LOCALLY BASED SHARED LEARNING

Surveys in two English Counties

by
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Commissioned by:
The UK Centre for the Advancement of Interprofessional Education
from:
The School of Social Studies at the University of Nottingham
and funded by:
The Nuffield Provincial Hospitals Trust

A CAIPE publication

Published by CAIPE
the UK Centre for the Advancement of
Interprofessional Education
344 Grays Inn Road
London WC1X 8BP

First published 1995

ISBN 0 952 0830 27

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Acknowledgements

I am especially grateful to Dr. John Horder for creating the opportunity to undertake this research and for his support, encouragement and wise counsel at every stage, and to the Nuffield Provincial Hospitals Trust for its financial backing.Colleagues at the University of Nottingham have been most supportive, notably Professor Barr as my co-worker and Professor Robert Dingwall who has advised on the review.

Ian Shaw

March 1995

CONTENTS

Acknowledgements 2

Foreword 4

Summary 5

Introduction 5

SECTIONS

1
The survey of educational institutions 7

2
The survey of service units 10

3
Discussion 11

References 13

Foreword

Dr. John Horder, CBE – Chairman

Centre for the Advancement of Interprofessional Education in Primary Health and Community Care (CAIPE)

This paper is one of three resulting from the review of shared learning in health and social care undertaken for CAIPE by Professor Hugh Barr and Dr. Ian Shaw at the University of Nottingham. It reports upon telephone surveys in two English shire counties to establish the incidence, nature and use of shared learning. These surveys have helped to inform the design of CAIPE's second national survey of interprofessional education. The first national survey (Shakespeare et al., 1989) concentrated upon primary health care. The second also includes community care, which now forms part of CAIPE's remit.

The first paper, by Professor Barr, drew upon the experience of people at the forefront of developments in shared learning throughout the United Kingdom. With their assistance, that paper identified trends in health, social care and education which have prompted and shaped recent initiatives in shared learning. These initiatives were then described; priorities for promotion and development are floated. A third paper, by both Professor Barr and Dr. Shaw will review selected examples of shared learning from the UK literature. This is the outcome of a library search, augmented by a wealth of material brought to light during Professor Barr's interviews.

March 1995

Summary

The first part of the survey involved educational institutions and training providers. It revealed a number which stated they were actively involved in interprofessional education. Information was provided which indicated a wide range of courses available to a host of different professions. From the documentation provided the degree of interprofessional education in the two shire counties, compared with the 1988 study carried out by CAIPE, was impressive.

The second part, a survey of service units in the same two counties, was expected to support the initial evidence from the educational institutions. However, around 98 % of the 240 service units reported that none of their staff had been on courses which were also attended by participants from other professions. This painted a bleaker picture of the state of shared learning in these counties than that indicated by the educational institutions. However, further examination of information on those courses which staff in the service units had attended revealed that a small, but significant, number of units replying negatively actually cited training courses which the educational institutions claimed were interprofessional. This generated the hypothesis that much of what is called shared learning by educational institutions is actually nothing of the sort. A distinction could be made between interactive courses which drew upon the different professional backgrounds of participants and courses which trained a number of different professions about the same topic. In the latter, participants were learning about the same subject matter, but not about each other and their respective roles. Consequently, participants may be genuinely unaware of each other's backgrounds. The argument made here is that only courses which include interactive learning should properly be termed shared learning.

Introduction

In recent years there have been calls from central government and elsewhere to promote collaboration between those involved, at all levels, in providing primary health and community care (DHSS, 1989). In particular it seemed that almost any reference to the government's priority groups (DHSS, 1976) – children, the elderly, the mentally ill, the physically disabled and people with a learning disability – automatically included some mention of the need for increased collaboration. Also, much of the literature in primary health care contained some stress on the need for 'team building' or 'team work' (Lambert, 1991). Despite this apparent commitment, progress towards shared learning remained, at best, uneven (Shaw, 1994).

That picture began to change with the implementation of the NHS and Community Care Act 1990, which provided a clear direction for the development of health and social care in the years leading up to the next century. The introduction of the internal market, with purchasers and providers negotiating contracts based upon the needs of users for particular services, has permeated all policy discussion. The impact has been profound, not least in the area of staff education and training.

As new patterns of service delivery evolve, traditional lines of occupational demarcation and staff preparation are being questioned. This has been accompanied by the Government actively promoting the development of interprofessional practice and training. The question which this report addresses is the impact of such policy in the field.

This paper is the second element of a three-part research report on shared learning. The first paper (Barr, 1994) reported on the analysis of 50 interviews with key individuals involved with the development of shared learning. The third paper (Barr and Shaw, 1995) will review selected examples of shared learning in health and social care found in the literature. This, the second of the three papers, reports on surveys which were undertaken to map the incidence, location, objectives, form and use of shared learning in two English counties. These were chosen because, although both had a rural/urban mix, County A's services were primarily urban, whereas County B's services were primarily rural. Both had also displayed evidence in a previous research project in the field of learning disability (Brown, Clifton and Shaw,1992) of good interprofessional training. The counties adjoined and this helped to make the project more manageable.

The surveys were conducted initially by telephone, but in a few instances this was followed up by interview. Documents on shared learning were also collected when made available by respondents. The survey, which was conducted between September and December 1993, focused on – education and training providers and service providers.

Providers of education and training included University Departments, Medical Schools, Schools of Nursing, Inservice Training Sections of the Social Services Departments, Local Authority and Health Services, Police Training Colleges, independent training providers, the Open University and voluntary sector local training agencies. The service units consisted of a sample of 240 residential homes and day care centres (120 from each county). These service units were selected evenly between the various fields and as proportionally as possible between the various sectors (private, voluntary, local authority and health authority).

Fieldwork teams were not included in this second part of the survey because their training budgets were held centrally and training was arranged through the educational institutions already involved in the first part of the survey. However, training budgets for residential and day care sevices were devolved and there was a suggestion of greater diversity in the purchase of training.

The report is in two main parts The first deals with findings from that part of the survey which focused upon education and training providers. The second part deals with the findings from the survey of service providers. The anonymity of respondents has been preserved.

SECTION ONE:

The survey of educational institutions

Thirty three educational institutions were identified in the two shire counties. For historical reasons, most of the courses leading to qualifications for health professions in County B are undertaken in County A. Twenty-one of the institutions claimed to be running at least one shared learning course in health and/or social care. Information about the number and professional backgrounds of teachers and participants was not sought.

The Shared Learning Courses

1 The Universities and Colleges

There were two universities in County A, none in County B. Likely departments within both universities were contacted to ascertain their involvement in shared learning. A few reported positively and are briefly described below.

The Medical School ran most of its undergraduate courses and some of its postgraduate courses on a shared basis. These involved students from medicine, pharmacy and nursing. Many of these courses were modular and had places available for qualified health care staff, should the NHS wish to buy places.

Four MA courses were marketed as interprofessional, notably a Master of Public Health.

A number of one-off workshops and other training events were run interprofessionally, including programmes on HIV, health promotion, genetic counselling and research methods.

There were also courses run by the Office for Professional and Industrial Training which served both universities. This office has been established to provide courses which were geared to attracting participants from industry including the public and commercial sectors. Its courses brought together people from different professional and working backgrounds, including academics. Topics included 'operations management', 'international marketing' and 'leadership and team building'.

Adult education departments in both universities ran interprofessional courses, but mostly in the arena of criminal justice. They brought together police, magistrates and magistrate's clerks, probation officers and others.

Perhaps the most interesting developments were in colleges of further education where some care courses were being run in association with health and social services agencies. These were developed to a fine degree in County B. Here the Social Services Department had got together with the Health Authority, voluntary agencies and two of the major colleges to establish a 'care consortium'. The training at the colleges was linked to employment needs and accredited within the National Vocational Qualifications (NVQ) framework. The majority of courses were geared to NVQ levels II and III, the levels at which most staff required career development, though plans were being made to provide courses at NVQ level 4. This initiative

combined training for the health care assistants, developed originally by the National Health Service Training Authority (NHSTA), with that for residential, domiciliary and day care staff developed by the Joint Awarding Bodies (JAB).

2 Social Services

There were a number of shared learning courses run by the training units of the two social services departments. These were mainly in the field of child protection. Seventeen such courses were identified, many of which lasted only one to three days. Nine of these were in County B and eight in County A. They included staff from the police, social services, health, education, voluntary organisations and occasionally the army and the RAF. The literature provided for these courses identified aims such as "improving staff competency and confidence". Only one course run by social services, in County B, had as its explicit aim:

"..to encourage and enable participants from different agencies to work together. As a consequence staff should be able to co-operate and communicate with each other across agencies – both formally and informally."

Other than in child care, shared learning courses were few on the ground. Exceptions were four courses in learning disability – dealing with issues of advocacy and challenging behaviour – and two courses in physical disability. In both counties social services' training budgets were held centrally. Line managers had therefore to apply centrally for places for their staff within priorities determined for the whole Department in line with funding ear-marked within the Department of Health Training Support Grant. If a line manager wanted to place staff upon a course that was not on offer, then a special case had to be made.

Courses such as the Open University's 'The Children Act 1989: Putting it into Practice' were multi-disciplinary. One of the main aims of that course was to:

" bring together voluntary and statutory bodies through shared training... which helps towards the creation of partnerships between statutory and voluntary carers".

This course consequently used an interactive format, so that participants "..learned a little about each other as well as about the Children Act".

Training organised by the other social services department on the NHS and Community Care Act 1990, race issues and rural issues was also designed to include the voluntary sector as well as its own staff.

The training section of both social services departments also reported that they had run, over the previous twelve months, 'one off' conferences which were open to wide audiences on topics such as disability and mental health. Typically, these ran for one day and were focused on an issue rather than on how professions can best interact.

British Association of Social Work (BASW) courses such as 'Financial Skills and Care Management' and 'Children and Families with HIV/Aids: Practice Skills' which are targeted at personnel in both health and social services, were also bought into in both counties.

3 Health Services

One College of Nursing covered both counties, and was located in A. At the time of the survey it offered no pre-qualifying courses interprofessionally, although three post-qualifying

courses had recently been offered on that basis:

- a drug and alcohol counselling course open to physiotherapists, occupational therapists, nurses and radiographers;
- a community mental health course, open to 'everybody' (but this course had not yet been marketed, so the response was not known);
- a child and adolescent psychiatry course, open to health and social workers as well as police officers.

The College of Nursing was beginning to merge its courses with the Medical School in one of the universities. Modularisation was also envisaged. This was expected to open a number of courses to staff from social work, probation, general practice, and penal services. The Medical School already had a number of undergraduate and postgraduate courses which were shared by students of medicine, pharmacy and nursing. This development had been influenced by the advent of modularisation and the rationalisation of teaching throughout that university.

In both counties, in-service training units in four of the NHS Trusts also reported that they ran courses on a multi-professional basis. These courses tended use Department of Health information/training packs, such as:

- Drug abuse and counselling: such courses were open to a wide range of professionals – physiotherapists, occupational therapists, nurses, radiographers and non-medical staff.
- Child Health: using packages such as "Aspects of Child Health". These courses were described as 'interprofessional'. Although nurses, midwives and various residential care workers (from both statutory and independent sectors) trained together, GPs trained separately. This was reportedly the case also in the field mental health.

Additionally, five of the in-service training units of the trusts marketed their short courses in the voluntary and private sectors. One trust, in County A, reported that it had trained 340 staff from the voluntary and private sectors over the last twelve months, and that much of this training had involved staff from different professional backgrounds. These courses covered a wide range of topic areas, from clinical practice to counselling skills.

4. The Independent Sector

Every attempt was made to include all voluntary and private organisations, within the two counties, in the review. However, only a small number (around 12%) claimed to be involved in shared learning:

- The Red Cross ran first aid and health and safety courses which were open to staff from all professional backgrounds and none in both counties.
- The Enterprise Councils, in both counties, ran courses in youth training which included staff from social services and schools, as well as parents.
- The Spastics Society's national office ran two multi-professional courses to 'train the trainers' which covered both counties. These were based in a local college.

- The Councils of Voluntary Service (CVS) in both counties, ran one day workshops open to different professions, including care managers. In county A the CVS also ran five courses in financial management, interpersonal relationships, organisational structures and equal opportunity policies. While not strictly interprofessional, they often ended up so because a number of organisations bought into them.

SECTION TWO:
Survey of the service units

Choosing the sample

A sample of 240 residential and day care units from all fields of primary health and community care was selected to gain some indication of the up-take of shared learning. The identification of the service provider population was made from information provided by the health and social services authorities. This sample was evenly divided between the two counties, 120 from each. They comprised approximately 23% of the total number of units. The sample for each county was then broken down evenly into five, to match the government's five priority groups in community care – elderly, the mentally ill, the physically disabled, the learning disabled and children. This left a sample of 24 in each county for each priority group. The sample for each county was then subdivided into those service providers from different sectors – health services, social services, the private sector, and the voluntary sector. Six units from each of these sectors were then chosen randomly to participate in the survey.

The questionnaire

A phone call was made to the manager of each unit. He or she was then asked to provide information on staff training within that unit. No respondent refused the request and, if the information was not to hand, a further telephone call was made. The following was sought:

- information on all the courses upon which any care staff had been sent over the preceding twelve months.
- whether any of those courses involved participants from more than one profession. If so,
- who had run these courses and where
- how many staff from the unit had been involved
- what topics had been covered
- which professions had been involved.

The respondent was also asked whether he or she was aware of any other such courses.

The responses

Of the 240 responses only five replied that their unit had staff who had trained with other professions. Three of these responses were from County B, and involved the Care Consortium, two were from County A. Both of the latter were in child care, as were two of the three responses in County B, the remaining one being in learning disability. In both counties a total of nine staff had reportedly been involved in shared learning over the preceding year. Fifty four percent of respondents stated that none of their staff had been involved in any form of training over the last twelve months. Lack of training for residential and day care staff, is widely known and reported in a number of research projects (e.g., Shaw, 1994).

Although the questions were not designed to gauge attitudes, these occasionally came through. Twelve respondents (mainly nurse managers) offered unsolicited comments. One said:

"Nurses need to concentrate upon their own job and shouldn't be messing around trying to find out what every one else is doing."

Historically, shared learning has been policy inspired and the battle to promote interprofessional education has been fought at the level of senior management. However, with the devolution of training budgets, particularly in Health Authorities, the people who are important in the success of shared learning became the line managers. These responses, albeit few in number, may indicate that some degree of antagonism exists at that level, in which event the case for shared learning may need to be fought all over again.

Furthermore, the contrast between the amount of shared learning provided by the educational institutions and the number of staff who had been thus trained could hardly have been greater. However, when the information on the training courses which the service provider units had been involved with was examined, it was found that in three circumstances a course had been listed which the training providers stated was interprofessional, but which had not been noted as such in the response.

It must be acknowledged that phoning service managers to gain information on the courses undertaken by their staff is problematic. Some may have been talking from memory and may not have been aware of the nature of the training which their staff had undertaken. It should also be recognised that there may be a mismatch between university and college based shared learning and the type of training which is available for residential/day care workers.

SECTION THREE:
Discussion

Policy developments

The data collected during the 1988 national survey (Shakespeare et al., 1989), were not directly compatible with the data contained in this paper for a number of reasons. First, the boundaries of the two surveys were not coterminus; second, the methodology in data collection differed; third, the 1988 survey focused only upon 'main sites' of training.

The 1988 survey identified only four shared learning programmes in the counties involved with this case study – a short course between social workers and health visitors at one of the universities; a short course between GPs and Social Workers run by another University; a multi-professional course on child abuse run by one of the Social Service Departments and a one day-course on AIDS awareness run by a Medical School.

None of the courses identified in the 1988 survey were still operational in 1994. However, the same training sites identified in 1988 were running a significantly higher number of shared learning courses – including shared learning in post-basic training by the Medical School. The increase in shared learning since 1988 seems large. As one social services training officer said:

"... there has been a tenfold increase in the (social services department's) interest in providing interprofessional education".

This is, of course, one persons view and cannot be backed up by a comparison between the 1988 and this survey. There were indications that much of social services departments' current interest in shared learning is focused upon child protection. Government policy leads, already outlined, are perhaps a partial explanation for the increased number of courses in this field. Certainly, there have been a number of other pressures and opportunities.

The movement of professional schools and colleges into universities has removed many of the barriers to shared learning. For example, qualifying and post-qualifying training for medicine, nursing and professions allied to medicine, now often occurs in the same institution as that for social work and other related professions. Pressure to rationalise courses, especially with modularisation, is breaking down many of the traditional managerial and professional obstacles.

Working Paper 10 of the White Paper Working for Patients (DH, 1989) outlined the future arrangements for managing and financing non-medical education and training within the NHS. As a result, Regional Health Authorities (RHAs), in consultation with employers, now have the main responsibility for funding pre-registration training rather than sharing the responsibility with the Boards.

One consequence is that the role of the English National Board has been restricted to that of a validating body, with funding transferred to employers. Furthermore, there is presently a surplus of nurses (Shaw, 1993), which has resulted in less training being purchased by Regions – certainly in the two counties surveyed.

In response, the Colleges of Nursing involved in the survey were marketing their courses to a wider clientele in an attempt to maintain income. Courses originally designed for nurses or midwives were being adapted to include social workers, residential care workers, probation and prison officers, police, general practitioners etc. At the same time the social services units were opening their courses to the independent sector for financial reasons. Thus nursing and social services were competing in the same market which may serve to hinder collaboration.

These multi-professional courses involved people from different professional backgrounds, and none, learning about a particular subject – such as drug counselling, HIV, and the Children Act. The courses were thus designed to impart knowledge about a particular topic. The aims of the courses were to give participants a greater understanding of that topic. The courses were not designed with a focus upon understanding the unique contribution each

profession makes to client care or how professionals can best work together. Consequently, people from different professional backgrounds may be trained in the same room – but that training is organised in such a way that they learn little of each other.

This thesis is, in part, substantiated by evidence from the course material and from interviews with training officers. As a consequence, although such courses have increased dramatically, many are better described as 'common learning' (with a focus upon acquiring information on a subject) rather than interactive learning (with a focus upon learning about each other).

The danger here is that government, and others, may be misled by the scale of common learning into thinking further investment in the development of shared learning is unnecessary. There is consequently urgent need to evaluate both the common and shared forms of learning in order to assess their relative usefulness to interprofessional practice.

It is hoped that the national survey currently being undertaken by CAIPE will provide a base from which comparison can be made between the findings of this survey and the position nationally.

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CAIPE – the UK Centre for the Advancement of Interprofessional Education – was founded in 1987 to promote interprofessional education as a means of engendering collaboration between practitioners in primary health care. Following the 1989 NHS and Community Care Act, its remit was extended to include community care.

It is an independent charitable trust with some 500 individual and organisational members comprising advisers, educators, managers, practitioners and researchers from medicine, nursing, professions allied to medicine, social work and related professions.

Through its members, CAIPE provides a network for discussion and information exchange by means of conferences and seminars, a bulletin and occasional papers. It also commissions research, represents members' views in national and sometimes international forums, and works closely with other bodies to promote and develop interprofessional education and practice.

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The School of Social Studies, at the University of Nottingham, comprises sociology, social policy and social work. Its staff are actively engaged in research, teaching and consultancy on a range of professional and interprofessional topics within their UK and European context. Interprofessional conferences, seminars and workshops are held regularly under the auspices of the School's Professional Development Group and Social Work Section. Many of these activities cater for health and social care professions. Topics include aspects of community care, community development, child protection and family jurisdiction.

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