PERSPECTIVES ON SHARED LEARNING

by
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A CAIPE publication

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FOREWORD

By Dr John Horder, CBE.

Chairman

CAIPE – The UK Centre for the Advancement
of Interprofessional Education

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 and funded by the Nuffield Provincial Hospitals Trust.

Professor Barr's varied past experience and contacts have enabled him to find and interview a wide range of people with special knowledge of shared learning in all parts of the United Kingdom. With their assistance the report identifies trends in health, social care and education which have prompted and shaped recent initiatives in shared learning. These initiatives are then described, priorities for promotion and development floated and a strategy outlined for future action.

Although almost all those interviewed had in common a belief in the value of shared learning, the aspects which they wanted to discuss and the opinions which they expressed created a daunting challenge for anyone attempting to derive a well organised synthesis. Professor Barr has brought their contributions together in seven chapters which offer the most up to date, clear and readable descriptive review at present available on a subject the relevance of which to most of the current changes in health and social care is increasingly recognised.

July 1994

THE REVIEW

The aims of the Review were:

a) to identify and describe trends in shared learning throughout the United Kingdom (UK);

b) to map the incidence, location, objectives, form and use of shared learning in two geographical areas;

c) to develop tools for future surveys of shared learning.

The research was in three parts:

1 interviews with key people to identify trends and issues affecting shared learning, which are reported in this monograph;

2 a survey of shared learning in two English shire counties, which will be the subject of a second monograph by Dr Ian Shaw;

3 a review of the UK literature on shared learning over the past five years, on which work is continuing with a view to a third monograph by Professor Barr and Dr Shaw.

The term 'shared learning' was used to cover all opportunities where two or more professions within and across health and social care studied together, whatever the purpose, form, content and setting. The intention was to avoid being drawn prematurely into debates about the bewildering choice of terms employed until data were available with which to devise a more purposeful classification. Ways in which others have used terms such as 'interprofessional education', 'multidisciplinary studies' and 'joint training' will be discussed in the literature review.

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.

Dr Pat Owens, then Director of CAIPE, shared in thinking during the formative stages of the Review, while Lonica Vanclay, CAIPE's current Director, advised upon the editing of the text and organised publication.

Colleagues at the University of Nottingham have been most supportive, notably Dr Ian Shaw as my co-worker and Professors Robert Dingwall and Olive Stevenson who have offered constructive criticisms of this paper in draft.

Friends and colleagues in interprofessional networks associated with CAIPE, the Marylebone Centre Trust, the University of Nottingham and elsewhere have done much to shape my thinking and I have drawn on this unhesitatingly.

Above all, I am indebted to the 'contributors' who so generously provided the material upon which this paper is based and from whom I was privileged to learn so much.

Hugh Barr

July 1994

SUMMARY

The views of some 50 'contributors' were enlisted in helping to understand 'the state of the art' in shared learning. The contributors drew attention to different circumstances which had prompted shared learning. They described its rationale, its purpose and its form, and identified issues demanding attention.

There was no consensus. Arguments for shared learning differed markedly. For some contributors it effected economies of scale in large classes with common curricula. For others it created a more adaptable workforce. For yet others it furthered collaboration in practice as a step toward more rounded care and treatment.

Agendas competed. Large groups in modular systems might be economical, but they did nothing to enable professions to learn from and about each other. Common curricula, albeit helpful in introducing common concepts and language between professions, could inadvertently detract from learning about differences in professional roles and responsibilities upon which effective collaborative practice relied. Most seriously, covert use of shared learning to redraw boundaries and relocate responsibilities between professions, invited resistance from students and teachers alike.

Contrary to conventional wisdom, shared learning was gaining ground in qualifying courses, but with difficulty. Modularisation, competency-based education and open learning were accelerating that trend and perhaps ironing out problems. Shared learning in continuing professional development was becoming increasingly widespread and seemed less problematic.

Setting sights firmly upon the goal of collaborative practice, suggestions follow to promote and develop shared learning within a concerted strategy between key organisations.

INTRODUCTION

This paper reports on interviews with some 50 'contributors' at the leading edge of developments in and relevant to shared learning. (See list appended.) Contributors included policy makers, managers, practitioners, researchers, teachers and trainers, in health, police and local authorities, colleges and universities, professional associations, development centres and government departments. While preference was given to people not previously known to the interviewer, he also felt free to call upon what he had learned from his ever widening circle of friends and colleagues in interprofessional networks.

Contributors invariably suggested other people well placed to help. Sadly, only a few of these could be added within the time available. Even so, the original estimate of 30 interviews was exceeded.

Fifty or so people, however carefully chosen, cannot represent the diversity of developments in shared learning, but they can contribute a series of informed impressions. These can then be tested by readers against their experience and as a prelude to more representative enquiry.

All four countries of the UK were covered. Particular importance was attached to including Northern Ireland. Its Health and Social Services Boards provided a unique opportunity to learn about shared learning within a unitary structure, while its intention to include both health and social services within Community Trusts was attracting much interest at the time.

Contributors' anonymity has been preserved except where reference is made to a project or publication for which one of them was responsible. Other references are limited to those which reinforce or amplify points made by contributors which bear directly upon the themes explored. Readers are referred to the literature review for more thorough coverage (Barr and Shaw, forthcoming).

THE INTERVIEWS

Letters requesting interviews sought help in reviewing 'the state of the art' in shared learning. 'Markers' for possible discussion included:

- circumstance which had prompted shared learning;
- professions covered;
- rationale, duration and form;
- changes affecting shared learning;
- funding;
- roles of validating bodies;
- student assessment;
- awards and credits;
- programme evaluation;
- preparation and support for tutors and supervisors;
- European and international links.

Later, letters tended to be more focused on filling gaps and tapping particular expertise.

Interviews were typically conducted on contributors' home ground. They ranged in length from three quarters of an hour to five hours. Each contributor was invited to select those fields and aspects of shared learning where she or he felt best able to help. In consequence, some topics were dealt with more thoroughly than others.

Each interview took the form of a dialogue in which the interviewer felt free to engage in discussion about issues raised by the contributor, to make connections from one interview to another, and to test his understanding of the emerging picture. All interviews were recorded and transcribed. This paper is an analysis of the salient themes.

THE FIELDS

There are many fields in which shared learning is developing. The following were covered during the interviews, albeit lightly.

Primary Health Care

Developments in prevention and treatment have led to the appointment of nurses, practice managers, social workers and others as fellow team members with general practitioners.

Public Health

Joint education and training have been introduced for environmental health officers, health educationalists, health service managers, nurses, psychologists, public health physicians, social workers and others as part of a move away from an exclusively medical approach towards a more broadly based professionalism.

Health Education

College-based courses have been promoted to prepare health educationalists drawn from various professions. Rolling programmes of workshops have also been mounted to alert practitioners from a range of professions to their roles and responsibilities in health education and promotion.

Mental Health

Moves from hospital to community-based care have led to the formation of Community Mental Health Teams which has required team development. Specialist courses are open to a number of professions.

Learning Disability

Moves from hospital to community-based care favoured a social not medical model. Territorial disputes between nursing and social care resulted. Shared learning was invoked in an attempt to resolve these and to establish bases for collaboration.

Child Protection

Successive enquiries have attributed tragedies to failures in communication and trust between professions. Advisory Committees for Child Protection (ACPCs) were charged with responsibility for promoting training to improve collaboration.

Community Care

Implementation of new policies called for joint planning and collaborative practice between health and social services. This carried implications for the respective roles of each profession, for the creation of new roles, and for the redefinition of working relationships within a mixed economy of welfare.

Interviews were also included in the fields of dementia, homelessness and HIV where shared learning was thought to be taking hold and lessons might be learned with wider application.

Other fields were introduced by contributors as the interviews progressed. Shared learning, it seemed, knew no boundaries. Each field spread into others, bringing in additional professions who, in turn, drew attention to yet more related fields, spilling over still further from health and social care into education, law enforcement and beyond. This made it hard to contain the review within manageable limits. In the event, the outer boundary was drawn around the sum total of the examples which contributors introduced, the only test applied being that at least one health or social care profession was included.

The above fields have never been discrete and are becoming less so. Space between them is collapsing and boundaries are being blurred, principally as a result of two recent policy developments. First, growing emphasis upon health promotion and education (in response to The Health of the Nation, 1992) brings public health, health education and primary health care even closer together. Second, policies for community care incorporate and up-date earlier developments in care in the community, notably in the fields of mental health and learning disability, while also encompassing other client groups, including people who are frail and elderly, chronically sick or have physical and sensory disabilities. Operational relations between primary health care and community care become more important and the distinction between them becomes more difficult to sustain. Only child protection remains conspicuously separate with its own legislative base.

While introducing illustrations from a number of these fields, this report generalises about shared learning across them in a way which recent trends encourage.

SEVEN THEMES

The fund of material provided by contributors is organised around seven themes, each comprising a separate chapter. The first teases out reasons for introducing shared learning from educational, political and practice perspectives. The second identifies recent trends in health and social care which have prompted shared learning and influenced its development, including inquiries which have criticised professions for failures in collaboration. The third identifies trends in higher and vocational education. The fourth rehearses arguments for and against shared learning during qualifying courses and gives examples of pilot projects. The fifth moves on to 'shared continuing development' (SCD), a term introduced to cover diverse examples introduced by contributors. The sixth points up priorities for the promotion of shared learning and ways in which it can be developed to further collaborative practice. The last calls for concerted action between interested organisations to devise and implement a strategy to promote and develop shared learning throughout health and social care.

1 COMPETING AGENDAS

The classic argument for shared learning rests on the belief that it encourages interprofessional collaboration which, in turn, provides better integrated care and treatment. It soon became clear that that was by no means the only argument. For some contributors it was just one among many.

This brief opening chapter points up markedly different 'agendas' for shared learning which carry markedly different implications for its aims, form, content and methods. It looks at each on its merits through the eyes of its proponents.

These agendas were responses to: pressures on colleges and teachers, pressures on education and practice from policy makers and service managers, and the concerns of practising professionals themselves. Some bow to the inevitable. Others take advantage of quite exceptional opportunities into which teachers and trainers have injected imagination, creativity and energy.

1 Effecting Economies of Scale

In a cost-conscious climate, courses of all kinds were reportedly being monitored closely to ensure that numbers were viable and resources put to optimum use. In colleges small courses seemed to be increasingly vulnerable. Basic qualifying courses for the smaller professions were at risk as were post-qualifying courses where take-up was problematic. Similarly, conferences, short courses, seminars and workshops (mounted by colleges, specialist institutions, voluntary organisations and commercial training agencies) were subject to increasing competition in a shrinking market as training budgets were cut and preference was given to in-house training. All had to generate income in a market economy with few subsidies and diminishing scope for concealing true costs.

The solution, as contributors demonstrated, lay in designing more broadly based courses to cater for more diverse student groups. Advantage was being taken in many colleges of modular and credit accumulation and transfer systems to meet the needs of a number of professions within the same qualifying and post qualifying courses. Similarly, conferences, short courses, seminars and workshops were being thrown open to applicants from a wide range of professions and none.

The capital outlay necessary to produce open learning materials of good quality made these arguments even more compelling. Except for the largest professions such as nursing, production and marketing of open learning courses was only viable by catering for students from a number of professions and, again, often none.

So economic strictures were leading to larger courses and greater emphasis upon common learning needs across the professions.

2 Augmenting Knowledge and Skill

Changes in the organisation and delivery of services meant that practitioners had to be constantly up-dating their knowledge and skills if they were to keep abreast of developments. Few of those changes were perceived to be peculiar to any one profession. Most could, it was argued, be addressed by producing information packs, learning materials and courses to be used by a range of professions. This was seen to apply to up-dating about new health and social problems, the implications of new legislation and policy, and new organisational structures. Training officers and teachers tended to start from the assumption that needs were common until shown to be otherwise and that learning should therefore be shared.

At its most basic, shared learning was a convenient way to raise awareness of developments, such as the implementation of community care plans, affecting a number of professions. One programme could be widely used in the knowledge that all workers were hearing much the same message, while including spokespersons from different organisations demonstrated solidarity, sometimes quite literally on a common platform.

Such awareness raising was, it transpired, sometimes a step towards shared exploration of implications for each profession and organisation. This could test where power and responsibilities were likely to shift, where boundaries between organisations and professions were being redrawn, where give and take would be necessary and, thus, where collaboration was needed. Differences in organisational function and professional role could be explored within a common framework.

However, arguments for shared learning went beyond up-dating. Contributors also made the case for courses designed to make good deficits in basic professional education. Diploma and masters programmes had, for example, been introduced to strengthen social science foundations and introduce research skills for nurses, professions allied to medicine and others. These programmes aimed not only to further career progression but also to equip their graduates to hold their own more effectively with other professions who had enjoyed earlier educational advantages. Some contributors saw establishing parity of scholarship and scientific method as fundamental to mutual respect and mature collaboration in practice.

Similarly, shared learning was commended as a means to enable practitioners from a number of professions to acquire new methods and skills. Sometimes this was to augment their skills as practitioners, for example, in counselling. At other times, it was to enhance their competence in handling additional responsibilities, for example, in managing devolved budgets, in practice teaching or in practice-based research. Such up-dating could be advantageous for those practitioners wishing to move into management, teaching or research, whatever their practice profession.

3 Deconstructing and Reconstructing the Professions

Interviews revealed that more radical moves were also afoot. Some contributors saw shared learning as the means to redraw the professional map. It could make it easier to transfer roles and responsibilities from one profession to another, and for practitioners

to move from one profession to another. A few went further. They were frustrated not (they insisted) by professionalism itself, but by the demarcations, protectionism and vested interests of so many separate health professions. They argued for fewer such professions, seeing shared qualifying courses as a means to that end. Amalgamations were said to be needed, with the professions allied to medicine candidates for early attention. Service managers were said to favour this as part of their wider strategies to create a more flexible workforce.

Other contributors saw shared learning as the means to edge towards the creation of new professions, typically around commitment to client groups, such as children under seven and people with learning disabilities, whose interests were deemed to have been ill-served by existing professions.

4 Promoting Collaboration

The classic argument for shared learning was, however, alive and well. Many contributors did see shared learning as a means to break down barriers between professions and between organisations, to dispose of stereotypes, to generate trust, to improve communications, to understand respective roles and responsibilities, and to be more alive to the opportunities which others enjoyed, as well as the constraints under which they laboured. Far from diminishing, the need to effect collaboration by means of shared learning had increased. First, such learning helped in implementing new policies. Second, it was a response to sustained criticism by inspections, enquiries and the media, where failures of trust and communication had resulted in tragedies, notably in cases of child abuse.

5 Competing Agendas

The issue was becoming painfully clear. Were these markedly different agendas compatible? Most importantly, could they be accommodated within the same shared learning courses?

Some teachers were sceptical about how much learning, or even socialising, occurred between the different professional groups when they were combined in large classes within modular systems. Without interaction, they found it hard to see how better collaboration in practice could result.

More positively, sharing the same broadly based courses was seen to introduce commonalities of language and concept, and to lead to more consistent educational standards. At the very least, these paved the way for collaboration.

It was, however, the use of shared learning to engineer changes in professional definitions, boundaries and functions which gave most cause for concern. How could students and teachers be expected to enter willingly and wholeheartedly into shared learning which might prove to be a thinly disguised threat to their very existence?

2 TRENDS IN HEALTH AND SOCIAL CARE

Contributors drew attention to numerous trends either prompting or shaping initiatives in shared learning. Some were architects of the changes which they described or actively engaged in their implementation. Others, often those who had been engaged in shared learning for some time, found themselves responding to trends which were not of their choosing and with which they were by no means always sympathetic. Optimists welcomed the challenge of the new and some were building their reputations upon the opportunities created. Pessimists feared that values and philosophies which they held dear were being put in jeopardy.

Those trends are divided between two chapters. The first refers to trends in health and social care, the second to trends in education. Implications for shared learning are pointed up in both.

This chapter begins with new ways in which the professions were said to be responding to the needs and expectations of service users*. It then looks at ways in which those responses are being affected by changes in the organisation and management of services, including the deployment of the workforce, and by the implementation of health and social policies. It finishes with the notion of holism and the significance which some contributors accorded it.

Encouraging User Participation

No attempt was made to canvass views from users, but contributors were quick to champion their interests. They found the trend towards more effective user participation pregnant with implications for collaborative practice and for shared learning. As users became better informed, more articulate and more assertive, they also became more critical of the manner in which they were passed from organisation to organisation. They were said to be bewildered by the stream of different workers to whom they were often referred, and had no desire to find their problems dissected, compartmentalised and objectified within the preordained frames of reference of each profession. They wanted to be treated as whole people.
Yet their rising expectations outstripped the capacity of any one profession to respond adequately, precipitating the very problem of which they complained.

Experience suggested that shared learning was likely to achieve more when users were brought in as planners and participants (see page 40).

Responding to New and Changing Needs

New and changing health and social problems invariably challenge the capacity of the professions to respond adequately. The more complex the problem, the greater the need to pool experience and to act in concert.

* The term 'users' is generally preferred rather than 'patients' and 'clients'.

The HIV epidemic was cited as a stark example. None of the professions, said one contributor, had answers when the full horror of HIV had begun to be realised. All had started from the same position of fear and ignorance. They had no option but to learn and work together, and to involve users and their carers who had often been the most knowledgeable of the interested parties. It was this, she believed, which had given the resulting interprofessional collaboration its unique quality and held so many lessons for other fields where roles and relationships between professions were more entrenched and habitual ways of working less open to challenge.

In contrast, the implications of an ageing population might be said to have crept up on the professions, but here, too, no one profession could respond adequately alone. This was most clearly demonstrated by the work being done in Scotland to educate professionals about dementia. There the University of Stirling's Dementia Services Development Centre was not only responding to the needs of a range of professions, but also calling upon the expertise of each to benefit the others. Architects had been found, for example, who were willing and able to help to design residential establishments which mitigated the effects of disorientation. Nurses were benefiting from medical knowledge about the pathology of the brain while social workers were sharing their expertise in counselling and group work.

To take just one more example, the increasing incidence of homelessness, and belated recognition of the complex problems which often lie behind it, had prompted concerted professional action. As one contributor argued from his experience in London, medical intervention alone was not enough. While health professionals were often the first point of contact, they were presented, in the main, with non-medical problems with which they were not trained to cope. They needed to recognise other kinds of problem, to know where to refer and, most importantly, to be confident of a positive and collaborative response from the housing department, the social services department, the social security office, voluntary groups and so on.

Understanding and Meeting Needs

Advances in medicine and the social sciences were said to be making health and social care professions increasingly aware of the complexity and diversity of problems which users present, advances which were being picked up in less insular professional educational systems as reported later.

This was prompting conflicting responses. On the one hand, greater knowledge was leading to greater specialisation within professions to concentrate available expertise and to contain what had to be learned within manageable limits. On the other hand, it was calling for closer collaboration within and between professions to respond adequately, as already noted, to the breadth of users' needs and expectations.

Relating Specialist and Generalist Practices

Specialist and generalist trends were said to be in tension, within and between the professions. Within nursing, Project 2000 had integrated specialist training systems, but commitment to specialist fields remained strong. In the professions allied to medicine moves towards amalgamation encountered resistance. Conversely, within

social work, emphasis upon genericism had reportedly weakened as specialisation had begun to be re-established.

The tension was illustrated most graphically within medicine. There, as one contributor explained, specialisms and sub-specialisms had multiplied in response to scientific advance. While this concentrated expertise, it was making it more difficult for any one doctor to relate to the patient as a whole person. Collaboration between specialisms within the one profession was becoming ever more complex and ever more demanding. The problem, he said, was particularly acute for the generalists – the general practitioners (GPs) – who had to relate, as circumstances dictated, to a growing number of specialists within their own profession. This, he suggested, was one reason why GPs sometimes fell short in collaborating with other professions. According to this line of argument, ensuring effective intraprofessional collaboration takes precedence, absorbing time and energy at the expense of interprofessional collaboration.

It was the generalists who were expected somehow or other to resolve the problem. It was they who were seen to occupy the pivotal positions in their respective services (general practitioners and nurses in health, and social workers in social services). Between them the primary and continuing collaborative relationships had to be forged. To them, the specialists within their respective professions had to relate as occasion presented.

While collaboration between nurses and social workers had been the subject of a succession of shared learning initiatives, much less attention had been paid to collaboration between GPs and social workers which was reportedly more problematic. GPs were said to be reluctant to join in shared learning. The Northern Health and Social Services Board (in Northern Ireland) did, however, report that GPs were represented on its in-house courses, which may suggest that a unified organisational structure helps.

Collaboration was also seen to be critical between much the same specialist fields within different professions. This could bolster an insecure and undervalued specialism in one profession by association with that in another.

Some argued that roles were convergent for specialists across professions, eg approved social workers and community psychiatric nurses. Others went further, wanting to create new professions, for example, in learning disabilities and for the education of young children by amalgamating specialisms from two or more professions. Arguments for professional definition by client group were, it seemed, gaining renewed momentum.

Changing the Workforce

Changes within and between professions could, it became increasingly clear, only be understood in the context of wider changes in the workforce. Managers were said to be looking for a more flexible workforce, willing and able to respond to changing needs in changing services. Skill mix had its friends amongst the contributors who saw it as a driving force behind much shared learning. However, one saw it as reductionist, weakening professional identities, negating long term planning, undermining professional education, and storing up trouble for the future as the reservoir of qualified workers

was allowed to run low.

Arguments were rehearsed for shifting responsibilities from one profession to another. Some contributors saw this as vital in using scarce and highly qualified workers to optimum effect, and in relieving excess pressures. Baggage had to be jettisoned, said one. These were the arguments of economy and efficiency. Others, suspecting dilution and mindful of the interests of their own profession, feared that a high price would be paid in terms of effectiveness. Professional boundaries, said one, were always being redrawn and always would be. Each profession needed, said a second, to protect its core activities, while entering into more flexible ways of working on the margins.

More radical views were, however, voiced. Some lent their support to arguments for fewer and larger health professions, starting with professions allied to medicine (see page 26). The pattern envisaged was similar to that in social work since the Seebohm Report (1969).

Traditional professional identities, functions and boundaries were, it seemed, being threatened, prompting defensive reactions which were liable, in turn, to provoke the wrath of managers and policy makers. Professionals were exposing themselves to the criticism that they were impeding reform if they adopted a conservative stance.

One contributor argued for shared learning as the catalyst to accelerate changes in professional boundaries and functions. Others feared that it was being used by management to manipulate. Yet others saw the manipulation as coming from central government and as going further. One was convinced that there was a 'broader political agenda' in which the established professions were seen to be standing in the way of what government wanted to do. Like the trade unions before them, they were to be humbled. Shared learning was, he feared, in danger of being used as a device to weaken the professions. Anti-professionalism might, it seemed, be masquerading as interprofessionalism.

Practising in a Mixed Economy

All this may seem complicated enough, but it was not the end of the story. The changing professional map could, it became clear, only be understood when superimposed upon the changing map of services, which was at least as complex. No longer did health and social care professionals work predominantly in health and local authorities. They were now deployed in a rapidly expanding number of organisations, – public, private and voluntary –which made up the mixed economy. Furthermore, creation of internal markets had created divisions within the public sector. Professionals found themselves on both sides of the purchaser/provider divide. There was a double message. On the one hand, professionals were being exhorted to collaborate. On the other hand, they were locked in competition within and between organisations. Competition, as much as collaboration, was extolled as a virtue.

Some contributors were apprehensive about the attitude of purchasers towards the professions. In what circumstances would purchasers require providers to employ qualified personnel? Conversely, in what circumstances would providers see advantage in employing them to strengthen their credibility and attract business? These questions were at their most acute in Northern Ireland where Trusts were being established with

responsibility for both health and social care in the community. Established staffing policies in the Health and Social Services Boards had been thrown open with the impending transfer of responsibilities to Community Trusts.

Collaboration was becoming harder, said several contributors. Referring to work with young children, one said that there was now more central control of education, but less cohesion round the edges. Professions were being set against each other. While many professionals had become more aware of the need for collaboration, there was less time to pursue it. Therein lay the rub.

School teachers no longer had time to do anything other than core tasks. Attending case conferences was one casualty, while social workers had to liaise with each opted out school instead of one Local Education Authority. Professionals now joined in shared learning in their own time and at their own expense. Yet the same contributor held on to the belief that new collaborative systems would be set up. Parents and teachers would undo the worst effects of educational reform.

The need to promote collaboration by means of shared learning seemingly grew stronger as the circumstances in which it could be provided grew more difficult.

Changing Management and Service Delivery

Contributors also recognised that the adoption of new managerial philosophies carried implications for shared learning. Professionals were expected to carry a greater degree of management responsibility for devolved budgets, for determining priorities and sometimes for purchasing care and treatment. Additional training was needed for these responsibilities, training which may be common across health and social care. Examples given included the Financial Management and MESOL programmes from the National Health Service Training Directorate (NHSTD).

New roles, and quite possibly new occupations, were being invented, such as care managers, while emphasis put upon quality control and assurance had generated more inspectorial posts. These were just two examples given where new functions called for new training provision for workers from a range of professions and organisations. Again, there was a strong case for shared learning.

Professionals were finding themselves accountable to managers outside their own ranks and sometimes subject to contracts which some saw as encroaching upon their autonomy and clinical judgement. One contributor saw dangers in giving more power to managers; they must share power with professionals, be open to users, and be servants of the public, he said. Another saw signs of a new alliance between health and local authority managers against professionals.

Tension was inescapable, said another, if better services were to be delivered. Breaking down large organisations into smaller ones helped to personalise relationships and lessen difficulties. On the other hand, collaboration will inevitably be more distant and more difficult between organisations.

Managers, said yet another contributor, saw professionals as impeding reform, while professionals seemed angry and bewildered. He was actively exploring ways in which managers and professionals could engage in shared learning designed to help them confront and reconcile their differences.

Changing Health and Social Policy

These organisational and managerial changes are built into policies for primary health care, community care and child care, all of which were frequently discussed during interviews.

In primary health care, GP contracts had introduced tighter controls and new roles, for example, in prevention and health education. Fundholding was calling for managerial and entrepreneurial acumen and paving the way for more flexible deployment of staff regardless of profession.

In community care, the shift from institutional to community-based care was moving beyond traditionally defined rigid professional demarcations into open ground where roles and responsibilities had to be rethought and territorial disputes and rivalry resolved. Packages of care had to be negotiated across professional, sectoral and organisational boundaries, with potential for rivalry, notably between social workers and general practitioners, concerning who had the lead role.

In child care, the 1989 Children Act was putting new emphasis upon involving children and parents in decision making and upon collaboration in the interests of the child, while the unrelenting stream of child abuse reports maintained that pressure.

All three of these examples highlight the need to help professionals to explore each other's changing roles and relationship.

Embracing Holistic Care

Many contributors were struggling to hold on to the ideal of user-centred care and treatment. Some embraced holism as a philosophy to embody that ideal.

Given the different connotations which holism so often carries, contributors were asked to explain their use of the term. Most talked about it, rather than defining it.

Holism offered, said one, an alternative perspective to policy implementation, less rigid and less tied, more integrative, more responsive, and more flexible. It countered reductionism, technocratisation and managerialism. It began with the personal relationship between user and practitioner as fellow human beings, making the professional role secondary. Boundaries between professions became permeable and subject to constant testing. This was liable to generate tensions, best resolved by keeping the user centre stage. Holism did not work to rules. It accommodated, encouraged and valued. It used idiosyncrasies. It was liberating. It depended upon personal and professional identity and security to operate, and could be problematic in relating to other systems.

Holism, said another, was gaining popularity in general practice. She attributed this to the impact of developments in community care, even though many GPs (at the time of the interviews) still seemed unaware of its detail. Yet another observed that, from its inception, training for GPs had addressed the need to work with the whole person in her/his social environment.

Holism, it was suggested, provided a legitimate place for the complementary medicines, whose growth in numbers and influence is, itself, a significant trend. Some contributors welcomed this.

However, several medical contributors distanced themselves from the term 'holism' when it was introduced by the interviewer, preferring terms like 'humanitarian'. Contributors from nursing and social work seemed even less likely to refer to it, although both professions may claim that responding to the whole person is the essence of their roles. The music, it seemed, if not the words, was similar for a wide band of contributors across the professional spectrum.

3 TRENDS IN EDUCATION

The chapter identifies trends in education which promise to create conditions favourable for shared learning, but argues that these will only become apparent as reforms within separate professional education systems bear fruit and as each profession emerges from its internal preoccupations.

Reforming Vocational Educational and Training

Contributors knowledgeable about Scottish and National Vocational Qualifications (S/NVQs) were in no doubt about their likely impact on education and training in health and social care. They saw the systematic use of functional analysis to determine practice competencies as the means, first, to distinguish between commonalities and differences between occupations and second, to free up curricula. Together, these would make it easier to stake out territory for shared learning within less hidebound systems. They pointed to work in hand on occupational mapping throughout health and social care and to pressures to extend the S/NVQ rationale to determine practice competencies at the professional level.

Critics of S/NVQ were, however, to be found amongst the contributors. For them its approach was too mechanistic and too prescriptive. They viewed its extension to professional education with misgivings and doubted how helpful it would be in facilitating shared learning which relied upon a reflective and open view of learning within a liberal tradition. Many contributors had linked shared learning with the application of principles of adult learning as means to encourage participation and collaboration between professions. S/NVQ, they feared might threaten that.

Some contributors were aware of resistance to S/NVQ amongst health professions, with the likelihood that work relating to them would lag behind that for social care. Pressed by government, CCETSW had taken the lead by entering into a partnership with the Occupational Standards Council for the Care Sector to redraft outcomes for the Diploma in Social Work (DipSW) and to move into S/NVQ. It remains to be seen whether comparable pressure will be applied to other professions and with what results. Without parallel developments, opportunities to determine commonalities (and differences) in outcomes, and therefore to reinforce arguments for shared learning, will be missed.

One contributor, however, was exercised about the consequences if, as seemed probable, different health and social care professions were tied to different NVQ levels. This would confirm and institutionalise invidious distinctions of status which might further inhibit collaborative practice which depended upon parity of esteem.

Reshaping Higher Education

Many recent developments in higher education were seen by contributors to hold promise for shared learning.

The incorporation of specialist professional schools and colleges into universities had removed some of the barriers to shared learning. Professions allied to medicine had been drawn together into the same institutions, often with nursing, social work and other related professions. Managerial and organisational obstacles standing in the way of shared learning had been eased, although far from removed.

Within large educational institutions, educational managers had assumed overall responsibility for courses from teachers drawn from the constituent practice professions. While some of the latter had backgrounds in one or other of the professions, they had become distanced over time. That distance, some contributors argued, enabled them to take a broad view, to be even-handed between the professional interests, and unbeholden to conventional professional wisdom. Others were less sanguine.

Examples given of college based shared learning were, indeed, between professions which had been brought together within the same institutions and , more especially, the same departments. Where professional education was still spread between departments, shared learning was more difficult to effect and less often found. This was at its most marked where medical students had their own schools largely separate (organisationally and often geographically) from their parent university where other professions were located. This led to social as much as intellectual distance. As one contributor recalled, he had played rugger for the medical school, sadly not for the university where he might have got to know fellow students entering other walks of life.

Shared learning was even more difficult and even less likely where professional education was located in different universities and different university traditions, although one contributor insisted that it did take place in her (relatively small) city across institutions which enjoyed good working relations and were in close proximity. Others saw greater obstacles. Medicine, for example, was in the older universities, while nursing and the professions allied to medicine were typically in the newer universities (and social work in either). This carried implications for research and scholarship, not just status. The ending of the binary divide between the old universities and the former polytechnics had brought both traditions within a single system although it was too soon to gauge the significance, if any, for shared learning.

Of more immediate concern to many of the contributors was the introduction of modular systems and credit accumulation and transfer systems (CATS). Designing these at undergraduate level had called for collaboration between academic disciplines, which pointed towards similar collaboration between teachers for the professions. Some contributors were, indeed, applying the same rationale to courses leading to professional qualifications. One was, however, guarded about this, fearing that it would weaken the socialisation of students into their chosen professions, dilute disciplinary teaching and detract from its application to practice. She doubted how far modularisation and CATS would be taken in professional education, anticipating widespread resistance.

Modularisation was not necessarily beneficial for shared learning. Contributors who had pioneered interactive models for shared learning had seen this undermined by modularisation. Broad brush assumptions had been made about commonalities of learning at the expense of differences, while students had been lumped together in large classes which were inimical to intellectual or even social intercourse between the professions.

Assessment of Prior Learning (APL) and Assessment of Prior Experiential Learning (APEL) were also mentioned. It was, said one contributor, now virtually impossible for a university not to accord credit for prior learning. This was working in favour of movement between professions (and between para-professional and professional levels). Transferablity of knowledge and skills across professions was, he said, now firmly planted.

Rapid expansion in open learning was seen to hold promise for shared learning. Several contributors were pioneers in open learning, and at the forefront of moves to introduce it into basic and post-qualifying professional education. Open learning, as they demonstrated, had opened the door to programmes for students from a range of professions.

For example, Open University (OU) courses were being widely used for professional up-dating and development (as well as pre-professional study). They also enabled students to accumulate credits towards diplomas in the expectation that these would count towards professional awards, or at least enhance chances of being accepted on to professional courses. One of these was the Diploma in Health and Social Welfare. It comprised core modules on 'health and well-being' and 'community care' with a wide choice of options including ageing, children and young people, disability, mental handicap, special needs, health and disease, management, roles and relationships, and social problems and social welfare.

Similarly, the University of Dundee had launched its Community Care Training Programme for health and social work professionals. Workbooks could be purchased for individual or group study, giving students the option of submitting assignments to be assessed for the award of a Univertiy Certificate. Further units of study were in preparation for those students wishing to continue their studies to diploma level and, beyond that, to a masters degree.

While open learning was mentioned quite often in the interviews, advances in educational technology (with great potential for shared learning) seem not to have been spotted. The work of Thomas (1994) is noteworthy in beginning to explore this. One contributor had produced a game in which professional roles were assigned to players who had to negotiate for resources to develop community care (Rowley, 1994). Applications of computer assisted learning may be something for the future.

Reforming Professional Education Systems

Some contributors were familiar with recent and current changes in basic professional education. They were heartened by the trends. Systems were becoming less insular and more broadly based. Overlaps were becoming more apparent, while the health

and social sciences were providing an underpinning of common and academic foundations. Progress was being made in levelling up standards, while elitism was slowly losing ground. Such developments could only help to pave the way for collaboration and shared learning.

Contributors welcomed improved standards and qualifications resulting from Project 2000 for nursing and the introduction of graduate education for professions allied to medicine. They saw these developments as helpful in narrowing status differentials with medicine.

Some were closer to reforms in social work education with the introduction of the DipSW. This, too, was about levelling up, but had not been taken as far as CCETSW and others had intended. Efforts to extend the minimum length of qualifying programmes from two to three years had been frustrated, and many remained non-graduate. These two constraints, together with delays in establishing a General Council to cover social work, were seen to hamper moves towards parity with the more established health professions.

Several contributors placed great store by reforms in basic medical education emanating from the General Medical Council. They welcomed greater emphasis upon caring for patients in the community, upon the role of the GP, and upon adult learning methods. One particularly welcomed the chance to redress the balance from the hard edge of research-based specialisms towards a softer more humanistic edge. He looked forward to a move away from anatomy towards human biology, focusing upon the whole person until particular theoretical perspectives were brought to bear. Moves towards less elitist recruitment into medical schools were seen to be narrowing the social gap with other professions, while the growing number of women entering medicine was thought to favour collaboration (viewed as a female trait). These contributors were optimistic that medical education would become more participative and patient-centred, and that this would produce more reflective practitioners who would be more open to other professions.

Obstacles to shared learning were, it seemed, diminishing. In the short term, however, each profession was seemingly too preoccupied with its internal affairs to recognise this, still less to find the time, the energy and the inspiration to act upon it.

Redrawing the Relationship between Education and Practice

Relations between colleges and agencies were changing with regard to their respective responsibilities for vocational education and training. In large measure, this was a consequence of S/NVQ where determination of outcomes had become employment led and colleges were now expected to equip students to meet the competencies prescribed. The same will apply also at professional level when S/NVQ is extended to include it.

For social work, as some contributors knew well, organisations and universities had been made jointly responsible for courses leading to the DipSW. This put organisations in a strong position to argue for curricula which responded to changing practice needs.

Others were more familiar with the relationship built into Project 2000 for nursing.

The devolution of education and training funds to health authorities carried major implications for relations with colleges. Contributors said that this was strengthening the hold of service managers over college-based courses. Some welcomed that as reinforcing relevance to the demands of contemporary policy and practice. Others viewed it as a myopic preoccupation with the short term at the expense of laying foundations for career-long professional development. Trust managers were said, for example, to be on short term contracts themselves, and not interested in training beyond the acquisition of skills for current tasks. Some contributors went so far as to see this as an attack on the integrity of educational systems for at least some of the professions.

One contributor, long active in shared learning, had thought that major strides were being made until the NHS was reorganised. Funds available for training had, however, turned out to be grossly inadequate and the future of shared learning was on the line. It was, he said, hard to sell shared learning in the prevailing atmosphere. That view was contested with equal vigour by others who supported service managers to the hilt and saw many opportunities to be seized for shared learning.

4 SHARED QUALIFYING STUDIES

Shared learning occurs at all stages in education and training from foundation courses to continuing professional development, but for different reasons, in different ways and with different degrees of difficulty.

Foundation courses, for example, in health and social sciences, include students contemplating careers in a variety of professions or none. The breadth of that foundation, and the mix of students, may predispose those who proceed to professional studies to be more open-minded and perhaps more willing to collaborate with other professions in their subsequent careers, although evidence to support such a hope would be hard to find. These studies cannot, however, be included within a review of shared learning for the professions, given that students have yet to affirm their career intentions.

Shared learning during continuing professional development is also well established and clearly within the scope of this review. Experienced practitioners from a variety of professions enrol for the same courses as the next chapter illustrates

Shared learning during courses leading to basic professional qualifications has traditionally been treated with more caution. Colleges and validating bodies have often resisted it, although opinion may be moving in its favour. It is in this problematic area that the present chapter concentrates.

Some Basic Differences

The choice (if it must be) between shared learning at the qualifying or post qualifying stage is not so simple. Like is not being compared with like.

Qualifying students still typically enrol for their separate courses, coming together, at most, for a small part of their studies. Shared learning almost invariably assumes that learning needs are the same across the professions. Differences are left to be addressed in discrete studies for each professional group. If and when such differences are raised during shared learning, students have little or no professional experience with which to contribute for the benefit of their classmates from other professions. Finally, students are usually assessed separately for their respective awards.

At the post qualifying level shared learning students typically enrol for the same programme, following the whole of their studies with other professions. Shared learning may address differences as well as commonalities. Students come as established professionals, presumably secure in their respective identities and with tried experience to share from their different perspectives. Sometimes they are already working together. Finally, they are assessed by the same means for the same awards.

Two Schools of Thought

There are two schools of thought regarding the place of shared learning during qualifying courses. Both had their exponents amongst the contributors.

One holds that shared learning should be delayed until some time after qualification when the worker has experience to share. During qualifying courses, so this argument runs, students are finding their professional identities and being socialised into the values and culture of their intending profession. Seen thus, qualifying courses are exclusive rites of passage and essentially inward looking, avoiding contamination and protected from alien influences (Clarke, 1994). Each profession concentrates upon transmitting values, knowledge and skills to which it claims, if not unique possession, at least proprietory rights. To the extent that other professions are considered, they are secondary or marginal. Shared learning may therefore be seen as intrusive, disruptive or distracting.

Painful experience, as some contributors testified, has also demonstrated how time consuming and frustrating it can be to satisfy two or more sets of regulations, to overcome resistance amongst the teachers, to resolve the logistics of timetabling, and to design studies for groups of students whose age, life experience, abilities and education may differ appreciably.

According to this school, shared learning, if it is to be included at this stage at all, must be extra-curricular, for example, through student societies. One contributor had been closely associated with the Medical Group at her University. One of a number of such groups in British universities, it had provided social, and sometimes educational, activities for students from law, medicine, professions allied to medicine and social work.

The other school of thought holds that leaving shared learning until later denies the extent to which values, knowledge and skills are (or should be) common to health and social care professions. Failure to appreciate this, and to act upon it, may, according to this school, be one reason why students often form exaggerated beliefs in the capacity of their chosen profession and, conversely, undervalue the contribution of others, while adopting stereotypes which sustain their prejudices. Unlearning is then needed to modify attitudes, perceptions and behaviour, before horizons can be widened and the practicalities of collaboration can be addressed as part of continuing professional development.

Yet practitioners are obliged to work with members of other professions from the moment of qualification. They cannot wait for 'remedial studies' some years later before learning about the values, knowledge bases, roles and functions of other professions. By then attitudes and habits are established. Hardening of the arteries has already set in.

Contributors volunteered a number of examples of shared learning during qualifying courses from their experience.

Bringing Together Community Workers, Primary School Teachers and Social Workers

Probably, the most systematic example of shared qualifying studies is still that at Moray House, Edinburgh, in the early eighties. Promoted then to be Head of Department, one of the contributors had been concerned about the attitudes held towards each other by students in the three professional subjects taught: community work, primary school teaching and social work. She therefore devised ways to bring them together. Starting from her own discipline of social psychology, she defined the aims to include: the provision of knowledge about group formation and conformity, role perception and stereotyping, increasing students' ability to take the perspective of the other professions; encouraging use of other professions' expertise; and enhancing students' awareness of the demands of communication and co-operation. Placements were offered in alternative professional settings, an integrated course mounted in social psychology, and interprofessional workshops held on problem solving. The last of these was evaluated more rigorously than the others. Questionnaires were administered to students, augmented by some interviews, before and after the shared learning. Organisational constraints prevented the inclusion of control groups.

Following the workshops, students reported some increase in knowledge and understanding of each other, and also indicated greater willingness to work with the other professions in their future practice.

Overall, the researchers concluded that potential co-operation between the three professions was hindered by their experience during their qualifying courses. They argued for shared learning before stereotypes hardened.

While valuable and lasting lessons were learned, the contributor acknowledged how stressful the experience of shared learning had been. Changes in the senior ranks of College management brought it to an end, and it was not repeated during the following decade. (McMichael, Molleson and Gilloran, 1984, McMichael and Gilloran, 1984, McMichael, Irvine and Gilloran, 1984)

Bringing Together Professions Allied to Medicines

A very different example came from University College, Salford (Lucas, 1990). There, shared learning was introduced across qualifying courses for occupational therapists, physiotherapists, radiographers and chiropodists. Efforts were made to win the active support of staff by first mounting a part-time degree programme for college teachers, clinical tutors and clinical supervisors to demonstrate the advantages of shared learning. Students were also involved in the preliminary stages. Prior to registration their attitudes towards shared learning and the possibilities of deferred career choice which it held were canvassed. Shared learning was piloted in two ways.

Initially, four students from each of the four professions, plus one staff member from each, came together for half a day. Questionnaires elicited perceptions of the roles of the other professions present. Each professional group then gave a ten minute presentation outlining the nature and extent of its work, with time for questions. Students were then divided into multiprofessional groups for a case study in which they were expected to act as a team, each staying within her or his professional role. An open forum followed. This experiment was welcomed by all concerned.

Subsequently, shared learning was built into the first year of diploma courses in chiropody, occupational therapy and physiotherapy (but excluding radiography) and written into submissions for degree programmes destined to replace them. Three subjects were chosen: information technology, health education and promotion, and communication skills.

While students were well disposed towards shared learning, they felt that its objective was not achieved. It had not created the opportunities for interaction which they had expected

Staff from the respective professions were said to be unsupportive of the philosophy of shared learning (Davidson, 1994). It had, they said, been forced upon them, in spite of the earlier preparation. They resisted its introduction, perceiving it as a threat to their professions and themselves. They sometimes repeated the same ground with their separate student groups to ensure that it was covered 'properly'. College management, however, hoped that new staff would take a more positive view and regarded this as important in future selection.

Joint Training in Learning Disabilities

The problems were most graphically illustrated from the tortuous history of shared learning in the field of learning disabilities, with which several contributors were familiar. Proposals for 'joint training' for nurses and social care workers had been made by a joint working party of the (then) General Nursing Councils and CCETSW (1982). The plan had been to develop specialist pathways of study within Certificate in Social Service (CSS) schemes which would satisfy requirements for the award of the CSS and for registration as a mental handicap nurse (RNMH). This was put forward as an alternative to discredited proposals in the Jay Report (1979) to transfer responsibility for training for mental handicap nursing from the GNCs to CCETSW.

After protracted negotiations in several regions, only two pilot projects had got off the ground. One, based at Havering College in North East London, was in partnership with South Ockendon Hospital. The other, based at Bromley College in South East London, was in partnership with Darenth Park and Leybourne Grange hospitals. They were to encounter similar problems.

Both had had to meet requirements for validation from the English National Board (ENB) (which had taken over responsibility for England from the former GNC for England and Wales) and CCETSW. Regulations differed and called for flexibility of interpretation if they were not to prove incompatible. While both schemes recruited from nursing for its special mental handicap pathway, neither did so from social care as employers rejected arguments for an additional period of study to meet requirements for nurse registration over and above the CSS. Furthermore, expansion of RNMH training in neighbouring areas raised questions regarding the viability of the joint training. Far from being resolved, rivalry between the two professional camps, which Jay had fanned, remained a problem until the end. The projects terminated when both training systems were overhauled radically (with the implementation of Project 2000 for nursing and the introduction of the DipSW for social work). Brown (1993) has provided a fuller analysis, while Harding (1991) has explored implications for shared learning which, in spite of the problems encountered, was soon to be introduced between those new systems of qualifying study.

Learning from that earlier experience, South Bank and Portsmouth universities have developed joint degree programmes for nursing and social work in the field of learning disabilities. Contributors from South Bank reported that this second generation of 'pilots' was being carefully monitored and, albeit at an early stage, seemed to be progressing well.

The Tide Turns

Talking with contributors who had been involved in these initiatives, it was clear that the frustrations had been considerable. On the face of it, that reinforced arguments against shared learning at the qualifying stage. Their continuing commitment told another story.

However difficult such pilot projects had been in the past, there was a feeling amongst these contributors that the tide was turning in their favour. Much depends upon how far and how fast changes outlined in the previous chapter take effect.

Canvassing the Views of Students and Teachers

Research suggested that students and teachers may now be more favourably disposed to shared qualifying studies than might previously have been thought. One of the contributors (Tope,1994) had sent questionnaires to all teachers for 13 qualifying courses in health and social care in the Cardiff area inviting their views on shared learning. She had also negotiated half hour slots to solicit the views of students on those courses by means of a questionnaire. Response rates were impressive: 86.9% for the teachers and 98.4% for the students.

Teachers and students were asked whether they believed in shared learning, whether they would be interested in taking part in it, and at what stage. Both groups (for all the professions) were overwhelmingly in favour of it throughout qualifying and post-qualifying studies. Subjects thought to be suitable for inclusion were: psychology, sociology, law, ethics, research methods, economics of health, health promotion, quality control and assurance, and computing.

Attitudes did seem to be moving, at least in Cardiff, in line with changing structures and policies in higher education, generally, and in at least one of the major educational institutions, locally.

Reframing the Questions

So the argument moves on. The point may fast be approaching when the question is no longer whether learning should be shared at the qualifying stage, but how, between whom and to what ends. It is then that dividends may be reaped from those painstaking (and painful) experiments.

5 SHARED CONTINUING DEVELOPMENT

The last chapter looked at shared learning during qualifying courses.

This chapter picks up from there. It coins the term 'shared continuing development' (SCD) to describe forms of continuing professional development which cater for two or more professions.

Location

SCD was often work-based, with the object of effecting organisational change or service development. Furthering collaboration was a means to those ends. Preoccupied with internal matters, work-based learning seemed ill suited to furthering collaboration between professions working in different organisations, although that constraint was overcome where two or more organisations got together.

SCD was also college-based, with the object of providing up-dated and additional skills. Explicit references to furthering collaboration were rare. If learning alongside students from other professions helped later in working more effectively with others from those same professions that was a bonus.

Voluntary organisations and specialist institutions also ran conferences, courses, seminars and workshops. Often open to all comers, such events included a mix of professions as well as non-professional workers and sometimes volunteers, users and carers.

There were also networks and forums wholly dedicated to creating opportunities for shared learning. Some were local. In Liverpool, for example, 'multidisciplinary forums' met every fortnight at neighbourhood level to debate the relevance of a local initiative or a new idea. Each profession took its turn to make a presentation on a topic of its choosing.

Others were national. In Scotland, 'Interact' brought together individuals from health and social work professions. National conferences and workshops alternated every six months, focusing upon topics of common interest. These ranged from implementing community care to disabled people and their sexuality, and from audit to handling data.

CAIPE, as a UK forum, organised conferences, seminars and workshops. Membership was individual and across a wide spectrum of health and social care professions, drawn together by common commitment to collaborative practice and to the advancement of interprofessional education as a means to that end.

Learning at Work

Sceptical about the value of SCD in college, one contributor argued that such learning was only effective in the work place. He stressed the need to organise and structure work so that shared learning would be more likely to occur. Based upon his experience in a research setting, he argued for multidisciplinary teams to be assigned to tasks. There need, he said, be no preconceptions about the discipline from which the leader came, provided that team members were also accountable to a supervisor in their respective disciplines to ensure quality and to encourage systematic professional development.

A second contributor stressed the concept of the learning organisation, in which developments were seen to be more broadly-based than any one individual or any one profession. Such learning was a continuing process, to which the organisation returned repeatedly, helped when necessary by outside consultants or facilitators.

A third contributor recounted her experience in pioneering the role of facilitator in primary health care. Initially, the focus was helping practices to identify cardio-vascular risk, but her role widened to cover general health promotion more generally including alcohol use, diabetes, HIV prevention and facilitating teamwork. For her, the role was more than just facilitating process; it also called for technical competence and credibility, backed by scientific evidence of the benefits of the proposed change. A fourth contributor challenged that view. He rejected the 'technocratic model', preferring the 'hermenuetic model', seeing his role as essentially interpretive. This came closer to the notion of 'facilitation' as found amongst tutors and trainers in shared learning within social care, although facilitators, as an identifiable occupational group, were not in evidence.

Teambuilding

Many contributors preferred task-centred approachesto team building exercises which were said to alienate members from one another. Grappling with 'team' as a concept diverted attention from the job in hand. There was a need to help people to develop beyond preoccupations with teambuilding.

The task-centred approach set aside differences to deliver the outcomes. When tensions or blockages got in the way, the facilitator or consultant could help the team to look at what was preventing progress and how it could be overcome. Allow trouble to surface, said one contributor, and then deal with it.

Numerous tasks were mentioned, each important in its own right, but also capable of generating change in working relationships: introducing preventive strategies, developing multiprofessional assessment protocols, coping with new problems and designing systems for internal audit.

Taking the Show on the Road

In Liverpool teams of 'primary health care facilitators' each comprised a GP, a district nurse, a practice nurse and a practice manager. Each worked with primary health care centres on its patch 'to assist the development of teamwork and skills to solve complex practice problems'.

'Roadshows' lasted just one and half hours, but required much preparation in advance to make optimum use of that short time. Each practice chose the topic with which it wanted help. Popular examples included immunisation and cervical cytology. Ground rules were agreed at the outset of the meeting and respective roles identified as they related to the topic, which was then explored. The object was to draw up an action plan. The visiting team legitimated and provoked the sharing of knowledge within the home team, but it did not advise. Follow up questionnaires invited participants to comment upon what, for them, had been most important, what they had learned, what they expected to happen as a result of the meeting and whether they were clear about their roles in implementing the action plan.

Some contributors rejected the 'teamwork obsession'. One was disillusioned by her experience in primary health care. Team members, she said, too easily got stuck in their respective roles without relating to each other as people. Doctors retained the dominant roles, while husband and wife partnerships within teams could complicate relations for others. It was not that she was opposed to teamwork. It had not gone far enough. Too often, it was trite.

Developing that theme, another wanted to turn the conventional team model on its head. The 'intrinsic team' began with the patient, brought in the carer, and then related the professionals. Yet another reminded the interviewer that 'team' was no more than a metaphor. Being limited to just one metaphor was constricting and impoverishing, denying creative imagination. Allow your thinking to stray off the pitch, she urged.

Cadres of people within an organisation began to think and work alike by learning together. This could apply to teams, but it could equally apply to networks scattered throughout a large organisation. Either team development had to be given an exceedingly wide meaning, or treated as one of a number of ways in which professionals learn together in the work place.

Learning Sets and Networks

Nor need participants necessarily be in a working relationship. In 'learning sets' participants from different organisations met regularly over an agreed period to address common concerns and to work towards common goals, with the help of a facilitator. Where such sets comprised a mix of professions, shared learning was implicit. As trust grew, participants addressed issues across their respective professions, work settings and organisations. Similarly, 'learning networks' sometimes followed workshops where participants were intent upon keeping in touch to continue their learning and to offer mutual support.

Shared Learning through Evaluation

Growing emphasis upon quality assurance was said to be prompting professions to work together in a number of ways to review services and organisation.

Examples were given from both primary health care and social services where a mix of professionals had 'away days' when they escaped from the normal practice setting to take stock of their work or to consider impending changes. These days were said to provide an opportunity to get to know each other better in more relaxed surroundings, to learn about respective roles and to become more sensitive to the experience and feelings of others.

Other contributors focused upon clinical audit as a more systematic means by which a team could review its work, each profession being free to comment upon the contribution of the others in pursuit of shared goals and targets. The effect could be 'heart rending' when one profession, said a contributor, had to admit mistakes in front of the others.

Another contributor feared that audits often became prescriptive and disempowering, but he was optimistic that new models were emerging which were truly interprofessional. For him, 'total quality audit' was needed which was grounded in common value bases and avoided preoccupation with 'testing the latest fad'.

Two contributors had experience in using 'collaborative inquiry' as a means by which practitioners become partners in research and development. While it could be applied within single professions and single organisations, it was equally applicable between professions from two or more organisations.

Collaborative inquiry was described as a method of action research which enabled a peer group to explore its own practice or a commonly agreed issue. It relied upon an iterative cycle of action, reflection, generalisation and planning, which enabled participants to understand, operate in, and modify their working environment.

This proved to be a powerful tool for shared learning. Participants had found that their experience was valued and put to use. All had participated on an equal footing, setting aside status differentials and lowering barriers. A rapid route had been found towards individual and organisational change.

Unlike clinical audit it could be applied across organisations. While clinical audit had prescribed or desired performance targets and a facilitator within the system, collaborative inquiry was described as an agent of change facilitated by researchers independent of the system.

Community Care for the Elderly

The Professional Development Group in the School of Social Studies at Nottingham University was invited by Northamptonshire Social Services Department to contribute to the evaluation of four pilot projects each of which had adopted a different structure for care management. The objectives were: to consider the impact of these different structures, to explore the shifts in knowledge, skills and attitudes which each structure required and to elicit the perceptions of the professionals involved regarding the impact on their roles and upon service delivery.

The inquiry lasted nine months. Managers, care managers, social workers, nurses, housing officers and voluntary sector workers formed the inquiry group, together with personnel from the University. The Group sought, first, to clarify the role of care managers and the knowledge, skills and attitudes which they required, second, to gauge the sensitivity of services with particular reference to race, gender, disability and age, and, third, to identify steps needed to create a working environment favourable to development and delivery of high quality services. Consultative meetings were convened with users, carers and providers from private, public and voluntary sectors about the implementation of community care.

Care managers were found to be working in a hostile enviroment, spurned by existing professional networks. They acknowledged their need to develop skills to deal assertively and appropriately with other professional hierarchies and power structures. More encouragingly, building working relations was said to have accelerated between care managers and other key professionals when they were in close proximity to one another, had the opportunity to share information informally and developed shared processes, eg for joint assessment, co-operative screening and building new resources.

Apprehension, scepticism and fear were all in evidence. Health purchasers were worried about rising demands for health care. Concern was expressed about the isolation of GPs and some medical consultants. Housing Officers felt marginalised. The voluntary sector worried about the adjustment necessary to fulfil contracts, while independent home owners feared that the local authority would be forced to undercut them, purchasing cheaper, but not necessarily better, residential care. Yet most participants were eager to establish regular channels for communication. Regular meetings of the Group did, indeed, follow, revealing even more causes for concern. (Stevenson et al, 1993)

Shared In-house Courses

Contributors confirmed a move away from releasing staff for external courses and towards in-house courses. The latter were said to offer several advantages. They were cost effective. Tutors could be bought in, when necessary, and the needs and wants of the organisation could be discussed with them in advance. There were, however, also deficits which may not always be fully appreciated. Courses could be too constraining

if staff were reluctant to open up to colleagues and managers, too narrow within the professional mix of that organisation, and too insular without cross fertilisation of ideas between organisations.

Opening Courses to Other Organisations

One way to mitigate this was to throw open an in-house course to staff from other organisations.

Coping with Post Traumatic Stress

The Metropolitan Police Training Unit was exercised by the frequency with which police officers suffered from post traumatic stress, yet there was difficulty in acknowledging this and doing something about it within the prevailing culture. The Unit decided to explore the issues with a view to mounting some pilot courses. Research from the Lockerbie air and the Clapham rail disasters was consulted and confirmed that something was needed, while programmes developed in the United States and Norway gave leads. The Chief Medical Officer for Strathclyde, an army psychiatrist and a clinical psychologist all offered advice.

Consistent with the style for the Unit's programmes, the emphasis was upon experiential learning, including self-disclosure, role plays and use of triggers, within an agreed framework of confidentiality and mutual respect. Counselling was on hand when needed.

Police officers discovered that stress need not be suppressed by drink and sick humour. It was okay to cry after the murder of a colleague. Police officers were not alone in needing such help. Others organisations were invited to participate including other police forces (notably the Royal Ulster Constabulary with its unique experience), the army, the fire brigade, the ambulance service, the health service, and banks and building societies (where staff had been victims of hold-ups).

Demand far outstripped places on the pilot courses and police officers were soon the minority. This inevitably raised questions about whether the programme was meeting its primary purpose and could be allowed to continue on such a broad front. The Unit, which was by then seen to be at the cutting edge of psychological debriefing nationally, had become a victim of its own success.

Searching for ways forward, the Training Unit agreed to run courses for the Metropolitan Police's Occupational Health Unit which would then take over work with London police officers. Outside the police, officers from the Unit taught similar courses (in their own time) at St Mark's and St John's College (University of Leeds) for a wide range of professions.

Promoting Shared Learning between Organisations

In Scotland, funding had been made available to encourage inter-organisational initiatives.

Inter-Change

This was the title given to a series of joint workshops between organisations in Scotland engaged in implementing aspects of community care policy. Grants were made available from the Scottish Office through the University of Dundee to back projects designed to improve collaborative practice between organisations, to strengthen links between planning, management and service provision, and to share what was learned more widely. Eleven local projects were supported. They ranged from finding ways to involve GPs in community care to hospital discharge arrangements, and from advocacy to contracting and commissioning. (Rowley, 1993)

Learning from Alternative Work Experiences

Learning between organisations could also be effected by outposting staff. An example was given of 'job shadowing' in the London Borough of Lambeth to develop better services for homeless people. Front line staff in health, housing, social services and the voluntary sector spent from one to three weeks with one another. They learned about ways of working in other organisations, about opportunities and constraints, about projects mounted by other organisations and got to know key people with whom to collaborate in future. No money changed hands and free training was provided.

Similarly, organisations made specialist expertise available to others by seconding personnel. Learning about the latter was a spin off. For example, the West Lambeth Community Care Trust seconded personnel to three homelessness projects run by other organisations for eight weeks in each instance as consultants, researchers and evaluators. Applications were advertised internally and open to managers, clinicians and administrators.

Open Learning

Use of opening learning for continuing professional education had increased markedly. Sometimes this included elements of SCD. Two initiatives were highlighted by contributors.

One was programmes in health and social welfare studies, management studies and the social sciences developed by the Open University (OU).

Open University Programmes

These were reportedly used by a growing number of health and social care workers to up-date their knowledge and to acquire specialist skills. OU programmes were, with few exceptions, designed to be equally relevant to students from a range of professions and none. They introduced common language, common concepts and often comparative perspectives.

While the image of the typical OU student may still be of the lone learner, he or she may also attend group tutorials and sometimes summer schools. There, students from diverse personal and occupational backgrounds learn with and from each other. No 'health warnings' about this were said to be issued in advance (and the OU waved no 'interprofessional banner'), but students reportedly found these encounters agreeable and stimulating. Away from work, it was safe to debate issues, freed from immediate constraints. Their shared identity as OU students provided common ground, while their common commitment as adult learners was said to provide the motivation. Work-based study groups had also become a feature of some OU health and social welfare programmes. Where these brought together workers from two or more organisations, they became vehicles for cross fertilising experience and ideas.

The other major initiative was management programmes developed by the NHSTD. Originally intended for use in-house by Health Service managers, some programmes had been stretched to cater also for social services managers. Relying mainly upon the same units of study, this also provided common language, common concepts and common approaches, although some contributors were critical that NHSTD materials had not been sufficiently grounded in social services management and practice.

The Management Learning Scheme by Open Learning (MESOL)

MESOL has been designed for in-house use. It is a collaborative venture between the NHSTD, the Social Services Inspectorate, the Open Learning Foundation and the Open University. It aims to improve levels of management performance in all parts of the health and social services by offering accessible, flexible and practical management development opportunities to all managers, irrespective of their professional backgrounds. Benefits were said to include 'encouraging health and social services managers to learn then work together towards community care'. Joint study opportunities were reported to be developing quite slowly, but a guide to 'building strategies for shared management development is available (NHSTD, 1993).

The two main programmes are: 'Managing Health Services' (MHS) and 'Health and Social Services Management' (HSSM) or 'Advanced MESOL'. MHS is for first line managers in the Health Service, covering the Management Charter Initiative (MCI) and offering access to NVQs and Institute of Health Service Managers (IHSM) certificate level awards. HSSM comprises six modules designed for joint study for middle/senior managers across the care sector and leading to a choice of awards. Centres have been established for shared learning between health and social care managers (NHSTD, 1993).

Release to Attend External Courses

One contributor suggested that it was now slightly old fashioned for organisations to release staff to go off on courses. Others confidently asserted advantages in getting away from base. Staff were less tied by the need to act in professional role, were less preoccupied by organisational policies and procedures, were less likely to be interrupted by work crises, had less reason to fear that behaviour and performance during the course would be fed back, and could be more critical of current practice. The college setting was, they said, better suited for reflective learning which was so essential in standing back from narrow professional preoccupations and in seeing oneself, one's patients, profession and organisation within a wider context.

Such courses may be run by universities and colleges, professional associations, trade unions, voluntary organisations, pressure groups and specialist centres as means to promote good practice in fields of particular concern to them. They may be large or small, residential or non-residential, as short as half a day or as long as several weeks. Only a few are assessed in which case they may carry awards or count towards them. Many are open to all comers, while some specify the groups for which they are intended.

Masters courses lay at one extreme of this spectrum. Storrie (1992) found 21 multiprofessional masters programmes in health and social care in the UK. Some were part-time, others full-time. Their number has almost certainly grown since she made her survey, as has the number of courses leading to postgraduate certificates and diplomas. Most concentrated upon strengthening academic foundations and acquiring research skills. Focusing upon interprofessional collaboration was the exception.

Towards Reflective Practices

Embodying the philosophy of the Marylebone Centre, the part-time MA in Community and Primary Health Care at the University of Westminster takes a whole person approach to both practice and learning. Like comparable masters programmes it has a unified knowledge base for all students, but it goes further.

Subtitled 'towards reflective practice', it encourages creative and critical thought by means of trained observation and analyses of policy, theory and research. Collaboration between the professions is treated as a series of inter-cultural phenomena. Assessed assignments include: writing up observations of an agency other than the student's own, describing roles, tasks, structure and cultures in inter-professional/inter-organisational work, and applying group dynamics to the analysis of inter-personal, inter-group and leadership issues.

Each MA course takes advantage of one of a rolling programme of working conferences on collaboration and change, which is also open to others whose work involves interprofessional or inter-organisational collaboration. Entitled 'Pride and Prejudice' and lasting five days in residence, each conference offers an opportunity to explore changing demands in health, community and education settings including conflict and stress generated for both staff and users, taking into account pride, prejudice, rivalry and envy towards other professionals. The conference emphasises learning by experiencing small group and inter-group behaviour, within the conference as a whole system.

6 PROMOTION AND DEVELOPMENT

Shared learning was gaining ground rapidly, especially within continuing professional development as the last chapter amply illustrated. Its advocates were, it seemed increasingly, pushing on a half open door. To assume, however, that their work was done would be to misread the situation.

New initiatives needed to be targeted in areas where working relations were either problematic or critical to the implementation of policies and to the improvement of services. Determined efforts were also needed to demonstrate how the generality of shared learning could be developed to further collaborative practice and to rally support for that cause. Both these themes were explored fully during the interviews, and are reported in this chapter.

PROMOTION

The following are some of the key areas in which contributors wanted to see the promotion of shared learning targeted.

Joint Assessment

Several wanted to create opportunities for practitioners from different professions to come together to learn how to make joint assessments. This was said to be especially desirable in community care where needs-led assessment called for a frame of reference which was wider than that for any one of the professions. It was just one example of a situation where some contributors put great store by problem-based learning as a means to concentrate upon a common task, to value and utilise respective contributions, and to set aside unhelpful differences.

Community Care and Primary Health Care

At the time of the interviews legislation for community care had only just been implemented. While joint planning may well have provided a vehicle for shared learning at senior management level, and joint programmes were available for a range of managers, shared learning for more junior staff was only beginning. This had typically taken the form of joint briefings, although the Inter-Change Programme in Scotland (see page 35) had demonstrated just how diverse initiatives could be.

It was too soon to expect to find many examples of shared learning between professions in primary health and community care. Yet the need for this was increasingly evident, notably to bring together GPs and social workers to explore bases for collaboration at operational level. Pilot projects had been launched and CAIPE was embarking on a

review of them to gauge implications for sustaining collaboration. Meanwhile, the Nuffield Institute for Health was about to publish a Development Pack and the NHSTD had published guidelines for managers (Undated). Finally, Nottingham University was engaged in preliminary research into working relations between GPs and social workers. Rapid expansion in the number of fundholding GP practices made action in this area even more pressing as the potential for rivalry with social services departments heightened.

Middle Managers

One contributor pinpointed middle managers as the priority group. Unlike senior managers, they were not, he said, routinely involved in joint work between health and social services. Their role was pivotal in effecting collaboration, vertically within their own organisations and laterally between organisations. NHSTD learning materials were relevant (Undated), while pilot programmes by NHSTD and the Social Services Inspectorate have given a lead (1993).

Senior Managers and Practitioners

Tension between managers and practising professionals concerned many contributors. Shared learning could, they hoped, offer a means to explore differences and to find common ground. That may best be attempted off site, in confidence and with the help of independent facilitators or consultants.

Managers had, of course, participated in numerous shared learning events, but rarely with the express intention of looking at relationships with particular groups of practitioners regarding particular organisational or service issues.

Policy Makers and Practitioners

While shared learning was frequently invoked to help in implementing policies, it was used far less often in policy formulation when ideas could be tested against professional experience and judgement. Nor was it often used for policy makers and practitioners to review progress.

There had, however, been occasions when policy makers, managers, practitioners and others had met off limits. For example, Cumberland Lodge in Windsor Great Park had hosted such occasions, including some for CAIPE. There was then some experience upon which to call in exploring how shared learning can operate more often at the interface between policy and practice.

DEVELOPMENT

Important as promotion was, developing existing shared learning seemed even more important. Many contributors from colleges and universities were quick to acknowledge that something more than modularisation, CATS and open learning materials was

needed if shared learning was to realise its full potential as a means to engender understanding and collaboration between practising professionals. In work-based learning, too, it was acknowledged that much remained to be done to bring the generality of shared learning up to the standard of the best, while many of the initiatives by voluntary and other independent bodies also needed to sharpen their aims, their target groups and their learning methods.

In all three areas, persuading teachers and trainers of the force of the arguments, equipping them with the additional skills, and willing the means, lay at the heart of the matter.

Involving Users and Carers

Confident claims were made for involving users and carers, not only as participants but also in planning, teaching, assessing and monitoring courses. It was their presence which brought out the best in the professionals and their needs which put rivalries and differences in perspective.

Such involvement was a feature of the post-graduate mental health course at the London School of Economics where users and carers were involved at every stage. It had also been used by the King's Fund Centre to concentrate professional minds in a series of day workshops designed to formulate plans for commissioning particular services. For example, the National Eczema Society had helped to plan a workshop about skin conditions and had invited users to participate. A 'critical mass' of users was, said the organiser, 'incredibly powerful'. Their presence had stopped the professionals from wrangling over resources and from 'lapsing into Health Service games'.

For some contributors, user-centred learning was sufficient to put shared learning on the right track. For others, it was one of a number of ways.

Cultivating Reflective Learning

Several contributors put great store by cultivating a reflective approach to practice, and were much influenced by the work of Schon (1983). The argument here is that professionals need to stand back from the technicalities of their own practice to respond to the needs of users in a context which is wider than the remit of any one profession and so, requires collaboration (Elliott, 1991).

Introducing Interactive Learning

Value was added to shared learning, many contributors held, when participants not only learned alongside each other, but also from and about each other. This could only happen when small groups were built in, when methods were devised which prompted interaction and mutual learning, and when a climate of honesty, openness and trust had been cultivated. Part of the savings from modularisation should be ploughed back, they argued, to cover the cost of small group learning and the relatively high staff/ student ratios upon which it depended. Helped by modern teaching methods and educational technology, said another, acquiring knowledge and skills could become

infinitely more efficient thereby freeing up time for interactive learning.

Such learning was said to be rooted in principles of adult learning. Ground rules should be agreed at the outset. A climate of confidence had to be generated in which participants felt safe, but also a climate of expectancy which held the possibility of change. Participants had to be released from the constraints of their own cultures yet, paradoxically, called upon to use their particular professional experience within the group.

Interactive learning was experiential. It included role plays, games and case studies. Ice breaking exercises helped to expedite interaction, especially when time was short. Interactive learning went through phases. Initial assertions of sameness could generate togetherness at the price of learning about differences not just in roles and responsibilities, but also in values, beliefs and perceptions. Given time, said one contributor, cosy relationships began to snap! The final phase, all being well, arrived at the point where participants had a mature understanding of that which they held in common, of that which distinguished each profession present, and how such differences could be put to optimum use in collaborative practice.

The mix and balance between professions was critical. Which professions to cater for had to be decided at an early stage. The minimum (by definition) was two, but some contributors preferred to bring together as many as five or six. Thought had also to be given to balancing numbers from different professions. In the real world precisely equal numbers was unlikely, but maxima and minima had to be fixed for each profession. Recruitment had to be targeted accordingly and consideration given to introducing quotas.

Balancing numbers, as contributors had found, was more difficult than it sounded. Depending upon the topic, some professions came forward more readily than others. Nurses (being the largest of the professions) often predominated, while social workers were well represented. GPs were the reluctant joiners, except reportedly in parts of Northern Ireland where their inclusion in Health and Social Services Boards seemed to have made a difference.

Building Common Curricula

One contributor hotly challenged the view that added value lay in interactive learning. For her, the crucial step was to recognise commonalities of learning between the professions about the same client group. She saw no need to facilitate interaction beyond that which occurred naturally amongst her mature students, and had found the literature on the interactive learning limited and unconvincing. Asserting that it was this that added value by inference devalued common learning.

Others were also unconvinced. It was unfair to assume problematic working relations. Professions often worked well together. That point was made persuasively in Northern Ireland where the structure of the unified health and social services boards had reportedly done much to improve collaboration. As a result, the need to address differences during shared learning had been reduced and initiatives could concentrate upon common learning within a common framework.

Where professions were already working well together, said contributors, what they needed was technical input. If common learning was not enough the deficit had to be defined and agreed before it could be made good. Even so, interactive learning was only one way to do this.

While college-based study could, with advantage, be common, said one contributor, it had to be applied separately to each field of professional practice, before being applied to collaborative practice. Once learning took root in the student's own field, it was possible to engage with others to explore implications for collaborative practice from a secure base. That advice seemed especially pertinent with reference to students on qualifying courses, in view of their general lack of practice experience.

Building in Comparative Learning

However, shared learning which failed to develop beyond building common curricula invited criticism for its lack of respect for the distinctive attributes of each profession. That need not always be problem-centred; it could equally be about the positive mobilising and deploying of professional difference within good working relations. Viewed thus, it was easier for each profession to enter into the experience, free of taint of criticism and concomitant defensive reactions.

Comparative learning had to be built in if participants were to explore respective roles within their legal, political, organisational and cultural context. At its most basic, this could mean no more than the judicious choice of case studies to illustrate similarities and differences, but it could also lead into the imaginative use of simulated learning.

Common, Comparative and Interactive Learning

For the interviewer, as he struggled to reconcile these arguments, it seemed as though false choices were being pressed upon him. Surely, comparative learning complemented common learning and paved the way for interactive learning. Arguing about the relative merits of these three deflected attention from trying to understanding their essential interdependence. Only then, it seemed, would shared learning be complete and enable the professions to make a rounded response to needs as articulated by users.

7 A CONCERTED AGENDA

This final chapter looks to the future. It sets out an agenda for action which it invites interested organisations to consider and support.

Communication

Contributors, intent as they invariably were upon promoting and developing shared learning to surmount barriers between professions in their respective fields, seemed largely unaware of developments in other fields. Attitudinal and organisational impediments were, it seemed, at least as formidable between fields as between professions.

Networks within some fields appeared to be gaining strength. This was most evident in primary health and community care, through conferences and seminars run by CAIPE and its information Bulletin, although the number of individuals and (through them) organisations reached remains small, relative to the size of those two fields.

Wider networks across fields were conspicuous by their absence. The Journal of Interprofessional Care had begun to provide a vehicle for communication and its readership was growing, but conferences and seminars spanning different fields were lacking. These could do much to open channels for communication and for mutual learning.

To engender broad support, inter-professional networks and gatherings would need to be sponsored by key bodies in each of the fields to be covered. Deciding which are 'key' depends upon establishing where the boundary is to be drawn.

Boundaries

Limiting shared learning exclusively to health, or even more narrowly to primary health, is no longer tenable. Account must now be taken of developments in community care. If the rhetoric of a seamless service and user-centred care means anything, it means weaving health and social care together. For community care to establish its own collaborative networks in isolation from primary health would serve only to institutionalise the divide, making arbitrary distinctions between health and social needs, and the eventual act of reconciliation even more difficult.

There are compelling arguments for bringing child protection within the same boundary as primary health and community care thereby including the other major field of shared learning in social services.

Drawn thus, the boundary takes in not only health and social care professions, but also (depending upon the particular field), housing officers, lawyers, police, probation officers, social security officers and others. It is not, however, an argument for including fields of shared learning primarily between these others, eg in the criminal justice system, without reference to health and social care and its professions. That would make the difficult task of forging collaboration between interested bodies well nigh impossible.

Collaboration

Within health and social care, national responsibility for furthering shared learning is divided between, and sometimes within, fields. Public health has the Standing Conference on Public Health. Health education and promotion has the Health Education Authority. Primary health has CAIPE, the Alliance of Primary Care, the Commission on Primary Care and, in Scotland, Interact. Community care is included by CAIPE and Interact, but not by the Alliance and the Commission.The Health and Care Professions Education Forum brings together professional bodies at national level for biomedical sciences, social work, chiropody and podiatry, dietetics, occupational therapy, orthoptics, physiotherapy, psychology, radiography, and speech and language therapy. It facilitates collaboration between its constituent professions in the provision of health and social care. CONCAH (Continuing Care at Home) brings together members from health and social work professions to enable chronically ill people to remain in their own homes as a result of coordinated care and treatment. ACT (Anticipatory Care Teams) promotes teamwork, mainly between doctors and nurses.

In many fields the lead comes from research and development centres, where promoting shared learning and collaborative practice are two among many functions. For example, the National Children's Bureau addresses interprofessional questions in child protection, while Stirling University's Dementia Studies Development Centre influences collaborative care and treatment for confused elderly people within and beyond Scotland.

National charities such as Age Concern for elderly people, Mind for mentally ill people, and Mencap for people with learning disabilities, promote education and training open to a mix of professions. Few, however, would claim to be in business to provide shared learning expressly intended to further collaborative practice. While many of their concerns fall within primary health and community care (which makes them natural allies for CAIPE), each could also be encouraged to provide an alternative and complementary focus for shared learning.

Some professional associations are active in shared learning, notably the Royal College of General Practitioners. It has played a leading role in establishing the Alliance, which brings together professional associations for health administration, health visiting, medicine, midwifery and nursing, but neither social work nor the professions allied to medicine are included. The latter do, however, have a single Council for Professions Supplementary to Medicine.

A wider grouping of professional associations is essential if primary health and community care are to be drawn closer together. The Association of Directors of Social Services (and, in Scotland, the Association of Directors of Social Work), the British Association of Social Workers and the Social Care Association are the key ones to involve for community care.

Bearing in mind those other professions engaged in particular fields of shared learning, lines of communication need also to be kept open with bodies such as the Association of Chief Officers of Probation, the National Association of Probation Officers, the Institute of Housing, the Police Federation and so on.

The boundary between professional associations and trade unions is never clear and no useful purpose may be served by trying to draw it. Unison, in particular, includes a

number of relevant professions amongst its members.

Validating bodies each relate to their respective professions. Inspite of much effort, joint initiatives in shared learning remain the exception. Hedged about by two or more sets of regulations, conventions and assumptions, successful initiatives are all the more remarkable. Even so, they are often short lived. There are lessons to be learned with a view to finding more expeditious, more economical, more effective and more lasting ways to promote shared learning.

If and when that is achieved, the way will be clear, not merely to sanction shared learning from time to time, but to build it in routinely as a necessary and valued component in a rounded education and training for each and every professional. This proposition found favour with contributors strategically placed to pursue it.

Other training bodies are more broadly based, notably the NHS Training Directorate (NHSTD) and the Local Government Management Board (LGMB). Both of these promote programmes which span professional fields, notably in management, but both also respect the territory of the professions with regard to education and training for practice. This sets limits upon their contribution in promoting shared learning, limits which could, however, be eased in partnership with validating bodies.

When and how the National Council for Vocational Qualifications will enter professional education remains, at the time of writing, in the future. That it will do so seems no longer to be in doubt. Whatever disquiet that may cause, it may also create hitherto unimagined opportunities (see page 18 and Barr, 1994).

Fortunately, health and social care fall within the purview of the same central government department, the Department of Health, but education, housing, police, probation and social security all relate to other departments. No one department is therefore in a position to deal with all the professional interests caught up in shared learning in health and social care, still less more widely. Locating lead responsibility within government, and establishing communication channels between departments, would be helpful.

Local authority associations have relatively wide remits and a natural interest in matters interprofessional. However, unlike the National Association of Health Authorities and Trusts (NAHAT), they have yet to be invited to play an active part in promoting conditions favourable to shared learning and collaborative practice.

There is much to be done to forge a coalition between UK bodies dedicated to interprofessional education and practice, and, together, to work, as occasion demands, with research and development bodies, major charities, professional associations, trade unions, validating bodies, government departments, local authority associations and others within a concerted strategy to promote and develop shared learning.

The same spirit of collaboration needs to be forged within the four countries of the UK, regionally and locally. Much might be learned from examples of successful individual and organisational networks, with a view to replication.

Recognising the politics and the complexity involved in working with other bodies, CAIPE has, so far, settled for the relatively simple task of enabling individuals to come together, leaving them to take back what they may for the benefit of their organisations.

Valuable as that is, only corporate participation, nationally, regionally and locally, holds the promise to enlist powerful allies to the interprofessional cause.

These observations go beyond ground covered during the interviews, but the case for promotion and development which contributors made can only be taken forward if and when the interested bodies combine their best endeavours.

Promotion and Development

It is the UK bodies which are best placed to debate, and hopefully agree, priorities for the promotion and development of shared learning, in consultation with their 'constituents', to instigate action and to will the means. It is they, working through their regions, local branches and members, which have the machinery to encourage and support shared learning on the ground, although initiatives need not, of course, wait upon national leadership, as examples in this report have demonstrated.

Of the priorities suggested by contributors for promotion, perhaps the most pressing is to explore scope for collaboration between primary health and community care. It is here that cultures clash, systems are at variance, and key professions most distant. CAIPE, with a remit covering both these fields, is peculiarly well placed to give a lead, in partnership with key interests in both.

Of the priorities suggested for development, the most pressing may be to refine, test and evaluate methods held to further collaborative practice. The resulting papers, publications and conferences could help organisations running courses, seminars and workshops to recognise ways in which they could be made more relevant to collaborative practice.

Monitoring

Ways to monitor shared learning are now well tried and could readily be propagated in guides to good practice. These would need to help teachers and trainers decide which kinds of monitoring were practicable in different circumstances and suitable for different purposes.

Monitoring should clearly be the norm. It ensures that initiatives are sensitive to participants and that lessons are learned and improvements made accordingly.

Evaluation

Monitoring cannot, however, test claims made for shared learning in furthering collaboration. That calls for evaluative research, preferably under independent auspices and controlled conditions, and building upon experience already gained (Shaw, 1994).

In the light of this report, it is no longer tenable (if, indeed, it ever was) to generalise about the benefits of shared learning. It takes many forms, each calling for separate evaluation. Decisions must be taken about which to select, and where to deploy scarce research funds. Targeting evaluative research and applying its findings, depends upon being able to identify types of shared learning within a coherent framework. Constructing such a 'typology' is now a priority.

Resources

Promoting, developing, monitoring and evaluating shared learning depends upon mobilising and deploying resources – human, material and financial. Courses are needed for the teachers and trainers to sharpen and acquire skills in experiential, interactive, applied and user-centred learning between adults, with reference to selected learning methods. Learning materials need to be produced for use by teachers and participants to reinforce elements within shared learning thought to further collaborative practice. Particular attention needs to be paid to augmenting and modifying open learning materials for use in shared learning for collaborative practice. Potential benefits from educational technology, notably Computer Assisted Learning, merit exploration.

Research methodologies need to be devised, tested and refined before being applied more widely.

Throughout the interviews, concern about funding was never far away. As contributors argued (page 40), some of the savings from modularisation do need to be ploughed back to meet the relatively high cost of interactive learning in small groups. Pump priming funding is needed to plan, test and evaluate pilot projects, to mount courses for teachers and trainers, to manufacture learning materials and to test the potential of educational technology.

In the Health Service, devolution of training budgets to Regional Health Authorities has made attracting funds more complex, more time consuming and more problematic. Many of the developments envisaged hold potential nationally, with the inference that the initial outlay should be found nationally.

There is a further problem. Budgeting, whether national, regional or local, is invariably compartmentalised by service, organisation or user group. Applications to support shared learning invariably fall between stools. Sensitive to these problems, some of the major charitable foundations have stepped in, notably the King's Fund, Nuffield and Rowntree. While the promotion and development of shared learning has owed much to their support, it would be unrealistic and unreasonable to imagine that they could provide the scale of funding necessary to back a concerted strategy.

It is the implemention of government policies which has reinforced the need for shared learning. It is government therefore which must will the means if shared learning is to realise its full potential in furthering its goals.

The International Dimension

This review has been limited to the UK, but the major challenges which it has posed cannot be met in national isolation. Other countries are addressing those same challenges. There is much to be learned from each other.

Links have been established with some, notably Australia, Canada, Finland, Norway, Sweden, and the United States. A core of UK delegates are active in the European Network for Multiprofessional Education (EMPE), while the Journal of Interprofessional Care is strengthening its overseas links.

Just as shared learning is enriched as it reaches out across interprofessional cultures, so it is doubly enriched when it reaches out across international cultures.

A POSTSCRIPT

Promoting and developing shared learning as contributors envisaged largely depends upon whether their commitment and enthusiasm, and that of countless others like them, is infectious. Their testimony, one in particular , suggests that it is, indeed, caught not taught.

First Encounter

Faced with persistent drugs problems on his patch, the Chief Inspector was looking for fresh understanding and new approaches. He had heard about the three day course on drug abuse and decided to apply, only to be told that a decision had been taken to exclude the police as self disclosure was expected. Subject to reassurances, his application was accepted and he found himself alongside probation officers, social workers and youth workers. Together they learned the effects of legal and illegal drugs, and about difference in their use and abuse across cultures. The tutors were from health education. They encouraged participants to be candid about the organisations and professions from which each came and 'to get stereotypes out of the way'. Attitudes and behaviour were challenged forcefully within the group. Participants acknowledged their own misuse of alcohol, tobacco and caffeine. The police, the Chief Inspector learned, were not alone in having to decide between taking the hard or soft line. He learned something more – that drug abuse need neither be condoned nor condemned. It could be dealt with like any other problem. There perhaps was common ground upon which to work together.

The impact was lasting. Back at work lessons learned were applied to practice, influencing relations with other agencies and the community, not least as a member of the Force's Drugs Policy Team. Furthermore, he arranged for two other officers from his patch to attend the course and then for the tutors to run an in-house course so that more of his colleagues could benefit.

On his initiative, shared learning was instigated to further collaboration in diverting mentally ill offenders from the criminal justice system, while his colleagues were taking the lead in developing shared learning for child protection.

Like an elephant, 'real' shared learning may be hard to describe, but you recognise it when you meet it.

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APPENDIX

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Hugh Barr is a Special Professor in the School of Social Studies at the University of Nottingham, with particular reference to interprofessional research. He has undertaken a number of assignments for CAIPE and is currently directing its second national survey of interprofessional education. Related interests include serving on the Editorial Board for the Journal of Interprofessional Care and external examining for interprofessional courses at the universities of Dundee and Westminster. He also acts as a consultant in education and training and, through the Charities Aid Foundation, for voluntary organisations.

He was formerly an Assistant Director of the Central Council for Education and Training in Social Work (CCETSW), having spent his earlier career in the Probation Service, the voluntary sector of prison after care and the Home Office Research Unit.

About CAIPE

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 body with some 500 individual 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.

CAIPE's Director will pleased to tell you more if you telephone or write to her:
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About the School of Social Studies at Nottingham University

The School of Social Studies 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 the UK and in their 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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