

***Changing Professions: Inter-professional collaboration
in health care education.***

**Report of the proceedings of the
Staff Development Seminar**

Thursday 14 December 2000

**held at
Institute of Physics
76 Portland Place
London**

**Edited by Mike Downes
SEEC Development Officer**

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FOREWARD

Graham Morgan, Chair, SEEC Health and Social Care Professions Network.

The SEEC Health and Social Care Professions Network is pleased to present the publication of the deliberations from their seminar/workshop held in December 2000. The event focused on the topical issue of inter-professional education for health care students.

This review provides a synopsis of the presentations made by four speakers covering general factors currently impacting on the delivery of health professionals' education and specific case studies on practical scenarios. This is followed by compilations of the recorded discussions surrounding those inter-professional issues facing health care educators.

The findings will be of interest to all those involved with or embarking on the complex and often controversial subject of inter-professional teaching and learning.

Gratitude is extended to all of the speakers who have provided their presentation material and who also facilitated workshops and to all workshop participants for freely offering their views and agreeing to them being recorded.

Particular thanks also goes to Mike Downes, SEEC Development Officer, for his support for the network. In addition to chairing this event he transcribed the collective views of participants and collated and edited the material.

Graham Morgan is Head of the School of Radiography, Faculty of Health and Social Care Sciences, Kingston University and St George's Hospital Medical School.

Seminar Rationale

The issues associated with collaborative ventures across the health care professions are the focus of considerable debate. The issues reflect political, professional and educational perspectives. The aim of collaboration should result in a net benefit to the patient or client. Management driven initiatives support the developments with statements, such as, “breaking down and blurring of professional barriers”, “multi-tasking and skill mix” and “multi/inter-professional learning opportunities”. Other initiatives are inspired by the genuine concerns of those who directly influence and function at the inter-professional inter-face. These may arise where collaborative working already exists and the benefits that can derive for both patients and staff are recognised and acknowledged.

The evaluation of such inter-professional working presents a major challenge for the future.

Seminar focus

The seminar’s focus was on collaborative initiatives in health care education and considered:

- their origins
- the approaches adopted
- the expectations and aspirations of the decision makers.

The seminar was opened by Professor David Sines, Dean of the Faculty of Health at South Bank University. Professor Sines described the context of changes faced by the health professions in both their practice and their professional preparation and development both currently and in the future.

Three case studies were presented each based on inter-professional practice. The seminar provided an ideal opportunity to engage in a discussion of the influences that are affecting the changing health care climate and an exploration of the ways in which the related professions may be expected to respond.

This publication will be of interest to all those in higher education who are involved in the policy and the practice of the health care professions.

The Presenters

Professor David Sines, Dean of the Faculty of Health, South Bank University. David has extensive experience of the health service as a manager and as an academic. At the time of the seminar he was chairing a working party on behalf of UKCC (in partnership with the GMC, CCETSW and the CPSM) developing recommendations for inter-professional education.

Geraldine Francis, Principal Lecturer in the School of Radiography, Faculty of Health & Social Care Sciences, Kingston University & St George's Hospital Medical School

Geraldine has practised as a therapeutic radiographer in London and overseas and has an MSc in Cancer Care.

Gillian Jordan, Principal Lecturer, Open Learning, School of Health, University of Greenwich. Gillian, a physiotherapist with a long career in both clinical practice and education, is responsible for a multi-professional and international MSc programme in continuing professional development (CPD) for health care professionals using computer conferencing.

Sally Feaver, Principal Lecturer, Rehabilitation Studies Department, Oxford Brookes University. Sally is part of the pedagogic research team looking at “stakeholders” expectations of multi-professional courses.

Opening Address

Changes and Challenges in the Provision of Health Care Education

Professor David Sines, South Bank University

Until 18 months ago, I was the head of school of an inter-professional school of health sciences at the University of Ulster. My experience in Ulster was particularly useful in facilitating access to 18 health and social service trusts, each promoting inter-sectoral service delivery between a range of health and social care agencies. Such opportunities permitted understanding of the principles of integrated care planning across service boundaries. I soon learned however that despite structural alignment of service provision the real challenge came from my attempts to manage an inter-professional health faculty, consisting of multiple professional agendas and implicit tribalism. My experience in Ulster placed me in an excellent position to return to London in 1999 to assume my present role as Dean of an inter-professional faculty of health and social care at South Bank University.

My return to England coincided with rapid change in the health and social care service, promoted and sponsored by the NHS Plan and its associated nursing and PAMS strategies. The new 'modern and dependable agenda' professes to provide a vision for the future that will respond to the views and aspirations of service users, based on the assimilation of best practice. The aim will be to improve the quality of user lives, enhance health status, and yet at the same time encourage radical change in the manner in which the NHS and its staff conduct their business. This will require health and social care professionals to prepare themselves for significant change and to form new alliances within, and between, professional groups in order to move forward collectively within a template of common principles and goals.

Each partner in this process has a pivotal part to play in realising the new health agenda. The trusts and social service departments, for example, will be required to ensure that they are prepared to equip the workforce with the requisite skills, knowledge and values to respond positively to the needs of clients and patients and to follow integrated care pathways. Such approaches to corporate care management and care planning, whilst not new to these agencies, have not always been implemented in the 'true spirit' of inter-professional/user partnership. The health and social care agencies will also become active partners in the commissioning and provision of education and training for the total workforce and in so doing will assist in the erosion of the theory/practice gap that has further developed during the past decade (following the enforced partition of higher education and clinical learning brought about by Consortia commissioning strategies). The aim of the proposed strategic alliance between service and education staff should provide greater opportunity to ensure that practitioners are fit for both practice and purpose.

Other challenges for the health care agencies relate to the Government's expressed concerns about clinical governance and risk management. Take the medical profession for example, where the 'Junior Doctors' issue has created a major problem with regard to the number of hours doctors were working, risk assessments, safety/cost and the impact that any proposed changes would make in respect of 'role substitution' on the other health professions. One definite response has been the creation of new Consultant

Therapist and Consultant Nurse posts which have been designed, not just as a celebration of the success of our professions, but also as a direct response to our Government's agenda to encourage role substitution for some of our Junior Doctors' functions and to encourage role-mobility between other members of the health care professions.

The emphasis on inter-professional teamwork is of course not new to the NHS and social services. Indeed the Primary Care agenda has long been extolled as a vitally important part of our work, despite continuing to be under-resourced. However even such positive role models fall far short of the scope of inter-professional practice that is envisaged in the NHS Plan. This agenda is set to diminish boundaries between the primary, secondary and tertiary care sectors and encourage care planning delivery and planning that enhances continuity of care (within the context of integrated care pathways), in partnership with Local Authority Social Service Departments.

The higher education sector is also experiencing significant change, not least with the advent of the benchmark standards for nursing and PAMs recently published for consultation by the Quality Assurance Agency. In addition professional recognition of learning and teaching standards have been the subject of discussion between regulatory bodies and the Institute for Learning and Teaching. Both agendas also coalesce with changes heralded with the launch of new Workforce Development Confederations in England, which will demand greater transparency of reporting arrangements in respect of how we conduct our provision within higher education. At present there are three main strands to our reporting arrangements. The first, of course, relates to our professional bodies to assure compliance with regulation standards. Secondly, accountability to NHS contracting procedures are becoming particularly complex, with reliance on the provision of both qualitative and quantitative data. The third, responds to the Higher Education Funding Council's own requirements for quality assurance.

It is inevitable that there had to come a point when the professional regulatory bodies, the NHSE and the higher education sector recognised the need for some synergetic approach to monitoring and assuring quality. One common tool that might be utilised to supply quality data relates to subject benchmarking and the QAA subject review process which is set to integrate reporting streams that will respond to the needs of multiple stakeholders. The professions have been significantly involved in engineering proposals for the new subject review process and have been supportive of the need to work in partnership with the higher education sector and the NHSE to integrate quality assurance procedures. This combined approach will aim to ensure that the quality of education and training provision responds positively to the performance agendas of the NHS and the standards agendas of the QAA and professional bodies.

Other external influences impacting on the quality agenda witnessed during the last few years have stemmed from the evidence based care agenda sponsored by health and social care imperatives. Examples of guidelines issued by the National Institute of Clinical Excellence, The Centre for Health Improvement and the National Audit Office combine to demand that HE providers develop new curricula based upon best evidence to enhance the quality care delivered to patients/clients. In addition the publication of National Service Frameworks, the quest for clinical effectiveness, outcomes arising from clinical audit, clinical governance and risk assessment will demand new approaches to care delivery in the workplace and a new inter-professional approach to education.

One other key driver for change relates to the central role that service users will play in determining the effectiveness of care provision. Whilst Community Health Councils will cease to exist in 18 months' time, new informed user groups and advocacy groups will be introduced across the care provider agency network to provide further evidence of consumer influence in the manner in which education is provided.

Many of you will recall the basic tenets of the 1990 NHS and Community Care Act – based on the need to discharge sensitive care management for individual clients. Despite this aim an artificial division was often experienced between health and social care. The NHS Plan revisits some of the principles of care management, albeit demanding its transaction in a rather different way through case management, based on the concept of integrated care planning. If this approach is to be adopted in the NHS, it surely makes little sense for the HE sector to continue to educate its health and social care pre-registrants in singular intra-professional pathways or 'silos'. Rather new solutions that enable students from different professions to learn together very regularly at key points during their education experience are required. In particular the value of inter-professional practice learning (in the workplace) is a particularly effective mechanism to promote team learning in partnership with clients and patients who present with similar needs.

Take, for example, stroke rehabilitation or cardiac rehabilitation. A meaningful learning experience may be provided for students if they are actually learn together as an inter-professional team in a designated clinical area. Such work-based learning opportunities, reinforced by focussed inter-professional learning sessions/workshops in the classroom, may promote effective care delivery and collaborative practice.

I am currently chairing a committee on behalf of the UKCC, the GMC, the CPSM and CCETSW, which is developing principles, designed to promote and improve inter-professional education for professional undergraduate education. Whilst the working group is totally committed to the principle of inter-professional education, it has been cognisant of the professional boundary issues and challenges that militate against realising its full potential within the HE sector and its partner agency settings. However we remain confident that we will be able to bring forward proposals in June 2001 that will be accepted by each of the representative professional regulatory bodies.

Such proposals will come as no surprise to many service/education providers. For example, Chapter 9 of the NHS Plan alludes to the possibility of introducing inter-professional common elements to the first year of undergraduate health programmes. Such initiatives are already being realised and several universities are already collaborating with medical schools to plan graduate accelerated pathways for PAMs, nursing and medicine. Such innovative initiatives will facilitate opportunities for professionals to move between professions and develop flexible career pathways that respond proactively to the evolving needs of the NHS.

The professional regulatory bodies are generally supportive of such initiatives but require evidence to ensure that students are fit for both practice and purpose at the end of their undergraduate programmes of study. Achievement of profession-specific competencies and standards will therefore continue to be a prerequisite for future course planning. The latter will ensure that the workforce of the future is fit for purpose in both

their local area as well as being fit for purpose to transfer skills within the United Kingdom and Europe as is required through EU Directives.

For the nursing profession at least 50% of all educational delivery must take place in the practice setting with responsibility for the assessment of practice competence. Signing people off as being 'fit for practice' and 'fit for purpose' in the workplace will therefore require the development of robust partnerships with the NHS, local authority social services departments, the independent sector and HEIs to confirm that a student is fit for practice. The importance of ensuring shared understanding of practice competencies, assessment strategies and procedures will be critical if we are to move towards an integrated approach to the assessment of practice competence.

All of this of course is dependent upon the provision of a suitable range of practice placements. The NHS Plan, and the approach advocated by the new NHS Workforce Development Confederations takes us some way towards resolving the key question – who is responsible for finding practice placements? Both suggest that responsibility for the identification and supply of such placements should be a joint responsibility shared by the NHS (taking a lead role) and the HEIs. How might this work in practice?

I suggest that if a local Trust/Confederation requires the local HEI to provide 'x' number of radiographers or radiotherapists, for example, each year for employment in a designated local trust, then it seems logical that the designated trust for whom the student are destined at the end of their programme should be actively involved in the students' education. This will commence with joint selection of the students, early induction to the trust environment, maximum exposure to clinical practice experience within the 'host trust', joint assessment of practice competence and exit interviews prior to the conclusion or completion of their programme with the aim of securing employment within the same trust. Such an approach is designed to provide the student with continuity of exposure to their 'host trust' throughout the three years of their education and in return to develop a sense of loyalty and commitment to both their trust and HEI. This is the philosophy underpinning the new nursing curriculum.

There is of course a caveat to all of this – the model supposes that the local 'host trust' can actually provide the full range of practice experience demanded by the curriculum. Where a trust cannot provide the full range then partnership placement circuits will need to be developed between trusts (e.g. acute and primary care trusts) on a reciprocal basis.

The new Confederations will significantly assist the process of practice partnerships by bringing together HEIs, NHS Trusts, local authority social services departments and Primary Care Trusts into membership. The aim will be to develop a seamless partnership based on the principle of equal representation within the Confederation.

Moving on – the other big changes relate to professional regulation. Each of the professions represented here today has recently been the subject of independent review with regard to regulation. One such change will affect the nursing, midwifery and health visiting professions with the forthcoming dissolution of the national boards for nursing, midwifery and health visiting. Their role will be absorbed within a new inter-professional education and training department within each NHS regional office. This may well lead to the integration of professional standards advice being offered by a

range of professional advisers through the workforce and development confederations. This will combine both professional and contractual advice via the local Regional Office.

The UKCC will be also disappearing in September 2001 to be replaced by a 'slimmer' Nursing and Midwifery Council. The major focus will continue to be the maintenance of professional standards and the protection of the public. The GMC is also under review and is actively seeking new models to emphasise regulation of the profession and to provide greater public trust, confidence and protection of the public. We also know that the CPSM is shortly to be replaced by a new 'eclectic' Health Professions Council. Changes in the regulation of social work complete the review of the professional regulatory bodies with the introduction of four national General Social Care Councils. Together these four professional bodies will be expected to work in partnership in accordance with common agendas and shared principles designed to regulate practice and protection of the public.

One other key agenda for the professional bodies relates to the development and implementation of effective competence based approaches to lifelong learning. This will be a central agenda item for the new confederations, complemented by new learning accounts, for all NHS staff envisaged by the NHS plan. An evidence based standard to recognise a higher levels of practice is also being developed by some professions (such as nursing) which in turn will result in the development of new career opportunities for consultant therapists and consultant nurses.

With revised regulatory systems there will be requirements for professionals to self-report on their achievement of personal and professional competence. The CPD approach advocated by the UKCC is designed to respond to this demand by introducing a system of peer review and work-based portfolio assessment. The measurement of performance will also be assisted through the development of benchmark standards e.g. NSF standards.

One specific example that is being explored in a number of universities is the concept of the professional doctorate, specifically designed for expert clinical leadership/practice linked to trusts and HEIs. Such programmes aim to focus on innovative clinical practice and the generation of robust research theses related to the students' cognate area of applied practice. The model demands the appointment of a dual supervision system shared between expert clinical mentorship and academic supervision.

At the other end of the 'market' HEIs will of course be encouraged to diversity their portfolio of course provision to provide flexible access programmes. Many of you, for example, have learned that the Quality Assurance Agency recently published a consultation paper defining a new qualifications framework. The proposed framework makes an important statement with regard to Level 2, now Intermediate, programmes (such as those witnessed in the majority of pre-qualifying programmes for nursing in England). The paper implies that DipHE programmes could be reconfigured to provide an academic standard qualification equating to a Foundation degree. Such a model could be adopted rapidly across the UK. The concept of the Foundation degree also achieves something else – it opens up new opportunities to encourage diversity of input at the point of entry to the programme as evidenced by the development of many innovative

access programmes currently being planned within the context of the NVQ portfolio. In response to this challenge significant partnerships are being forged across the UK with the FE sector to provide direct access to pre-qualifying health care programmes.

Take my own university at South Bank for example. We now have five access partnerships with the FE sector and three nursing cadet schemes. Together these aim to increase the home student market and provide a new local access route to our courses. Such partnership access courses/cadet schemes have been jointly planned between the NHS, the HEI and the local FE college with the result that both theoretical and practice competencies are mapped onto the access curriculum, thus permitting direct access to the mid point of the first year of the pre-qualifying nursing curriculum. In addition students receive an NVQ 3 in Care and a further NVQ 3 in Customer Care. Such schemes are set to expand to attract an inter-professional access market. These changes provide the catalyst for the development of inter-professional Foundation degrees for the health care workforce. In practice, therefore our nursing care assistants and our therapy assistants will soon be able to access a range of access courses, in-service programmes and part-time routes to achieve full professional recognition.

Finally, a further word on the important role that the new NHS Workforce Development Confederations are set to play. The confederations will enable medical schools and non-medical health/social care faculties to collaborate within the context of larger geographical areas. These changes will enable confederations to link medical and non-medical education providers with the aim of developing shared undergraduate curricula. In return for flexible inter-professional curriculum development between HEIs and partner trusts, it is likely that contracts will be extended to longer term periods of say 10 years with less emphasis on competition between universities.

In conclusion, the achievement of flexibility in workforce development will be the key challenge for us to us all. At the heart of this will be the development of competence-based curricula and inter-professional education initiatives provided within the context of a lifelong learning continuum. New collaborative approaches will be encouraged between HEI institutions, underpinned by mapping exercises designed to ensure that curricula are responsive to the needs of the workforce development agenda emerging from the NHS Plan and local health service user needs.

The Case Studies

Case Study 1: Multi-professional education for multi-professional practice

Geraldine Francis, Kingston University

The perceptions of a group of radiography students of the first term of a Common Foundation Programme involving six professional groups.

(The Case for Therapeutic Radiography Education within an Inter-professional Undergraduate Common Foundation Programme)

Introduction

The establishment in 1995 of the Faculty of Healthcare Sciences (now Health and Social Care Sciences) within Kingston University and St George's Hospital Medical School provided an ideal opportunity for inter-professional education (IPE) between a range of undergraduate health care professional students. Among other initiatives, a Common Foundation Programme (CFP) was established in 1998, designed to meet the preparatory needs of all these students. It was to offer the opportunity for each professional group to acquire certain skills, knowledge and understanding from which to develop their discipline-specific skills and competencies. The multi-disciplinary context of the programme was expected to facilitate a collaborative inter-professional atmosphere where student groups could work together and begin to understand the different dimensions of other health care profession roles.

Therapeutic Radiography was one of four undergraduate courses originally included in the programme. The importance of providing a multi-disciplinary dimension to the education of those involved in cancer services has been driven by recent developments in service strategy and delivery. In 1995, the 'Calmine Hine' report emphasized the need for seamless care and team-working in cancer care (1) and the implementation of the NHS Cancer Plan will require a service delivered by an increasingly flexible workforce with the capacity to develop new skills (2). Furthermore, the College of Radiographers recognizes that therapy radiographers may be responsible for aspects of cancer care other than the central role of the delivery of radiation (3). If multi-professional working is an integral part of being a health care practitioner, the concepts and skills should be instilled from the outset of professional development.

Students and curriculum

Approximately 300 students comprising six groups of undergraduates, namely MB and BS Medical students, and B.Sc. students of Physiotherapy, Therapeutic Radiography, Diagnostic Radiography Nursing and Bio - medical Science now take part in the CFP throughout the first term of their degree. The content of the programme centres on five key themes: structure, function, therapeutics, evidence-based practice and patient-oriented practice. Topics have immediate relevance to students in their chosen career and continued importance as the themes are developed throughout their courses. The multidisciplinary teaching team, with all professions involved in the delivery of all parts of the curriculum, reinforces the links between theory and professional practice extending the sense of identity of the students with the programme.

Within the CFP there is also the opportunity to provide some discipline specific content. Thus, while other groups focus, for example, on aspects of primary care within the patient-oriented practice theme, radiotherapy students follow a ‘cancer journey’. Screening, diagnosis, radical treatment modalities, palliative and supportive care and psychosocial issues are all explored from the perspective of a patient with breast cancer. These sessions are extremely popular with the students. They were intended to reinforce, as early as possible, a career choice in this highly specialized area of health care. Other outcomes for students have been the establishment of a distinct group identity, increased radiotherapy tutor contact and an eagerness to extend their knowledge of cancer management.

Teaching and Learning

The teaching strategy for the CFP entails learning the same knowledge alongside other disciplines (4), for example key lectures delivered to the whole group or histology practicals at the laboratory bench, when little if any interaction may occur between students. Students also learn interactively with other professionals (ibid) during anatomy demonstrations and tutorials in critical reading with small multi-disciplinary groups of twelve students. In such situations, there may be as much exchange of ideas and information between students as there is between student and teacher.

Problem Based Learning sessions extend this interactive learning and are pivotal to the aims of the CFP. Each week small multi-disciplinary groups meet to discuss one of three scenarios: issues of structure and function, mechanisms of disease, impact of illness on individuals, groups and society, public health, and professional attitudes may all be raised. These sessions provide integration of themes through exploration of the relationships between basic science, clinical practice and the social context of health care provision. They also provide integration of students during the discussion and decision-making processes, as they exchange ideas, philosophies and experience.

Evaluation

Evaluation of the programme, in the form of a longitudinal study, is in progress. It will be of importance to determine the benefit of IPE to the health service and in particular its impact on patient care. Preliminary evidence relating to educational issues is available. The range of achievement within all student groups reflects the importance of tailoring the teaching to accommodate the variation in academic entry level (from 16 to 30 A-level points). Radiotherapy students enjoy being part of a larger, inter-professional group for at least part of their education, and look forward to similar opportunities provided in other sections of their course. In years 2 and 3 Research Methods, Communication, Inter-professional Debates and Management are all subjects taught in a multi-professional forum. All students praise highly clearly relevant sections of the curriculum, for example the anatomy demonstrations. Some students have been less positive about other topics, for example critical reading. However, as they progress through the 3 years of their course, perceptions of relevance change and they frequently revise their opinions. These sessions are then often equally valued and seen as essential for their skill development when they undertake level II and III module assignments and embark upon their independent research.

Apparent, even in this first term, is that the student population is not an undifferentiated group of health care learners. They have a strong sense of professional identity, the product, perhaps, of a lengthy process of aspiration and attainment to enter their chosen field. Further refinement of the CFP will seek to fine-tune the balance between introducing a concept of inter-professional collaboration and the students' enthusiasm to 'get on with what they've come to do'.

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Case study 2: Computer mediated communication.

Gillian Jordan, University of Greenwich.

A multi-disciplinary and international approach to postgraduate continuing professional development (CPD) for health professionals.

The objective of this workshop is to demonstrate how computer conferencing is being used as a medium for continuing professional development for health professionals in a Master of Science degree delivered by the University of Greenwich.

In the context of continuing professional development today, busy professionals are increasingly looking to higher education institutions to provide flexible and high quality programmes of study that will facilitate professional updating. It was in order to meet this challenge that staff in the School of Health at the University of Greenwich developed the part-time MSc CPD (Health), now in its fifth year of delivery, specifically for a multi-professional health market. A wide range of professions is represented in the student cohorts, including medicine, physiotherapy, occupational therapy, podiatry, speech and language therapy, orthoptics, nursing, midwifery and osteopathy. The programme is international and we have students from the UK, Canada, USA, New Zealand, Malaysia, South Africa, Malta, Greece, France, Italy, Switzerland and Austria. In order to be eligible to register, students must be qualified and practising health professionals with either a first degree or evidence of recent academic study at degree level.

The programme was devised originally as a generic model, applicable to any professional group and not only to those working in the health field.

The challenge we had to meet when planning the programme was to create a flexible curriculum that would apply the principles of adult learning, be relevant to each individual's continuing professional development needs and delivered through distance learning. In addition we wanted to facilitate collaboration with peers and the development of reflective and critical thinking skills. Our chosen method was to use asynchronous computer mediated conferencing (CMC), which has been defined as "*...the use of computers, telephone lines and specialised software to facilitate interaction between students and tutors irrespective of geographical location or time zone.*" (Ryan, M. 1997) The platform selected was Lotus Notes. This has proved to be an inconspicuous tool, enabling the students to participate fully in the programme without having to be more than reasonably proficient computer users. Although Lotus Notes has fulfilled all our requirements in terms of being easy to learn to use, versatile and adaptable, and reasonable in cost, there are other platforms available, several of which could have been equally acceptable.

We consider that asynchronous computer conferencing offers participants an enhanced learning paradigm when compared with conventional paper-based distance learning and even face-to-face teaching. As our students are located in many countries throughout the world, this time and location independent medium gives twenty-four hour access to the system, something certainly not available for attending students. Time to reflect, a feature of conventional distance learning, is not always possible in face-to-face teaching

situations, but is a major element in this programme. Reflective activity involves challenging the taken-for-granted assumptions and values of practice and is a complex process of learning from experience. When collaboration, defined by Kaye (1992) as “...*individual learning as a result of group processes*”, is also a feature, reflective activities enable a learning community to develop where experiences and communal knowledge can be shared for the benefit of all. Reflective skills are further promoted as all the computer conference entries are archived and can be searched through key words or phrases. This is a very rich resource for all participants as the whole of a conference can be accessed to see how discussion topics and themes develop and links are made between and across professional boundaries.

The MSc CPD (Health) consists of five core courses delivered sequentially over the two and a half years of the programme. Originally the course team considered that the focus on collaboration would demand a cohesive student group and thus preclude options. We now have experience of students who have had to interrupt their studies and then returned to a different cohort as well as students on other Masters programmes joining courses on our programme. It is apparent that these students have all have integrated well without affecting the group processes adversely and we are now planning to introduce option courses in order to increase the total flexibility of the programme.

The first course is entitled *Collaboration and CMC*. This provides the initial framework within which the programme as a whole operates. Participants examine the nature and scope of CMC and collaboration and explore them critically within the context of professional development. Part of the summative assessment for the course involves the students forming themselves into groups in order to write a collaborative paper on an aspect of professional practice or continuing professional development. Some excellent papers have been produced but this activity has also provided the course team with an opportunity to develop and implement marking criteria that take account of the collaborative nature of the assignment. The marking criteria thus adapted result in the tutors awarding the marks for the content of each paper and giving an aggregate mark for the development process which the students then divide among themselves. This system was devised, with the support of the programme’s external examiners, in order to ensure due recognition of the amount of work each student might have contributed to the process. To date the students have always divided the marks equally among each member of the group, despite, on occasions, clear evidence that some have contributed more than others. Perhaps this is an example of a team spirit developing in this collaborative environment?

The second course, *The Reflective Practitioner*, involves the development of critical reflective skills in the context of professional practice. Reflective practice is not a skill that all health professionals acquire easily and the expertise of the course leader is essential to ensure that the students are able to meet the learning outcomes successfully. The nature of reflective practice also means that there is less collaboration in this course than in any of the others and, apart from the theoretical considerations of reflection which occurs in the conference area, much of the dialogue is conducted at an individual level through email. The assignment requires each student to present an autobiographical account, including critical analysis and synthesis, of the role and contribution of reflection to the individual’s continuing professional development.

Reflection in context, the third course, involves wide ranging exploration of the epistemology of professional practice through consideration of political, social, economic, historical and cultural perspectives. Here the advantages of having multi-professional and world-wide student cohorts ensure that these perspectives take account of the many different systems of health care in force in different countries. In the assignment the students use their reflective skills to critically analyse an area for change within their practice area, with strategies to implement the change, or if it has already been implemented, develop strategies to maintain the improvement.

A *Research Methodology* course provides students with a broad understanding of theoretical perspectives and methods of qualitative and quantitative research and statistics. They develop skills in the use of a range of techniques to analyse and interpret data from experiments and surveys and use these skills to identify and justify appropriate methods they might consider in preparation for the research project course.

The *Research Project* is the culmination of the programme and is seen as the key means through which students can demonstrate their abilities in integrating knowledge, skills and competencies. Research is essential for the health professions, not only for the well-being of patients and clients but also for the future of the professions. It is only through research that these professions can share their theories and practice and open them to inspection by the scientific community. During the process of the programme the multi-professional participants have developed skills of critical appraisal and reflection and have developed deeper understanding of the professional paradigms of others. In the individual research projects they are enabled to bring this knowledge and experience to bear whilst they investigate and report on a topic of relevance to their own professional development. At the start of the course the students have unique opportunities to work collaboratively whilst they are each identifying their proposed research topic and intended methodology.

One student commented on this process:-

“... in the unusual nature of CMC classrooms, it is fascinating to watch the evolution of students’ research ideas from first thoughts to the final version of the research project. It is unusual because, following a traditional degree pathway, students and tutors would not have intimate insight into the development of each of our research projects. In effect we are baring our souls for all to see and opening ourselves up to constructive criticism. The evolution and the shaping of our research ideas gives us, students and tutors, an extremely rich source of information: indeed this information is privileged; would students and tutors on other degree pathways have this opportunity to share such information? I doubt this very much.”

Once the topic area has been decided and the proposal accepted, the students are assigned a project supervisor with whom they then work. The final project is an individual piece of work.

So how does this process actually contribute to the professional development of the individual participants? The programme has a strong foundation in the concept of the student-as-resource and the students on the programme are all senior and experienced

practitioners. Each task set in each course conference is responded to in the light of the individual student's practice setting and professional background. The entries in the conferences therefore reflect a wide range of professional experiences and it is this experiential feature, backed by experienced and evidence-based tutorial support, that ensures that the content and context of every course will have relevance to each individual student's present and previous experience and future needs.

The next important question is, of course, how do we know that we are achieving the aims of the programme? These aims are, as for all M level programmes, to provide an intellectually demanding academic study programme that will enable graduates to advance as both autonomous professional practitioners and as professionals responsible for the guidance and motivation of others. By the end of the programme they will have developed their research and investigative skills, their reflective and critical analytic skills and, perhaps uniquely, be actively prepared for collaborative and multi-professional working. Evidence that we are achieving these aims comes from student evaluations, external examiners' reports, QAA monitoring through a recent Subject Quality Review and feedback from outside bodies with whom we have been involved in consultancy work.

One such consultant wrote:

"firstly may I say how deeply impressed I was with the programme and the way you are really getting to grips with distance learning. It is great to see such flexibility and learner-centred focus..."

One student wrote, after completing the first course:

"... I think that this programme is stunning and now take for granted the fact that I can communicate asynchronously with people in other continents and produce a paper together..."

Another said:

"...with CMC there are a lot more advantages than with other distance learning because you have the support of your peers... this is a very positive strength..."

Another commented:

" people from other professions bring in ideas that I haven't discussed with my own colleagues because we are all from the same profession – you get more from other people".

One student nearing the end of the programme wrote somewhat wistfully:

"... it is like face-to-face really but it is conversation on paper. It is very easy to get used to and when it is all over, I shall miss it".

Further evidence that the programme has a positive effect on participants is that many of them gain promotion, either during or on completion of the programme. Others move into different spheres of practice, often as a direct result of their experiences in the two reflective practice courses when the outcome of exploring their own practice in depth encourages them to make quite significant career changes.

Students and staff have also completed an evaluative study of the programme through an electronic conference in which the initial discussions highlighted the areas that should be evaluated. These included the MSc CPD (Health) as a distance learning experience for both learners and tutors, the influence of the multi-disciplinary and collaborative aspects and the effectiveness of Lotus Notes as a curriculum support tool. A content analysis of these discussions directed the selection of questions for a questionnaire that was distributed and returned electronically and anonymously. An interview schedule emerged from further content analysis of the data received from the completed questionnaires and interviews were subsequently conducted by both students and tutors through email, telephone or face-to-face. An independent researcher then used all the data that had been collected to write an evaluation report. (University of Greenwich Centre for Learning and Teaching 2000)

Some interesting findings have emerged from this evaluation some of which have already resulted in changes being made to the programme and its assessments. Other findings have highlighted areas that merit further evaluation and research. Of particular interest is the students' very high expectations of tutors and the demands they make on them. This has clear implications for the number of hours that tutors on computer-mediated courses are given to fulfil their tutoring role adequately. One fascinating finding was that, although the majority of students considered that they had benefited from the collaborative environment, a minority felt frustrated by the requirements for collaboration. A few students were unwilling to share professional knowledge and some respondents considered that the expectations for collaboration could, at times, infringe on autonomy and an individual pace of working. However the majority of participants felt that the on-line collaborative process had resulted in increased self-esteem and self-confidence, greater knowledge and an increased enthusiasm for collaboration in their own workplace.

A relevant finding of the evaluative study was that many of the participants would not have been able to undertake M level study without this medium. On the other hand there are inevitably potential students who, whether because of cost or lack of relevant IT skills, can not participate in this programme precisely because of the delivery medium. However two students with visual impairment are able to access the programme effectively using screen magnification software and this delivery method would make access possible for students with a range of other impairments.

There was consensus of opinion that enhanced reflective and critical skills impact positively on professional practice and that computer-mediated conferencing provides an effective way for working professionals to fulfil their requirements for professional development.

There are many other issues that any programme teams considering exploiting the advantages of using information and communication technologies (ICTs) should consider. These include the importance of staff development for tutors who will be tutoring on ICT-delivered courses, the changed working practices that result from using these delivery methods and the benefits that opportunities for team-working bring. A major challenge for a programme exploiting information and communication technology must be to ensure that adequate provision is made for ongoing technical support so that there are no technical glitches which affect students' and staff's abilities to connect to the system regularly.

In this brief summary the implications of using CMC as a tool for continuing professional development have, inevitably, only been addressed at a superficial level. However any readers interested in exploring the topic in more detail are invited to contact me and I will be delighted to discuss things with them.

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Case Study 3: Multi-professional education - three years on Sally Feaver, Oxford Brookes University

The experiences of initiating and delivering a combined teaching programme within nursing, midwifery, physiotherapy and occupational therapy pre-registration programmes.

Abstract

A group of academics in the school of health care¹ made a successful bid for internal money ring-fenced specifically to support pedagogic research. The money was used to complete the first stage of a project to identify meaningful indicators for evaluating the new multi-professional programme at Oxford Brookes University.

The review of literature looking at methods of evaluation indicated that a 'responsive' method (Stecher and Davis 1987) was needed that was user focused and process driven rather than content driven. Informed by this, the research methodology was identified; focus groups were used to establish themes related to outcomes of multi-professional education and the themes were used as a basis for a survey of a sample of stakeholders. Stakeholders were given the opportunity to rate the themes in order of importance and levels of agreement were ascertained. The outcome of the research showed wide-ranging support for multi-professional education and some key indicators for evaluation.

Outline

Aims of research: *to identify a set of baseline perspectives regarding outcomes of the school of health care multi - professional programme, from a range of stakeholders.*

Methodology: *using focus groups to establish themes, engaging stakeholders in the process of ranking themes in order of importance and using descriptive statistics to determine the levels of agreement between stakeholders.*

Background

Who are stakeholders?

Establishing who the stakeholders are in NHS education provision is complex. They include students, clients, users, carers, employers, as represented by commissioning consortia, and professional bodies. Balancing the expectations from such a diverse group is problematic and the results of the survey showed although there was agreement about most of the expectations, there were also clear differences in expectations of the multi-professional programme.

Why multi-professional?

Multi-professional education (MPE) for health professions is an activity prioritised by the World Health Organisation in order to reach the goal '*Health for All by the Year*

¹School of Health Care, Oxford Brookes University.
Multi-professional school with nursing, midwifery,
occupational therapy and physiotherapy

2000' (WHO, 1988). Latterly, the need for aspiring health care professionals to learn and work together towards the achievement of common aims has been emphasised by a number of sources e.g. Secretary of State for Health (1996) and (1997); Standing Medical and Nursing & Midwifery Advisory Committees (1996).

The White Paper "A Service With Ambitions" (Secretary of State for Health, 1996) identified five strategic objectives. Among them was a clear objective for professional consultation that would seek to consider how best to encourage multi-professional and effective team-working. In addition to this, a report by the Standing Medical and Nursing & Midwifery Advisory Committees (1996) points to the difficulties caused by fragmentation of services resulting from competition between providers, new administrative systems and short-termism in planning. They conclude that professionals need to work collaboratively and that further work on clinical audit is essential in order to improve the outcomes of multidisciplinary practice.

The Government White Paper "*The New NHS: Modern, Dependable*" (Secretary of State for Health, 1997) echoes these views in presenting a set of ideals based on the notion of 'Clinical Governance'. The need for partnerships at all levels in the NHS is encouraged if quality assurance programmes are to be implemented.

The NHS Plan 2000 set out a clear vision for a health service designed around the patient with a focus on the 'right care, in the right place by the right people'. Embedded in the implementation programme, is the commitment to modernising education of NHS staff and implement skill mix changes. Work is currently in hand looking at a common foundation programme for all health care professionals.

What is multi-professional education?

Multi-professional education is not simply about the knowledge base which the various professions have in common: it is education which is to do with the relatedness of professional groups. "*MPE is a process by which health professionals learn together and about each other during certain periods of their training in order to then be better able to interact and work together to provide co-ordinated care towards commonly agreed goals.*" (Davidson and Lucas, 1995).

Gregson et al (1991) state that since the inception of the National Health Service (NHS) it has become generally accepted that the future development and efficient operation of the NHS would depend increasingly on co-operation between the various health professions and occupational groups.

Connor and Rees (1997) emphasise the need for a clear understanding of one's own and others' roles if the benefits of collaboration for the enhancement of care are to be appreciated while Bennett (1988) provides an example, in the context of neurorehabilitation, of how this can be achieved through action research. Braye and Preston-Shoot (2000) argue that collaboration and teamwork involves working creatively across difference and a willingness to cede power to others, not just to share control. A genuine commitment to empower others will unlock benefits for workers, users and carers alike.

The agreed philosophy of multi-professional education, within the school of health care: *to enhance understanding across professional boundaries and foster collaborative attitudes in professional practice.*

The multi-professional programme

The approach to learning and teaching adopted by the School of Health Care has enabled multi-disciplinary and multi-professional learning to take place, whilst simultaneously underlining the distinctive and special features of specific health care professions. This method aims to produce a better understanding of professional boundaries and roles, whilst giving the health care professional time to examine the benefits of multi-professional working in practice.

The new programme introduces a ‘multi-professional spine’ into all pre-qualifying programmes, including nursing (adult, children’s, learning disability, mental health), midwifery, occupational therapy, and physiotherapy. The aim is to inform and engage students in the possibilities and the limitations of multi-professional working from the very beginning of their professional training. The overall aim is the prevention of the need for relearning, or undoing, socialisation processes that have been problematic in the past, for example, in producing practitioners who are only functional within their own discipline (Hilton, 1995).

The multi-professional spine is a collection of 11 modules², delivered throughout the three years. The content includes, *research, professional skills, sociology, psychology, health care management and issues about the transition from student to practitioner.* It equates to approximately one third of the taught content for each of the pre-registration programmes. Lectures are given to the full cohort, with students divided into groups for seminars. The teaching team is led by a co-ordinator responsible for the multi-professional developments in the school. The cohort size is approximately 300 students made up of 90 occupational therapists 90 adult nurses, and the rest from physiotherapy, children, mental health and learning disability nursing.

Evaluation: how do we know it's working?

An extensive literature review was completed in order to identify the current body of knowledge about evaluation. The research identified the most effective stance as been ‘a responsive approach’ outlined by Stecher and Davis (1987). This approach is user-oriented, designed to have an impact at local level through an active, reactive and adaptive stance towards programme planning and evaluation. Informed by this, the team instigated the research identified in this paper, in order to establish some indicators for evaluation.

Results and Conclusion

Themes

Several themes emerged from the focus group in relation to expected differences in outcome from a multi-profession programme as opposed to uni-professional one.

² Equates to 150 student effort hours

Themes included *experience of patients /user/carer, use of resources, effects on service delivery, understanding of roles across professions, effects on team-working and attitudes.*

In summary, within the limitations of the research design, the findings from the study indicate substantial support for the idea of multi-professional programmes from all the stakeholder groups provided the main expectations can be demonstrated as outcomes. These expectations include:

- *observable differences in patients'/clients'/carers' care, particularly in terms of a change of focus and culture towards meeting their needs;*
- *a concentration of learning on how to work in teams and accepting members of user groups into teams;*
- *improvements in communications across professional boundaries; learning how to be open to ideas from professionals other than ones' own;*
- *shared decision-making;*
- *the establishment of shared visions and goals of care;*
- *a willingness to cede power with all members of team;.*
- *establishing clear and explicit goals of care across professional groups, including negotiations with patients'/clients'/carers' themselves.*

It could be argued that two aspects of care emerge as particularly important to all stakeholders from these findings. One is that relationships between professionals and those in their care supersede any other considerations. The other is that inclusion of service recipients in decision-making and the establishment of goals (and outcomes) of care are of paramount importance. While these observations could be made of any professional education programme, the significance for MPE is even more relevant given the aims of different professional groups to work together to co-ordinate patients'/clients'/carers' care.

Personal Reflections

Multi-professional education is neither cheap nor easy! With the value of hindsight, there needed to be attention paid to the considerable resource implications of a large student cohort and the need for staff development in relation to the delivery. The professional identities of the students needed to be developed, as it is clear that retention of uni-professional identity is seen as beneficial, provided it supports the need for team working and working across professional boundaries.

Evaluation is a problem; there is no foolproof process evaluation and no clear indication of when is the best time to evaluate. In order to gain clearer insight into the effect of MPE, longitudinal studies of the professional socialisation process are needed and this process needs to be maintained out in clinical field.

It is also clear that educational time given to the MPE impacted on the ability to meet the profession specific learning outcomes. Accordingly, the ratio of MPE to profession

specific content may require further attention as it is becoming clear that, in the drive to find a common core curriculum for all professions, the generic content is less than was originally perceived.

‘Difficult subjects’ need addressing. These include the difference in education attainment of students for each profession, brought into sharp focus by the profession specific cohort analysis of results of the shared modules. This may become more evident when medicine is brought into the multi-professional arena.

In spite of all the resultant problems, there is no going back. Embedded in Government policy on health care education is the need for MPE, with the medical profession being brought into the NMET levy arrangements, and work underway for a common foundation programme, health professional education will no longer be a ‘silo’ culture.

To quote from one of our students;

“ in a hospital environment and in treating a patient you have to rely on the expertise of a lot of different professional people – not just one person so you are not working in isolation. You work in a team – learning what the roles are of everyone else in that team rather than going in and doing you own thing. For the patient to get their proper treatment, that is the best they can get, they need something from everyone”.

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Discussion

Discussion

Discussion of the seminar themes and case studies took place in three groups each facilitated by one of the presenters. The three groups had a single set of questions as a focus.

The questions:

1. Inter-professional learning - does the practice reflect the philosophy?
2. What are the barriers to the blurring of the health care boundaries:
working practices;
professional bodies;
legislation;
finance?
3. Is a one-year inter-professional foundation programme feasible?
4. How far can inter-professional education be taken - pre-qualification and post-qualification? (This question was not directly addressed by the discussion groups however the issues were raised and the responses incorporated in the report.)

The three groups approached the questions from different directions however the discussion raised a number of common issues, themes and concerns.

Inter-professional learning - does the practice reflect the philosophy?

What is the philosophy of inter-professional learning? Is there a contradiction in locating the inter-professional foundation at the start of pre-qualification studies when students are unclear about their own prospective professional role.

There is no one practice but many different practices reflecting the differing origins of programmes and the aims and aspirations of the programme designers.

The philosophy of inter-professional learning focuses on the care of the patient/client rather than the separate expertise of each of the professionals. It is the identification of a common, shared set of competencies and an understanding of what is different as well as what is common. The patient's/client's needs are paramount and the interventions of the professionals are guided by what is needed for the patient/client rather than what can be provided by the professional. A simple yet profound change of emphasis.

It is important to emphasise what it is not. It is not the development of a hybrid health care worker, the search for the lowest common denominator, the proletarianisation of the health care workforce. All these concerns were expressed. Inter-professionalism is knowing what is unique to each profession, what is common, and importantly, understanding differences and being able to discuss, as equals, the variety of contributions to each care situation.

The aim is to establish an inter-professional identity alongside the professional identity so that all practitioners will, in time, share an integrative ethos.

An educational approach that reflects the philosophy of inter-professional practice and is applicable to the Common Foundation Programme would be problem-based learning. Here a single case, based on a real care situation, is researched by a group made up of different 'professions' where the emphasis is on the core requirements to meet the needs of the patient/client.

What are the barriers to the blurring of the health care boundaries:

- **working practices;**
- **professional bodies;**
- **legislation;**
- **finance?**

A barrier that was explored was that of professional identity both real and imagined. Students entering the Common Foundation Programme bring with them stereotypical perceptions of the profession with which they identify. These stereotypes are maintained by the media and are very persistent. Students expect to concentrate on preparation for their chosen profession and often seek profession-specific placements with opportunities to be involved in 'acute' care. There is evidence that students have a low regard for inter-professional activities which they see as diversions from their real professional preparation. The students are often reluctant to take placements where generic care is the norm such as health centres that are, in fact, ideal for experiencing inter-professional practice.

There is a degree of 'tribalism' among health care professionals that students are likely to encounter on placements. All professional groups are socialised and inducted into their specialist knowledge and to differing degrees protective of their specialist role for the very best, and sometimes the worst, of reasons. It can be argued that the more secure a person or group's professional identity the more willing to share what is common with other professions.

There are, however, real differences of working practices, skills and knowledge and the differences must be acknowledged as well as the similarities.

The traditional power relations between professions in health care must also be recognised and these will influence inter-professional practices.

There is a growing recognition that inter-professional practice is desirable as well as efficient and is part of a general trend towards a patient/client's rights and expectations being seen as paramount.

A real question that should be asked is "*Are all the different professionals involved in the assessment and care of a patient/client absolutely necessary or would a focus on the identification of the 'real' needs reduce the role of some existing professional groups?*" The question is interesting; the answer was not forthcoming.

The existence of separate professional bodies with differing status, and consequently power, is a barrier to inter-professional practice. The professional bodies are beginning to promote inter-professional practice but the statutory bodies that regulate the professions under Acts of Parliament, are a real impediment. Some statutory regulations effectively preclude the inter-professional approach that Ministers want and legislative change will be a pre-requisite of change of practice.

There have also been situations where professional bodies have worked together to identify common elements of practice yet ultimately the enterprise has failed because of statutory regulation.

It is important to remember that without state-registration everything a nurse or PAM could do in a hospital requires the supervision of a medical doctor.

Finance is critical. An important part of the Government's agenda is to increase the number of nurses and other areas of personnel shortage without additional cost. Inter-professional practice is seen as more efficient and therefore the source of cost-reduction. An inherent contradiction is that inter-professional education, done well, implies problem-based learning and other innovatory approaches and these are expensive. However the income that accrues to a university from the trusts is such that whatever the requirements of the trusts they will be met by the institutions at the agreed price.

Ultimately what the funding bodies want will have to be provided.

The differential reward structure of the professions is also a barrier to true inter-professional practice.

3. Is a one-year inter-professional programme feasible?

The assumption, and the practice, of the pilot programmes is that the inter-professional year is the first year - a common foundation programme shared by all those entering the health service, prior to registration. The real issue is whether or not it is really possible in the first year to establish a professional identity that is secure enough to enable the students to 'step outside' and share and value the identity of others. It may be that the first year of training when stereotypes are so strong is not the right time to attempt this.

Some Common Foundation Programmes focus on other practitioners' roles to such a degree that a strong sense of "what I'm not and what I don't do" emerges that increases the stereotypical sense of identity.

A year may be too long? Perhaps it would be preferable to have an orientation **term** genuinely shared by all intending professionals in health and social care. That way the necessary professional socialisation will not be too long delayed and as it develops it will do so through a deep inter-professional awareness.

A more appropriate model may be a long thin inter-professional programme alongside the professional training so that the students are continually required to consider inter-profession perspectives.

A genuine common foundation programme that really developed the generic skills and understandings would be possible if there was common entrance to all the professions in health and social care. This would be particularly beneficial if students were able to make the choice of their specialism towards the end of the common programme. Differential access, the commissioning process, the dramatic differences in demand for places in the separate professions and the very different professional identities, particularly of the medical profession, prohibits this approach.

If this, or some variation, were possible it might offset the huge waste of resources that is the consequence of the very high drop-out from the nursing diploma courses at the end of the first year. As there is no alternative route for them to remain in the health service they are a total loss to the service. The transferability inherent in true inter-professional education would reduce this loss significantly.

There are enormous benefits from inter-professional learning which can and do influence practice. The core question to pose is "*What do you need to know about how you work with people who have different skills to yours?*" With enquiry based learning such a multi-dimensional perspective becomes possible. It requires tutors who are secure enough in their own professional identity to enter the professional experience of their colleagues and identify the common and shared as well as what is what is different yet still valuing their own professional identity.

A particular challenge is the current nature of the practice setting and yet is here that there exists a great opportunity for educational practice to begin to change clinical practice in a positive direction.

The prospects are challenging and exciting!

Summary of the discussion in the three groups by Mike Downes, SEEC Development Officer.

Thanks are due to the facilitators: Sally Feaver, Geraldine Francis and Gillian Jordan

Appendices

Appendix I

SEEC Southern England Consortium for Credit Accumulation and Transfer

Staff Development Seminar

Changing Professions: Inter-professional collaboration in health care education

The Seminar Programme

9.30 Registration and Coffee

9.55 Welcome, Mike Downes, SEEC Development Officer

10.00 Changes and Challenges in the Provision of Health Care Education,
Professor David Sines, South Bank University.

10.45 Case Study 1: Multi-professional education for multi-professional practice.
Perceptions of a group of radiography students to the first term of a Common Foundation Programme involving six professional groups. Geraldine Francis, Kingston University.

11.15 Coffee

11.30 Case study 2: Computer mediated communication. A multi-disciplinary and international approach to postgraduate continuing professional development (CPD) for health professionals. Gillian Jordan, University of Greenwich.

12.00 Case Study 3: Multi-professional education - three years on. The experiences of initiating and delivering a combined teaching programme within nursing, midwifery, physiotherapy and occupational therapy pre-registration programmes. Sally Feaver, Oxford Brookes University

12.30 Lunch

1.30 Discussion groups. Each group facilitated by one of the case study presenters

3.00 Coffee

3.15 Panel of the presenters

4.00 Close

Appendix 2 - Delegates

| | | | |
|-----------|------------|------------------|--|
| Mr | Anthony | Bone | University of East London |
| Mrs | Theresa | Britt | The Open University |
| Dr | Shelagh | Brooke | University of Huddersfield |
| Dr | Peter | Burley | Council for Professions Supplementary to Medicine |
| Mrs | Anna | Clampin | Canterbury Christ Church University College |
| Miss | Jean | Clayton | Thames Valley University |
| Ms | Jayne | Crow | Anglia Polytechnic University |
| Mr | Peter | Dennis | University of Sussex |
| Mr | Charles | Duguid | Anglia Polytechnic University |
| Mrs | Christine | English | Hull University |
| Mr | John | Eversley | Queen Mary & Westfield, University of London |
| Professor | Gavin | Fairbairn | University of Glamorgan |
| Ms | Wendy | Farrow | University of Luton |
| Mrs | Mary | Hall | Hull University |
| Mrs | Moira | Helm | Canterbury Christ Church University College |
| Dr | Linda | Hutchinson | Kingston University & St George's Hospital Medical School |
| Mr | Andrew | Ironside | Salomons Centre Ltd |
| Ms | Jan | Jensen | Canterbury Christ Church University College |
| Dr | Sylvie | Marshall-Lucette | Kingston University & St George's Hospital Medical School |
| Dr | Peter | Martin | University of Essex |
| Mrs | Diane | Morgan | Kingston University & St George's Hospital Medical School |
| Ms | Peggy | Nettleton | Edge Hill College |
| Ms | Jacqui | Potter | University of East London |
| Mrs | Marian | Redding | Anglia Polytechnic University |
| Dr | Frances | Reynolds | Brunel University |
| Mrs | Terry Jane | Scott | Canterbury Christ Church University College |
| Ms | Jo | Skinner | University of North London |
| Ms | Susan | Smith | Leeds Metropolitan University |
| Dr | Sue | Tatum | DARE Foundation |
| Mrs | Hazel | Taylor | Anglia Polytechnic University |
| Mrs | Belinda | Watts | Anglia Polytechnic University |
| Dr | Colin | Whittington | Independent Consultant |

Appendix 3

The SEEC Networks

SEEC provides opportunities through its networks for individuals working on credit-based developments in member institutions to meet on a regular basis to discuss issues of policy and practice, to increase their knowledge in the field, and to feed this back into their own institutions. New networks are created in response to members' needs. SEEC enables its networks to develop proposals to bid for projects or funding for work of specific interest to network members, to publish occasional papers, and to hold seminars or conferences under the aegis of the Consortium.

The Health and Social Care Professions Network

The Health and Social Care Professions Network provides a forum for discussion of education and training issues for colleagues within the Health and Social Care sector.

The aims of the network are to:

- share ideas and develop and promote good practice in the award of credit-based learning;
- provide an opportunity for members actively involved in the design and delivery of credit-based education and training to discuss and develop issues of practice;
- create a mutually supportive and informal environment for members to network with each other for their personal development;
- disseminate information on educational developments within member institutions and inform externally as appropriate;
- create a stimulating environment by inviting external speakers and ensuing discussion on local and nationally related developments.

SEEC also currently supports and facilitates the AP(E)L Network and the Key Skills Network

Appendix 4

SEEC PUBLICATIONS

The following SEEC publications are available from the SEEC Office. The address is on Page 54.

| | |
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| Crediting Key Skills | Report of the Proceedings of the SEEC National Conference 4-5 September 2000 Edited by: Dianah Ellis ISBN 0 9522219 3 4 First edition 2001 Cost: £9.95 inc. p&p (SEEC member) £11.95 inc. p&p (non SEEC member) £19.95 inc. p&p (institutional purchases) |
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