Studies at Bournemouth University and its practice partners and symbolises the Institute's and the collaborating Trusts' vision for academic excellence: high quality, evidence-based practice, teaching and research. The brief these Centres had was to establish a collaboration between learning and practice whereby the synthesis of research, learning, knowledge transfer and education could be tied explicitly to service, management of change, redesign and development for the overall purpose of improving patient care. The model for an ACP was based on work addressing communities of practice and learning (Lave and Wenger, 1991; 1999; Wenger, 1998a; 1998b; Wenger and Snyder, 2000).

Evaluation Methodology

The evaluation has the following aims:

- To evaluate, using a formative evaluation utilising transactional, illuminative and responsive evaluation frameworks, the Academic Centre in Healthcare Improvement collaboration between Bournemouth University and Salisbury Health Care NHS Trust;
- To evaluate, using a formative evaluation utilising transactional, illuminative and responsive evaluation frameworks, the Academic Centre in Practice in Mental Health and Primary Care collaboration between Bournemouth University and South West and North Dorset Primary Care Trusts.

And the following objectives:

- **Objective 1:** Narrate the genesis, implementation and development of each ACP;
- **Objective 2:** Highlight the value of each ACP to patient care, practice development and governance of the Trust, including mapping against current Trust priorities;

- **Objective 3:** Highlight areas of best practice and recommendations for overcoming barriers that would inform future work between higher education institutions and healthcare trusts and organisations;
- **Objective 4:** Develop a model of critical reflection to allow such collaborations to evaluate themselves throughout their development, aiding them to become critical self-sustaining communities.

To achieve these aims and objectives, the evaluation undertook the following methodology:

- **Phase 1**: Documentary analysis of ACP papers;
- **Phase 2**: Interviews with 42 key stakeholders from Salisbury Health Care NHS Trust, North Dorset Primary Care Trust, South West Dorset Primary Care Trust, and the Institute of Health and Community Studies, Bournemouth University;
- **Phase 3**: The analysis of phases 1 and 2 was completed which informed further interviews focusing on key issues with some stakeholders from the above;
- **Phase 4**: Interim reports delivered to key stakeholders;
- **Phase 5**: Using analysis from phases 1, 2 and 3 and feedback from phase 4 to develop recommendations;
- **Phase 6**: Write-up, dissemination and reporting.

Analysis of the data can be split into two distinct areas: successes for practice and issues in collaborative strategy.

The Academic Centres in Practice Achievements and Successes

Within the Salisbury Academic Centre for Healthcare Improvement work has centred on:

- The Burns Unit Quality Improvement Team;
- Quality and Improvement Learning Set;
- Improving Patient Safety Group;
- Patient Involvement Group;
- Educational Programmes for Spinal Unit Staff;
- Learning Set for Consultants;
- Modernising Medical Careers Programme;
- Involvement in the Design of South Wiltshire Academy.

In particular, the Centre has left lasting legacies through its work with:

- **The Burns Unit Quality Improvement Team.** This has improved healthcare provision for the patient, improved professional practice of healthcare professionals and led to accreditation for the learning;
- **Medical Careers Foundation Programme.** The centre has been involved in making a specific contribution to the Foundation Programme which underpins the Modernising Medical Careers initiative through helping junior doctors learn about improvement and patient safety;
- **Design of the South Wiltshire Academy.** The work of the ACP has supported and informed the development of this initiative.

The Dorset Academic Centre in Mental Health and Primary Care has carried out a needs-driven programme of work based on three main targets:

- Providing support and advice for practitioners in the development of research-based practice;
- Identifying and developing communication network systems to disseminate evidence-based practice;
- Developing and implementing a comprehensive educational package covering a wide range and level of research skills and knowledge to meet the individual needs of practitioners in the workplace.

In achieving these targets, the work of the Dorset ACP has centred on:

- Audit programmes;
- Providing workshops on research and audit topics;
- Supporting practice development units;
- Working with lecturer practitioners in the area of palliative care, centred on ethics and moral decision making;
- Team building and leadership training;
- Setting up a resource room for research active staff;
- Developing a research and publication database;
- Offering bespoke sessions for Masters-level students;
- Helping individuals achieve scholarships.

In particular, the Centre has begun to develop a lasting cultural change through:

- **The audit programme.** Support with regards to audit has afforded an opportunity for managers and practitioners to see mandatory audits as an empowering instrument that helps them to reflect on practice and develop individual and group practice;

- **Team building and leadership training.** Focusing on the philosophy of care, individual members have increased in confidence and been able to share best practice. The group has been encouraged to take control and ownership of the agenda and curriculum in the hope that the group will continue beyond the ACP;
- **Establishing a research culture.** The ACP has also been successful in helping to establish a research culture throughout the Trust, through establishing a research and publication database, setting up a resource room for research active staff and workshops addressing presentation skills, literature searching, writing, evidence-based practice, research appraisals and proposal and report writing.

Case studies with learners in each ACP have highlighted improvements in practice at an individual level, including:

- **Reflective practice.** This has been improved by increasing opportunities to engage in reflection for practitioners and reaching practitioners not previously engaged in such work;
- **Bridging the theory-practice gap.** Establishing action learning groups and delivering workshops have enabled individuals to link day-to-day work in practice with theory;
- **Relating clinical governance, audit and quality to practice.** Work at both Centres has allowed practitioners to see real practice improvement as a result of carrying out tasks aligned to clinical governance, quality and audit.

Issues in the Collaborative Strategy

With regards to the strategy, the following issues were areas of debate throughout the development of each ACP:

- **The Vision –** including the ACP as a concept, agreed and shared vision, change and flexibility in the vision, and anchoring and appropriateness of the title;
- **Implementing the Vision –** including shared understanding of how to convert aims and objectives into practice and clear boundary setting;
- **Barriers to Operation –** including cultural, language and physical barriers;
- **Roles within the ACP –** including identification and utility of key stakeholders;
- **Resources –** including management of the budget, regular and transparent budget reporting, and a model of equable effort;
- **Monitoring –** including the need for measurable objective outcomes and a desire for creative open space.

Discussion

The achievements of the ACPs, in both a hospital trust and a primary care trust, have been valuable and timely, and have challenged and therefore enhanced and improved practice. However, there has been a great deal of angst in both settings, much of it surrounding the strategic nature of the collaboration. A number of reasons for the angst are discussed, including perception and interpretation of the nature of collaboration, understanding the model of knowledge transfer, management of change, leadership, ownership and philosophical differences between the collaborators.

Recommendations

- To develop an integrated education, learning and training strategy between strategic healthcare authorities, healthcare service providers and higher education institutions;
- To develop a collaboration between and healthcare service providers and higher education, taking into account the following:
    - Understanding and being a collaboration, including deciding on the model of collaboration at the outset, building up relationships in a formal and informal manner and appropriate allocation of funding;
    - Appointing a quality administration team to undertake day-to-day work and develop quality policy and procedures;
    - Highlighting outcomes and increasing benchmarking, including sharing targets, dissemination of outcomes and sharing best practice;
- To continue the work of the ACP, including:

    At Salisbury Health Care NHS Trust:
    - The work with the Burns Unit Quality Improvement Team;
    - Imitating the work with the Burns Unit in other established quality improvement teams within the Trust;
    - Developing the Modern Medical Careers Foundation Programme;

    Within South West and North Dorset Primary Care Trusts:
    - Continuing the growth of research-based practice through enhancing and developing the resources room, utilising the research database and further provision of research skills workshops;
    - Extending the excellent work of the audit programmes to other areas of the Trust;

- Extending team building and leadership training to other areas of the Trust, perhaps further cascading through a ‘train the trainers’ model of learning.

Glossary

Action Learning – Usually within a group of workers concentrating on a similar work-orientated task, action learning is a continuous process of learning and reflection. The learning is driven by the learners and facilitated and coordinated by a trainer. Any solutions or outcomes can be tested in practice and reflected on again in subsequent sessions. Individual and group development is as important as finding direct solutions.

Benchmarking – Comparing information of one entity to like information of another entity or composite group for the purpose of determining areas for potential improvement and to identify the best practices.[1]

Clinical Governance – A framework through which National Health Service (NHS) organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (Scally and Donaldson, 1998). Clinical governance is composed of a number of key elements including education, clinical audit, clinical effectiveness, risk management, research and development, and openness.

Health Providers – An organisation that has a main responsibility to provide a service to meet the health needs of a population. Currently in the United Kingdom, health trusts are such organisations.

Idiographic – The creation of knowledge through the In-depth study of individuals.

National Occupational Standards (NOS) – National Occupational Standards were developed by Skills for Health 'to raise the standard of practice in a given sector…providing a benchmark against which performance both at individual and organisational level may be assessed and measured' (NIMHE, 2003, p3). They have their roots firmly established in the modernist, positivist paradigm and claim to be 'capable of reliable, objective and consistent assessment across the UK' (NIMHE, 2003, p16; also see Musselwhite and Freshwater, in press).

[1] Glossary of Alternative Risk Transfer see: http://www.harperrisk.com/ArtGlossary/ArtGlossab.htm (Last accessed 11th November 2005)

National Service Frameworks (NSF) – NSFs have two main roles:

- To set clear quality requirements for care based on the best available evidence of what treatments and services work most effectively for patients;
- Offer strategies and support to help organisations achieve these.

One of the main strengths of each NSF is that they are inclusive, having been developed in partnership with health professionals, patients, carers, health service managers, voluntary agencies and other experts.[2]

Strategic Health Authority (SHA) – SHAs are responsible for managing and setting the strategic direction of the NHS locally. They support primary care trusts and other NHS organisations and make sure they are performing well.[3]

Abbreviations and Acronyms

ACP – Academic Centre in Practice
DoH – Department of Health
HEI – Higher Education Institution
NHS – National Health Service
PCT – Primary Care Trust

[2] See http://www.nhs.uk/England/AboutTheNhs/Nsf/Default.cmsx (Last accessed 11th November 2005)
[3] See http://www.nhs.uk/England/AboutTheNHS/Default.cmsx (Last accessed 11th November 2005)

1. Introduction

1.1. Higher Education Reform

1.1.1. Exchanging and Developing Knowledge and Skills

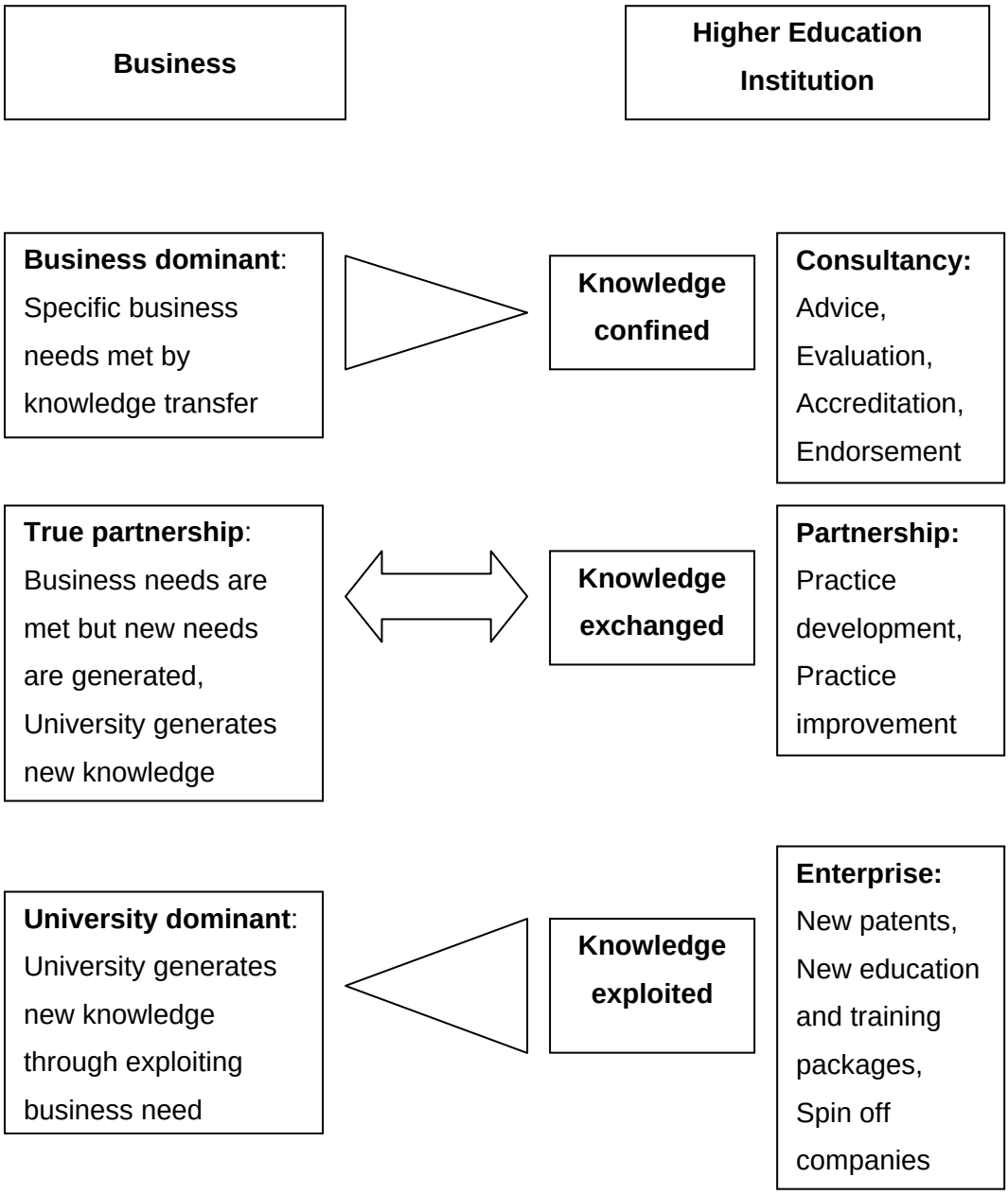
Improvements in quality of life for individuals depend on the effectiveness of knowledge transfer, sharing and exchange. Education, enterprise, research and development are key drivers in this knowledge economy. Universities and higher education institutions (HEIs) are increasingly being seen as the producers of knowledge and therefore have a vital role to play in the knowledge economy. HEIs have a huge knowledge resource. A major function is not only generating this knowledge and building this resource, but sharing, disseminating and passing on this knowledge resource to wider society. Knowledge transfer from knowledge producer (HEIs) to society may happen through structured education, needs-led consultancy, research and partnerships. HEIs have traditionally been good at education and research and see these as their primary aim. HEIs have not, however, explored the potential of consultancy or partnerships. Through education and research, HEIs have traditionally served the needs of a publicly funded society. However, there is a growing need for knowledge transfer to target specific businesses in order to enhance the competitiveness of local business and industry. The recent Government White Paper on higher education reform has specifically addressed the need for HEIs to expand their knowledge transfer work through consultancy and partnerships in order to serve such business and industry needs.

1.1.2. Higher Education Consultancy, Partnerships and Enterprise

Diagram 1.1 shows three different partnerships that HEIs can have with organisations. In the first instance, the business dominates the university and has specific needs that it requires the HEI to meet. As such, the knowledge transfer tends to be a one-way process. This is usually characterised by consultancy and may include specific knowledge transfer in terms of advice, endorsement, evaluation or accreditation. At the other extreme, the HEI dominates in the partnership. This is usually characterised by the development of knowledge exploitation and the development of spin-off companies and business. Equal partnerships in the middle of the

diagram show a balance between individual company and business needs and the sharing of resources from the university. This balance results in the development of needs-led programmes of education and research in which the business is able to clarify needs and reflect and learn as an organisation. Examples at this level are practice development and improvement. In this way, knowledge is exchanged, is neither confined nor exploited, and can even be generated.

Diagram 1.1: Knowledge transfer between business and higher education institutions



1.1.3. Good Consultancy

Buunk and Van Vugt (in press) outlined a four-step process for maximising good consultancy, called the PATH methodology (see Table 1.1):

- **Step 1. Problem: Identifying the Problem –** Identify what the problem is, why it is a problem, for whom it is a problem, what are the possible causes of the problem, and whether the problem can be influenced by social-psychological intervention.
- **Step 2. Analysis: Conducting a theory-based problem analysis –** Explore many possible explanations for the problem (divergence) and then select plausible ones (convergence). There are three approaches to finding a suitable explanatory framework: a topic-specific approach, a concept-specific approach, and a generic approach.
- **Step 3. Test: Testing the explanatory model –** At this stage, a process model is formed to identify relevant proximal and distal causes. An empirical test of the model is then formed.
- **Step 4. Help: Developing and testing an intervention programme –** The process model is scrutinized for intervention opportunities and is carefully assessed in terms of intervention 'potential'. Initially, many possible interventions are researched before convergence of the most appropriate ones leads to an intervention programme. Implications of the intervention programme are then assessed before guidelines are given for its systematic, empirical evaluation.

Table 1.1: Performing good consultancy: The PATH methodology (after Buunk & Van Vugt, in press)

Problem:	Identifying and defining the problem
Analysis:	Conducting a theory-based problem analysis
Test:	Testing the explanatory model
Help:	Developing and evaluating a programme of interventions

1.1.4. Good Partnership Working

Developing effective partnerships among the public and private sectors is on the increase in the UK. There are a number of reasons why an organisation may develop a partnership (Audit Commission, 1998; DoH, 1998; MacCabe et al., 1997):

- To deliver quality, coordinated packages of services to individuals;
- To align the services provided with the needs of users and provide more benefits for disadvantaged groups;
- To stimulate innovation and encourage more creative approaches to problems;
- To reduce the impact of organisational fragmentation;
- To bid for, or gain access to, new resources and to make better use of resources;
- To increase efficiency;
- To increase negotiating power in order to influence partners or government bodies in ways that could not be achieved separately;
- To meet a statutory requirement.

Where the higher education sector is involved in partnerships, their input would be through knowledge transfer and exchange, involving education, training and research.

Research into partnerships has highlighted four main models of partnership arrangements (see Audit Commission, 1998; DoH, 1998; DTI, 2000; Thorlby and Hutchinson, 2002):

- **Separate organisation.** The partnership creates a strong new identity that operates as a distinct entity. People are employed in the new organisation which also has separate finances and strategy;
- **Virtual organisation.** The partnership creates a concept that the partners work within. The new identity may only exist in name and people still retain their roles from their partner organisation but work together on specific tasks or projects;
- **Partnership dominant organisation.** Similar to the virtual organisation except people take on new titles and roles from the new partnership, despite still being employed by the partner organisations;
- **Steering group organisation.** The partnership exists only in a steering group which aims to bring together streams of work and strategy from each partner. The partnership is merely a coordinating body, the day-to-day running still occurs for each partner.

Previous research has suggested that partnership and collaboration between large organisations can mean it takes a long time to set an agenda and develop as a collaboration.

Particular issues that arise during the initiation of a partnership or collaboration include the following (Audit Commission, 1998; Boydell, 2001; Johnstone, 2001; MacCabe et al., 1997):

- Difficulty in agreeing an overall vision, mission or aims and objectives;
- Difficulty in agreeing actions and order of actions needed to achieve the vision, mission and aims and objectives;
- Change happening at a strategic, operational or personal level among the partners;
- Difficulty in agreeing fair allocation of resources and effort;
- Difficulty in achieving and maintaining the trust of other collaborators or partners;
- Differences in culture of different partners hampering the action and work of the collaboration;
- Communication difficulty where each group uses different language to describe similar things.

It is important that strategy and communications are developed at an early stage among the partners before work is actioned, otherwise problems may occur (Audit Commission, 1998; Boydell, 2001; Johnstone, 2001; MacCabe et al., 1997):

- Trying to implement work and action without a structure or strategy can result in poor utilisation of effort and resources, and often means action has to be halted or changed during its course;
- Individuals in groups can have role ambiguity and as such are likely to feel stressed, may not engage with the collaboration or may leave;
- Individuals may work for their own goals rather than for the group effort, resulting in duplication of effort or inappropriately directed effort.

As a result, it is suggested that the following areas must be considered for partnerships and collaborations to operate effectively (Audit Commission, 1998; Boydell, 2001; Johnstone, 2001; MacCabe et al., 1997):

- **Acknowledge group formation.** Any group of people coming together goes through a four stage model and members of partnerships need to recognise the following phases (see Boydell, 2001; Tuckman, 1965):
    - Phase 1: Storming – everyone's values, vision, attitudes and ideas are explored;
    - Phase 2: Norming – these need to be brought together and a common ground needs to be established;
    - Phase 3: Forming – the group forms its own purpose and identity;
    - Phase 4: Performing – the group begins to make decisions and act on them;

- **Agree a shared, clear vision.** There should be a clear agreed vision, shared among members of the partnership, that helps to define the purpose of the partnership. Within the vision, the following aspects should be agreed between the partners:
    - Mission – purpose of working together and the reasons for the partnership's existence;
    - Principles – guidelines need to be adopted for working and decision making;
    - Values – explore the beliefs the partners hold and from these develop values for the partnership as a whole;
    - Infrastructure – ascertain how the day-to-day business will be carried out;
    - Contribution – make roles within the partnership explicit;
- **Redefine the vision periodically**. The agreed, shared vision addressing mission, principles, values, infrastructure and contribution needs to be redefined at regular intervals;
- **Capacity for change.** The organisation needs to build in capacity, resources and a strategy to deal with changes, in terms of a redefinition of vision and individuals leaving and new people joining, that occur within a partnership;
- **Commitment and involvement of partners and stakeholders is important.** Unless all partners believe they are meaningfully involved in the work, they can become disengaged. All partners need to be kept informed and, where appropriate, involved in decision making. It is noted that partnerships can move very slowly, particularly at the start of a new concept, and it is imperative that progression of the partnership proceeds at the pace of the slowest members, rather than leave them behind;
- **Getting things done.** Actions must follow any decision-making to keep the interest of all group members. There is acknowledgement that the partnership must move beyond a 'talking-shop' and provide outcomes. In some cases, depending on the size of the partnership, success has been achieved by employing dedicated staff to ensure decisions are turned into action;
- **Merging the partnership's activities and that of its members**. It is important that the partnership appropriately involves partners in their particular areas of expertise and, if possible, in areas they are already working in. It maximises commitment if partners are able to meet their individual aims, goals and requirements through the partnership;
- **Appropriate allocation of resources.** Fair and equal allocation and provision of resources is needed for effective operation. This may involve lengthy debate, but decision-making must be transparent and open. One major disadvantage to partnership working can be 'cost shunting', which stems from increased pressure on a partner's budgets. It is suggested by previous research that pooling of resources can help equality of resource allocation;

- **Understanding each other and going beyond the other.** Partners need to understand how other members of the partnership view the particular concept being developed. There needs to be the understanding that everyone has an agenda and has a right to put their agenda forward. There is a need to realise that diversity within a partnership is natural and should be used to help solve problems. Consensus is not always possible and differences must be acknowledged. Consequently, conflict is to be expected, but it is 'the respect for diversity that lays the groundwork for a dynamic partnership' (Boydell, 2001, p35). In addition, they need to be able to think beyond their own and others' perceptions to create radical new thinking 'outside the box'. Following on from this, partners must be ready to accept attitude change throughout the process and realise that their own attitude change could mean distancing themselves from their own organisation and being an advent for change in their own organisation;
- **Building trust between partners.** This is often argued as the most important ingredient in success. It is suggested that regular away days for partners to have a frank exchange of views on the partnership progress is important for building trust. Although this may require an excessive amount of time, it does reduce large amounts of bureaucracy found when partners' trust of each other is limited;
- **Balance of developing the partnership and keeping a focus on the objectives.** It is easy for partnerships to lose sight of their overall objectives or to assume implicit objectives or that a shared desire to work together is enough;
- **Boundaries.** Partners need to know where the boundaries lie between the partnership's work and their own organisation's activities;
- **Strong leadership.** It is suggested that partnerships are moved forwards through 'partnership champions'. They play a vital role in establishing a partnership early on in the process through dedication, enthusiasm and determination. It is recognised that such champions may move on after the partnership has become established but that they leave a legacy. It is acknowledged that the skills and attributes needed to bring partners together initially are often very different to the leadership needed to deliver the work. Leadership proceeds through four distinct stages in the evolution of a partnership:
    - Stage 1: Leader as Driver – enthusiasm and determination needed to bring the right people together;
    - Stage 2: Leader as Chair – the leader needs to establish structures, roles and responsibilities, develop mechanisms for decision-making and conflict resolution, facilitate and support team building, capitalise on diversity, ensure political and cultural sensitivity, and optimise group and individual strengths. The leader must be responsible to the group and needs to know when to take risks and make decisions on behalf of the rest of the group;

- Stage 3: Leader as Enabler and Arbiter – a leader must act responsibly and as a member of the group, turning up and engaging actively in discussion and negotiation. The leader must give investment and commitment to build the credibility of the group. The leader must enable all partners to equally get involved and to try and resolve disagreements and reach a decision to move forwards. Leadership at this level also needs to deal with conflict to allow continuation of the group;

- **Communication.** A structure for formal and informal communication is needed both within and outside the partnership. How proceedings and decisions are recorded and disseminated and who receives them needs to be addressed. Consideration must be given to who records the activity of the group and what inherent biases may distort that record. Communication to the outside world needs to be addressed through working closely with the media and the image of the partnership for others needs to be defined to achieve clarity, distinction and support;
- **Insight into power and equality.** It is important for a partnership to remember that not all members are equal and that, to proceed, some partners have to be prepared to relinquish power since partnerships need to be constructed with a balance of power. Risk-taking is an important part of partnerships and the power dynamics of risk-taking need to be explored since it creates a certain vulnerability among group members. It is impossible to achieve total equality of power, but it is important to maintain the esteem and respect of individuals throughout the power imbalances. Sometimes people are blind to the power they hold and so partners need to highlight where the power resides and discuss openly and honestly about power relations.

In addition, it is suggested that partnerships should continually review their success. Research on partnerships has suggested that the following areas are important to help in this process (Audit Commission, 1998; Boydell, 2001; Johnstone, 2001; MacCabe et al., 1997):

- **Measuring progress.** It is suggested that partnerships devise their own objectives agreed across all partners and ensure that continual measurement to those objectives is undertaken. It is important to measure the progress against outcomes of the partnership, but also to review the partnership itself. Continual monitoring means that results from feedback can be used to inform future practice. However, it is acknowledged that measuring progress is a particularly difficult challenge for partnerships; particularly early on in a partnership, it is difficult to measure the extent to which the partnership has succeeded, especially where goals might be long-term and difficult to measure. In addition, it can be unclear as to how much of a change is attributable to the partnership or to other factors;

- **Testing value for money.** It is important to ascertain whether the outcomes and the benefits outweigh the costs involved in the partnership. Added to this should be an analysis of the costs if the partnership had not been formed. These costs are often very difficult to measure;
- **Ensuring accountability.** Partnerships must be accountable to the members of the partnership, to the stakeholders outside the partnership (including relevant funding bodies) and to service users and members of the public. Accountability is increased through activities such as annual general meetings or away days with all partners and through regular communication of information;
- **Planning the end of the partnership.** Every project needs an exit strategy or a continuation strategy when an end is not appropriate. This helps the project fit into a timetable in terms of funding and in relation to meeting objective targets.

1.2. The Work-Based Knowledge Terrain

1.2.1. Introduction

Through knowledge exchange, higher education has a transforming role in society (Costley, 2000) and this inevitably involves the culture of work. Since learning takes place within a work context, the influence of education could aid this experience through experiential and work-based learning. Work-based learning in practice is usually viewed in terms of experiential learning incorporating reflective cycles. Reflection is seen as key to learning new skills and can also be a very powerful personal experience incorporating socio-emotive responses. The central theme is therefore the individual learner's Gestalt, where cognitive, affective, ability and responsibility are totally integrated (Castillo, 1974). As such, work-based learning is powerful in terms of providing insight for the individual learner and changing, enhancing and developing practice as a whole (Benner, 1984).

Workplace learning has been described as:

> '…a general term for that learning which is (normally) provided by the employing organisation to ensure that staff have the minimum competence or knowledge to carry out their role' (Clarke & Copeland, 2003, p238),

and work-based learning as:

> '…commonly taken to refer to structured learning opportunities which derive from, or which are focused on, the work role of individuals within organisations' (Clarke & Copeland, 2003, p237).

This appears to link to some degree with UNESCO's ideas underpinning work-based learning in which they suggest it is:

> 'A term that assumes that it is up to each individual to identify and pursue opportunities for his or her employability – including formal studies *and* informal experiences' (UNESCO, 1999 in Garrick & Clegg, 2001, p119).

Although the concept of work-based learning by UNESCO appears, initially, to place more responsibility on the individual to develop themselves than on the employing body to provide the necessary learning opportunities, they do suggest the following support:

> '…facilitating approaches that include designing courses in modular format, introducing competency-based assessment, using self-paced learning to meet individual requirements, and giving recognition to experience, knowledge and skills already possessed' (UNESCO, 1999 in Garrick & Clegg, 2001 p119).

The justification for a HEI to engage in work-based learning in the workplace is the improvement it would bring to the performance of the organisation, which could be anything from transformation of organisational learning, changing tacit into explicit knowledge, through to correcting inaccurate knowledge or altering bad learning habits (Garner and Portwood, 2002). Whatever the motivation for work-based learning, the HEI has to work within an established work culture or the communities of practice of the organisation (Wenger, 1998a; 1998b).

1.2.2. Types of Work-Based Learning

Work-based learning can include accredited work and involve the following methods:

- **Lectures, seminars, workshops;**
- **Distance learning materials.** The use of distance learning materials can help support people in practice, allowing people to complete modules in their own time while at work;

- **Mentorship.** Distance learning may involve the use of mentors. These could be work-based employees, who may have undergone a course in mentorship, or could be academic and have a tutoring role within the learning;
- **Portfolio of evidence of learning.** Workers are encouraged to bring together a portfolio of evidence of prior work experience with a particular focus or theme. This portfolio may lead to accredited work and might be used as a basis for a learning set;
- **Learning sets.** These are used to embed the learning in practice. Often they will involve individuals focusing on an aspect of theory or learning and then being asked to reflect on this in practice and bring those reflections to the next learning set. Models of learning in these sets can include reflective practice and action learning sets, involving seminars and workshops, refresher lectures, seminars or workshops.

1.2.3. Advantages of Work-Based Learning

Introducing work-based learning has a number of advantages at a variety of different levels:

Organisational level:

- The organisation as a whole has a chance to improve its own practice through enhancing the knowledge base of the employees;
- There is a move towards integrating theory and practice, providing a theoretical or scientific underpinning to work, allowing more complex and novel exploration of work tasks (Wagner and Childs, 1998);
- Staff at the organisation may feel rewarded for the work they do and as such are more likely to stay at an organisation, reducing staff turnover costs;
- Staff are more likely to want to join an organisation if a coherent package of training and education is available, meaning companies get to choose the best employees.

Cultural level:

- Group work can be enhanced through learning;
- In multi-disciplinary or cross-role work-based learning, individuals get to know more about the attitudes and perceptions of other groups and their workers and the way other groups work and operate;
- New ways of working together to achieve tasks can be tackled and addressed;
- Group work may promote bonding between members.

Individual level:

- Learn new skills or enhance existing skills;
- Learn theory that underpins work-based activity;
- Give a contextual framework to the work carried out, to understand the wider implications of action;
- Learning can be empowering and can raise self-esteem, confidence and self-efficacy;
- Individuals may feel their job is valued;
- Individuals gain qualifications they can take with them, showing their commitment to tasks, learning and their job;
- Reflection gives individuals a chance to speculate about their job and to enhance their work;
- Reflection may lead to better working practices for individuals;
- Learners actively construct their own experience and critically reflect on their development within this experience;
- Personal identity and growth are central elements;
- The learner is part of a greater body of knowledge and is respected for their input;
- Tacit knowledge becomes visible;
- Greater possibility for theory/practice integration;
- Quality of care and quality of work are improved;
- Individuals' potential is put to optimal use;
- Cohesiveness within a healthcare team, due to actively building and developing new insights.

Education provider:

- An up-to-date understanding of the needs of a workforce;
- Gaining further knowledge on a particular element of society;
- Ability to plan and deliver up-to-date and relevant education to a wider audience;
- Form a collaborative relationship that can lead to future work.

1.2.4. Barriers to Effective Work-Based Learning

Smith and Spurling (1999) outlined some major problems with work-based learning:

- **Traditional learning is a deeply held belief.** It is often difficult for learners to realise they are engaging in learning during work-based learning. Often they will modify their environment into a formal learning situation with tutors and students, rather than facilitators and workers. In other cases, it may be that these deeply held views mean

that work-based learning is devalued and is not seen as important as traditional methods of education, even by those actively engaged in the learning;

- **Group assessment is problematic.** In many cases, group work based on working in teams is assessed, rather than assessment of individual work. This has led to many instances where individuals are aggrieved at feeling they have put more effort in than others who then jointly take credit for it, or where individuals feel their mark has been reduced by the poor input from other team members;
- **A competitive rather than cooperative approach.** Similarly, many individuals felt that the learning opportunity within work increased rivalry and competition. Often trust and sharing was limited because education was viewed as a way for individuals to progress their career and, as such, mutuality and reciprocation of learning is often rare;
- **Culture of the workplace can inhibit learning.** Organisations with little history of education and development may find individuals reinforce that culture through disengagement with any learning process or methodology;
- **Sub-cultures of roles and positions can inhibit learning.** Teams and groups within organisations already have their own, sometimes competing, cultures. As such, it is not always easy for individuals from different groupings within an organisation to learn together, particularly among individuals from different hierarchies.
- **Pitching the learning.** The workplace often contains people with a variety of educational backgrounds and experience. In some cases, learners may have been out of the system for a long time. As a result, it is often difficult to pitch the learning at an appropriate level for all learners, meaning some fail to comprehend or keep up while others get bored with not progressing fast enough;
- **Higher education culture.** Where HEIs are involved in delivering learning, it is important that academic language is not used because this is often a barrier to effective learning in the workplace. In many cases, simply the perception that a HEI will deliver a certain type of learning and use certain language creates tension among the learners.

1.3. Higher Education and Health

1.3.1. Higher Education in Modernising Health Services

The NHS in the UK has been tasked with providing modern, effective and dependable services. In addition, workforce development must keep apace with service development and change. As such, educating the workforce through learning, training and personal development needs to respond to a rapidly changing, needs-led modern health and social care system (DoH, 2000). A

number of initiatives across a variety of professional groups support this, including the National Service Frameworks (NSFs), the development of National Occupational Standards (NOS), and the Knowledge and Skills Framework (KSF) (DoH 2004). All of these use standards, competencies and skills to aid workforce planning and highlight the importance of learning and development. Effective partnerships between the NHS and the education and research sectors are therefore vital to the modernising agenda.

The health and social care and education sectors are interdependent and indistinguishable in delivering strategic objectives of mutual interest regarding:

- Diversity and life-long development of the health and social care workforce;
- Widening access to and participation in learning;
- Curriculum development;
- High quality research and evaluation;
- The development of high quality health and social care services and wider strategies for health and welfare.

Within local health and social care and education systems, the strategic and operational decisions of one sector can have a major impact on the other. Decisions about configurations of services can affect clinical placements or location and viability of academic departments and research groups. Research and knowledge transfer in universities can, in turn, have consequences for research and practice in the NHS. The impact of *The NHS Plan* (DoH, 2000) and the Modernisation Agenda present a welcome opportunity to develop alliances, joint arrangements and integrated networks across the education and research sectors within the health and social care community. Robust partnerships and networks between these two sectors that span the healthcare community have the potential to support the modernisation of the NHS through ongoing and current research, learning, knowledge, management and education, and service relationships across organisational boundaries. This could be initiated by effective joint strategic planning and effective joint working within and between sectors.

1.3.2. Examples of Higher Education and Health Collaborations

There are a number of examples of higher education and health collaborations and partnerships (see case studies 1-3). Chapter 2 considers an appropriate methodology for the study of a partnership that embraces all three of the visions highlighted in the case studies, taking into account the background context to the partnership as outlined in the chapter.

CASE STUDY 1: Work-Based Learning Project 2000-2003 (see Moore, 2004)

Avon District, Gloucestershire and Wiltshire NHS Workforce Development Confederation and Faculty of Health and Social Care, University of the West of England.

Organisational objectives of the project:

- Develop a process for converting development needs and projects in practice which can be operationalised within an educational frame that can attract internal and external recognition and, if desired, academic credit along with local currency;
- To promote and develop an ethos of lifelong learning and its contribution to a learning organisation;
- Identify how individual activity through work-based learning contributes to strategic developments and direction;
- Identify the links to clinical governance;
- Evaluate the impact of work-based learning on recruitment and retention and a personal and professional development.

Project lead: Senior academic from the Faculty of Health and Social Care who was guided by a steering group which included participating trusts, the chair of the consortium, a representative from the original health authority and an external representative from Bath University.

The literature review identified a criticism of single loop learning in the NHS, which focuses on task orientation and not on the underpinning skills needed to strengthen a learning organisation in a culture of change. There is a need to develop higher levels of thinking and learning including the valuing of reflection, mentorship and supervision.

Work-based learning prototype and educational resources. Following a scoping exercise, a programme of academically accredited work-based learning was prepared by a small working group drawn from practice. This was piloted within the acute trust and was open to all professionals. Further learning tools and strategies have been developed to meet the needs of the various groups of learners and interest in work-based learning is now starting to gain momentum.

Types of learners. Despite keeping managers in the health and social care sectors informed of the work-based learning programmes, it was mainly nurses that signed up to the modules, including:

- Nurses undertaking a Trust Personal Development Plan;
- The Department of Health Evercare pilot to advance nurses' skills in the community setting for the benefit of the elderly population;
- A group of users and carers from the learning disability field;
- Senior nurses undertaking the MSc in Advanced Practice.

Recommendations:

- Facilitation and assessment workshops need a high priority in the staff development strategy and plan;
- Learning strategies and tools that enable the development of the higher levels of thinking and learning need to be valued at all levels of the partnership organisations and implemented by the mentors, coaches and supervisors of learning. Further support is required in practice;
- Conscious learning needs to be enabled through dialogue, discussion and reflection;
- Sharing best practice, both within and outside the organisation is required, especially in the areas of success such as team learning from governance initiatives, action learning sets, user involvement and the spiralling of learning;
- The advantages and uses of work-based learning need to be marketed across the University;
- Good leadership is imperative to influence interdisciplinary learning in the workplace;
- Need to consider the greater involvement of users of health and social care in work-based learning programmes.

CASE STUDY 2: University Health Partnerships

Leeds University, Leeds Metropolitan University, West Yorkshire Strategic Health Authority and West Yorkshire Workforce Development Confederation.

University Health Partnerships explores innovative methods of working in the field of health and social care. The partnership is based within Leeds University, with membership spanning Leeds Metropolitan University, the NHS trusts and primary care trusts in Leeds, the new West Yorkshire Strategic Health Authority and the West Yorkshire Workforce Development Confederation. The partnership strengthens working relationships and joins up activity related to health and social care in the region.

Responsible for the strategic direction of the partnership, the University Health Partnerships Board provides leadership and oversees the implementation of the strategy by:

- Joint planning between the University of Leeds and local partners;
- Agreeing and monitoring the work programme;
- Evaluating the effectiveness of joint collaboration;
- Promoting University Health Partnerships, its purpose and main responsibilities.

The University Health Partnerships Executive is responsible for transforming the strategy into tangible benefits for the local health economy by:

- Establishing a joint work programme;
- Maximising existing resources, reducing duplication and identifying new sources of funding;
- Responding to and influencing future health policy;
- Disseminating 'good practice' in collaborative work.

CASE STUDY 3: Mental Health Research Network

An innovative country-wide network has been established to facilitate research into mental health problems and improve collaboration between researchers and NHS partners.

The prime objective of the UK Mental Health Research Network is to provide the infrastructure necessary to support large-scale, high quality research into mental health and social care. In particular, it will free up researchers from some of the burden of administration, allowing them to focus on research.

This research network is an exciting opportunity for the trusts and universities involved. It will make a real contribution to increasing collaboration between academic and NHS partners to improve research in the area of mental health, which in turn will improve the mental health services provided.

The 'West Hub' of the Network is a partnership between a number of universities and NHS trusts within Avon, Wiltshire, Devon and Cornwall. The Avon and Wiltshire Mental Health Partnership NHS Trust, together with the Universities of Bristol, Bath and the University of the West of England, form the northern part of the West Hub. The southern part of the West Hub is in Devon and Cornwall and includes the Peninsula Medical School (a collaboration between the University of Exeter and the University of Plymouth), Devon Partnership NHS Trust and Cornwall Partnership NHS Trust. The Mental Health and Primary Care partnership in Southampton is also a linked clinical site to the West Hub.

2. Methodology

2.1. An Evaluation

2.1.1. What is an Evaluation?

Despite the growing number of evaluations taking place within research departments and clinical practice, there is no universally agreed definition of what constitutes an evaluation. Indeed, evaluations vary in terms of aims, purpose, methodology and focus. Although research methods are adopted within an evaluation, the application and 'real world' nature of such an inquiry makes an evaluation a unique hybrid of research philosophy, paradigms and methods (Evaluation Research Society (ERS), 1980; House, 1978; Robson, 2002). In addition, the many prospective uses (and also abuses) of an evaluation mean that the potential audience must be provided with a structured, accountable and honest piece of work. This must be held in mind when developing an appropriate methodology. Diagram 2.1 shows a number of different purposes of evaluative research. These purposes fit under the broad definition of assessing the effects and effectiveness of a concept, often in the form of an innovation or intervention (Robson, 2002).

2.1.2. Choosing the Conceptual Framework

A number of important issues relating to the evaluation need to be addressed in order to establish the model or conceptual framework from which the research strategy and methodology can be determined.

Philosophy

It is important to predetermine the underpinning philosophy of the concept to be evaluated; assessing how the world is viewed can help understand this philosophy. It could be that it is initiated from a positivist stance, whereby it fits a view of the world that includes objective organisation, and so the concept may be viewed as having a definite positive or negative effect. At the opposite extreme, the philosophy may be post-positivist or radically postmodern, whereby the concept challenges the current world-view and where boundaries and narratives

are blurred (Lather, 1991; Lincoln and Guba, 1985). The evaluative framework should therefore reflect this and adopt an appropriate framework and models.

Stance

Similar to the philosophical underpinning, the concept under evaluation will, over time, adopt a stance, and it is important to assess whether the concept is viewed objectively or with a degree of subjectivity throughout its development. It may be that the stance affords understanding at both an objective and subjective level, which can be reflected as required by an appropriate methodology.

Outcomes

The concept under evaluation is likely to have various outcomes. To capture these, an evaluative framework needs to assess how rigid these have been; the outcomes may have been specified and fixed or more varied and flexible, with the possibility that it may not have been known what outcomes could emerge. An appropriate framework is needed to capture these and care must be taken in choosing suitable methodology. If the outcomes have been more varied and flexible than the methodology allows for, then other outcomes may go uncaptured and be missed from the evaluation.

Focus

The focus of the concept under evaluation must be studied. The concept could be viewed as having a traditional focus and simply be a new version of an already evaluated or tested concept. Alternatively, it may have a novel and different focus to those concepts already evaluated and tested.

Feature

Finally, the feature of the concept under evaluation needs to be addressed. In any evaluation, the concept could be viewed as an attempt to alter or change a current approach. This could range from a simple alteration or change in the style of a basic intervention, through to an innovation.

The above aspects can be mapped to Diagram 2.1 where the models of evaluation are outlined with their corresponding research methods (adapted from ERS, 1980; House, 1978; Robson, 2002). Diagram 2.1 suggests that patterns of philosophy, stance, outcome, focus and feature lie along the same axis. Therefore, extremes within each aspect correlate with each other. At one extreme, a positivist philosophy has an objective stance with fixed outcomes and a traditional focus, and features an intervention; at the other extreme, a post-positivist philosophy

has a subjective stance with varied and flexible outcomes and a novel focus, and features an innovative approach. In practice, this is probably simplistic and there will be some variation. Nevertheless, it gives an example of where evaluators can pitch their conceptual framework and so adopt an appropriate methodology. A number of evaluative frameworks are suggested and have been highlighted from two major texts on the subject (ERS, 1980; House, 1978). The methodology can be placed on a continuum between the extremities of the axis according to their appropriateness to the philosophy, stance, outcomes, focus and feature of the evaluation. From the positivist side to the post-positivist, these include the following (from ERS, 1980; House, 1978; Robson, 2002):

Programme Monitoring

This involves systematic checks with current policy, tracking of services delivered and measuring targets set. It is largely a quantitative exercise, assessing output against objective goals and direction, and includes a number of different types:

- **Systems Analysis:** Addressing the effectiveness and efficiency of the concept under evaluation. Measurements are likely to be through large scale quantitative work sometimes, involving a control group in a quasi-experimental design;
- **Discrepancy Study:** Compares and contrasts ideals and targets with actual achievements through large scale quantitative survey work;
- **Behavioural Objectives:** Addresses clear, focused, objective targets and analyses to what extent these have been achieved. Often this is a mainly quantitative exercise;
- **Accredited Evaluation:** Determines whether the concept under evaluation has achieved professional standards. Often these are pre-agreed with an external accreditor using a clear methodology to achieve the standards. The work is often quantitative, although some qualitative work, albeit reduced to categorical analysis, is sometimes included;
- **Connoisseurship:** Addresses how close the concept under evaluation has come to the evaluator's own standards, which often originate from analysis of previous work in the area. As such, a mixed methodological approach is often seen, depending on the concept;
- **Needs-Based Evaluation:** Examines the degree to which stakeholder needs are being met. The needs may be the same as or in addition to the targets and goals set, and therefore a needs analysis is often required. Again, the methodology can often be a mix of qualitative and quantitative.

Impact of Summative Evaluation

This determines the results and effectiveness of programmes often using strategies outlined above, but also in light of the future of the concept under evaluation and so may include one or more of the following methodologies:

- **Decision-Making:** An evaluation is structured by the key decisions that need to be made by stakeholders following the evaluation. In-depth qualitative work is needed to address stakeholder need and expectation, although a large amount of quantitative work is also required. This sort of evaluation is often seen when specific questions are being addressed and so much exploratory work is not always evident;
- **Adversary:** More than one evaluation takes place with different evaluators. This affords triangulation of possible outcomes, but the focus is often on difference and diversity rather than similarities and continuity. The evaluators work together to discuss the differences and use these to report alternative sides of the argument. Much of the work may be a mix of quantitative and qualitative approaches in the data collection phase, but then in-depth qualitative work is used to address similarities and differences.

Formative Evaluation

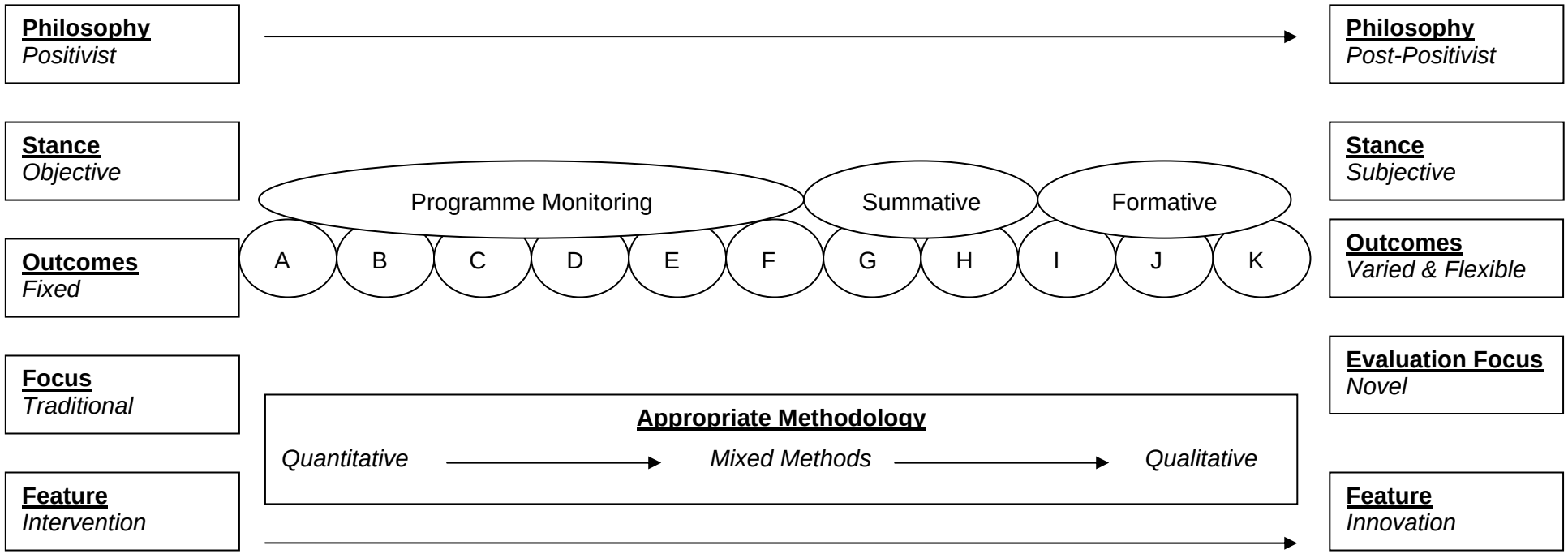
The focus shifts away from the outcome and effectiveness of a concept to a study of the development and processes involved throughout the concept. This produces more in-depth work using a substantial qualitative approach and may involve case study techniques. There are several models including:

- **Transaction Analysis:** The focus shifts away from goals and targets to capture the underlying processes. The work can be multi-method but often involves structured qualitative analysis to address hidden processes;
- **Illuminative Evaluation:** The focus is on depth rather than breadth. Developments, relationships, roles and people are at the centre of the evaluation, rather than focusing on outputs, targets and achievements. Qualitative research methods accompany this model, including semi-structured interviews, documentary or textual analysis, inductive analysis and naturalistic inquiry.

Responsive Evaluation

This presents a response from all individual stakeholders. The concept under evaluation and what it means to them is addressed rather than an objective snapshot of the concept. The methodology accompanying such a model is again exclusively qualitative.

Diagram 2.1: Conceptual analysis of evaluation frameworks



Key: Models of Evaluation (A-K from ERS, 1980; House 1978; Robson, 1993):

A – System Analysis
B – Discrepancy
C – Behavioural Objectives
D – Needs-based Evaluation
E – Connoisseurship
F – Accreditation
G – Decision-making
H – Adversary
I – Transaction
J – Illuminative Evaluation
K – Responsive Evaluation

Using the map outlined in Figure 2.1, a conceptual framework was developed for this evaluation of the ACPs. Taking into account the aims and objectives of the initiative (see Chapter 3.2.4), the following was decided:

The **philosophy** behind the ACP initiative was seen to be somewhat post-positivist. The idea that the University and healthcare Trusts could blur their boundaries to work together as a learning community reflected a move away from the traditional roles of universities and trusts. The concept challenges the world-view of separate organisations for learning and practice by attempting to merge ideals together.

The **stance** of the ACPs has been somewhat developmental. Although there are aims, objectives and targets, these have been qualitative and so deliberately open to interpretation to aid the building and development of each Centre as an ongoing feature. Therefore, the stance adopted is largely subjective in nature, which sits comfortably with the post-positivist philosophy underpinning the concept.

Although the **outcomes** of the ACPs have tended to be relatively fixed, they have been developed in such a way that the methods of achieving those outcomes are varied and flexible.

The **focus** of the ACPs has certainly been novel, and challenges previous models of collaborations between healthcare and education providers.

Finally, the **feature** of ACPs is not simply an intervention aimed at change, but moreover an innovation aimed at transformation of the education and healthcare relationship.

Overall, the ACP concept seems to have an approach that lends itself to the post-positivist, subjective, flexible, novel and innovative end of the spectrum. It can be seen, therefore, that there is some justification for adopting a model of formative evaluation, using transactional, illuminative and responsive evaluation frameworks. The use of appropriate aims, objectives and qualitative methodology to reflect this have been adopted.

2.2. Aims and Objectives of the Evaluation

2.2.1. Aims

The evaluation has the following aims:

- To evaluate, using a formative evaluation utilising transactional, illuminative and responsive evaluation frameworks, the Academic Centre in Healthcare Improvement collaboration between Bournemouth University and Salisbury Health Care NHS Trust;
- To evaluate, using a formative evaluation utilising transactional, illuminative and responsive evaluation frameworks, the Academic Centre in Practice in Mental Health and Primary Care collaboration between Bournemouth University and South West and North Dorset Primary Care Trusts.

2.2.2. Objectives

In achieving the aim, the evaluation has the following objectives:

- **Objective 1:** *Narrate the genesis, implementation and development of each ACP* – to tell the story of each ACP from its origins throughout its development, highlighting how and why it has evolved and the changes along the way.

- **Objective 2:** *Highlight the value of each ACP to patient care, practice development and governance of the Trust, including mapping against current Trust priorities* – to note areas in which the ACPs have been beneficial to the Trust or where they have begun to add value to the Trust. This addresses areas where they have succeeded in providing something that was not in evidence before. In particular, it addresses what they have added or are beginning to add to patient care, practice development and clinical governance issues.

- **Objective 3:** *Highlight areas of best practice and recommendations for overcoming barriers that would inform future work between HEIs and healthcare trusts and organisations* – this will show areas of the work of the ACPs that have been successful and those areas that need further work. It will address where issues have arisen, how have they been dealt with and how have they been resolved. This information will inform how future collaborations between universities and trusts can work more effectively, particularly in the continuation of the ACPs and in the development of new academies. It

will also inform other partnership working involving universities, health trusts and the wider community.

- **Objective 4:** *Develop a model of critical reflection to allow such collaborations to evaluate themselves throughout their development, aiding them to become critical, self-sustaining communities* – to develop an action learning model of self-evaluation that will help the ACPs become self-sustaining where appropriate. Therefore, any future continuation of the ACPs means they can move forward as independent, self-critical and reflective organisations.

2.2.3. Features of the Evaluation

Robson (2002) notes four criteria that any evaluation should adhere to, and it was taken that this evaluation should be no exception:

Utility

Any evaluation must consider its potential audiences and must be useful to that audience. The evaluation of the ACPs has been carried out with this in mind in that key stakeholders have been central throughout. It was essential to make sure they felt part of the research. These stakeholders were identified through the academic leads of the Centres followed by a 'snowballing' sampling technique. The stakeholders were kept informed of the development of the evaluation at steering group meetings and through regular presentations of preliminary findings, giving the stakeholders the opportunity to respond. Most importantly, all the key stakeholders were interviewed and were therefore able to be a major part of the research findings. In addition, the layout of the report has been considered in light of the needs of these key stakeholders, with highlighted sections on each ACP, and key learning points and ways forward split into recommendations for the Trust, recommendations for the University and recommendations for Workforce Development Confederations.

Feasibility

An evaluation can only be done if it is considered feasible in terms of political, practical and cost-effectiveness reasons. In this instance, the political motivation for the evaluation was that it is crucial to capture not only the added value of the ACPs but also the learning that will inform future collaborations. Practically, access to key stakeholders to help inform and develop the evaluation has been possible and most of the individuals approached responded. Finally, in

terms of cost-effectiveness, money had been set aside for the evaluation from the initiation of the ACPs because it is crucial for key stakeholders to learn from this novel concept.

Propriety

An evaluation can only be done if it can be demonstrated that it will be carried out fairly and ethically. This evaluation aimed to examine trustworthiness through the use of triangulation and auditing, investigating similarities and exploring differences.

Triangulation

The emphasis was not on building a representative sample per se, but to build up a picture of how individuals' backgrounds may influence their views and to address the complex psychological and sociological multidirectional interconnections found. However, more information was needed from certain groups of people with regard to specific areas of study. Thus, following the initial interview stage, follow-up interviews with certain individuals were necessary to clarify areas of interest. Furthermore, more than one researcher was used in the process of interpreting data to help achieve consensus.

Auditing

Interviews were transcribed and made available to the interviewees for confirmation that they were a fair reflection of the interview process. An open accountable system of interview to report through interpretation and analysis was made explicit.

The project also examined the issue of conflict of interest, since the researchers are employed by Bournemouth University and have a duty to reflect and (re)present the views of both the Trusts and the University.

Ethical issues

Ethical consideration was given to the following issues. Participants also had this information in the form of participant information sheets as highlighted in Box 2.1.

Informed consent:

Banister et al. (1994) mention that informed consent from the participant interviewee can only be given when certain questions about research are disclosed. These are addressed in Box 2.2 and were mentioned to the participants twice: generally, during the initial approach when attracting individuals to take part, and in more depth at the beginning of the interview.

Protecting the participant:

Once the participants have had these areas about the research disclosed, they can then give informed consent to take part and allow their answers to become part of the research. The right to withdraw any information or answers given is allowed at any time, including after the interview.

Anonymity and confidentiality:

It is imperative that anonymity is assured and that the participants' answers are kept confidential. Thus, the participants in this evaluation knew exactly what would happen to their answers, who would read them, and how they may be used. Transcripts were written by professional transcribers and the names removed. They were coded and cross-referenced with a name and address in a separate secure filing system. The results were written up in such a way that no-one could be identifiable.

- **Technical adequacy.** The evaluation must be carried out with technical skill and sensitivity and so it was necessary to have a research team that could deliver a quality evaluation. The team in this case has previous experience of carrying out large scale evaluations of a similar nature, and has a background in education and the nature of collaborative partnerships.
- **Data storage.** The data is kept in locked filing cabinets: interview tapes are kept for one year after the interview, and interview transcripts and data analysis sheets are kept for five years.

Box 2.1: Participant information given to interviewees

Area of research to be addressed	How it will be addressed in this project
State the purpose of the research	'I am writing the story of the formation of the South West and North Dorset Academic Centre in Practice and discussing the first three years with key informants from the Trust and the University.'
State researcher position and involvement	'I am a Researcher at Bournemouth University involved in the evaluation of the Academic Centres in Practice.' Contact details of researchers provided.
State what is involved	'The interview will last for around 30 minutes to one hour. I am interested in your role in the setting up of the Centre and how you feel about the process you went through. With all questions there are no right or wrong answers – just be as open and honest as possible.'
State how the research is conducted	'With your permission, I would like to tape our conversation but anything you say will remain confidential between me, as the researcher, and yourself. You are welcome to a transcription of our conversation so you can amend or add to any comments you make.'
State what happens to material collected	'Knowledge gained from the interview will be used to develop an evaluative report on the ACP which will be available to you from Bournemouth University at the end of 2005.'

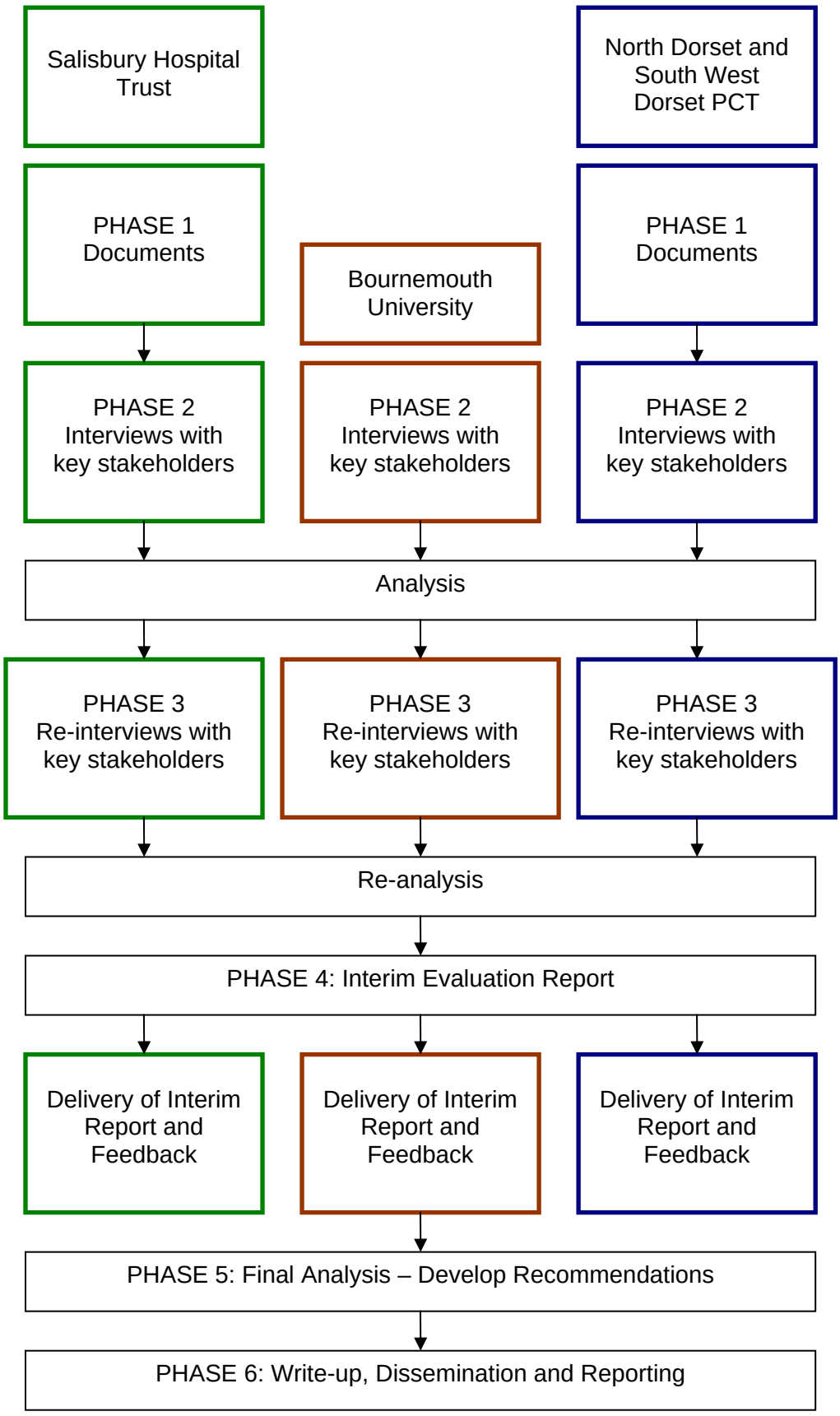
2.3. Design of the Evaluation

2.3.1. Procedure

The evaluation procedure went through a number of phases (see Diagram 2.2):

- **Phase 1:** Documentary analysis of ACP papers. A systematic analysis of a variety of papers took place. The papers included initial aims and objectives and terms of reference, steering group and working party minutes, academic papers developed as a result of the work of the ACP, documents showing the evaluation of workshops, and annual and interim reports;
- **Phase 2:** Interviews were carried out with key stakeholders from the participating organisations (Salisbury Health Care NHS Trust, North Dorset Primary Care Trust, South West Dorset Primary Care Trust and the Institute of Health and Community Studies at Bournemouth University – see Section 2.3.2);
- **Phase 3:** The analysis of phases 1 and 2 was completed and informed further interviews with some stakeholders from the organisations involved, focusing on key issues;
- **Phase 4:** Interim reports were delivered to key stakeholders from the participating organisations;
- **Phase 5:** Using analysis from phases 1, 2 and 3 and feedback from phase 4, recommendations were developed for the health authorities, the healthcare trusts and Bournemouth University;
- **Phase 6:** Write-up, dissemination and reporting.

Diagram 2.2: The evaluation procedure



2.3.2. Participants

Key stakeholders were identified from each participating Trust (Salisbury Health Care NHS Trust, North Dorset Primary Care Trust and South West Dorset Primary Care Trust) and from within the Institute of Health and Community Studies at Bournemouth University. The ACP lead for each Centre (Salisbury and Dorset) nominated an initial list of key stakeholders who had been closely involved with the development of the Centres to date. A snowballing technique was then employed, whereby extra participants were nominated by initial participants as they were interviewed. Participants were divided into categories according to their role within the Centres. Stakeholders were identified at three levels:

- A strategic level – those responsible for the strategic direction of the organisation were identified as senior managers or directors;
- A management level – the day-to-day drivers and leaders of the initiative were identified, including middle-managers;
- A practitioner level – those practitioners who used the services of the ACPs.

In total, 42 participants were interviewed: 15 were primarily involved with the Dorset ACP, 26 were primarily involved with Salisbury ACP and 1 senior manager oversaw both projects (see Table 2.1). A number of re-interviews also took place.

Table 2.1: Numbers of participants by role in the Academic Centres in Practice

	Staff involved with Salisbury Academic Centre in Healthcare Improvement	Staff involved with Dorset Academic Centres in Practice – Mental Health and Primary Care	Staff Attached to Both Centres
Senior Managers	6	4	1
Leads of the Centre	12	6	0
Users of the Centre	8	5	0
TOTAL	**26**	**15**	**1**

2.3.3. The Interview

Type

In this research, the structure of the interview remained similar throughout, examining key areas of interest including the participants' role within the ACP, their view and perception of what the Centre is, what they see as the value of the Centre, how they view the Centre

working, the future of the Centre and the key learning points for the Trust and the University (see Box 2.2 for outline of initial questions). However, the design of the interview structure was emergent, in that key areas of interest developed from the interviewees could be studied in subsequent interviews and so did not always follow the outline in Box 2.2.

2.3.4. Data Analysis

Since the research was based on an emergent design, data analysis ran concurrently with data collection. Initially, an interview was transcribed exactly, including all relevant verbal and non-verbal behaviour where noted. A process of constant comparative analysis was then adopted whereby a summary of the interview was further reduced through the division of units of meaning into areas of distinction: general, essential, and relevant. Recurring themes were detected using axial coding and further reduction was possible by placing the axial coded responses into discrete categories. Finally, independent analysis took place to ensure investigator triangulation and so enhance the validity of the evaluation.

Since this approach deals with interconnected perceptions, it would be wrong to analyse one interview after another without then returning to the original interviews. Thus, further data analysis occurred at the end of the interviewing. This involved a re-check of the phases of the audit trail and highlighted differences found in light of new evidence uncovered in the subsequent interviews. This technique led to reporting in a narrative form, which represents the knowledge acquired in a human and cultural dimension. Thus, actual examples of knowledge are included in the form of speech narrative and dialogue, highlighting the main outcomes of the analysis.

The results are presented over the following three chapters. Chapter 3 shows the initial findings from the data in terms of the initiation and development of the collaboration; Chapter 4 highlights the success stories, and Chapter 5 addresses issues with the collaborative strategy.

Box 2.2: Outline of initial questions asked in the interviews

What is your role within the Trust?

Position

Responsibilities

What was your role in the formation of the ACP?

When did you become involved?

How were you involved?

What is an ACP?

What is your definition of an ACP?

Has that changed during the process?

What is the value of having an ACP?

How is it different to what was in place before?

Has it been productive?

Do people support the idea of a Centre?

How in your view is the Centre working?

Is it working differently to any other way that you have worked in the past?

Where do you see it going?

How do people view the University in relation to the Centre?

Has in been productive? – If so, what is the product?

Difficulties and barriers/overcoming barriers.

What is next for the ACPs?

Sustainability

Links in Academy formation

What could the University learn from the setting up process?

If they were doing it again, what could they do differently?

What could the PCT learn from the setting up process?

3. Introducing the Academic Centres in Practice

3.1. Introducing the Trusts

Two ACPs were initially developed. The Academic Centre for Mental Health and Primary Care is a collaborative initiative established by Bournemouth University and North and South West Dorset NHS Trusts. The Academic Centre for Healthcare Improvement is a collaborative venture established by Bournemouth University and Salisbury Health Care NHS Trust.

3.1.1. Salisbury Health Care NHS Trust

The Salisbury Health Care NHS Trust provides a range of clinical care, which includes general acute and emergency services to approximately 187,000 people in Wiltshire, Dorset and Hampshire. Specialist services such as burns, plastic surgery, cleft lip and palate, genetics and rehabilitation extend to a much wider population of more than three million. The Duke of Cornwall Spinal Treatment Centre covers most of southern England. The Trust employs around 3,750 staff and manages Salisbury District Hospital and Hillcote, a centre for children with learning disabilities. The Trust has close links with other NHS organisations and its staff provide outpatient clinics in community hospitals in Dorset and Hampshire. Specialist staff hold outreach clinics in hospitals within the Wessex area. Some community services provided by South Wiltshire Primary Care Trust are also based at Salisbury District Hospital.

Salisbury District Hospital

3.1.2. North Dorset Primary Care Trust

The North Dorset Primary Care Trust provides primary care and community hospital services for North Dorset and mental health services for the people of West Dorset. The Trust is responsible for the Blandford Community Hospital, Forston Clinic in Dorchester, Westminster Memorial Hospital in Shaftesbury and Yeatman Hospital in Sherborne.

Plate 3.1. Forston Clinic, Dorchester, North Dorset Primary Care Trust (photo – C. Vincent)

3.1.3. South West Dorset Primary Care Trust

The South West Dorset Primary Care Trust is responsible for providing the people of South West Dorset with an integrated range of primary care and community health services. These are community hospital services at Bridport, Weymouth and Portland; community nursing and health visiting services across South West Dorset; and the Trust is also responsible for the GP practices in its area.

Plate 3.1. Dorset and Somerset Strategic Health Authority, Yeovil (photo – C. Vincent)

3.2. Development of the Academic Centres in Practice

3.2.1. The Start

Two Nurse Executives – Mary Monnington from Salisbury Healthcare Trust and Jill Pooley from Dorset Community Trust (later integrated into North Dorset Primary Care Trust and South West Dorset Primary Care Trust), together with Professor Iain Graham (Institute of Health and Community Studies, Bournemouth University), submitted a proposal in 1999 to Dorset and South Wiltshire Education Purchasing Consortium for funding to create two ACPs. The brief these Centres had was to establish a collaboration between learning and practice whereby the synthesis of research, learning, knowledge transfer and education could be tied explicitly to service, management of change, redesign and development for the overall purpose of improving patient care.

3.2.2. The Model

The model for an ACP was based on work addressing communities of practice and learning (Lave and Wenger, 1991; 1999; Wenger, 1998a; 1998b; Wenger and Snyder, 2000). Wenger (1998a; 1998b) defines a community of practice as being distinctly different to traditional businesses:

> 'A community of practice is different from a *business or functional unit* in that it defines itself in the doing, as members develop among themselves their own understanding of what their practice is about. This living process results in a much richer definition than a mere institutional charter. As a consequence, the boundaries of a community of practice are more flexible than those of an organizational unit.' (Wenger, 1998b, unpaginated)

A community of practice is also seen very differently to team work:

> 'A community of practice is different from a *team* in that the shared learning and interest of its members are what keep it together. It is defined by knowledge rather than by task, and exists because participation has value to its members. A community of practice's life cycle is determined by the value it provides to its members, not by an institutional schedule. It does not appear the minute a project is started and does not disappear with the end of a task. It takes a while to come into being and may live long after a project is completed or an official team has disbanded.' (Wenger, 1998b, unpaginated)

Finally, Wenger comments on how different a community of practice is compared with a network:

> 'A community of practice is different from a *network* in the sense that it is "about" something; it is not just a set of relationships. It has an identity as a community, and thus shapes the identities of its members. A community of practice exists because it produces a shared practice as members engage in a collective process of learning.' (Wenger, 1998b, unpaginated)

According to Wenger (1998b), the value of a community of learning includes the following:

- Communities of learning are nodes for the exchange and interpretation of information;
- Communities of learning can retain knowledge in 'living' ways, unlike a database or a manual;

- Communities of learning steward competencies to keep the organisation at the cutting edge;
- Communities of learning provide homes for identities. They are not as temporary as teams and, unlike business units, they are organised around what matters to their members.

The core value of the ACPs, based on the work of learning communities (Lave and Wenger, 1991; 1999; Wenger, 1998a; 1998b; Wenger and Snyder, 2000), is that patient and client views are understood in order to improve services, design new approaches, manage change and ensure that learning underpins the design and evaluation of change. There is an emphasis on interprofessional learning embracing a multi-professional education strategy.

It is critical that the work of the Centres serves as an investment that produces benefits for a number of stakeholders, including patients and staff as well as the wider health community and higher education arena. These benefits are likely to be a variety of short-term measurable outcomes and long-term process focused developments.

3.2.3. The People

Diagram 3.1 shows the key informants in the development of each ACP since their conception in 1999.

Diagram 3.1: Key informants in the development of Salisbury ACP

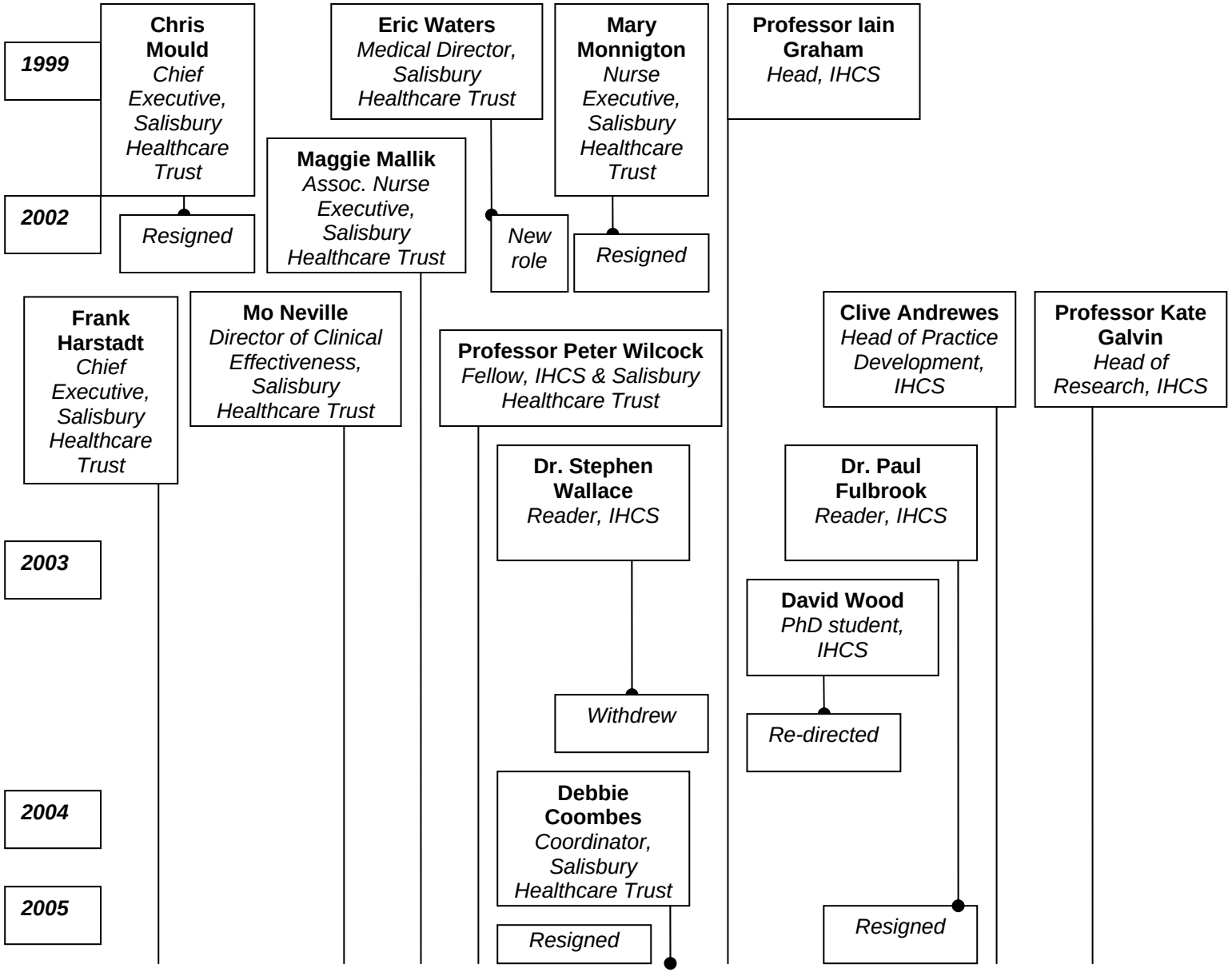
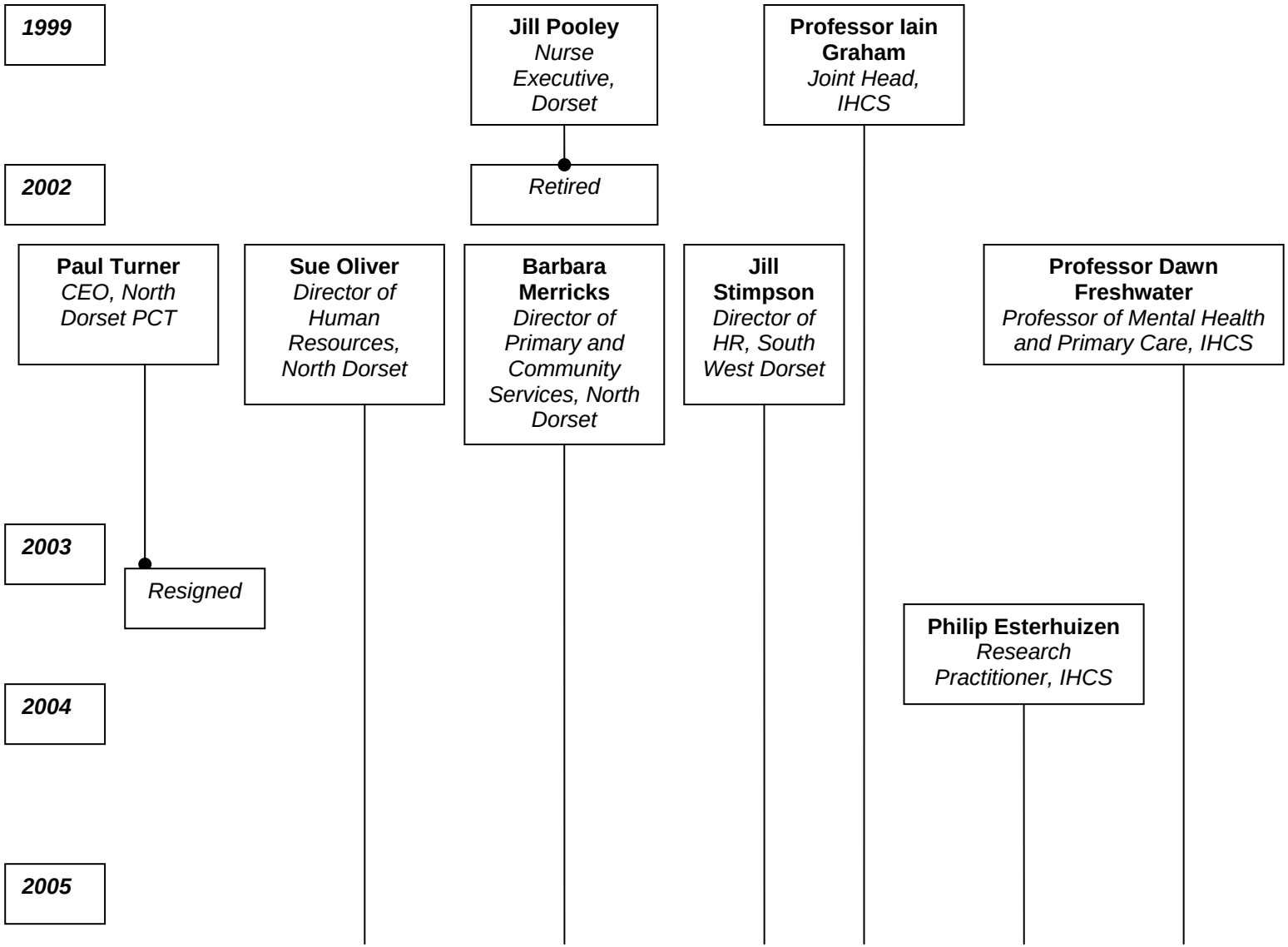


Diagram 3.2: Key informants in the development of Dorset ACP



3.2.4. The Vision

The initial vision of each ACP was drafted in primary documents and each Centre related the anticipated benefits for patients, Trust, staff and University. Box 3.1 shows the anticipated benefits of the Salisbury ACP. Overall, as Box 3.2, shows the Dorset ACP builds on the strengths of IHCS and its practice partners and symbolises the Institute's and the collaborating Trusts' vision for academic excellence: high quality, evidence-based practice, teaching and research.

- In research, the ACP seeks to ensure a rich programmatic development with its scholarship demonstrated through integrity of independent thought, in conjunction with a concern for relevance;
- In education, the ACP seeks to develop learning in the workplace and in external institutions that is based on key research-led principles, focusing on enhancing competence and capability;
- In practice, the ACP is concerned with practice improvement and seeks to enhance the contribution to health delivery of all health professionals. The Centre identifies the integration of practice with education and research as fundamental to achieving its aims (taken from Freshwater, 2003).

In setting out to achieve this vision, the Dorset ACP, in conjunction with the steering group, developed a list of targets as outlined in Table 3.1.

Box 3.1: Anticipated benefits – Salisbury

For patients:

- Care that improves the way it meets their needs, and their involvement in the provision of that care.

For the Trust:

- Reduced risk in identified areas;
- A growing capability and capacity for improving practice that will spread across the Trust;
- Improved staff morale and potential benefits for recruitment and retention;
- A strong addition to the Trust's continual professional development (CPD) programme
- Improved care and outcomes for specific groups of patients, demonstrated with specific feedback measures;
- Recognition as being at the leading edge of national NHS developments.

For staff:

- A sense of being valued and supported by the Trust in their desire to improve the care they provide to their patients;
- Academic recognition for their work;
- Specific academic awards/points at appropriate levels for individual learners, from Doctorates to NVQs, with rigorous evaluation and to make a clear impact on improving care (links: e.g. revalidation, Investors in People standard, CPD processes).

For the University:

- Development of knowledge and experience about establishing accredited professional and interprofessional learning in practice settings that has a demonstrable impact on improving practice;
- Experience of making learning relevant in the workplace and connecting this with the concept of 'lifelong' learning;
- Increased understanding about bridging the theory-practice gap in education (links: academic professional development pathways, MA in Interprofessional Health and Community Care, taught Doctorates).

Box 3.2: Anticipated benefits – North & South West Dorset

Broadly these are:

Health care improvement:

- The development of the capacity and capability for continuous improvement;
- The development of a growing cadre of staff who have the skills, knowledge and experience to lead quality improvement teams;
- The development of robust systems and processes to support clinical governance and risk management;
- Demonstrable improvements in clinical outcomes and reduced risk to patients and staff.

Research:

- The development of the capacity and capability for undertaking research within the Trusts and the University;
- Research and development projects;
- Publications;
- Contributions to the next Research Assessment Exercise;
- Provide an auspice for higher degree students and their academic supervisors.

Higher level learning:

- The opportunity for Trust staff to gain accreditation for work-based learning;
- Contribution to the development of units of education for Bournemouth University's professional doctorate.

More specifically:

For patients:

- Care that improves the way it meets their needs, and their involvement in the provision of that care.

For the Trusts:

- Reduced risk in identified areas;
- A growing capability and capacity for improving practice that will spread across the Trust;
- Improved staff morale and potential benefits for recruitment and retention;
- A strong addition to the Trusts' CPD programme;
- Improved care and outcomes for specific groups of patients, demonstrated with specific feedback measures;
- Recognition as being at the leading edge of national NHS developments.

For staff:

- A sense of being valued and supported by the Trust in their desire to improve the care they provide to their patients;
- Academic recognition for their work;
- Specific academic awards/points at appropriate levels for individual learners, from Doctorates to NVQs, with rigorous evaluation and to make a clear impact on improving care.

For the University:

- Development of knowledge and experience about establishing accredited professional and interprofessional learning in practice settings that has a demonstrable impact on improving practice;
- Experience of making learning relevant in the workplace and connecting this with the concept of 'lifelong learning';
- Increased understanding about bridging the theory-practice gap in education;
- Synergy of practice-based academics.

Table 3.1: The latest progress made by Dorset ACP against initial targets

Dorset Academic Centre in Practice Targets
1. To provide support and advice for practitioners in the development of research-based practice: ❖ Set up a database of individuals with research knowledge, skills and expertise to provide advice and support to professionals; ❖ Identify and prioritise areas for health science research within the Trusts; ❖ Provide practical support and supervision for practitioners undertaking research and submitting articles for publication or conference papers; ❖ Run quarterly drop-in surgeries at community hospitals' resource centres; ❖ Review access to library facilities with IHCS; ❖ Provide support and advice on seeking external and internal funding for research; ❖ Continue to foster links with academic institutions in research and development activities.
2. To identify and develop communication network systems to promote and disseminate evidence-based practice: ❖ Maintain University representation on the research governance group to support dissemination of research findings; ❖ Establish and maintain research interest groups/forums across the Trusts; ❖ Set up accessible resource rooms across the two Trusts for purposes of learning, updating and dissemination of information; ❖ Establish and develop a research and publication database; ❖ Facilitate an annual research study day; ❖ Run research seminars on identified topics.
3. Develop and implement a comprehensive educational package that covers a wide range and level of research skills and knowledge to meet the individual needs of practitioners in the workplace: ❖ Undertake a training needs analysis; ❖ Liaise closely with academic institutions to develop educational support and ensure high quality education and supervision; ❖ Develop an educational programme based on research awareness, appreciation, application and ability; ❖ Explore and develop schemes to enable key clinical staff to undertake training in research while retaining their clinical base; ❖ Facilitate a series of publications workshops.

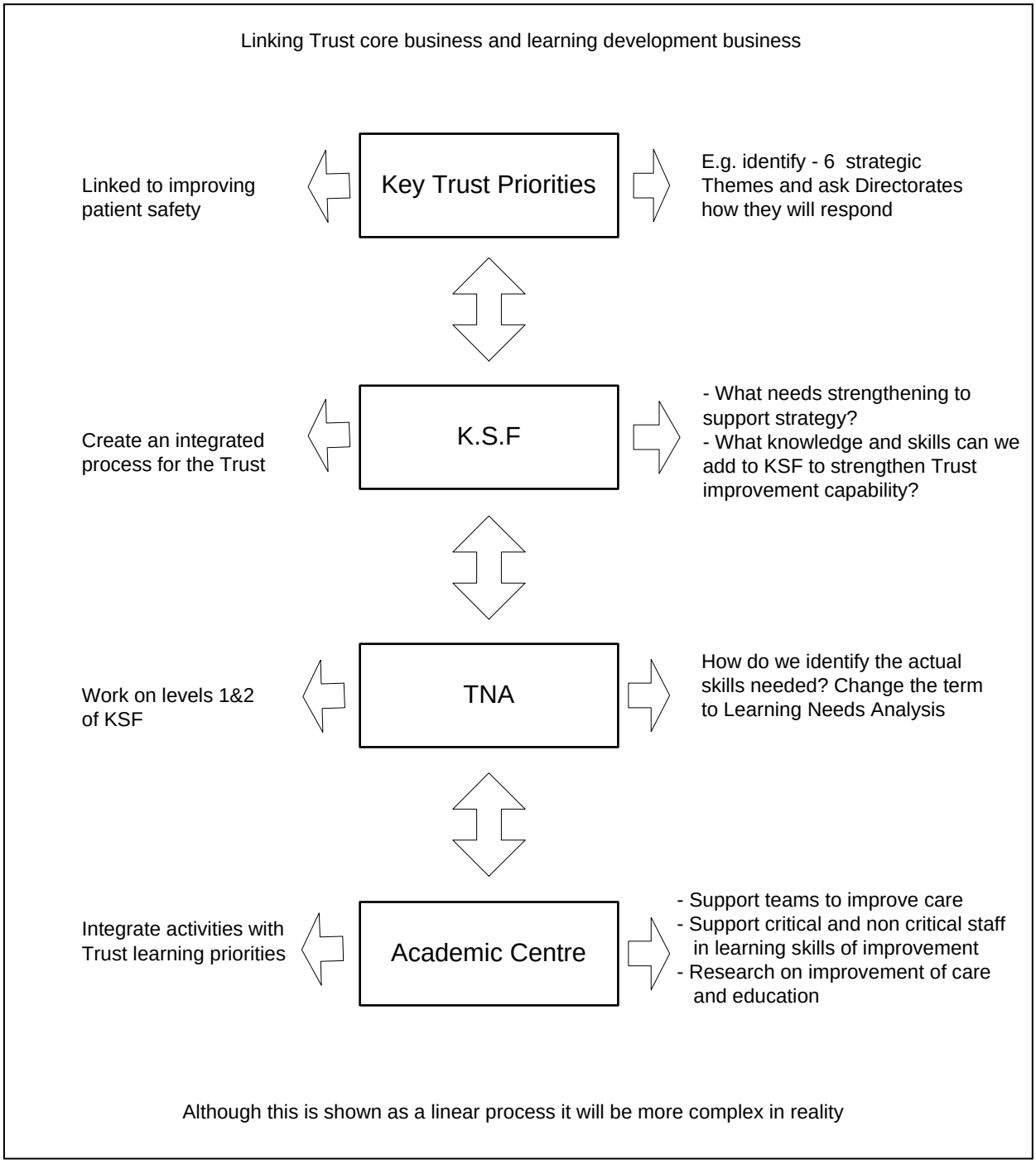
3.2.5. Links

Each ACP formed a steering group that oversaw the work of the collaboration. In addition, the Salisbury ACP had a working group. However, the working group and steering group merged into one meeting and took the form of a working group. In each ACP, these groups met regularly and focused on the following issues:

- Information sharing;
- Brainstorming;
- Monitoring targets;
- Reports of ongoing work;
- Actions.

In addition, each ACP spent considerable time developing models showing links and accountabilities of current activity with regards to learning and development at each Trust. Diagram 3.3 shows how the core work of the Salisbury ACP links to key Trust priorities, the Knowledge and Skills Framework and the Training and Learning Needs Analysis. Diagram 3.4 shows how the ACP at Salisbury is linked and is accountable to various stakeholders within and outside the Trust. Diagram 3.5 shows how Dorset ACP is linked to the learning centre within the Trusts.

Diagram 3.3: Salisbury Academic Centre in Practice (prepared by Mo Neville and Peter Wilcock)



Key:

KSF – Knowledge and Skills Framework
TNA – Training Needs Analysis

Diagram 3.4: Salisbury Academic Centre in Practice links and accountabilities (prepared by Eric Waters)

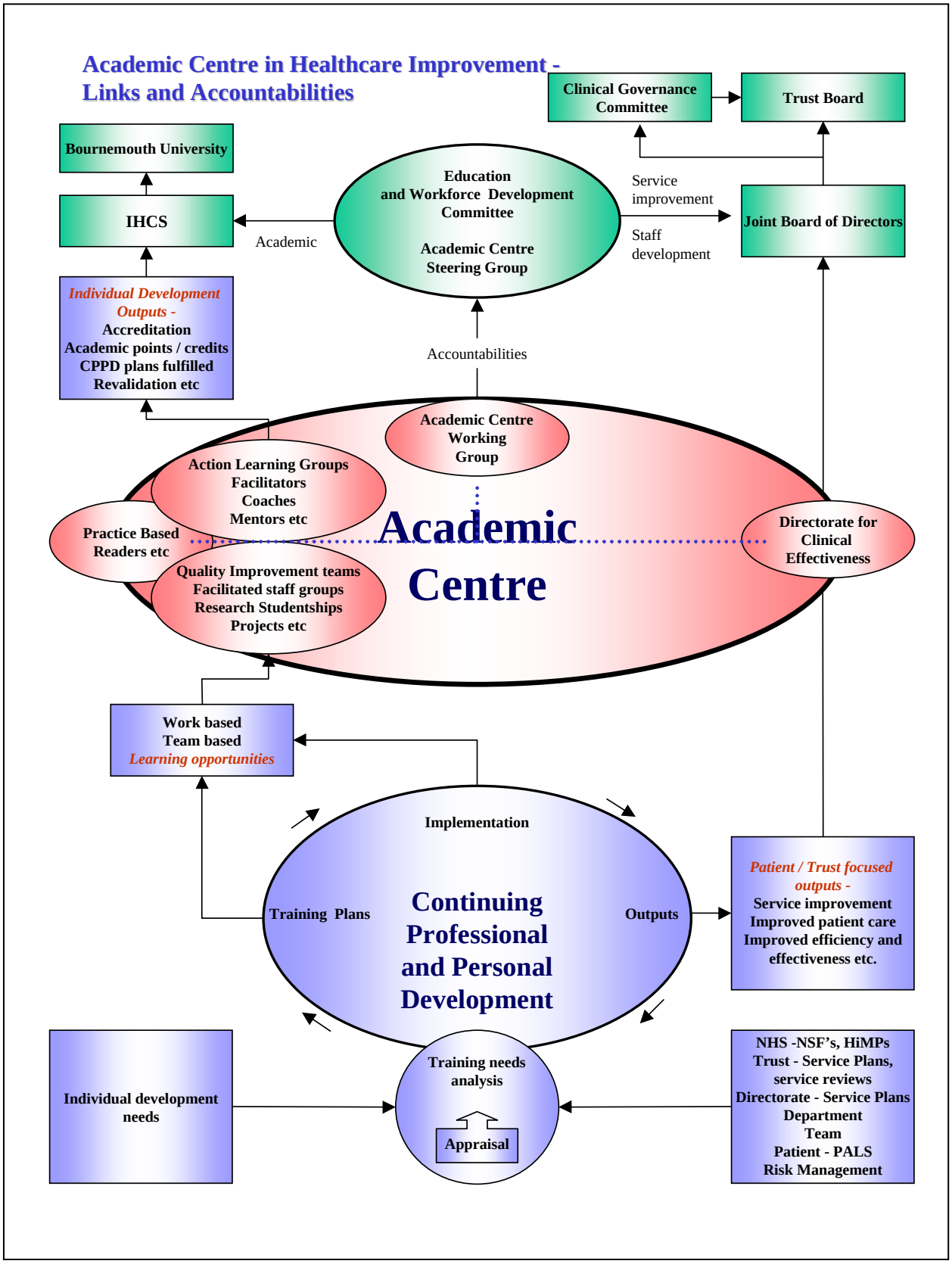
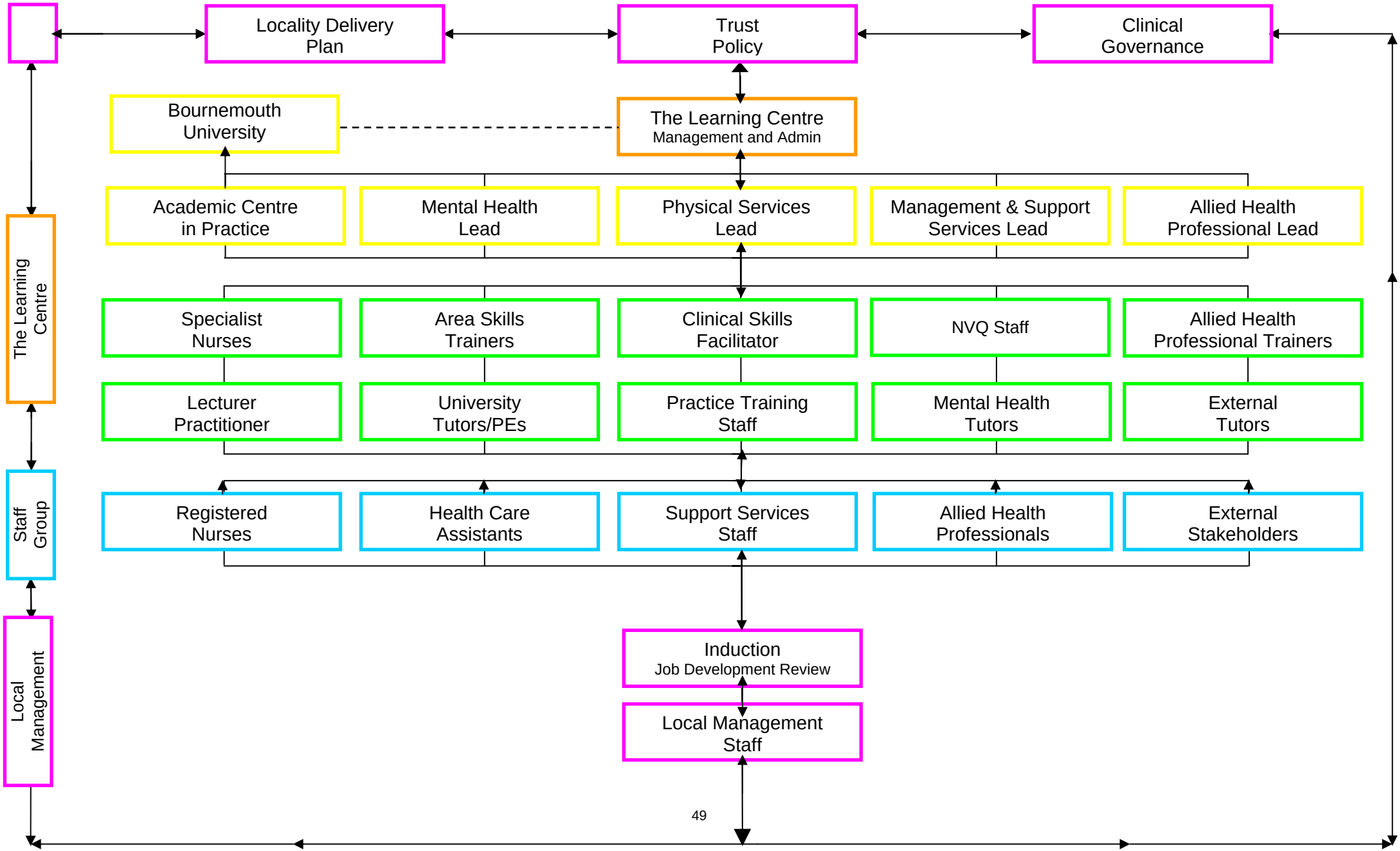


Diagram 3.5: Dorset Academic Centre in Practice learning and development flow chart



4. The Work of the Academic Centres in Practice

4.1. Approaches

Despite each ACP employing a needs-led approach, each has taken a slightly different route in delivering the work. Salisbury Academic Centre in Practice has taken a pro-social approach, creating a collaborative learning community through the development of new initiatives and also through the enhancement of existing well-established learning groups. Such an approach puts groups, connectivity and connections together to make better services for patients at the heart of the work. Dorset ACP has taken a bottom-up approach that transcends the work within the Trusts. Such an approach puts people and individuals at the heart of the work, which in turn leads to practice and patient improvement through generating new models and theory developed from within existing practice. The Dorset Centre attempts to create sustainability, whereby practitioners engaged in learning are encouraged to become self-sufficient and in turn lead others in learning. The differences not only reflect different personalities leading and working within each Centre, but are also a function of the difference between working with an acute hospital trust, whose employees and focus are based on a main site, and a rural primary care trust, whose employees and focus are diverse and geographically divided.

4.2. Achievements and Successes

4.2.1. Salisbury Academic Centre in Practice

Work within the Salisbury ACP has centred on healthcare improvement and so is often referred to as Salisbury Academic Centre in Healthcare Improvement. Work has involved developing action learning sets, developing Masters-level support and frameworks to suit the needs of groups at Salisbury. To date, the work has focused on the following groups:

The Burns Unit Quality Improvement Team

The work undertaken by the Academic Centre for Healthcare Improvement with the Burns Group at Salisbury Hospital reflects the original ethos and aspirations of the ACP concept. Driven by the needs of the hospital and undertaken by a multi-disciplinary team, the Centre has facilitated work that directly resulted in:

- Improved healthcare provision for the patients;
- Improved professional practice by the healthcare professionals;
- Academic accreditation for the learning that took place.

The Trust perceived a need to improve the care of adults with major burns so that these individuals could receive the appropriate care. A multi-professional team was formed to undertake this. The Burns Unit Quality Improvement Team comprised a consultant surgeon, a ward sister, ward nursing staff, a dietician, a clinical psychologist and a physiotherapist. This team and work were facilitated by a member of the Academic Centre in Healthcare Improvement staff. The aims of the team were to improve the care provided to patients with major burns through:

- Improving knowledge of the current care received in the Burns Unit;
- Constructing a process map;
- Gaining feedback from the patients concerning the care they were receiving and needed.

The improvement team used the Plan Do Study Act (PDSA) cycle in order to continuously monitor and improve their practice (see Table 4.1). This model contains four steps:

- Plan – Develop a plan for improvement;
- Do – Execute the plan;
- Study – Evaluate feedback to confirm or adjust the plan;
- Act – Put the plan into action and monitor for potential adjustments.

The initial PDSA cycle identified a number of potential areas for improvement, including:

- To provide information to patients and carers as and when they need it;
- To identify patients who need psychological support;
- The receiving and acceptance of referrals;
- The structure and process of case conferences;
- Criteria for agreeing surgery.

A key area for improvement was recognised as the identification of patients in need of psychological support. In order to accomplish this improvement, the team introduced a

screening tool to improve detection of those patients with psychological distress. Workshops were organised for nursing staff and reminders were built in to ward routines. The screening tool was piloted with five patients and appropriate refinements were made in light of this. The initiative had built in success criteria to measure whether the changes in practice were an improvement, in that the screening results would be available within the patients' notes and to assess whether appropriate referrals were being made to the clinical psychologist.

In terms of making a clinical difference to the patients, this improvement resulted in:

- 91% of patients being checked for psychological distress;
- Approximately 30% were found to need psychological support for anxiety, depression or post-traumatic stress disorder;
- Referrals to the clinical psychologist increased by 600%.

In broader terms, the work of the Burns Unit Quality Improvement Team and the Academic Centre in Healthcare Improvement resulted in:

- Specific improvements in everyday practice;
- The team continued to learn and improve after the project ended;
- There was an improvement in team working relationships;
- There was personal growth and development for the individual practitioners within the team.

The ACP worked with the Burns Quality Improvement Team and identified a number of areas of improvement:

- Providing psychological screening for patients. A process has been designed and tested using improvement methodology and has been integrated into the care pathway. Results have been measured to show a significant increase in identification and referral of patients who need psychological support;
- Improving the process for referrals. These are included in the recently designed integrated care pathway;
- Identifying improvements in patient information via the use of discharge booklets, patient video and pain assessment tools.

Table 4.1: Example of a process map used by the Improvement Team in their evaluation and audit of the Burns Unit Care Pathway

Accepting Referral	Assessing	Treating	Evaluating	Discharging from Acute Phase
Enquiring About the patient	Taking clinical baseline	Treating other medical conditions	Evaluating wounds	Organising follow-up appointments
Preparing for arrival	Informing relatives and carers	Responding to psychological needs	Evaluating psychological progress	Writing and sending discharge letters
Advising re. initial treatment	Taking swabs and photos	Mobilising and moving	Sharing information at case conferences	Providing appropriate patient information
		Managing pain	Feeding back to patients and family	Giving emergency contacts
		Planning for discharge	Evaluating infection status	

Quality and Improvement Learning Set (QUAILS)

The ACP has focused the work of QUAILS in two main areas:

- Action learning groups have met monthly to consider topics in healthcare improvement as defined by group members;
- Some members have signed up to a Masters in Practice Development programme and the Centre supports the development of these individuals.

Improving Patient Safety

Two cohorts of students, including preceptorship nurses and PRHOs, have attended the regular Improving Patient Safety action learning group.

Patient Involvement Project

An interprofessional team within the spinal unit is involved in a project to involve patients in exploring how best to provide outreach support services to reduce in-patient admissions and in ensuring that individual patients' needs are met.

Educational programmes for spinal unit staff and MDT coordinators

A three-year programme has been designed by ACP staff which will enable participants to gain both NVQ and academic credit. The key elements of the programme are customer care, IT, communication and audit.

Learning set for consultants

The ACP supported a learning set for 12 consultants and senior registrars who have educational responsibilities for junior doctors.

Modernising Medical Careers Foundation Programme

From the work undertaken with the ACP and the Patient Safety Group grew the experience and confidence to undertake work to satisfy the demands of the Modernising Medical Careers Foundation Programme. This programme is a national requirement and will profoundly change the educational approach for doctors during their first two years after medical school. The focus is on core and basic skills of improvement and patient safety, some of which will build on the students' undergraduate learning, and some of which will be new. The aim is to bind them all together in ways that clearly demonstrate how the students are using their learning and creating real benefits for the patients.

The underpinning ethos is that the integration of clinical learning with improvement learning will help develop doctors who, as well as being clinically competent, understand the need for, and have basic skills in, improving practice and the safety of the care that patients receive. One key characteristic will be the use of processes that will encourage students to become learner/ practitioners in the future rather than simply pass tests of competency at particular points in time. The proposed structure of the learning is at the following stage:

Foundation Year 1

Year 1 will be used to introduce students to basic improvement principles and methods that will enable them to address real issues that they have encountered in their practice; these may be clinical or otherwise. The issues will have real meaning for the students and, by being based in their work setting, will create the opportunity for them to leave a legacy of improved and safer care. The framework will contain the following key dimensions:

- Students choose a topic around which to base their learning;
- Students improve their knowledge and understanding around their chosen topic, for example through:
    - Literature searching and critical appraisal of the evidence;
    - Learning from patients and carers;
    - Checking current practice through audit, process mapping etc.;
- Designing safer, improved practice and building in feedback measures – using quality improvement and risk management principles and methods to design, test and learn from changes;

- Professional and personal reflection – students will be formed into groups using action learning set methodology and will be encouraged to maintain portfolios of their experience and learning;
- Presentation of their projects – at the end of the year, students will be expected to present their projects at one of the Trust's regular clinical governance meetings and to publish in the local medical bulletin.

Learning will be undertaken through regular meetings over the 12 month period. The sessions will be designed for:

- Learning new ideas and applying them to their projects;
- Reflecting on experience since the previous meeting;
- Planning next steps and use of time, and agreeing responsibilities for activity between meetings.

Support will be available from a range of hospital departments including the research and development support unit, library, risk management and clinical governance. Student assessment will be designed to integrate with assessment approaches built into the curriculum, including the use of portfolios.

Foundation Year 2

Foundation Year 2 will be used for students to consolidate and build on the basic skills they learnt in Foundation Year 1 as well as being introduced to the bigger picture of improvement, including the wider organisational context within which it must take place. This will instil an element of progression into their learning.

Involvement in the design of South Wiltshire Academy

The work of the ACP has supported and informed the development and design of the South Wiltshire Academy. This has involved substantial partnership working between Bournemouth University, the Trust, the Primary Care Trust and social services, underpinned by the ACP.

4.2.2. Dorset Academic Centre in Practice

The Dorset Academic Centre in Practice has focused primarily on mental health and primary care. The Centre has worked on a number of strategic targets devised and agreed at a series of Centre steering group meetings. Table 4.2 shows the progress that the Centre has made against these targets between September 2002 and January 2005. As can be seen, many of the targets have been or are being met.

Table 4.2: Progress made by the Dorset ACP against initial targets

ACP Targets	Action Agreed	Final Date
1. To provide support and advice for practitioners in the development of research-based practice		
1.1 Set up database of individuals with research knowledge, skills and expertise to provide advice and support to professionals	Database is functional. Continual updating process. Need to establish how to effectively utilise the database and link with other objectives and the education programme.	Achieved and Ongoing
1.2 Identify and prioritise areas for health science research within the Trusts	Link with Clinical Audit & Effectiveness and Clinical Governance groups in both Trusts.	Achieved and Ongoing
1.3 Provide practical support and supervision for practitioners undertaking research and submitting articles for publication/conference papers	Mapping exercise throughout both PCTs and via PDUs to ascertain needs and requirements. Provide individual/group support as required.	Achieved and Ongoing
1.4 Run quarterly drop-in surgeries at community hospitals resource centres	Mapping exercise throughout PCT and via PDUs to ascertain needs and requirements. Provide individual/group tuition rather than set sessions as required.	Achieved and Ongoing
1.5 Review access to library facilities with IHCS	NHS resources in place & functioning. Outreach librarian in post.	January 2005
1.6 Provide support and advice on seeking external and internal funding for research	See target three, provide support on seeking funding and writing research proposals.	Achieved and Ongoing
1.7 Continue to foster links with academic institutions in research and development activities	PE and RS to collaborate on teaching programmes. CM, PE to link with RDSU and WREN. PE to support conference presentations and publications.	Achieved and Ongoing
2. To identify and develop communication network systems to promote and disseminate evidence-based practice		

ACP Targets	Action Agreed	Final Date
2.1 Maintain University representation on research governance group to support dissemination of research findings	Representation on/contact with Clinical Audit & Effectiveness and Research Governance groups in both PCTs.	Achieved and Ongoing
2.2 Establish and maintain research interest groups/forums across the Trusts	See target 2.1.	Achieved and Ongoing
2.3 Set up accessible resource rooms across the two Trusts for purposes of learning, updating and dissemination of information	Resource room set up at Forston for both PCTs, and each locality has access to resources.	January 2005
2.4 Establish and develop a research and publication database	See target 1.1.	January 2005
2.5 Facilitate an annual research study day	Incorporate ACP activities into Best Practice Conference study day. Contact with SI to set this up.	September 2005
2.6 Run research seminars on identified topics	Individual tutorials for (mainly) Masters students on request.	Achieved and Ongoing
3. Develop and implement a comprehensive educational package that covers a wide range and level of research skills and knowledge to meet the individual needs of practitioners in the workplace		
3.1 Undertake a training needs analysis	Initial and ongoing mapping exercise throughout both PCTs and via PDUs to ascertain needs and requirements. Lead in the future to the development of a work-based learning module (see target 3.3).	Achieved and Ongoing
3.2 Liaise closely with academic institutions to develop educational support and ensure high quality education and supervision	See target 3.3.	Achieved and Ongoing
3.3 Develop an educational programme based on research awareness, appreciation, application and ability	Accreditation of work-based learning module with IHCS under discussion within BU.	Achieved and Ongoing
3.4 Explore and develop schemes that would enable key clinical staff to undertake training in research while retaining their clinical base	As above, with plans for developing reflexive approaches to practice improvement. See target 3.3.	Achieved and Ongoing
3.5 Facilitate a series of publications workshops	Included as part of work-based learning module (see target 3.3).	Achieved and Ongoing

Table 4.3 provides more detail of the work being carried out within the ACP and North and South West Dorset PCT collaboration. Table 4.4 illustrates the work being done in supervising Masters-level staff studying through the ACP.

Table 4.3: Recently started and ongoing connections at the Dorset ACP

Activity/Project	Progress Summary	Start Date	End Date
Integration of ACP into learning centre activities	Initial discussions on a shared philosophy and integration of work-based learning bridging the two organisations. Planned teaching sessions on a variety of subjects are provided twice a year via the learning centre on an introduction to audit, literature searching and appraisal skills, presentation skills, evidence-based practice, proposal and project writing and report writing.	December 2003	Achieved and Ongoing
Audit of suicides in mental health	First meeting in 02-04 to discuss possible collaboration. Introduction and brainstorming – 04 and 05. Audit carried out using: questionnaire for team leaders and locality managers, documentation audit, educational audit.	April 2004	February 2005
Evaluation of new HCA role – dementia care	Discussion of project and support of MSc student (Southampton University). Discussion of project proposal – incorporation of KSF and job evaluation. Ongoing support as requested by student.	April 2004	Achieved and Ongoing
Audit and clinical effectiveness	Introductory meeting to introduce ACP and define boundaries between ACP and WREN/RM&G. ACP undertakes audit training in N Dorset and SW Dorset PCTs – audit programmes based on: essence of care for staff in Weymouth community hospitals, informed consent in Bridport Community Hospital Theatre, and budget and single assessment process for SW Dorset PCT district nurses.	July 2004	Achieved and Ongoing
Leadership strategies	Meetings held to support middle management in coaching/supervising ward staff. Team building days held to discuss vision, leadership and management strategies.	November 2003	Not set/ ongoing
Leadership teaching sessions	Monthly multi-disciplinary educational sessions for Heads of Departments at Blandford Community Hospital on leadership strategies held over a period of six months.	January 2004	August 2004 then ongoing support programme
Resource room	Single consultation regarding setting up and equipping resource room at Blandford Hospital	May 2004	May 2004
PDU steering group – Westminster Memorial Hospital	Initial meeting during which all PDU projects were presented and the PDU launched.	July 2004	July 2004

Activity/Project	Progress Summary	Start Date	End Date
PDU project: practice educator role – Westminster Memorial Hospital, Shaftesbury	Supervision in study and support in developing and presenting PDU project.	December 2003	December 2005
PDU project: minor injury unit nursing role – Westminster Memorial Hospital, Shaftesbury	Supervision in study and support in developing and presenting PDU project.	December 2003	December 2005
PDU project: preceptorship and work-based learning – Shaftesbury	Supervision of four nurses undertaking work-based learning unit 1, and support in developing and presenting PDU project.	December 2003	December 2005
PDU project: respite care – Shaftesbury	Support requested regarding questionnaire and project proposal. Possible support in literature search and appraisal skills.	July 2004	July 2004
Benchmarking minor injury unit standards	Meetings supporting the development of benchmarks for ankle injuries. ACP support focuses on supporting the working group to set benchmarks for nursing assessment related to complexity of care.	November 2003	Achieved and Ongoing
Consultation on evaluation of community health nurse role	Meeting to discuss the evaluation of new community health nurse role in June 2004 and resulting facilitation and support of district nurse cohort for a period of six months.	June 2004	December 2004
Development of working group – vulnerable adult (Willows)	Discussion regarding ACP role and regarding the possibilities of supporting a project focusing on vulnerable adults and a presentation to the staff of ACP concept. The subsequent project supports the staff in developing care for vulnerable adults based on Essence of Care Standards and NSF Standard 4 (Older patients in the acute hospital). This project is linked to educational sessions on audit directed at NVQ level and qualified staff.	December 2003	Achieved and Ongoing
Incidental consultation and possible inclusion of RNs in work-based learning study options	Consultation regarding the possibilities of study options for non-degree nurses, nurses wanting to start a work-based learning unit, and support for staff already undertaking a study.	April 2004	Achieved and Ongoing
Palliative care working group	Initial meetings to discuss objectives and set a plan of action for a working group followed by ongoing meetings to develop the profile of palliative care, to provide educational sessions and to provide ongoing support for staff dealing with this category of patient.	June 2004	Achieved and Ongoing
Palliative care working group	Educational input, support and teaching in a Macmillan ‘train the trainer’ package, aimed at nursing home staff (pilot) prior to the programme being extended to community hospitals.	June 2005	Achieved and Ongoing

Activity/Project	Progress Summary	Start Date	End Date
Development of work-based learning packages	Activity in university work-based learning working group to develop a number of appendices to complement work-based learning unit 1: trauma/orthopaedics, medical/gerontology, minor injuries unit.	November 2003	Not set
Development of work-based learning at NVQ level	Initial meeting with management at Westminster Memorial Hospital, Shaftesbury, to brainstorm about the possibilities.	May 2004	May 2004

Table 4.4: Supervision of Masters-level students at the Dorset ACP

Course	Progress Summary	Start Date	End Date
MSc Advanced Practice (Cardiac Rehab)	Five facilitated sessions with student on research in support of Masters programme. Critiqued two essays.	November 2003	March 2004
MA Health & Social Care Education	Supervision meetings with student, depending on needs.	September 2003	Achieved and Ongoing
BSc Clinical Leadership	Supportive meetings with student, depending on needs. Study linked to the PDU at Shaftesbury – PE role. Although the course has a primarily management focus, it has been adapted to the student's current role as practice educator.	September 2003	June 2005
BSc Dementia Care Studies	Student needed short-term, intense supervision to get research assignment ready for submission. Because it was a distance learning course, the student had virtually no supervision or tutorial.	June 2003	July 2004
MSc Public Health	Support provided in meta-ethnography research methodology for student undertaking Masters programme via Bristol University	January 2004	Achieved and Ongoing

The education programme has focused on the following areas:

Audit programme – proactive clinical environment – management, accountability and leadership

The ACP has become involved in a number of mandatory audits across the Dorset PCTs. What can often be a tick-box exercise is extended by involving the health professionals in a reflective practice environment where, during the audit process, they look at their own practice and philosophy as well as addressing the requirements of the audit. Often using the Essence of Care document as a non-threatening introduction to the procedure, the Centre works with staff to examine and deconstruct their own personal experiences and bring them face-to-face with their individual 'philosophy of care'. This makes the audit process an empowering instrument by making the staff accountable for their actions, giving them the ability and evidence to argue their philosophy and often place them in leadership roles with their peers. The Centre takes the

Trusts' staff through the audit process and helps them develop their own audit instrument that can be observational, documentational or analytical, as well as establishing time frames and guidelines. The skills and knowledge the Trusts' staff acquire in this reflective approach are transferable across the whole of their practice and make the mandatory audit much more relevant to the individual practitioners.

Audit programme – Weymouth Community Hospital

Working within Weymouth Community Hospital, the ACP has set up programmes that reflect the ethos of collaboration between the Trusts and the University. Two audit programmes have been undertaken and four more are set up. Using the Essence of Care document as a basis, the two audits undertaken were with registered nurses developing an audit instrument for record keeping, and with NVQ level staff setting up an instrument to audit privacy and dignity. Guided through the process by Trust and ACP staff, huge professional growth was noted within the NVQs as they took the responsibility, accountability and opportunity to critique the philosophy of care as it related to privacy and dignity within the units they were working in. The process empowered relatively junior members of staff to make judgements concerning working practices, and the insight they obtained from this exercise impacted on other areas of care they were providing. Findings from the privacy and dignity audit were disseminated to senior members of staff through a presentation by the NVQs. The recommendations for change were received enthusiastically by the matron and senior sisters.

Audit programme – linking with vulnerable people at Sherborne Hospital

Working with a group of NVQs based at the Yeatman Hospital in Sherborne, the ACP was involved in an audit looking at patient personal hygiene across two wards within the hospital. An instrument of audit was devised through the Essence of Care document to observe the quality of care being provided and an audit was also undertaken of the documentation. Staff were observed working with the patients by the senior sister in charge of the two wards and the ACP undertook the audit of the documentation. These audits were then compared and differences discussed in the form of group interviews. The findings were fed back separately to the individual ward teams. The staff, with support from the ACP, are now moving on to an audit focusing on patient privacy and dignity using and developing the skills they acquired in the initial audit. As the staff at Sherborne have become more skilled at the 'reflective practice' approach to the audit process, the ACP is able to support the different stages with theoretical and philosophical input rather than teaching the required skills. Staff are now able to carry out their own audits as the process becomes embedded in their normal practice.

Plate 4.1: Yeatman Hospital, Sherborne (photo – C. Vincent)

Workshops – presentation skills, literature search, introduction to audit, writing, evidence-based practice, research appraisals, proposal writing and report writing

At Forston, Sherborne and Shaftesbury, the ACP had organised a number of workshops that link into the acquisition of research skills and seek to develop the academic capabilities of the PCT staff that attend. The workshops take into account the level of the participants and are delivered at a pre- or post-degree level as appropriate. The most popular and successful courses have been those focusing on presentation skills, which have been fully subscribed to and positively evaluated by the participants. As the academic demands of the Trusts' staff have developed, courses have now been timetabled with Professor Freshwater on proposal and report writing. This has proved very popular, with all places taken. The ACP also intends to offer courses on audit and research in Autumn 2005.

Supporting three practice development units (minor injury unit role development and benchmarking of ankle injuries, practice education and preceptorship)

The development of minor injury units (MIUs) has placed huge demands on the Trusts' nursing staff to increase their knowledge and skills in medical diagnosis and the prescribing of drugs. The ACP has become involved with this initiative through its work at Westminster Memorial Hospital, Shaftesbury, where it worked with a multi-disciplinary team to turn the practical experiences and knowledge the team already possessed into a more formal benchmarked

approach that all staff could use to ensure uniformity of practice and care. The project focused on ankle injuries and the multi-disciplinary team and ACP addressed issues such as:

- What are the signs and symptoms?
- How do you reach a reliable medical diagnosis?
- Is an X-ray needed?
- How do you make decisions about treatment?
- What do you do about immobilisation?
- What treatment regimes are appropriate?

From this collaboration between the Trust and the ACP, agreed benchmarks were developed and incorporated into an intake assessment document and a patient diary. The ACP then assisted with critiquing the documentation to ensure uniformity, continuity and progression within the patients' care.

Plate 4.2 Westminster Hospital, Shaftesbury (photo – C. Vincent)

Collaborative work with lecturer practitioners

The ACP has worked closely with a number of lecturer practitioners, particularly in the area of palliative care and issues surrounding ethics and moral decision making. This work involves facilitating sessions with groups of interested nurses and other healthcare professionals. Previous work also involved lecturer practitioners in the minor injury units and work with the community nurses. Future plans in this area of collaboration include working with a group of GPs on end of life issues and working with trainers on similar end of life issues and moral decision making.

Team building and development – philosophy of care – leadership training (including self-awareness)

The ACP became involved with heads of department at Blandford Community Hospital on issues relating to leadership. Within the initial sessions, the individual managers, who were from a multi-disciplinary background, looked at their own philosophy of care and how that impacted on their own work, roles and the aims and objectives they had for their departments. This was extended to see how the individual philosophies related to the philosophy of the hospital and how they then related to the Trust's philosophy, and so on. Initially, these sessions were very much ACP directed but, half way through the six planned sessions, the group started to take control and ownership of the agenda and the 'curriculum'. This resulted in a much more dynamic and meaningful exercise for all involved, including the ACP. From that point, participants kept in contact with one another between the sessions, became proactive about the content of the meetings and worked on subject matter between times. The outcome of this new togetherness meant that they discovered how they related to one another within the Trust and that their own personal philosophies of care were very similar. They also discovered that their aims and objectives for their individual departments were almost identical. Within this new group identity, the confidence grew to share challenges they were facing with management or staff, and here again they discovered common themes. The proactive nature of the sessions allowed the ACP to bring forward issues relating to theoretical aspects of leadership and management, which enabled the participants to analyse their own roles and positions as managers and leaders in the Trust's hierarchy. The group now wishes to continue to meet and develop and feels confident enough to take issues of common concern forward to senior management.

Setting up resource rooms for Trust staff engaged in research

Across the South West and North Dorset Trusts, resource rooms have been set up at the Forston Clinic and the community hospitals at Blandford, Sherborne, Shaftesbury and Weymouth. The rooms provide facilities for quiet study and contain computers with internet access. Through the internet facilities, Trust staff can access the huge range of material available through the NHS library. In conjunction and collaboration with the librarian from Dorset County Hospital, the ACP organises workshops on how to access material through the NHS website as part of the workshop on literature searching. Because the resources rooms are not staffed, it is difficult to maintain and retain books and periodicals. As part of the ethos of the ACP is to take its work around the Trust and not just deliver courses and presentations at one central location, the resources rooms are also used as teaching areas.

Development of a research and publication database

A member of staff at Forston Clinic has created and currently maintains a database that records all pieces of research undertaken by staff and funded by the North or South West Dorset Primary Care Trusts. This enables potential researchers to check what research has already been done and also allows possible networking to take place between research and researchers interested in a common theme. The current database mainly consists of research undertaken for accreditation, but as the research skill within the Trusts develops, through the work of the ACP, it is expected that the number and variety of individual research projects will increase. It is now a requirement of research projects that seek Trust support, whether by funding or time, that they register their project with the Trust's database. A recent suggestion by clinical governance staff within the Trusts is that an audit database could in some way be linked with the research database and possibly follow the same successful format.

Bespoke sessions for Masters students

ACP staff are available to support individual students within the Trusts with their academic study that is leading to accreditation. This can involve processes from any part of the student's work: literature searching, methodology dilemmas, critiquing their written work. This area of work is important for the development of ACP staff as it gives them the opportunity to develop their own skills and knowledge at a high level.

Scholarships

Applications for scholarships have been made based on projects undertaken by the ACP in conjunction with Trust staff. These applications focused on research opportunities but had an educational bias. One of the projects focused on the role transformation of district nurses to community matrons and looked at the clinical decision-making within that role, how they learn and what information they need to learn The other application for funding was in the area of palliative care and examined the role of the staff trainer, initially in the nursing home environment and later to be extended into the community. Writing and devising the application proposals was a useful experience for the ACP and will help with future applications.

4.2.3. Individual Stories

Across both Centres, users of the ACPs praised the initiatives. Case study 4.1 highlights the story of a clinical psychologist working within the Burns and Plastic Surgery Unit at Salisbury Hospital. She highlights how the ACP has enhanced reflective practice and helped bridge the theory-practice gap. Case study 4.2 highlights the story of a Ward Sister at Salisbury Hospital who saw real quality improvement of care pathways within the burns unit, which led to better screening and referral processes. This also led to personal success in achieving accreditation for a clinical leadership degree. Case study 4.3 illustrates the story of a consultant who found the Centre useful in helping a multi-disciplinary learning group work effectively. She highlights the expertise in learning, clinical governance and reflective thinking that the ACP was able to deliver to the group. Case study 4.4 comes from a nurse consultant working in minor injury care within Dorset. She notes the advantage of the ACP in aiding the process of practice development and sharing best practice with other practitioners. Case study 4.5 is from a team leader at a minor injuries unit in Dorset who again mentions the positive experience of the Centre in helping with practice development. In addition, she mentions how the Academic Centre has helped with research skills and ethics. The final paragraph of her story emphasises the importance of the ACP in acting as a mentor and personal tutor to aid motivation and relate practice development work to real outcomes. Finally, case study 4.6 is from the clinical effectiveness audit and research coordinator, who worked closely with the ACPs on training needs analysis and audit work. She was impressed by the way the Centre could respond individually to the needs of staff within the Trust against a background of clinical governance and quality, and create bespoke solutions. Therefore, she is highlighting that the ACPs can bring governance and quality issues into focus and into practice, to make them real for practitioners rather than a bureaucratic, abstract concept. This has enthused practitioners who see the advantages of carrying out both audit and research for the advancement of their practice.

Case Study 4.1: A clinical psychologist's story

'I'm a clinical psychologist and I divide my time within various units within the hospital and some of that time is allocated to burns and plastic surgery and I specifically have involvement with that. That's how I came to be involved with the Burns Care Pathway...and worked alongside the team developing that. The initial drive for the Burns Care Pathway came from the team itself. I would say I was definitely aware at the beginning that this project was involving something called the Academic Centre at Bournemouth University and that it was a new initiative. I was more than happy to partake in it because as my background and training in psychology is quite rigorous academically anyway, it was nice to be involved in something that was very stimulating. I enjoyed the process of that and the fact that staff from the Academic Centre in Healthcare Improvement introduced a lot of quality initiative concepts from more of an academic side of things rather than just merely documenting a pathway and what we do.

I think to my mind the AC's role was that of a facilitator. He was very good at introducing ideas about quality initiatives. It would be very easy to just do a pathway and write down what we already do. There were definitely players within the team that very much felt that this was a real opportunity to step back from what we *always* do and say "Is that what we want to carry on doing, or is there another way to do this, or how could we improve that?". The AC added something to that process by enabling us to say "Let's identify areas that need that sort of work doing and let me help you to do that". From my point of view he helped me to run a series of projects looking at how we could improve the detection of psychological problems on the Burn Unit and how to involve the staff team in that.

What I felt was added to it was more of an academic background and we were bringing the clinical ideas ...the fact that he worked for a long time in clinical sessions within the NHS undoubtedly helped…he could straddle both camps in that sense…the shift in emphasis on the Pathway towards more quality development initiatives did prolong the process. I personally think that was useful because we gained quite a lot out of that but undoubtedly it did make it a more drawn out affair and so from that I think we have definitely got an end product. The Pathway itself is in existence and obviously we've done some work to try and let people know that it exists and is being piloted and the project that I did with the Unit as part of that, I actually wrote up and presented at the National Burn Care Conference in April last year.

I think the Academic Centre was a very ethereal thing so I think there perhaps there could be some work there about general presentation of the Centre and the information. I suspect you'll probably find there's a lot of people that would prefer things a little bit more concrete than the virtual aspect of it. I suppose the term Academic Centre implies something more concrete rather than the virtual.

What the Centre helped us to achieve was great...and I found it very stimulating because it was really nice to be able to be given that opportunity to spend allocated periods of time looking at what we do and saying "Is that what we want to do? Can we do it better? Can we do it differently? How are we going to go about testing that?"...and to do that in quite a rigorous academic way was refreshing. We do not normally have opportunities for that, because of the demands of everything on a day to day basis...'

Case Study 4.2: The story of a ward sister – Salisbury

'Initially we decided to create a care pathway for adult burns patients…it's a way of ensuring that care is as equitable as it can be and that everyone is following a certain pathway…we have always worked as a close multi-disciplinary team but the Academic Centre helped us strengthen our relationships and provide real quality improvements by giving us the opportunity to sit down as a team and process what we do…we wanted some system where we were all using and writing in the same place and that we were all following the same path.

The Academic Centre very much facilitated the process for us....because we didn't know how to set about doing a care pathway. We started off by process mapping and we looked at the patient's journey basically from admission to discharge. In fact we very quickly realised that the patient's journey started before they arrived with us, so we looked at what happened to them before they actually even got here...and we looked at…what happened after they left because with burns it's not just a case of "Well your burn's healed, off you go."…there is still a relationship through the Scar Management Clinic and through the support group…for several years down the line.

I think the difference about having the Academic Centre was, we went into it thinking we were developing a care pathway…which we were…but in fact we did some quality improvements as well which I don't think we would have done if the Academic Centre hadn't been involved. It made the process longer, which was quite frustrating at times, but we actually came out with some very good improvements from that.

We now do psychological screening as a routine while previously the psychological screening was just done on patients that we thought needed it, whereas now all patients have a proper screening done. We also did something for the junior doctors, on referrals and accepting of admission which ended up being a little pocket held card of who to contact and which burns should come immediately…the junior doctors have found that very helpful.

We looked at the patients' information and we're redeveloping all our patient information…All in all there were four, five, six things which have all come about because of the care pathway…we've seen some huge differences and improvements...in our service which we would never have done without the Academic Centre. I think there were times during the process when we thought it would have been easier just to do a care pathway but, looking back on the experience now, I wouldn't have done it any differently.

When we first started out we were told "You know, well you'll be able to probably get accreditation for this". So for one of my assignments on the clinical leadership degree I did something on patient focused services and I used the experience that we'd had and the knowledge I'd gained. Having the guidance and the knowledge from someone like the Academic Centre staff was invaluable.'

Case Study 4.3: A consultant's story

'My involvement started rather obliquely in that prior to knowing anything about the Academic Centre I was running a monthly session with the house officers about learning from their errors…that was something that the Academic Centre working party was interested in and therefore I got invited along and I've been a part of that from that point onwards, so that was my starting point.

Rather than it just being an informal chat with myself and the house officers, we tried to structure a programme whereby there would be continued learning from one set of house officers to another set of house officers rather than going through the same errors and the same learning processes, so that we can build on it with every single group that we've got.

Myself and colleagues provided a framework for analysis of error...and the AC staff were fantastic at group work and teaching me how to get the best out of people and leading the sessions. It's a mixed group so it's doctors and nurses which we found extremely powerful...and we did learn...we did role-playing sessions to start off with the nurses playing doctors and the doctors playing nurses which was highly entertaining but also very, very poignant...and we've led on now to where we have a proper learning portfolio for the house officers, with each session a particular learning point to try and get out of…something they can walk away with at the end...

AC staff helped a phenomenal amount because of the way that they handle people. If a house officer was talking about an error and said "But you know it wasn't my fault, it wasn't my fault, I had nothing to do with it"…rather than slam down on that person, which is a typical sort of surgical training...they would enable the person to actually learn that point themselves which is much more powerful than just...putting it down on the blackboard. The AC's skills in altering the tempo of a meeting and dealing with very strong feelings are just superb...

From a different angle I think they did bring in the University as well because...of their...experience in clinical governance and learning and they could apply a lot of what they know to making the sessions so much more valuable…and perhaps the most important thing for the people within that group is not to learn about not to do errors but to learn a completely different way of thinking…a reflective thinking which doctors don't have...so hopefully when that group of doctors leave this hospital, they go away with a different way of thinking which is almost more important than learning.'

Case Study 4.4: A nurse consultant's story – Dorset

'I'm a nurse consultant so I'm linked in with Bournemouth University as a senior lecturer…my specialised area is minor injury care so 50% of my time is in practice, and I work in minor injuries GP practice…The other 50% of my time is in education where I've been teaching emergency care practitioners and undertaking research activities, audit and an evaluation of clinical decision making…I understand the concept very well because at the inception of the Academic Centre I understood the rational behind having an Academic Centre in Practice and the ethos, if you like, the philosophy of it…but I have noticed in the early days people raised their eyes to heaven because of the word academic and they saw it as, what is this thing called an Academic Centre, and they didn't understand it, or they don't necessarily see the Training Centre or an Academic Centre as separate beings.

I think an Academic Centre in Practice is acknowledging that theory happens in practice and it marries up theory and practice and has recognised that practice counts, so I personally think an Academic Centre in Practice is very important and that we recognise it and we acknowledge that academia exists in practice. I would say that the University is integrated in our clinical practice. We are the University and the University is us. Together we are developing a knowledge base that informs nursing practice. We are studying our practice which is what we are about, and with support from the University we are making that liveable. We are making it true research while truly developing our practice…

I would also say that because of the Academic Centre in Practice, it is permitting practitioners to say, actually we're doing this good job and we're developing our practice and let's go forward and celebrate that practice to a wide audience…and that is thanks to those people working at the Academic Centre. It is a direct result of the practice changes that have occurred through people in practice engaging the Academic Centre, developing their practice and then celebrating the achievements in annual conferences. I work with the ACP staff quite closely on projects that we're doing at Shaftesbury but also when we first started developing the unit here, [we] worked very well together that I work with the staff practically and the ACP was able to come in and together we were able to challenge some of the assumptions and beliefs. I think the agenda for change gives us a nice lead in because everybody's job description has to have research and evaluation built in and therefore it could be nice to call them research leaders in each community hospital that met within the Academic Centre. If you had some sort of lead figure in each hospital it would become imbedded in practice, more than it is at the moment.

The Academic Centre and its concept is fantastic. There are blocks to it, and I don't know how you'd overcome them. There are blocks because of the way the Trusts work and Universities work and the Trust's perception of a University. I think we almost need to come back together and say here's the Academic Centre, identify key players, bring them round the table, and say how can we make this work for you? This is what we can offer, what do you need?…and then you could say "The wonderful work you're doing needs publishing, so let's bring in the person to come and help you publish". We all become integrated so that practitioners get credits for the practice they're developing, and it's no longer seen as academic, because at the moment all the wonderful stuff's going on and it's hidden.'

Case Study 4.5: Team leader of a minor injury unit – Dorset

‘I’m team leader of the minor injury unit and head up the minor injury unit staff. I basically liaise with our matron, and do audit and various things like that…we’re trying to get our staff academic levels of competency within the minor injury unit up so that we are able to stand alone and manage like a nurse-led unit.

We are doing a practice development unit, which involves looking at the perceptions people have of the minor injury nurse, and the practical skills they should possess. I’m looking at what perceptions different agencies have. I’ve asked ambulance crews, doctors, nurses, matrons and various others, physios, OTs, to get a perception of what they think a nurse in minor injuries – what skills, practical skills they should have, and then the ACP is going to look at the evidence-base behind that.

You go on a course and you, perhaps, learn how to do suturing, and then you don’t see somebody who you need to suture for another month. So you lose that ability to be able to do that skill, and you feel, “I can’t do it”, and the doctor rushes in and says, “I don’t have time to show you”. What really we need is someone, like, a nurse practitioner who is here who can work alongside us, who can actually oversee skills, practical skills like that, and that’s what we’re trying to build up and build on.

The ACP is involved in the practice development unit that we’re doing. We’re doing it as a hospital at the moment. He’s looking at the evidence base behind the practical skills…what evidence there is to suggest that nurses should be able to do this…We’re also doing benchmarking for ankle injuries and the ACP is involved in that as well and we’re just about to launch our protocol for ankle injuries…

The ACP staff are very available to us…helped us getting ethical approval, which was quite difficult, did a lot of the questionnaire and actually developed the front sheet with me so we could give it to the patients to fill in while they were waiting for us to see them. And we’ve actually been giving out patient diaries to various people who come in, and getting them to send them back to us.

I find working with the ACP staff very motivational. He’s very good and supportive at all times, a good listener. He points you in the right direction and makes you feel motivated and that you’re actually doing something that is worthwhile.’

Case Study 4.6: Clinical Effectiveness, Audit and Research Coordinator – Primary Care Trust

'My job is to set up systems, to record and disseminate findings of audit, clinical audit, and I have to focus on learning, shared learning from these and also looking at improved patient outcomes. We have an audit forum and the audit forum invites people from all areas of practice where they can see what we're doing with audit findings and how we value improved outcomes and how we look at sharing with relevant people. It is an ongoing process and it is not always a happy role because there is a perception that I am monitoring people, and that's not the case.

I put out some feelers for support on doing the training needs analysis and I was given a contact in the Academic Centre and I got an immediate reply...they came and met me and I said "You know...we need to do this training needs analysis, we need to get some audit training underway". So my idea was, send out a questionnaire...get them to say this, that and the other and the ACP was very clear, "Actually that's not how I work", which is great because everyone who meets them is actually enthused...and wants to get involved…they want to suit the training to their needs in particular... they didn't want to do it as a mass-produced thing...they wanted to tailor it to their needs.

Other outside agencies…wouldn't have done a training needs analysis…they wouldn't have tailored the training to suit the specific needs of the group they were meeting and we're talking multi-professional groups here...and as within any profession there are people with different needs. The ACP were able to meet that, which I think is crucial to motivating people in this field.

Unfortunately I think there's some failings on our part in advertising it or driving it for the ACP, that have probably meant that we haven't met as many people as we should have done but hopefully we can work on that now we've picked it up because...you notice problems once you run with them don't you?

The ACP is addressing a need that...is huge and crucial to clinical governance, crucial to quality and providing it free…Now I know the payback might be if some nurses develop their learning skills...further and go on to do a Masters...and I hope they do because we want to encourage researchers in...the PCT…in many ways...it's refreshing to have somebody from the outside taking an interest because the PCT are very much seen as the monitoring body...and the governing body...every single member of staff that has worked with the ACP has come back very positive and very enthused to undertake audit or research…without that boost of enthusiasm within the staff you don't go anywhere with audit or critical appraisal because it's just yet another task to do. It has to come from within and I think that's a key outcome...'

5. Key Strategic Learning Points

5.1. Introduction

Analysis of the interviews has identified a number of key strategic learning points for those involved in the ACPs. These were similar across both Centres and could be divided into eight main categories, each of which was further sub-divided into a number of themes. Each category is outlined in boxes throughout this chapter.

Vision

Vision: n. sight; insight; dream

Category 1: Theme 1

The academic centre as a concept

Summary

All stakeholders interviewed agreed that collaboration between university and healthcare trusts is useful, beneficial and timely. In particular, they thought the concept of an academic centre was opportune.

Salisbury Academic Centres in Practice

There was a clear vision centred on practice improvement through learning, and cascading the learning among centre staff:

'What we were interested in was looking at how we could link particularly service improvement work with…services and allowing staff to get some academic credit for that…and also plainly, learning and…spreading the learning that came out.' (Trust Staff)

In addition, there was acknowledgement that, because the concept moved beyond traditional trust and university collaborations, the concept was viewed as innovative and creative and was therefore somewhat risky:

'It's an initiative of the university to have a collaboration rather than just the university department in a hospital or a hospital department in a university to actually have something that's got both clinical and academic goals in some kind of collaborative and synergistic relationship. Very, very difficult to design, implement, discipline, manage, measure, evaluate but creative and risky.' (University Staff)

Dorset Academic Centres in Practice

The vision is timely and opportune and linked to the modernisation agenda and clinical governance:

'The concept of an ACP with its use of local evidence-based research would be an excellent vehicle by which the new [modernisation] *agenda could be managed and understood.'* (University Staff)

'...very impressed with the rationale, very keen to take it forward and we came here to the Clinical Governance Committee with it…all very impressed by what was going to happen.' (Trust Staff)

For practitioners, the vision helped to close the theory-practice gap:

'I think an Academic Centre in Practice is acknowledging that theory happens in practice and it marries up theory and practice and…has… recognised practice counts, so I personally think an Academic Centre in Practice is very important that we recognise it and we acknowledge that Academia exists in practice.' (Trust Staff)

Learning

Although early documents laid out the vision and the aims and objectives, it is unclear as to how wide these reached and what audience they were intended for. Continued reviewing of the vision and the aims and objectives is suggested as important and indeed this has happened. However, recording and disseminating of these changes appear not to have taken place.

Vision

Vision: n. sight; insight; dream

Category 1: Theme 2

Joint agreed vision and aims and objectives

Summary

A major theme from the analysis is that the ACPs must have a clear vision and a set of comprehensible aims and objectives. Furthermore, the collaborators must have an agreed vision of the aims and objectives of the ACP that must be shared among the partners.

Salisbury Academic Centres in Practice

It was acknowledged by many that the vision and aims and objectives were similar but not the same:

'I think communicating our visions was not very clear at the beginning. I think their vision is similar to ours and we should have bottomed out much earlier what we meant by the Academic Centre.' (Trust Staff)

However, other individuals saw that the vision and aims and objectives differed between individuals within the collaboration, especially between the University and the Trust:

'It took me a while to realise that the visions were different.' (Trust Staff)

There was also a feeling that the vision, aims and objectives had originated and were being driven by the University rather than the Trust:

'It was certainly a University vision and not a shared vision.' (University Staff)

Dorset Academic Centres in Practice

Similarly, it was mentioned among staff at Dorset that people did not seem to share in the same vision, aims and objectives, and purpose of the centre:

'People didn't have the same vision.' (Trust Staff)

Staff from the University have discussed the vision with Trust staff:

'I talked to people about their vision.' (University Staff)

But the cementing of a vision for the Centre is taking time:

'What I've tried to do over the last three years is ground that vision.' (University Staff)

Learning

The Centres need to constantly revisit the vision for the Centre. Initially, working through value-statements that can be attributed to the work of the Centre would be useful. Following this, perhaps strategic documents need to be developed with specific aims and objectives encompassing the vision and values. This needs to be done collaboratively with all key stakeholders involved.

Vision

Vision: n. sight; insight; dream

Category 1: Theme 3

Change and flexibility in vision and aims and objectives

Summary

It seems one of the major reasons for vision not entirely being shared among staff within the collaboration is the huge amount of change that staff from the Trusts and the University have worked under. Not only have key personnel changed or left, but organisational changes stemming from Government initiatives mean that new priorities resulting from a change in strategic direction frequently occur. The ACPs have not always responded to these changes and, in many cases, key culture carriers have left, meaning the culture of the ACPs keeps changing.

Salisbury Academic Centres in Practice

Clearly, when people left, their vision and ideas left with them and were not passed on:

'The Director of Nursing left and with her went many of the verbal consultations that had taken place.' (Trust Staff)

When new people took over the roles, the vision, attitudes and values could completely change and this changed the direction of the ACP:

'The thing to bear in mind is that you had key personalities change, leave and you know someone might step into their shoes...whether they actually step into the same views.' (University Staff)

'There was a stage where…everyone was incredibly excited...about the concept...and they were really going forward...and then it didn't go anywhere…if you've got a system that's constantly under pressure like the NHS is...and you have to some extent a bolt-on that might be brilliant…but requires a lot of drive and enthusiasm to really make it happen, if you take the main champions out of it…I think it does make it hard.' (University Staff)

Dorset Academic Centres in Practice

Reorganisation of the Dorset Community Trust into Primary Care Trusts caused a major change in strategic direction for the new organisations, and many key personnel changed:

'I think…the world changed very dramatically with the introduction of primary care trusts…the world changed practically overnight…But I think what was initially envisaged, I would say, got overtaken by events really.' (Trust Staff)

As a result, when key individuals left, particularly those involved from the start, so did their vision, and aims and objectives for the ACP:

'I think that the biggest problem we had with it since [key Trust person] *went, we found that there was no definition for the Academic Centre, so nobody actually knew what it was.'* (Trust Staff)

However, Trusts are continually changing and some staff felt any initiative needs to work within such change:

'The reorganisation and change of focus was an issue and yes we could say well because we were reorganised that's a problem, but having lived with this organisation of 15 years, every year we reorganise, so if you can't deliver something in a changing environment, you never deliver anything.' (Trust Staff)

Learning

The vision and aims and objectives need to be continually reflected on throughout the changing environment. Targets based on the aims and objectives need to be flexible and should change in line with Trust strategy and Government initiatives.

Vision

Vision: n. sight; insight; dream

Category 1: Theme 4

Anchoring and the appropriateness of the title

Summary

Many interviewees, particularly those working in the Trusts, mentioned that they felt the title 'Academic Centres in Practice' was inappropriate. There was a feeling that the term 'academic' was inappropriate for the work being carried out and was a barrier to the effectiveness of the Centre. It was felt that individuals would be put off from using a centre with such a grandiose name and that it reflected the 'ivory tower' image of the University.

Salisbury Academic Centres in Practice

University staff felt the title should use the word academic in order to help break down differences between the Trusts and University, so as to help a cultural shift in the Trusts' perception of higher education:

'To show that...partly because there's a lot of suspicion of...you know, even the term of calling it an Academic Centre, that took...they didn't like that for a year...but that's of…part of it they think that's elitist that is...we said no academic work is valued to clinical practice and it's part of a big cultural shift we're trying to achieve really.' (University Staff)

However, some Trust staff felt this did not work and continued to feel alienated by the word 'academic', suggesting that it was used to make the centre sound more important than it actually was:

'It was a big showy thing and that's what I think the Academic Centre is. A Clinical Governance Reader! Ooh, Academic Centre! It's a big shirt, it's the Emperor's New Clothes.' (Trust Staff)

Dorset Academic Centres in Practice

There was similar criticism over the title, with people saying they felt alienated by it:

'I have noticed ever since, whenever you call it Academic Centre in Practice, in the early days people raised their eyes to heaven because of the word academic and they saw it as well what is this thing called Academic Centre and they didn't understand it.' (Trust Staff)

'I'd probably say the title put people off.' (Trust Staff)

There was a notion that the title needed explaining when people were referred to the centre, otherwise people were put off:

'I mean when I've written to people and spoken to people I will say that he's from the Academic Centre in Practice…from Bournemouth University...and they'll say "What's that?"...and so I will explain and I won't ever just write it and not explain it.' (Trust Staff)

Learning

The importance of the title must not be underestimated. The title anchored individuals' opinions that the collaboration was driven by the University rather than collaboratively. The title of the posts within the Centre also reflected 'university' language which was seen as a barrier. Nevertheless, it is suggested that, to create a collaboration between university and trust, build up the confidence in the university, and reduce barriers and access to universities, then academic terms should continue to be used to bring them into the everyday language of trust employees.

Implementation

Implement: v. effect; execute; fulfil

Category 2: Theme 1

Shared understanding of how to convert aims and objectives into practice

Summary

There were differences among the key stakeholders interviewed as to how the aims and objectives of the ACP would be best put into practice. There was confusion in particular between a traditional academic learning approach and a bespoke work-based learning model. At both locations, the ACP gave the University an opportunity to provide work-based learning based on the needs of the Trust, and in both cases this was the intention. However, Trust members often felt that the University was still too traditional and offered education that relied too much on theory, rather than on practice. In addition, the University was able to offer more than work-based learning through research-based initiatives. At both locations, this was met with resistance and was seen as unnecessary.

Salisbury Academic Centres in Practice

The original view that the collaborators had in mind centred on providing research and education beyond work-based accredited learning. However, it was felt that this vision was somewhat watered down:

'The vision now for the Academic Centre was very attenuated and very much focused on practice development; I never got the sense that research was…welcomed. My attempts to broaden the work to include a wider range of scholarly and academic activities were resisted.' (University Staff)

In addition, the ACP was seen as being about providing traditional theory courses:

'The Academic Centre seemed to me to be very, you know, University…and it's about doing structured courses that get credits that lead to big pieces of paper for people to further their career.' (Trust Staff)

Dorset Academic Centres in Practice

The approach at Dorset was also to go beyond education and practice development alone and offer research-based expertise and coordination. However, it was felt that the Trust was not ready for such activity:

'I think initially when the Academic Centre was thought about it was very much about...a University agenda. Whereas the reality is...and this is more and more with the Department of Health, the NHS Plan, all of those things…it has to be a PCT agenda. It has to be an organisation.' (Trust Staff)

'I think universities could be more realistic and pragmatic about what organisations need. This is all very nice up here and all of the...you know, the academic frameworks and everything else but actually that's not really what organisations need entirely.' (Trust Staff)

Learning

There seems to have been a missed opportunity for using the in-depth resources and expertise of the University. The resulting methods of implementation were somewhat diluted and, although there were some excellent examples of research supervision, practice development and work-based learning, some of the wider underpinning expertise that a university can offer, such as in research and knowledge transfer, have been missed. The Trusts were unable to see the benefits of a research-led approach to their practice, objectives and strategic targets. Given the notion of clinical governance and evidence-based practice that places research at the heart of the practice, this is disappointing. The University and Trusts should work together to highlight the advantages of the work of research into practice to make use of this further.

Implementation

Implement: v. effect; execute; fulfil

Category 2: Theme 2

Clear boundary setting

Summary

It was clear that the ACP needed to define the limits of its work. There was often misunderstanding over what constituted the work of the ACP and the work of the University. Also, no limits were placed on the potential amount of work an ACP could get involved in. In addition to this, priority given to tasks and the work of the ACP seemed somewhat ad hoc and incoherent. Therefore, resources could be used up inefficiently and inappropriately. Also, consideration needed to be shown by the University and the Trusts of working with other collaborators to help deliver the work of the ACP. For example, some of the work-based learning may have been best delivered by further education providers.

Salisbury Academic Centres in Practice

There was confusion over what the ACPs offered that Bournemouth University did not already offer:

'What's the difference from me just going to Bournemouth and doing my Masters? What's the difference?' (Trust Staff)

In addition, it was felt that the concept of what areas the ACP was actually expert in was never explored:

'So it's a case of you only...we're not necessarily thinking well enough in advance to say "Right, this is what we're going to be focusing a lot of our effort on in the next year...?" Then asking the question which should be "So how can you help us in that?" Now if it's something they say "Well it's not really in our area of expertise" then that's fine but I'm not sure we even asked that question of the Academic Centre so I think that's the starting.' (Trust Staff)

Dorset Academic Centres in Practice

The University was found to have a history with other local trusts:

'It [Bournemouth University] *has a bit of reputation for not delivering high standards on time etc.'* (Anonymous)

Other aspects of the University's relationship with the Trust have tainted the ACP collaboration:

'I'd raised these issues about lecturer practitioners and bills not being paid…at the meeting…and nobody was helping and I would have thought, well if we're a partnership…ACP response was "it's not my problem, nothing to do with me".' (Trust Staff)

'Oh well, because of the ACP…with help we've achieved this, this and this with the CHI Report but by the way we've taken away your office space because you owe us some money. You know, the ACP doesn't owe you money but maybe the University owes you money, ah well it's just the University isn't it.' (University Staff)

Learning

Clear terms of reference and an 'operating procedure' need to accompany aims and objectives and strategic vision and these need to be disseminated widely and understood and agreed by all partners. Such terms of reference should include boundaries of the work of the ACP, highlighting what is and what is not covered in the collaboration. These could be mapped against priorities of the Trust and revisited frequently. As the ACP develops, it may be necessary to consistently revisit who might be appropriate partners. It may be the case that the Trust and University work as a central core or hub and have associated partners from further education or training companies. Trusts also need to address whether they want partner trusts to join the collaboration, for example, PCTs could work with acute or hospital trusts.

Barriers

Barrier: n. fence; obstruction

Category 3: Theme 1

Cultural barriers: Understanding each other better

Summary

Analysis of the key informants showed that there were definitely misunderstandings between perceptions and reality. Much of this began with preconceived stereotypical views of the other collaborator. In addition, the difference in the working culture of the two organisations had a huge impact on the quality and quantity of development of the ACPs.

Salisbury Academic Centres in Practice

The University and the Trust have very different strategies and therefore different operational issues, which are difficult to put into place together:

'They work on different years of course. You've got an Academic Centre here that runs from September to September, my books run from March to March, you know April to April...a fuller understanding I think of both organisations and the way they work and I still don't understand the way Bournemouth works. I mean it is a big, big organisation.' (Trust Staff)

In addition, the two collaborative organisations have very different agendas:

'I mean we've got different agendas. You know, they're trying to survive in an education world and we've got targets. They're going to have to marry somewhere.' (Trust Staff)

Dorset Academic Centres in Practice

Many staff who were engaged in work with the ACP articulated the problem of the Trust and University working together due to preconceived perceptions and stereotypes that cause a barrier to collaboration:

'The Academic Centre and its concept is fantastic, some of the blocks… I don't know how you'd overcome them because they're blocks because of a way the Trusts work and Universities work, and a perception of a Trust of a University and University's perception means that the perception of an Academic Centre suits the Trust when it suits them, if that makes sense. So there's the block from the fabric of a Trust so it will always be a bit suspicious.' (Trust Staff)

Some of barriers are caused through a perception that the University or the Trust will not proceed with certain work, much of which is unfounded:

'The Trusts get told the University won't do this and the University gets told the Trust won't do that and I sit in the middle of both and I know what I get told, I think well hang on a minute that's not true.' (Trust Staff)

Learning

There is the need to work through the differences found. It could be possible to hold more informal brainstorming sessions exploring these differences and discussing them, in order to remove the barriers and to explore how such differences could be used to best effect in the collaboration. Perhaps the concept of regular away days involving discussion of the barriers could take place, in addition to team-building exercises and time away from the organisations to explore any differences and create a bonding experience.

Barriers

Barrier: n. fence; obstruction

Category 3: Theme 2

Language barriers: Communicating with each other

Summary

Evidence of issues with communication exists. Frequently, people in all Trusts felt baffled and, on occasion, belittled by the use of language by academics. In addition, there were issues for users of the Academic Centres in that sometimes very clinical language was used that excluded a number of other individuals from taking part in activities. As such, the Centres were sometimes labelled according to the perceived dominance of language used and created barriers for individuals who would otherwise benefit from the work of the Centres.

Salisbury Academic Centres in Practice

Many staff within the Trust had great difficulty with all academic language, including the term Reader:

'It's a very nice word. Reader in Clinical Governance would be an absolute H because I have no idea what that is.' (Trust Staff)

In addition, many Trust staff had been completely baffled and felt excluded by academic language:

'I mean I'm not thick...but some of the stuff was just like on a different planet.' (Trust Staff)

'[University person] *spoke for 20 minutes and not a single person had a clue what he was talking about and when he left the room…all of the team turned to me and said "Well you said he'd be a lot of help…well none of us can understand him. He talked in such an abstract fashion that we couldn't work".'* (Trust Staff)

Dorset Academic Centres in Practice

On occasions when University staff had delivered lectures, many Trust employees had difficulty understanding terminology and felt excluded, distancing themselves from the Centre:

'I had hoped, particularly the lecture on the Academic Centre, that people would begin to understand. I'd hoped by doing that everybody there would understand. No, but it went...way over Trust employees' heads. (Trust Staff)

'Some of the language suggested it but again I mean I think...I didn't necessarily pick up a lot of respect for your common or garden practitioner.' (Trust Staff)

Learning

The Centres must consider the use of language during their work and use appropriate language, and at all times must try to reduce exclusion. Language that has become habitual may need revising. An open culture of challenge and action may help overcome this barrier.

Barriers

Barrier: n. fence; obstruction

Category 3: Theme 3

Physical barriers: Not being present

Summary

There was a definite feeling among the interviewees that the Academic Centres did not have a 'centre' as such. Interviewees knew people who were involved with the Centre and were aware of some of the work of the Centre, but could not quite 'place' the Centre anywhere.

Salisbury Academic Centres in Practice

People felt that the virtuality of the Centre excluded individuals from taking part its activities, both from the Trust:

'We were selling a product but without you know...without any real substance in behind it, so the bit about virtual...yes it was virtual but there should have been...there probably shouldn't have been that virtualness, actually there should have been these people in play that would hold their hands and support them.' (Trust Staff)

And from the University:

'There was no space, there was no dedicated...and I was advised it was a virtual centre. Well, I felt virtually alienated and virtually displaced being an academic – academics do not work well in cyberspace.' (University Staff)

Dorset Academic Centres in Practice

People did not feel part of the ACP because of the virtuality of the Centre:

'Practically I have the same difficulty initially in that I, we were having the centre and I was going to be part of the centre and I am part of the centre, but because the centre is a kind of non-physicality, it's sometimes difficult to feel you belong.' (Trust Staff)

Those who had used the ACP felt that it would help the centre to reduce the virtualness and that could simply be done through providing a room:

'It's…virtual and I think actually if you really want it to live, then in each Trust, in each hospital and of course rooms are a premium, but even if you had the computer area, somewhere where practice could develop, called Academic Centre…then people wouldn't know where to go to contact, but if you had: for further information about the Academic Centre's activities contact…' (Trust Staff)

Learning

It has become critically apparent that a concept such as an ACP needs a physical presence, in body and in terms of physical locality. There needs to be at least one room or office staffed during office hours by a 'known' face who is automatically related to the centre. It became apparent that such an abstract, novel and innovative concept needed a real tangible home and individuals were becoming increasingly frustrated by its non-organic, virtual image.

Roles

Role: n. specific task or function

Category 4: Theme 1

Identification and utility of key stakeholders

Summary

Because the Academic Centres bring together a large workforce, it is understandable that all individuals cannot be part of every activity. Identification of the most appropriate people is needed. It seems this has not always taken place in either ACP. People from both the University and the Trust felt left out of some major key decisions that appeared to be taken without their knowledge. This also means that certain individuals are not being communicated with about key decisions. It appears that, where stakeholders have been left out, it seems to have been by error rather than intention.

Salisbury Academic Centres in Practice

Key people felt left out of forming the ACP:

'The Academic Centre was formed without really taking me and the medical director with it.' (Trust Staff)

In addition, key people felt they had been left out of a key appointment within the Centre:

'We [the ACP] *appointed a Reader in Clinical Governance but without all key stakeholders being involved in the job description, advertisement and interviews. I didn't even know the process was taking place. I had a degree of ownership of the ACP and felt like…my idea of what we were going to do had been completely taken away from me*.' (Trust Staff)

The University had to learn the channels of communication within the Trust and could not always ensure that communication reached the intended audience:

'I became aware that certain individuals didn't speak to other individuals. So you were agreeing policy or whatever with an individual, believing that they were doing something back at the ranch and finding out later that...you know, because they didn't speak to that person.' (University Staff)

Dorset Academic Centres in Practice

Staff felt that it was important to involve key stakeholders in decision making and if this did not take place then mutual respect could be broken, resulting in broken relationships:

'I know that you don't do everything as you're told but you know that there's a political world there and if you want to get people on board you have to respect them, treat them appropriately. There are people that you have to upset, but I wouldn't be upsetting people that are key players.' (Trust Staff)

It was noted that having key stakeholders involved with the Centre can help increase the profile of the ACP:

'Some of our key players need to be seen to be in the Centre and be part of their job there and part of the Academic Centre, because only then will it become embedded.' (Trust Staff)

'Just to keep meeting the key potential culture carriers and keep reiterating the vision, working the vision out with them and getting them to see that it's not the University's vision, it's their vision.' (University Staff)

Learning

The Centres need to make sure that key stakeholders are involved and communicated with appropriately and that justifications are given for membership of groups that make decisions or direct work. A great deal of overlap in expertise is seen between the University and the Trust and this needs to be recognised, celebrated and used to maximise the output from the Centres. Perhaps creating directories of expertise and knowledge among the key stakeholders would help in the first instance.

Resources

Resource: n. ingenuity, that to which one resorts for support; expedient

Category 5: Theme 1

Management of the budget

Summary

The interviews highlighted that a major problem with the collaboration was the budget. It was unclear to many why the money rested with the University and had not been split between collaborators. This led to a general mistrust of the University and what it would do with the finance, and an unwillingness of the Trust to invest any money in the collaboration, feeling that the University had already been paid.

Salisbury Academic Centres in Practice

The issue of finance was repeatedly mentioned throughout the interviews:

'Never underestimate the importance of who holds the strings to the financial purse.' (University Staff)

'There will always be angst in collaboration about money, about who controls who and...I think you do need some very clear agreements.' (Trust Staff)

It was felt by some Trust staff that it was unfair that the University held the finances and suggested that a third-party should have been involved:

'I think there almost ought to have been a...third party with the money so that neither one of us had that angst about who was holding the money and... we would have been more collaborative.' (Trust Staff)

Dorset Academic Centres in Practice

Clearly there was angst over the money residing completely with the University:

'We've never had any money and like I say we, I mean before at the time when the bid was put in we had understood that that was a joint bid from the University and the Trust and the money was joint.' (Trust Staff)

'We knew that there was three hundred thousand pounds over the two years to support the Academic Centre and it was lodged with the University. I think the concern is how we've spent that money. Normally you know for a project you would expect to outline the key stages of that project and the final outcome, and then show what resources were allocated and how those resource are being spent.' (Trust Staff)

Learning

If indeed the ACP is a collaboration, then the money should either have been shared or better still held separately, perhaps through trustees or in an account that required signatures from representatives of all collaborators involved, ensuring that key financial decisions had to be made jointly.

Resources

Resource: n. ingenuity, that to which one resorts for support; expedient

Category 5: Theme 2

Regular, clear and transparent budget reporting is vital

Summary

The fact that the budget was often not discussed or reported at meetings led to a lack of clarity about what was being done with the money. There was a general mistrust of the University and its ability to handle the money appropriately. However, the University has responded by producing figures on demand.

Salisbury Academic Centres in Practice

There is a lack of clarity over the budget:

'I've seen a budget sheet once in the group but I have to say I wouldn't really know...I couldn't truly say…but I guess if somebody said "Does it give value for money?" the first thing...I would go away and figure out how much it cost because I couldn't tell you off the top of my head so...I'll be honest, I'm assuming someone else is doing it but maybe I shouldn't.' (Trust Staff)

Trust staff are asking for the budget to be reported much more openly and for it to be managed as a collaborative, rather than by the University:

'I think we need to be very open and honest...you know, this is the budget and we should have had the budget at every single meeting, we should have managed it as a collaborative group.' (Trust Staff)

'I think there should be some rules on collaboration, I think we need to be very open and honest…you know, this is the budget and we should have had the budget at every single meeting, we should have managed it as a collaborative group.' (Trust Staff)

Dorset Academic Centres in Practice

There was a general lack of clarity with regard to seeing the budget:

'I know that there were a couple of annual reports that were produced but I wouldn't have said there was clarity...and I wasn't aware.' (Trust Staff)

'I haven't to date ever seen any kind of breakdown or any statement to say how those resources are being allocated.' (Trust Staff)

For accountability purposes, there was a need for the budget to be reported in extremely clear terms:

'When we became more involved as a PCT, we wanted to know what they were spending it on...and where had all this money gone…we didn't get those answers…No we didn't. Not in a way that we could make sense of. I suppose it was the way it was couched – "there was so much for…role and we've done this and this and this" but trying to get that into reality, it wasn't that anybody was trying to be difficult or awkward but it's just the way that I suppose business was done but now when PCTs have to account for every penny, we need that spelt out really.' (Trust Staff)

Learning

Although the University was allocated the money and therefore had financial responsibility, reporting the figures to others in the collaboration on a more regular basis would have helped ease concerned minds. Continual reporting of the figures by those responsible is needed to help create trust within the collaboration. The figures must be clearly reported and understood by all.

Resources

Resource: n. ingenuity, that to which one resorts for support; expedient

Category 5: Theme 3

A model of equable effort needs to be realised

Summary

The University was viewed as 'provider' of a service where the Trust was a 'customer', despite this arrangement never being formalised. However, the Trust felt they were investing money through individuals' time and effort. The Trusts felt the University had not recognised this effort, maybe because education is core to their business. The tension has been present throughout and is a major reason as to why no concrete space has been allocated to the Academic Centres.

Salisbury Academic Centres in Practice

The Trust felt they were contributing through time:

'I wouldn't buy into this thing "Well the Trust themselves haven't spent any money on it"; there's a huge amount of senior people's time, so if you equated that to salaries we've spent a lot of money on it.' (Trust Staff)

And if they were to offer space as well, then they would require some of the funding for themselves:

'No money in at Salisbury at all so I was doing it gratis, office spaces were my office spaces and some of them were prima donna-ish about that…Hold on a minute, you know we need to have some funding in for Salisbury. I'm not even paid.' (Trust Staff)

University staff felt that they had a right to have physical space provided for them in the Trust:

'[The ACP] *spent quite a long and hard time getting a room, getting some desks, getting a power board to run the computers, getting spaces, computer networks mounted to the wall, getting chairs, tables, paper, printer. It's probably fair to say that the University, which is an academically oriented organisation, understood these demands much better and in fact provided...in fact all of the hardware, notwithstanding the room and the chairs.'* (University Staff)

Dorset Academic Centres in Practice

Trust staff were unable to provide accommodation for ACP staff until they received funding:

'I know [ACP staff] *were very upset about the accommodation, and thought we weren't taking it seriously because we weren't providing accommodation…How do I persuade my directors, when people are scrummed into rooms and cupboards, that I've got to provide space for six people at the University and they're not going to pay us.'* (Trust Staff)

Learning

Collaborators need to understand that resources, effort and money are all viewed slightly differently between partners. Away days and brainstorming activities should help explore and resolve these issues.

Monitoring

Monitor: n. person or device which checks, controls, warns, records

Category 6: Theme 1

The need for measurable objective outcomes and a desire for open, creative space

Summary

There was conflict between whether the ACPs should have objective, measurable outcomes or whether the ACPs should be allowed to develop in their own creative space. Middle managers from the Trusts in particular seemed unable to comprehend a centre without direct observable outcomes and felt most uncomfortable with a model of open development. Senior managers were much more of the idea that the Centre should be left to develop over time and not be constrained by measurable outcomes. Both Centres did embrace the open creative space but channelled their energies through broad qualitative goals, which still resulted in some individuals feeling uncomfortable and requiring quantitative targets.

Salisbury Academic Centres in Practice

It seems that, in many cases, the Trust hoped that the ACP would help achieve short-term goals and targets, which University staff thought inappropriate for the ACP to focus on:

'The Trusts wanted to know if it [the ACP] *would hit waiting list targets, patient turnaround etc. and the University were unable to give a definitive yes to those questions…It appeared that* [Trusts] *were fighting short-term fires and therefore unable or unwilling to look at the wider picture.'* (University Staff)

Trust staff were disappointed that no 'outcomes' were in evidence after a certain period of time, and felt any outcomes should be measurable:

'There have been no outcomes that we can prove...I accept that a new concept…will take time to bed in and I don't expect things to come out within six months, but I do think three years is a different matter.' (Trust Staff)

'I don't know if we're actually measuring the outcome but we possibly should be a bit more.' (Trust Staff)

Dorset Academic Centres in Practice

The Dorset Trust staff tended to want quick, short-term outcomes to embed the Centre within practice:

'If we can achieve some quick wins on those kind of practical things then staff will understand what we mean by the Academic Centre and they'll start to see some benefits.' (Trust Staff)

'If we had been able to engage people properly and demonstrated to people that tangible benefits are coming out of it…when you project manage you've got to get quick wins in…if you don't get the quick wins in you just lose people.' (Trust Staff)

'*My concern is that it will go off all over the place depending on the ACP's enthusiasm and the things that are important to them, rather than have some clear outcomes and milestones.'* (Trust Staff)

Learning

It seems that much of the initial work has been creating networks and assessing need. As such, objective targets would have been inappropriate and would have narrowed the focus of the Centres, resulting in a number of areas not being explored. Qualitative targets are a good idea to help channel the energy of the ACPs and should be encouraged. These need to be flexible and continually monitored. Informal brainstorming sessions may have helped introduce such targets and shift away from the constant demand by many for numerical 'objective' targets.

5.2. Summary

In conclusion, the issues raised by the key stakeholders are not uncommon in the development of community learning and communities of practice (see Lave and Wenger, 1991; 1999; Wenger, 1998a; 1998b; Wenger and Snyder, 2000). It is clear that each collaborative has been through a number of developmental phases and they are just beginning to emerge as functioning, operational centres making a real difference to practice and patient improvement. Taking a model developed by Wenger (1998b), it can be determined from the evaluation that each Centre has passed through two key stages:

- **Potential stage** – people face similar situations without the benefit a shared practice. Typical activities include finding each other and discovering commonalities;
- **Coalescing stage** – members come together and recognise their potential. Typical activities at this stage include exploring connectedness, defining joint enterprise and negotiating community.

In addition, within the last year both Centres have begun to reach the third stage:

- **Active stage** – members engage in developing practice. Typical activities here include engaging in joint activities, creating artefacts, adapting to changing circumstances and renewing and developing interest, commitment and relationships.

Continuation of the collaborations will help establish the ACPs in this stage, furthering the successes for practice.

Chapter 6 now contextualises these findings and discusses them in light of previous research and the wider picture.

6. Discussion

6.1. Introduction

The ACP initiative has undoubtedly offered a novel and innovative way to learn within practice. It has gone beyond the boundaries of traditional models of collaboration between healthcare and higher education, such as lecturer practitioner posts, research development support units and traditional work-based learning. The achievements of the ACPs both in a hospital trust and a primary care trust have been valuable and timely, and have challenged and therefore enhanced and improved practice. However, there has been a great deal of angst in both settings, much of it surrounding the strategic nature of the collaboration. The discussion examines the successes and the angst in light of previous research, giving the evaluation findings a context.

6.2. Practice Improvement

Both ACPs have had an impact in many important areas, particularly in terms of practice improvement and on the learning and organisational culture of an organisation.

6.2.1. Practice Improvement Legacies in Salisbury

Within the Salisbury Academic Centre for Healthcare Improvement, work has centred on the Burns Unit Quality Improvement Team, Quality and Improvement Learning Set, Improving Patient Safety Group, Patient Involvement Group, educational programmes for spinal unit staff, learning set for consultants, the Modernising Medical Careers programme and involvement in the design of South Wiltshire Academy. In particular, the Centre has left lasting legacies with the Burns Unit Quality Improvement Team, which has improved healthcare provision for the patient, improved professional practice of healthcare professionals and led to accreditation for the learning. Also, the Centre is now involved in an innovative version of the Medical Careers Foundation Programme which focuses on improvement and patient safety. The Centre has facilitated a far more exploratory model than would ordinarily have been adopted, bringing the

programme close to providing improved and safer care. The Centre has also left a legacy in underpinning the development and design of the South Wiltshire Academy.

6.2.2. Practice Improvement Legacies in Dorset

The Dorset Academic Centre in Mental Health and Primary Care has carried out a needs-driven programme of work focusing on three main targets:

- Providing support and advice for practitioners in the development of research-based practice;
- Identifying and developing communication network systems to disseminate evidence-based practice;
- Developing and implementing a comprehensive educational package covering a wide range and level of research skills and knowledge to meet the individual needs of practitioners in the workplace.

In achieving these targets, the work of the Dorset ACP has centred on audit programmes, providing workshops on research and audit topics, supporting practice development units, working with lecturer practitioners in the area of palliative care in terms of ethics and moral decision making, team building and leadership training, setting up a resource room for research active staff, developing a research and publication database, offering bespoke sessions for Masters-level students and helping individuals achieve scholarships. In particular, the focus of many of the workshops and the support with regards to audit appears to have been extremely successful in changing culture, the lasting legacy of which could have real benefits to practice improvement and patient care.

With regards to audit, the work of the ACP has afforded an opportunity for managers and practitioners to see mandatory audits beyond a ‘hoop-jumping’ and ‘tick-box’ style exercise. By introducing a reflective practice environment, practitioners and managers have been able to view audits as an empowering instrument that helps them to reflect on practice and develop individual and group practice. Establishing a change in perception and attitude towards audit will hopefully create a new culture, which will be passed on to future practitioners.

Another example of the ACP’s impact on Dorset Primary Care Trust staff is through team building and leadership training with the heads of department at Blandford Community Hospital. The group members have been encouraged to focus on their philosophy of care and how this relates to the philosophy of the hospital and the Trust. Individual members have increased in

confidence and been able to share best practice. Group work has been directed by ACP staff, although the group have been encouraged to take control and ownership of the agenda and curriculum in the hope that the group will continue beyond the ACP.

The ACP has also been successful in helping to establish a research culture throughout the Trust, by establishing a research and publication database, setting up a resource room for research active staff, and workshops addressing presentation skills, literature searching, writing, evidence-based practice, research appraisals and proposal and report writing. Through this work, a foundation for a research-based environment has been created which can now be built on by the Trust.

6.3. Changing the Learning and Organisational Culture

In both Salisbury Health Care NHS Trust and Dorset Primary Care Trusts, the ACP has made an impact on the learning and organisational culture. This has been through increasing the use of reflective practice for a variety of healthcare professionals, bridging the theory-practice gap and relating clinical governance, quality and audit to practice development and improvement.

6.3.1. Reflective Practice

At both Centres, the concept of reflective practice has been introduced in areas where previously it has not been used (such as learning with medical and managerial staff) and has been built on in areas where it previously existed (such as learning with the nursing staff). Reflective practice creates the opportunity for individuals to consider and evaluate their practice, use counterfactual thought to consider what might happen if aspects of practice changed, and understand the emotional response to practice, all of which will ultimately lead to more confident, empowered individuals who use considered skills within a practice environment. Within groups, this can help individuals understand each other and ultimately work more cohesively. Within the Trusts, it creates an environment in which learning and change are central to daily practice. This creates a healthy environment for patients who are receiving care from practitioners who do not just *do* practice, but who consider, reflect and therefore learn, build, act and change their practice based on that reflection.

6.3.2. Bridging the Theory-Practice Gap

Staff working within both Centres have acknowledged the importance of the ACP in bridging the gap between theory and practice. Establishing action learning groups and delivering workshops have enabled individuals to be able to link day-to-day work in practice to theory. The advantage for practitioners is that they are able to contextualise their work and create a framework from which to consider their practice. Therefore, practitioners can make informed decisions about their choice of method within practice and do so in light of evidence-based practice.

6.3.3. Relating Clinical Governance to Practice

Not only have both ACPs afforded an understanding of theory in relation to practice, they have also helped bridge gaps between clinical governance, quality, audit and practice. Work at both Centres has allowed practitioners to see real practice improvement as a result of carrying out tasks aligned to these areas. Previously, practitioners viewed many such initiatives as bureaucratic ‘hoops to jump through’. The work of the ACP has helped practitioners to change attitudes and perceptions of such initiatives and align them with helping to achieve practice improvement.

6.4. Finance

6.4.1. Costs

Although the original bid was submitted jointly by Bournemouth University, Dorset Community Trust and Salisbury Healthcare Trust to the Education Purchasing Consortium, it was agreed amidst the change to structure and governance of the Trusts at the time that the money should reside and be managed through Bournemouth University. The money was shared across both sites and was almost exclusively spent on the salaries of staff brought in to work specifically on the project. Appendix A shows the budget for Salisbury Academic Centre in Practice and Appendix B shows the budget for Dorset Academic Centre in Practice.

6.4.2. Value for Money

There are two main reasons why value for money is hard to assess during the evaluation of the Academic Centres in Practice. First of all, the outcomes of each ACP have changed aspects of practice that are very difficult to measure, such as closing the theory-practice gap, integrating audit, clinical governance and practice, and increasing reflective practice. These in turn lead to unanticipated benefits to practice, which a prior measurement would not necessarily capture. Second, any outcomes resulting in practice and patient improvement are likely to happen over a long period of time. One of the main targets of the ACPs is to harbour a cultural change for practitioners, allowing them to make change in practice for themselves through education and research. In addition, it is hard to isolate the ACPs as the only cause of any change. The ACPs are one of many 'wheels in motion' that could act as a catalyst for change. It is therefore beyond the scope of this evaluation to assess whether the ACPs have provided value for money.

Having said that, this evaluation would conclude that the money invested in the ACPs seems to be a small amount considering the depth of impact that has been felt among certain groups of practitioners. In certain areas of practice, the ACPs offered excellent value for money, with the foundations of real cultural change taking place, particularly regarding the legacies the ACPs have left as outlined in section 6.2. However, some individuals may have wanted the ACPs to provide less depth and more breadth, to touch more practitioners, and to work more widely across the Trusts. However, this was not the intention of the ACPs in the first instance. The Centres adopted the goal of making small but long-lasting changes that could be cascaded throughout the Trust, rather than having a small yet wide impact.

6.5. Learning from the Angst

Despite the successes of the ACPs, there was clearly much angst among some of the key people. This centred on a number of areas addressing the vision, implementation, barriers to operation, roles, resources and monitoring, all of which are not surprising when two large organisations collaborate on a new initiative (see Audit Commission, 1998; DoH, 1998; DTI, 2000; MacCabe et al., 1997; Thorlbury and Hutchinson, 2002). Implicit in the ACPs were issues surrounding the perception of the collaboration, and with regards to knowledge transfer, management of change, leadership and ownership. In addition, the philosophical stance of the ACPs is central to their development, creating idiographic and idealistic centres that may not be understood by all collaborators. The following discussion helps to show how the angst could be

used as an agent for change and as a central part of the learning from the ACP, rather than a barrier to output as has been traditionally viewed.

6.5.1. Perception of Collaboration

Both ACPs have struggled with the concept of being a collaboration. To further escalate this problem, many individuals, particularly those from the Trusts, viewed the collaboration as a 'steering group dominant' initiative. Therefore, they saw the role of the collaboration as being that of a steering group, overseeing and bringing together streams of work and strategy from each partner, where each partner still works separately in their original roles. The University staff believed that the project required greater cohesion and initially operated the collaboration as a 'virtual' organisation. As a virtual organisation, the collaboration creates a new identity that exists mainly in name only and people within it retain their roles from the previous organisation. More discussion on the model of collaboration was needed at the outset of the partnership so that there could be more transparency, clarity and agreement in the model adopted. This may have reduced much angst surrounding allocation of resources, the direction of the type of work the collaboration undertook, and who delivered such work.

The problem escalated as the concept grew and became a victim of its own success. As the work of the ACPs expanded, people and resources within the organisations were stretched and needed more dedicated room to develop. The collaboration has perhaps now matured into being a 'partnership dominant' organisation, whereby people within the collaboration have begun to take on new titles and roles, despite still being employed by the partner organisations. In many respects, the amount of work the ACPs were engaged in towards the last year of the project would suggest this would perhaps be a more appropriate focus.

Should the work of the ACPs continue to grow, it may be the case that a further model of collaboration should be considered in which a separate organisation is founded. Such an organisation would directly employ staff, manage separate finances and resources and operate a distinct strategy. The ACPs were not at this stage during this project but were moving towards it. Perhaps this could have been an additional goal for the collaborations to achieve. The initial goals focused on the specific tasks of the collaboration rather than on the collaboration itself. It may have been beneficial to set a target of continuing the collaboration beyond the time allocated for the project. As previous research has suggested, it is important to plan the end of the partnership and develop a continuation strategy (Audit Commission, 1998; DoH, 1998; MacCabe et al., 1997).

The development of a learning ‘Academy’ could be the next stage for an ACP where more partners engage in a collaboration of learning. The education, training and learning on offer is likely to include a variety of types and courses provided by a number of education and learning providers from further and higher education. As such, an Academy is likely to employ its own staff and have allocated resources from the start. Salisbury are working towards an Academy and Dorset is currently undecided about the development of such an initiative.

6.5.2. Knowledge Transfer

With regards to knowledge transfer, the model, at present, has not engaged pure knowledge exchange, meaning there has not been a true partnership within the collaboration. The University would view the current knowledge transfer as knowledge confinement within the collaboration. The ACP staff have been acting as consultants to specific needs within the Trust and again, as the ACP has begun to grow, there are signs that a true knowledge exchange partnership is on the horizon. The ACP is not only beginning to meet the needs of ACP staff, but is also starting to generate new needs as new knowledge is being formed. The benefits of such a partnership are potentially huge in terms of practice development and improvement for the Trust and the University.

However, many individuals in the Trust have seen knowledge exchange as a ‘university dominant’ collaboration. In such cases, it is viewed that knowledge and business needs are exploited by the University for its own benefit, for example to generate new business through developing new courses, new training materials and recruiting new students. Although this does not appear to be the University’s goal, the Trusts have felt that it is, but in a covert way. In all cases, one of the goals of the collaboration has been to empower individuals through encouraging engagement with learning. In addition, this has always been a goal of HEIs. Therefore, it is highly probable that, through engagement with the ACP, individual members of staff are likely to be encouraged to continue learning above and beyond the ACP and therefore may wish to register for HEI courses. It shows a uni-dimensional model of learning from the Trusts that they take a negative view of staff wanting to go on courses and see it in terms of generating new business for the University, rather than for the added value of improving practice for their own staff. However, the University should have made the aim of empowering staff and inviting them on to higher education courses explicit from the start of the collaboration and should have worked with the Trusts to strategically target relevant staff and allocate relevant resources.

6.5.3. Management of Change

Change has occurred during the ACP project at a variety of levels. Since the ACP programme began, there have been monumental Governmental changes in strategy that have affected the nature of the NHS and therefore the nature of the collaborations. Within the Dorset collaboration, the advent of primary care trusts resulted in a change in the organisation that the University originally initiated the bid with. At another level, there has been change with regard to individual members of staff. Initially, this was at senior levels within the Trusts and occurred at both Dorset and Salisbury. Some stability has been established at Dorset more recently, but changes in staff have punctuated the ACP at Salisbury throughout its development, including more recent changes at University level. Delivering a service against these changes has been incredibly challenging for the following reasons:

- Priorities, strategies and targets change for the organisation as a whole. As such, the ACP must be flexible and robust enough to change and adapt. This is not easy when the ACP has its own distinct agenda based on learning;
- New people engaging in the ACP bring new ideas, views, attitudes and also their own agenda relating to their role. In turn, they want the ACP to change and adapt to meet their needs;
- As individuals leave and new people engage with the Centre, the values, mission, aims and objectives of the Centre change from person to person. When major 'culture carriers' leave, the perceived version of the Centre is lost and a new version begins again.

In all cases, the work of the ACP has continued in spite of these changes in personnel. That is a testament to the work of the individuals within the Centres. Allowing for more flexibility of the Centres may well have reduced some angst but may have meant further delays in delivering the work, which could have generated further problems. Overall, a balance between adapting to change and achieving continuity is required, which is a challenge.

6.5.4. Leadership

It is suggested that collaborations and partnerships need partnership champions to move the project forwards. Such leaders are required at different stages and for different reasons:

- Stage 1: Initially the project requires a Leader as Driver. The enthusiasm and determination of the leader is required early on to bring people together and discover the initiative. This quite clearly occurred through the initial championing work of Mary

Monnington from Salisbury Health Care NHS Trust, Jill Pooley from Dorset Community Trust and Iain Graham from Bournemouth University. These three leaders successfully visioned the Centre into reality through securing sufficient funds;

- Stage 2: The project requires leaders as chairs to establish structures, roles and responsibilities, develop mechanisms for decision-making and conflict resolution, facilitate and support team building, capitalise on diversity and ensure political and cultural sensitivity, and optimise group and individual strengths. The initial championing work was delegated to two newly appointed Readers: Dawn Freshwater for the Dorset ACP and Stephen Wallace for the Salisbury ACP, to work as leaders, chairing the ACP and taking them forward. However, at the same time, two of the original champions left their posts, leaving the vision to be passed on through the work of one champion, Iain Graham, from the University. Given that the two new appointments were University-based and that the only remaining champion was from the University, it is easy to see how the vision has been University focused;
- Stage 3: The new ACP leads need to become leaders as enablers and arbiters. This facilitation role was largely met by the Readers, with the support of Mo Neville and Eric Waters at Salisbury;
- Stage 4: Champions of the ACP to realise the vision and implement the work into action are needed. This is occurring through the grounded work of Professor Peter Wilcock at Salisbury ACP and Philip Esterhuizen at Dorset ACP. Following the departure of Stephen Wallace, Peter Wilcock has also undertaken the leadership as chair, enabler and arbiter.

As work with practitioners has grown, leadership emerged from the champions in the ACP to champions within the Trusts, for example Mandy Rumley within the Dorset ACP and Helen Chave at the Salisbury ACP.

6.5.5. Ownership

With regards to the collaboration, there were initial leaders and drivers as outlined above. The project was initiated by Bournemouth University, Dorset Community Trust and Salisbury Healthcare Trust in collaboration with the Education and Purchasing Consortium and it was agreed that the funding should be held and managed by the University. However, it was hoped that the ACPs would continue in a collaborative vein. It is not clear that this shift in attitude or culture ever took place. It was viewed by many individuals that the ACPs were run by the University as a kind of service for the Trusts, to which the University played the provider and

the Trusts played the role of consumer. To this end, the ACP never really became a collaboration and ownership of the ACP never really left the University.

The issue with ownership of the ACP perhaps resides with the Trusts being unable to own change within their organisations in that the Trusts have never allowed themselves the luxury of being masters of change. The ACP offered them a chance to be responsible for change within their organisation through developing practice involving education and research, but this was not grasped. This is hardly surprising, given the cultural environment within which the Trusts survive. Change happens to the Trusts from outside, such as continual changes in Government policy affecting structure, governance and accountability, to which they have to respond. Change does not originate within the Trusts, leaving them vulnerable to change with little or no efficacy over their environment. Any future collaboration needs to help build the confidence of a health provider or trust, allowing them the authority to seize and lead on change and to move forward proactively and responsibly.

6.5.6. An Idealistic Centre

The model is undoubtedly visionary. No other collaboration between healthcare and higher education has such a wide breadth of aims and objectives. Although the model introduces university-level learning into practice, it goes beyond the developing, providing and managing of work-based learning courses that other collaborations offer (e.g. Moore, 2004 – see Chapter 1, case study 1). The model also offers strategic help in shaping the direction of the Trust in line with clinical governance and quality and audit procedures that exceeds simply working in partnership with strategic direction visionaries (e.g. see Chapter 1, case study 2). The model also brings research activity into action, setting research as an important driver for practice improvement, well beyond simple research collaborations (e.g. see Chapter 1, case study 3). In all, the ACPs offer the chance for healthcare practice to have full access to a range of university faculty resources, a needs-driven portfolio of multi-disciplinary work set within a context of clinical governance, audit and quality, with the ultimate aim to improve practice and patient experience. It is likely that every trust would relish the chance to collaborate with local education providers on these key areas.

However, the aims of the Centres were perhaps too grand and open, which has had two consequences. First, since the ultimate aims were too far-reaching (after all, there are a multitude of ways for resources to be placed to improve practice and patient experience) individuals were able to seize the work of the Centre for their own particular agenda. In

addition, the ultimate goal either seemed too distant and idealistic or perhaps too simplistic, mirroring work from other sectors of practice (what else is a practitioner's goal other than to improve patient experience through their work?). Groups and individuals work better with short-term, distinct, obtainable goals and targets and the Centre should focus on these, rather than the ultimate goal. Since the overall aim of the Centres has never been fully explored and deconstructed, objectives and goals set for reaching this have been difficult to pin-point and have been commandeered, manipulated and changed as they have been passed on throughout the Centre's genesis from person to person within the practice settings.

6.5.7. An Idiographic Centre

The University-based staff who have worked in the ACPs come from a department that incorporates multiple research centres carrying out qualitative research, including the Centre for Qualitative Research. The ACPs were also initially led through nurse educators, researchers and practitioners. Both of these points mean the ACPs reside in a culture where work is idiographic in nature, and celebrates the depth and transcendence of the work as more important than its breadth. These have inevitably led the ACPs to focus on achieving in-depth work rather than focusing on small-scale goals with wide implications. The work of the ACPs is clearly linked to a qualitative framework, since it addresses 'exploration, elaboration and systemisation of the significance of phenomena and illuminative representation of the meaning of a delimited issue or problem' (Banister et al., 1994, p3).

The current policy and structure of the NHS does not sit comfortably with this notion. Modernisation of the NHS has created an environment where, through governance and audit, accountability is key, resulting in a need for trusts to meet targets (DoH, 2000). This has meant that many middle managers have not fully grasped the impact and advantages the ACPs have created. The work of the Centres has gone beyond meeting targets and taken the work further. Indeed, some of the work within both Centres has concentrated on helping practitioners and managers see the added value of governance and audit beyond a simple 'tick-box' exercise. However, the cultural change of this will take time to become established.

The difference between governance within the Trusts and the approach taken by the ACPs can be described as the difference between a positivist and a post-positivist viewpoint of the world. Table 6.1 highlights these differences. Although differences between a positivist and post-positivist approach are not as polarised as Table 6.1 maintains, and indeed boundaries may become blurred, the difference in attitude and culture found may originate from these extremes.

A positivist approach tends to be technocratic, where work is driven by sponsors and serves largely bureaucratic needs, such as objective, measurable targets (Neumann, 1997). The post-positivist approach tends to be more transcendent (Neumann, 1997) in that it is generally people focused and addresses needs and problems from a grass root level. A positivist tries to gain control over the environment and to establish rules that, if followed, will represent the world as it is (Polanyi, 1958). A post-positivist tries to establish patterns of meaning and knowledge from people's words, actions and documents, rather than establish written rules (Maykut and Morehouse, 1994). Post-positivist approaches generate theory from understanding. They illuminate the quality of the experiences had by those who become collaborators in the discovery of knowledge, which is always subjective and one version of reality (Banister et al., 1994). The differences have most clearly manifested themselves in the need the NHS managers have for objective measurable outcomes against the developmental and exploratory nature of the University staff who have driven the ACPs. This has underpinned much of the angst.

Table 6.1: Postulates of the research paradigms (after Maykut and Morehouse, 1994)

	Questions	Postulates of the positivist approach	Postulates of the post-positivist approach
		NHS Culture	Academic Centres in Practice Culture
1	**How does the world work?**	Reality is one. By carefully dividing and studying its parts, the whole can be understood.	There are multiple realities. These realities are socio-psychological constructions forming an interconnected whole. These realities can only be understood as such.
2	**What is the relationship between the knower and the known?**	The knower can stand outside of what is to be known. True objectivity is possible.	The knower and the known are interdependent.
3	**What role do values play in understanding the world?**	Values can be suspended in order to understand.	Values mediate and shape what is understood.
4	**Are causal linkages possible?**	One event comes before another event and can be said to cause that event.	Events shape each other. Multidirectional relationships can be discovered.
5	**What is the possibility of generalisation?**	Explanations from one time and place can be generalised to other times and places.	Only tentative explanations for one time and place are possible.
6	**What does research contribute to knowledge?**	Generally, the positivist seeks verification or proof of propositions.	Generally, the post-positivist seeks to discover or uncover propositions.
	Dominant use of mode of science	Traditional approach for natural science and medicine.	Contemporary approach for social sciences.
	Dominant methods used	Quantitative research approach.	Qualitative research approach.

6.6. Conclusion

The work of the ACPs has undoubtedly been pioneering. As such it has taken champions and leaders to initiate and develop the work. The leadership and drive has come from the University and there is little evidence of a true collaboration in which knowledge exchange has taken place. Moreover, the model has seen individual champions move practice forward through acting as ‘academics in residence’ or ‘educational consultants in practice’. The idiographic philosophy of the Centres has resulted in developmental work that has been in contrast to the target-driven, modern NHS. The idealistic nature of the ACPs has perhaps allowed the vision and aims and objectives to be too open and too flexible.

Nevertheless, the work has certainly created the beginnings of a cultural shift in education and learning in the NHS. An increase in higher-level learning through work-based learning initiatives, including action learning sets and reflective practice in particular, has helped to close the theory-practice gaps and bridge the audit, quality, governance and practice divides. Such learning has undoubtedly helped practice development and improvement among those the ACPs have reached and engaged with. Similarly, as a result of such collaboration, the beginnings of a cultural shift within the University have begun to take shape. There is a greater understanding of the barriers that the NHS and healthcare providers face and a greater understanding of the needs and requirements of healthcare providers. The University is beginning to move away from traditional theories of learning to embrace work-based learning models among other practice improvement strategies. The value of such a collaboration for healthcare providers and future collaborative work will be long enduring.

7. Recommendations

7.1. Introduction

From the evaluation, it can be summarised that collaborative work between strategic health authorities, healthcare service providers and higher education is important. We would recommend that such collaborations, despite being challenging, are essential to the future of partnership working and should continue. Recommendations are made in 7.2 as to the roles of the three organisations in working collaboratively. Should the ACPs continue in their existing form or as a similar model, then section 7.3 makes recommendations as to how the organisations can work together. Finally, section 7.4 recommends what work started in each ACP should continue with immediate effect.

7.2. Recommendations for Strategic Health Authorities, Healthcare Service Providers and Higher Education Institutions

There is a real need for strategic health authorities, healthcare service providers and HEIs to work together to address the education, training and learning needs of healthcare staff in order to improve and develop practice.

7.2.1. Integrated Education and Training Strategy

There is a need to develop an integrated education, learning and training strategy. The three organisations need to work together to develop an integrated, long-term education and learning strategy in light of changing service needs and clinical governance issues. As such, a partnership should address:

- Local needs of current and potential service users;
- National policy directives;
- Current service and gaps in service;
- Current workforce skills and gaps in skills;

This would provide needs-based, timely and appropriate education and training. The strategic health authority needs to:

- Lead on the partnership;
- Liaise with all local health and social care service providers;
- Liaise with all local education and training providers;
- Benchmark nationally with other strategic health authorities and service providers to share best practice regarding the role of education and training in healthcare provision;
- Commission regular needs and requirement studies of current and potential service users;
- Commission regular audits on quality of service provision and delivery;
- Commission regular education and training needs analysis in light of service needs;
- Identify gaps and shortfalls in service requirements, service provision, and education and training needs in order to commission relevant education, training and research to reduce gaps and shortfalls.

The healthcare service providers need to:

- Collect and collate audit data from practice to provide information on service needs and provision;
- Personnel, education and training departments must provide information on training and education needs, and requirements of the workforce in light of service provision;
- Embrace the importance of education and research in practice improvement through assessing how education and training is strategically and practically linked to practice improvement and practice development;
- Provide practice expertise to set education and training in a practice context;
- Provide appropriate learning opportunities for the whole workforce.

Higher education institutions need to:

- Provide expertise in developing the content of education and training provision that could link to practice improvement;
- Provide expertise on types of learning and methods of delivery most appropriate to meet the needs and requirements of the healthcare service provider;
- Provide appropriate education and training for the healthcare service provider workforce in line with academic expertise;
- Develop joint appointments with Trusts to integrate education and practice through increasing lecturer practitioner roles;
- Develop joint appointments with Trusts to integrate research and practice through increasing research-practitioner roles;

- ❖ Maintain synergistic education, research and practice ethos throughout relevant faculties;
- ❖ Learn through collaborating with practice to inform curriculum and research work within the University as a whole;
- ❖ Work with other training providers to develop learning and education pathways for practitioners to aid continuity of learning in practice;
- ❖ Work with quality assurance agencies and appropriate accrediting authorities to validate and accredit suitable learning in practice.

7.3. Recommendations for Collaborations Between Healthcare Service Providers and Higher Education

Undoubtedly, healthcare trusts and HEIs will continue to work together in delivering needs-led, timely, high quality education and training. To achieve the recommendations addressed in 7.2, a formal collaboration, such as the ACPs, may need to be developed. Recommendations for achieving this can be mapped against the key strategic learning points from Chapter 5 (see Table 7.1).

Table 7.1: Recommendations for collaborative working between healthcare providers and higher education institutions mapped against key strategic learning points from the evaluation

Key Strategic Learning Point (see Chapter 5)	Recommendation
1. Vision	7.3.1. a) Nature and understanding of the partnership and collaborative experience should be agreed at the outset.
2. Implementation	7.3.2. a) Appoint Quality Team or Administrator – someone to undertake the day-to-day work; 7.3.2. b) Develop quality policy and procedures.
3. Barriers	7.3.1. b) Build up relationships so the ACP can 'form', 'storm' and 'norm' with the security that it will not damage existing relationships. The long-term development of a collaboration can then continue through having regular informal brainstorming sessions in addition to formal working and steering group meetings.
4. Roles	7.3.2. a) Appoint Quality Team or Administrator - Someone to undertake the day-to-day work; 7.3.2. b) Develop quality policy and procedures.
5. Resources	7.3.1. c) Allocation of funding to the partnership.
6. Monitoring	7.3.3. a) Share targets; 7.3.3. b) Frequent dissemination of outcomes to a local and national audience; 7.3.3. c) Local, national and international benchmarking is required to share best practice.

7.3.1. Understanding and Being a Collaboration

- **The nature and understanding of the partnership and collaborative experience should be agreed at the outset** (relates to Chapter 5 – Key Strategic Learning category 1: Vision)

From the outset it is imperative that the collaboration decides the formality of the model they wish to operate under; for example they may wish to set up as a distinct, separate organisation, a virtual organisation, a partnership dominant organisation or a steering group organisation (see Introduction, section 1.1.4) (Audit Commission, 1998; 1997; DoH, 1998; DTI, 2000; Thorlby and Hutchinson, 2002). In choosing an appropriate model, the collaborative partners need to see each other as equal associates in strategic direction and key decision-making. A HEI must address how the ACP fits within the strategic direction of the University. In turn, the Trust must have a clear vision of how such a collaboration fits within its own learning and teaching strategies, so that maximum benefit is gained from the experience, synergy is enhanced and duplication is eliminated.

- **Build up relationships so the ACP can 'form', 'storm' and 'norm' with the security that it will not damage existing relationships. The long-term development of a collaboration can then continue through having regular informal brainstorming sessions in addition to formal working and steering group meetings** (relates to Chapter 5 – Key Strategic Learning category 3: Barriers)

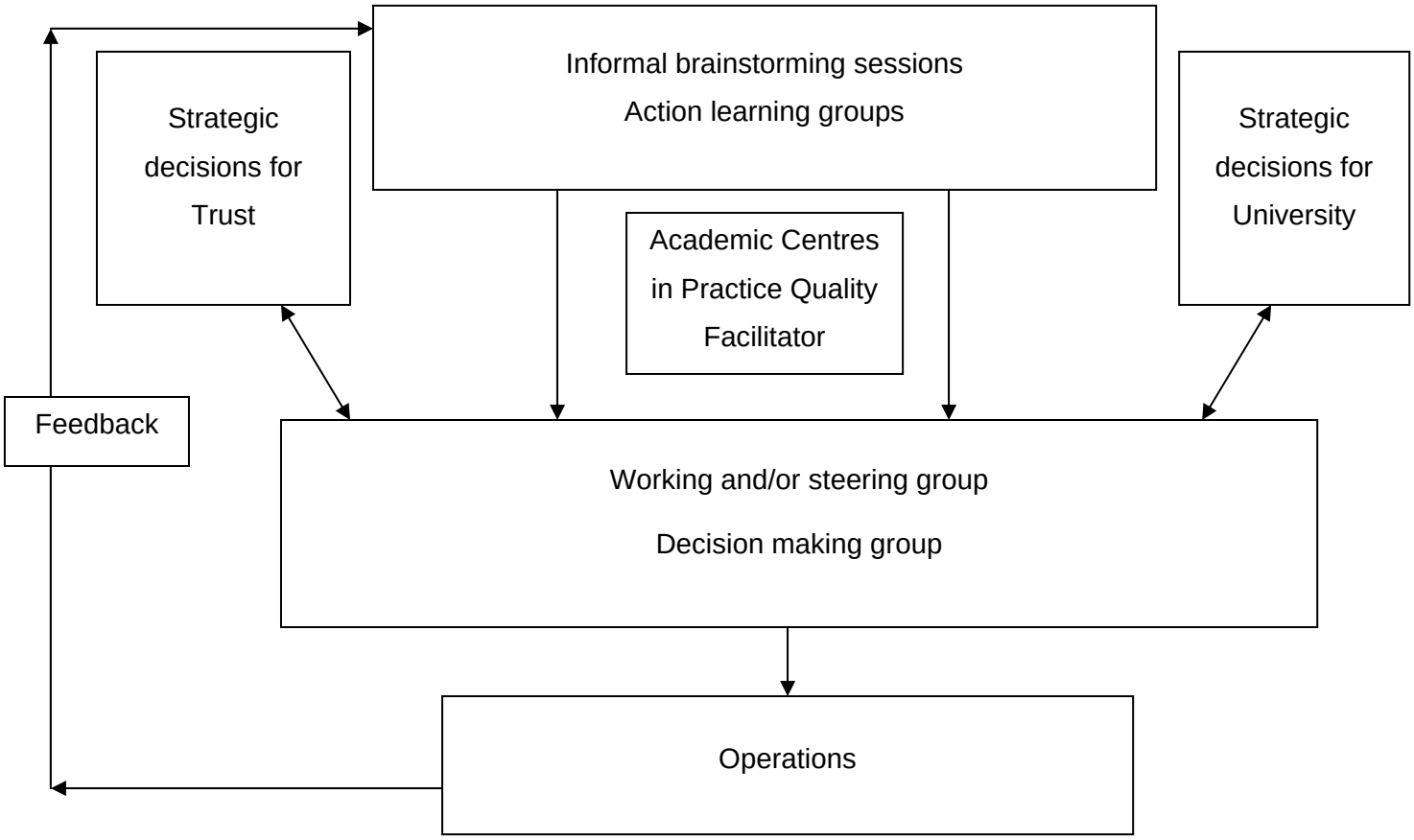
In addition to formal strategic working and steering group meetings, less formal brainstorming sessions should take place in a helping, cooperative and informal mode. Such sessions should involve key decision-makers from each collaborative and could focus on specific topics. Such meetings could also involve action learning sets, which would help evaluation and reflection on action throughout the development of the collaborative. As such, the learning is continuous throughout the process, rather than beginning towards the end of the project. How this feeds into the main decision-making process is highlighted in Diagram 7.1.

- **Allocation of funding to the partnership** (relates to Chapter 5 – Key Strategic Learning category 5: Resources)

The importance of who holds the funding and who has responsibility for spending the money cannot be underestimated. If the ACP is a true partnership, then funding should be held by the partnership. With all key stakeholders agreeing how the funding should be spent in working groups or steering group meetings, equable spending of the funding should occur. If the money is split equally between the partners, then agreement on responsibility for funding would have to be set. This would be difficult to achieve in an emergent partnership design as is found with

the ACPs. If one partner holds the money, then true collaboration is difficult to achieve because psychologically the other partner feels to have less control over the direction of funding and spending.

Diagram 7.1: Suggested Academic Centres in Practice Structure



7.3.2. Quality Administrator

- **Appoint Quality Team or Administrator – someone to undertake the day-to-day work** (relates to Chapter 5 – Key Strategic Learning category 2: Implementation and 4: Roles)

Staff working within the ACPs have typically been members of staff from the University or Trust, and generally work in response to the needs of the Centre, leading to a lack of continuity. Often these staff have been senior individuals, specialists in their field. It is essential that future collaboratives jointly employ a quality and continuity team or facilitator (depending on the size of the organisation) who would ensure continuing quality, act as a point of reference, coordinate staff and events within the Centre, make quality decisions and have the ability to refer and

confer information as appropriate. It is recommended that such appointments would be senior administration posts and be full time to ensure continuity.

- **Develop quality policy and procedures** (relates to Chapter 5 – Key Strategic Learning categories 2: Implementation and 4: Roles)

One of the main duties of the quality facilitator would be to develop quality policy and procedures for the collaboration, highlighting the governance of the collaboration, addressing roles and responsibilities, and structure and process in light of the strategic direction of the collaborative.

7.3.3. Outcomes and Benchmarking

- **Share targets** (relates to Chapter 5 – Key Strategic Learning category 6: Monitoring)

There is a need for the collaborative to develop targets for the ACP vision to be implemented into reality and in practice. The targets need to be agreed by stakeholders within the collaboration and be linked to targets within the collaborating organisations. These targets could be qualitative in nature and should be constantly revisited and updated in light of change.

- **Frequent dissemination of outcomes to a local and national audience** (relates to Chapter 5 – Key Strategic Learning category 6: Monitoring)

Regular communication with the partners and with the outside world is required. This should include ongoing work and could be mapped against key priorities. Learning from this needs to be disseminated to a wide audience and could help inform similar partnerships nationally.

- **Local, national and international benchmarking is required to share best practice** (relates to Chapter 5 – Key Strategic Learning category 6: Monitoring)

There should be increased benchmarking activity to note issues and problems with similar partnerships nationally, with a national network of similar initiatives to increase learning and share best practice. Regular information sharing could occur through summits or conferences to invite wider audiences to participate in the learning.

7.4. Immediate Recommendations for Continuing the Work of the Academic Centres in Practice

In the first instance, this evaluation recommends a number of important pieces of work that have begun under the auspices of the ACPs that should continue, particularly work that embeds learning in practice through increased reflective practice, including:

At Salisbury Healthcare Trust:

- The work with the Burns Unit Quality Improvement Team;
- Imitating the work with the Burns Unit in other established quality improvement teams within the Trust;
- Developing the Modern Medical Careers Foundation Programme.

Within South West and North Dorset Primary Care Trusts:

- Continuing the growth of research-based practice through enhancing and developing the resources room, utilising the research database and continued provision of research skills workshops;
- Extending the excellent work of the audit programmes to other areas of the Trust;
- Extending team building and leadership training to other areas of the Trust, perhaps a further cascading through a ‘train the trainers’ model of learning.

In addition, it is recommended that the learning of the ACPs should be used to develop the model of the South Wiltshire Academy and any similar initiatives within Dorset.

7.5. Conclusion

To deliver high quality healthcare services based on individual need, the healthcare workforce needs to be continually educated and trained to high standards. For this to happen, strategic health authorities, healthcare providers and training and education providers, including HEIs, need to work together. Collaborative working ensures a sharing of expertise and resources in key areas that can lead to a highly skilled, educated and motivated workforce which can aid practice improvement and development for ensuring better patient care. The ACP is an innovative model for enabling this to happen by concentrating on a research and education ethos and enhancing reflective practice to help reduce the theory-practice gap. As such, some of the work of these innovative Centres needs to be continued for real healthcare improvements to be seen over time. New initiatives like the South Wiltshire Academy could address these recommendations to maximise the potential learning of such a centre and to continue to build on existing foundations by identifying areas of strength and progressing the considerable work that has been initiated.

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Appendix A

Salisbury Academic Centres in Practice: Financial Statement

	Salisbury £
Setup Costs	
July 2000 - December 2001	**14,992**
Year One Costs	
1st January 2002 to 31 December 2002	**128,125**
Year Two Costs	
Academic Management Team	15,000
Readers	42,000
Doctoral Student (to October 2003)	15,503
Specialist in Healthcare Improvement	33,862
Other Costs (Travel/Admin/Equip)	13,041
Administration (via Trusts)	10,380
University Support	22,500
1st January 2003 to 31 December 2003	**152,286**
Year Three Costs	
Academic Management Team	15,000
Readers	42,000
SL Quality Improvement (1yr fixed term funded direct to Trust @ £35k)	35,000
Trust Management (total for project)	19,662
Specialist in Healthcare Improvement	35,176
Research Assistant (1yr from 01/06/04)	6,372
Administration (via Trusts)	1,497
Other Costs (Travel/Admin/Equip)	5,128
University Support	22,500
1st January 2004 to 31 December 2004	**182,335**

Continued>>

Evaluation Period to July 05

Research Assistant (1yr @ from 01/06/04) : 5 months	4,574
Specialist in Healthcare Improvement	20,215
SL Quality Improvement (overpayment - see below)	16,579
Administration (via Trusts)	1,946
Other Costs (Travel/Admin/Equip)	1,004
University Support	4,500
1st January 2005 to 31 July 2005	**48,818**
Project Fund Committed at 31 July 2005	526,556
Refund from Salisbury ref SL Quality Improvement	-34,465
Outstanding payments to Salisbury	8,027
Contribution to provision of Salisbury Clinical Academy	7,500
Total Project Fund	**507,618**

Appendix B

Dorset Academic Centres in Practice: Financial Statement

	Dorset £
Setup Costs	
July 2000 - December 2001	**2,000**
Year One Costs	
1st January 2002 to 31 December 2002	**80,162**
Year Two Costs	
Academic Management Team	15,000
Readers	42,000
Other Costs (Travel/Admin/Equip)	13,041
University Support	22,500
1st January 2003 to 31 December 2003	**92,541**
Year Three Costs	
Academic Management Team	15,000
Readers	42,000
Research Practitioner (1yr from 01/05/04)	22,035
Research Assistant (1yr from 01/06/04)	6,372
Other Costs (Travel/Admin/Equip)	5,128
University Support	22,500
1st January 2004 to 31 December 2004	**113,035**

Continued>>

Evaluation Period to July 05

Research Practitioner (1yr from 01/05/04) : 4 months	11,056
Research Assistant (1yr from 01/06/04) : 5 months	4,574
0.50 Research Assistant (1yr from 01/06/05) : 2 months	1,444
0.50 Admin Assistant (18 months from 01/06/05) : 2 months	1,066
Other Costs (Travel/Admin/Equip)	1,004
University Support	4,500
1st January 2005 to 31 July 2005	**23,644**

Project Fund Committed at 31 July 2005	311,382
Required to support 0.50 Research Asst at £800pm x 10 months	8,000
Required to support 0.50 Admin Asst at £600pm x 16 months	9,600
Required to support 0.50 SL at £1700pm x 12 months	20,400
Required to support SL travel at £150pm	1,800
Required to support dissemination & conferencing activities	6,000
Balance to support further planned expenditure	35,200
Total Project Fund	**392,382**