TOWARDS AUDIT AND OUTCOME EVALUATION

OF

INTERPROFESSIONAL EDUCATION

FOR

COLLABORATION IN PRIMARY HEALTH CARE

A CAIPE Discussion Paper

BY

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THE UK CENTRE FOR THE ADVANCEMENT OF INTERPROFESSIONAL EDUCATION

- May 1997 -

CAIPE, the UK Centre for the Advancement of Interprofessional Education, is a membership based, independent organisation, concerned to promote and support high quality developments in the practice and research of interprofessional education and training, in order to foster and improve user and carer focused collaborative care. For further information please contact CAIPE, 344 Grays Inn Road, London WC1X 8BP.

Note.

The views expressed in this report are those of the authors and not necessarily those of CAIPE.

CONTENT

FOREWORD

Collaboration, working with one another, in the health services and other sectors should be a *sine qua non* with the primary aim to ensure acceptable, effective and efficient care for individuals and groups, as well as to improve the health status of the community.

A further aim is to create and then to maintain a supportive working environment with resulting high levels of job satisfaction for all health professionals.

That is the theory. The reality is that the pressures of day to day practice, with little incentive to devote time and effort to collaboration, tend to reinforce the *amoure propre* in the pride and security of one's own profession. This has its origin in the sometimes quite deliberate influence of conventional professional education. To this should be added the reinforcing affect of institutionalization which breeds the perception that the system exists primarily for the benefit of the professional.

Recognising the importance and complexity of evaluating interprofessional education, CAIPE, the UK Centre for the Advancement of Interprofessional Education, is delighted to produce this discussion paper. It draws on a project which was funded by the National Health Service Executive.

The project underlines the fundamental importance of the need for a symbiotic balance between education for collaboration and the political, organizational and managerial will that enables professionals to practise what they have learned.

CAIPE looks forward to supporting further efforts to achieve this.

Professor Sir Michael Drury
Chairman

ACKNOWLEDGEMENTS

This paper has been written for CAIPE by Professor Charles Engel, an Associate at the Centre for Higher Education Studies of the Institute of Education at the University of London and Lonica Vanclay, CAIPE's Director, who undertook and reported on the evaluation and audit of the Prince of Wales Fellowship Scheme.

CAIPE wishes to give particular thanks to:

- Professor Charles Engel for his invaluable contribution to this project and for his continued advice and support to CAIPE over the years.
- the NHS Executive for providing the grant which enabled CAIPE to undertake the project which has resulted in this paper.
- Dr John Horder and Dr Pat Owens for developing project plans.

The authors wish to express their grateful thanks to the following:

- Dr John Toby, Chairman of the Royal College of General Practitioners and of the Commission on Primary Care and
- the RCGP's Prince of Wales Fellows for their support and collaboration in the development of the ideas herein, ideas developed by evaluating and auditing their work.

EXECUTIVE SUMMARY

This discussion paper concentrates on the identification of the aspects that should be considered in the audit (monitoring) and outcome evaluation of a practice-based interprofessional educational initiative which is designed to enhance interprofessional collaboration.

While educational interventions set out to engender change in performance and behaviour, the long term implementation of such change is largely dependent on the support given by those who can enable the professionals to practice what they have learned.

The measurement of change, in terms of acceptability, effectiveness and efficiency (sustainability) will be by comparing performance and behaviour, and the effects of collaboration in terms of perceived satisfaction and in terms of economy of time, effort and resources before the initiative, at the end of the initiative and subsequently.

A discussion of evaluation during and after an educational initiative is followed by summary protocols.

The report concludes with a summary of some resources and a selective Bibliography.

BACKGROUND

The UK Centre for the Advancement of Interprofessional Education (CAIPE) was funded by the NHS Executive to undertake a project to develop an approach to auditing, as well as evaluating, the outcomes of educational initiatives that seek to enhance patient care through improved interprofessional collaboration, based on the experience of auditing and evaluating the early stages of the Prince of Wales Fellowship Scheme.

This discussion paper is the final part of the project. It outlines an approach to auditing and evaluating practise-based educational initiatives for enhanced patient care through improved interprofessional collaboration.

The first part, a report dated January 1996, was entitled "An Evaluation of the Achievements Over Two Years of the Prince of Wales Fellowship Scheme of the Royal College of General Practitioners' Commission on Primary Care". It outlined the activities and the achievement up to that time of the first three Prince of Wales Educational Fellows.

The second part, a report dated September 1996, was entitled "Developing and Evaluating Local Interprofessional Education Initiatives: Lessons learned from evaluating the early stages of the RCGP's Prince of Wales Educational Fellowship Scheme". It summarized some evaluative comments on the progress and outcomes of the Fellowship Scheme halfway through its term. Drawing on the experiences reported by Fellows and lessons learned from the Fellowship Scheme, it made suggestions for developing local interprofessional education initiatives. It included some suggestions on approaches to evaluating interprofessional educational initiatives.

PURPOSE OF INTERPROFESSIONAL EDUCATION

Interprofessional education can be defined as occasions when two or more professions learn together with the object of cultivating collaborative practice. Its purpose is to develop, modify and maintain the knowledge, attitudes and skills needed for interprofessional collaboration. The aim of such collaboration is to foster coordinated user and carer focused care.
(Barr:1996; Vanclay:1997)

This, however, raises the question - what are these competences, and how are they best developed and maintained through interprofessional education?

When competences for interprofessional collaboration are seen in terms of *performance (what* a professional does) and *behaviour (how* the professional does it), education needs to be considered as interventions which are designed to *develop, modify, reinforce or maintain* specific competences.

What, precisely then, are the requisite competences, and would all of them be applicable under all circumstances and irrespective of the actual nature of the task involved?

These fundamental questions remain to be answered, so that appropriate educational interventions can be developed.

Nonetheless, any interprofessional education programme should seek to be based on information related to the characteristics of those who are to be involved in the programme, the specific purpose of the educational experience and thus the competences to be addressed.

Especially when concerned with *practice-based educational initiatives*, the organizers might also ask themselves whether such education should be aimed at particular tasks and circumstances, i.e. *learning in the context in which it is to be applied.*

PURPOSE OF AUDIT AND OUTCOME EVALUATION OF INTERPROFESSIONAL EDUCATION

Audit is here used in its more restricted meaning of *monitoring what* is being done and *how* activities are carried out. The purpose of such monitoring is primarily concerned with providing evidence which can assist in deciding *how to improve* the programme - from the identification of needs, to the specification of purpose, the design of interventions and the recruitment and selection of providers ("teachers") and participants ("students"). It is concerned not only with *what* was done, but also *how* and by *whom*.

A further purpose for monitoring is to obtain objective data and descriptive information which can be used to explain the results of outcome evaluation. This evidence is related to the questions:
How acceptable are aspects of the programme to providers and users?
How effective is it - how likely is it to achieve its aims?
How efficient is it in the use of time, effort and resources?

As audit is here concerned with gaining evidence to help decide what should be improved and how such improvement could be implemented, it is advisable to involve from the very beginning all those who will be involved in the subsequent development and amendment of the initiative.

Outcome evaluation is primarily concerned with the *results* of a substantial programme and sets out to provide evidence which can be used to reach major decisions, such as whether to adopt, adapt or abandon a programme in part or as a whole. It involves a judgement of worth or value, based on the collection and interpretation of information. (Coles&Gale Grant:1985).

Establishing the outcomes of interprofessional education involves two steps :

- the outcome of education: its effect on professional practice ie competence in collaboration;
- the outcome of practice: the effect of collaboration on care and services and their impoact on patients/carers.

Outcome evaluation seeks to establish the *acceptability* and *efficiency* of the programme and addresses aspects of *effectiveness*. Three aspects of effectiveness are worthy of attention.

First, randomized trials would be needed to establish the true effect of an educational intervention on the programme and on the behaviour of professionals. However, educational events are complex, dynamic and dependent on context, and only some of the numerous variables can be identified, controlled and measured. It might prove difficult, in trials, to exclude other factors, such as personal factors, varying circumstances and conditions of professional practice, which also exert an influence on performance and behaviour. (Coles&Gale Grant:1985; Gonnella et al:1994). Even when improved collaboration has been demonstrated, it might not be safe to credit education with any concomitant improvements in the outcome of health care provided by these professionals. Quite substantial, longterm trials would need to be mounted, in order to eliminate other potential influences on outcomes of health care.

Second, indirect as well as anticipated results should be considered during outcome evaluations. For example, apart from possibly enhanced job satisfaction, reduction of resignations from the service, or more economical use of resources, less obvious outcomes might relate to improvements in provider competitiveness, in changes in guidelines, or in amendments of policy.

Thirdly, the differing, sometimes conflicting, views of the many stakeholders will need to be acknowledged. These include patients, carers, participants, education providers, education purchasers, service providers and service purchasers.

As outcome evaluation is intended to lead to broad policy decisions, it may be advisable to employ an outside consultant to gather and analyse data and to document the analysis of the evidence. This would ensure that the results of the evaluation can be accepted without suspicion of bias. It will, of course, remain the prerogative of the funding/employing authority to draw its own conclusions and to decide on policy changes.

PROTOCOL FOR AUDIT OF INTERPROFESSIONAL EDUCATION

An audit should monitor each phase of an educational initiative. It should reveal which steps were omitted and how the remainder were carried out. The protocol should, therefore, provide a comprehensive list of the essential steps for a practice-based, interprofessional education initiative:

Planning

- Establishment of the reason(s) for the initiative;
- Specification of purpose and expected outcomes;
- Design of the intervention, including context, content and process;
- Specification of logistics and resources;
- Management of the initiative.

Preparation

- Funding;
- Recruitment and familiarization of staff for the initiative;
- Recruitment of the participants;
- Organization of timetable and related staff for the implementation of the initiative.

Implementation and Documentation

- Record of activities and progress;
- Collection of perceptions;
- Record of responses and analysis;
- Examination of immediate outcomes;
- Record of overall expenditure;
- Report of mindings and recommendations.

Planning

For each aspect of planning, the audit should establish how the decisions were arrived at. Where decisions were based on specific information, the audit should enquire into the validity and reliability of such data and whether the conclusions were based on sound analytical methods.

(i) Reasons for an interprofessional education initiative

The reasons may relate to the needs of the organization, needs established through audit of past practices, or needs of the health professionals.

The organization may have identified needs to:

- familiarize members of the team with modified or new roles;
- introduce modified or new approaches to interprofessional tasks;
- maintain or improve the acceptability, effectiveness and/or efficiency of one or more interprofessional tasks.

The *professionals* may identify needs to:

- familiarize themselves with what they recognize as amended or new roles;
- reflect on the effect of revised or new regulations or guidelines related to interprofessional collaboration;
- familiarise themselves with research results, surveys or audit data and agree on appropriate change in their collaborative practice;
- develop or extend specific competences for undertaking a new task, e.g. an interprofessional research project.

(ii) Purpose and expected outcomes

The above reasons should be translated into an explicit purpose. This, in turn, should be amplified by the specification of the expected outcomes, short term and long term, and how the related evidence would be obtained. Especially for long term outcomes, it may not be possible or logistically practicable to aim for very detailed, quantifiable data. It may frequently be necessary to accept *indicators* that suggest a satisfactory, more general outcome, if the data related to the indicators is acceptable as an *indication* that the purpose as a whole has been achieved.

(iii) Design of the initiative

A description of the professionals, the purpose and the expected outcomes will act as the main criteria for assessing the appropriateness of the initiative:

- the practice or task-related *context* for the educational experience(s);
- the educational *content* or knowledge and/or skills to be acquired;

- the educational *process* (e.g. problem-based learning, syndicate project work, discussion and planning).

The educational approach should be justified by reference to prior research and development or critical review of the literature (meta review).

The design should demonstrate that the purpose of the initiative could be met and that the expected outcomes could be achieved within the constraints of service commitments and accessible resources.

(iv) Logistics and resources

The plan should specify:

- numbers and composition of the participants, their qualifications and experience;
- the planned number of separate educational events and the duration of each;
- the planned number of persons and their qualifications and experience to support specific aspects of the initiative;
- material resources required;
- location and facilities for the initiative;
- arrangements for transport, catering, accommodation (if needed);
- estimate of expenditure and anticipated income;
- lead time prior to the implementation phase.

(v) Management

This section should specify the hierarchy of accountability, including the positions of those who are to be involved in, or recruited for, specific tasks in the management of the initiative, including evaluation. This should also anticipate how much of their individual time will be needed.

Preparation

(i) Funding

The identification of potential sources of funding and any subsequent difficulties experienced should be documented with a view to more successful approaches on a subsequent occasion.

(ii) Recruitment and familiarization of teachers/facilitators

This activity should document the qualifications and experience sought in the teaching staff, the approaches used for recruitment and selection, and any difficulties encountered. In addition, the administrator should record the performance of the staff in comparison with the judgements formed at interview and during familiarization sessions.

These sessions should be based on a documentation of their purpose, context, content and process, so that their expected outcomes can be compared with actual performance during the implementation of the initiative.

(iii) Contact with the participants

How the participants are recruited and how they are informed about the purpose and logistics of the initiative should be recorded as evidence for the monitoring of the initiative. The responses from the participants can provide evidence for subsequent improvement of the initial contact with participants.

(iv) Organization for implementation

How the initiative is run organizationally can only be monitored effectively on the basis of a detailed *timetable* of all educational and supportive activities, together with the names and responsibilities of those assigned to respective activities.

Implementation and documentation

(i) Record of activities during the implementation of the initiative

Teachers/facilitators should keep a simple diary of what they do, in what circumstances and with what response from the participants. This would provide essential information to explain the reasons for good and not so good perceptions from the participants. The diaries would also explain the perceptions of the teachers/facilitators themselves. For example, a "thin" set of activities in a diary might explain why a facilitator felt underused while the participants felt undersupported.

If other members of the organization, patients or carers were involved in the educational activities,

their experiences, as well as their perceptions would provide important contributory information for the monitoring process.

All who take part in the initiative, including the professionals for whom the educational experiences are provided, should record time spent on preparation, actual face to face activities, and subsequent but related activities. This information will be essential not only for the interpretation of their perceptions, but also for evaluating the efficiency ("at what cost") of the initiative.

(ii) Collection of perceptions

These responses relate to the "acceptability" of the initiative, how the teachers/facilitators, other members of the organization, participants, patients and carers perceived the activities in which they were involved.

The use of questionnaires may be convenient and yield quantifiable information. However, the questions may not represent aspects that were of concern to the respondents and thus provide responses of uncertain validity. Furthermore it would not be easily possible to verify the reliability of the responses.

It may, therefore, be advisable to use other methods, such as the Nominal Group Process, where each member of the audience is invited in turn to contribute one brief statement signifying approval and one statement expressing disapproval. When all further contributions have been exhausted, the group indicates its support for each recorded statement in turn by a show of hands. The advantages are that the responses reflect the genuine concerns of the respondents and the overall perception of the group as a whole.

(iii) Recording of responses and analysis

All the information gathered during the planning, preparation and implementation phases needs to be assembled in condensed form, so that it becomes possible to analyse the data to answer the questions:

- How *acceptable* were the various activities?
- How *effective* was the initiative in achieving its purpose, as assessed at the end of the

initiative? (see Protocol of Outcome Evaluation)

- How *efficient* (how sustainable) was the initiative? [It will here be necessary to compare the initial budget with the final budget of actual income and expenditure. The cost, in terms of time and effort expended by all concerned would be equally pertinent for assessing the overall efficiency of the initiative.]
- *Integration*. How well did the initiative fit in with the overall programme of continuing education for the different health professions?

The answers to the above questions should lead to a section which documents *what* should be added, omitted, changed and *how* such improvements should be implemented during the planning, preparation and implementation phases of a repeat initiative.

Appendix A provides a Checklist for Auditing/Monitoring an Interprofessional Education Initiative

PROTOCOL FOR OUTCOME EVALUATION OF INTERPROFESSIONAL EDUCATION

Evaluation should here concentrate on assembling and analysing data that are related to the outcome of an interprofessional education programme. It would be unrealistic to expect any substantial outcome to result from a single, discrete educational intervention. Education is designed to lead to change, in performance and behaviour, that is *how* professionals work with one another. Such change depends on the cumulative effect of a sequence of experiences and deliberate reflection on these experiences. Growing familiarity with members of other professions in relation to a particular task will create increasing confidence in collaboration, i.e. that sharing power is possible and perhaps even enjoyable.

The outcomes in terms of change may be assessed *immediately* after the termination of the educational initiative and *long term*, over a period of time. In both instances, change in competence related to collaboration would need to be assessed in the context of the practice-based purpose of the educational initiative.

An important consideration is that the *concept of change* suggests that outcome evaluation should use a *comparative* approach by establishing a *baseline*, prior to the initiative for comparison with post-intervention performance, behaviour, perception. The information obtained from audit will be of considerable value in identifying the *reasons* for change, whether positive or negative.

It will seldom be possible to institute a comprehensive, indepth assessment of change. It will usually be more practicable to concentrate on *indicators*. Participants' reaction to and satisfaction with the educational programme, important though that is for auditing programmes, will not help determine outcomes. Questionnaires and attitude scales can be used to gauge changes in knowledge and attitudes. It is preferable, however, to look at changes in performance and behaviour, how the learning effects practice. If these have been shown to have changed in a positive direction in a substantial activity/situation/circumstance, this would indicate with a high degree of confidence that real change in other dimensions has also taken place. The results of behaviour changes can be seen by considering the changes in outcomes for patients. (Batstone:1996; Harper&Beacham:1991)

Assessment of change should here answer the questions:

*What is the quality and extent of the change?	*Change in attitudes to/understanding of other professions. *Change in knowledge and specific competence(s). *Change in collaborative practice (acceptability, effectiveness, efficiency).
*What is the effect of the change?	*Change in job satisfaction, satisfaction of patients, and carers. *Change in health status. *Change in key elements of care or service provision.

Outcomes immediately after the end of the education initiative may show a perception of enhanced job satisfaction, due to intellectual stimulation, mitigation of professional isolation and a sense of achievement. However, other changes may be limited to one or more competence which would not guarantee change in actual collaborative practice.

Outcomes over a period of a month or so, following the end of the initiative, could be expected to demonstrate a change in collaborative practice. However, this change in collaborative performance and behaviour and its long term persistence would depend not only on the effectiveness of the educational initiative *but also on the administrative and logistic climate* that supports and enables the professionals to devote time, effort and skills to working together.

Outcomes in the long term could be expected to demonstrate enhanced job satisfaction and persistent change in performance and behaviour in interprofessional practice.

If the evidence were to support such continuing change in practice, further evidence could be sought in the domains of acceptability and efficiency. Efficiency, in terms of economy of resources, time and effort, would be of specific interest to the funding authorities. Acceptability, expressed as satisfaction with the delivery of collaborative care, would be of direct concern to patients and their carers. Comparison of the outcomes of interprofessional education with those of uniprofessional education would provide additional information, though this will not always be feasible.

Outcomes in terms of change in health status would be less readily ascribed to the affect of enhanced collaborative practice, unless collaboration could be identified as the dominant variable among a host

of factors that might influence change in health status.

Table 1 summarizes methods that may be employed to gather quantitative data and qualitative information towards answering the questions

- What is the quality and extent of the change?
- What is the effect of the change?

Attention will need to be paid to the precise aims of the initiative in relation to the *task and circumstances* of the interprofessional collaboration. So, for example, to agree a plan of action during a round table discussion would represent a quite different collaborative task from collaboration in the actual care of chronically ill patients in their own home. Similarly, the actual situation and circumstances may exert a significant influence, according to their *level of difficulty* (e.g. at the end of a long and stressful day as opposed to the first task on the first day after a relaxing holiday).

For outcome evaluation, as for the monitoring of the initiative, succinct documentation of the types of evidence sought, the methods used, and the results obtained should precede the analysis and conclusions.

Appendix B provides a Checklist for Outcome Evaluation of an Interprofessional Education Initiative

Table 1. Methods for outcome evaluation

When to evaluate	What to evaluate	
	Competence in Collaboration	Effect of Collaboration
At the end of the initiative	1, 2, 3 (participants)	7 (participants)
During the first post-initiative month	1, 4 (participants),5	6 (managers) 7 (participants) 8 (patients, carers)
Long term	1, 4 (participants),5	6 (managers) 7 (participants) 8 (patients, carers)

1. Assessment of an end product, e.g. an agreed protocol with identified roles and responsibilities for a given collaborative task.
2. "Modified Essay Question", a pencil and paper task, to assess decision making and implementation, each step with articulated justification showing recognition of each other's roles and willingness to share power, in the context of a collaborative task.
3. Observation of collaboration in a simulated task, with a standardized marking schedule.
4. Observation of an actual collaborative task, with a standardized marking schedule.
5. Interviews about practice with participants, managers, patients, carers.
6. Analysis of diaries and records looking at the time spent by staff and participants during planning, preparation, implementation, monitoring.
7. "Nominal Group Process" where individuals nominate the "good" and the "bad", and the group votes to establish order of importance of the nominated perceptions. (Chapple&Murphy:1996)
8. "Focus Group" to establish a group perception of the "good" and the "bad".

APPENDIX A

Checklist for Auditing/Monitoring an Interprofessional Education Initiative

PLANNING

Reason(s) for the initiative

- How specified?
- From whose point of view?
- How were the needs for an initiative established?

Purpose of the initiative

- How specified?
- Who was involved in arriving at the specification?
- How was the specification arrived at?
- What are the expected outcomes - short and long term?
- How are the outcomes to be identified?

Design

- Type, number of professionals to benefit from the initiative, together with their anticipated qualifications and experience?
- Type, number of organizers, consultants, facilitators who are to be recruited, together with expected qualifications and experience?
- What is to be the practice-based task as the *context* for the educational experiences?
- What is to be the essential *content* (knowledge, understanding, skills, etc.) to be acquired by the participants?
- What is to be the educational *process* to foster the acquisition of the expected competences and related content (e.g. problem-based learning, syndicate project work, discussion and planning)?
- What is to be the number and duration of educational sessions, and the interval between sessions?

Logistics and Resources

- What is the type of preferred environment and location for the initiative?
- What material resources will be needed (produced, loaned, purchased)?
- What equipment will be needed (hired, purchased)?
- What lead time will be needed prior to commencement of the initiative?
- What is the estimated cost, how will this be met?
- What is the evidence that this design can be implemented within the existing constraints of service commitments, available human and material resources, and funding?

Management

- Who has sanctioned this initiative?
- What is the hierarchy of accountability?
- Who is to be responsible for, and who else is to be involved in the preparation, implementation, audit phases?
- Has their availability and time commitment been assured?

PREPARATION

Funding

- Which potential sources of funding were considered, explored, how and by whom?
- What were the results (successes, failures)?

Recruitment and familiarization of staff for the initiative

- Who has been recruited (by what means)?
- Who has been selected (by what method(s))?
- How do their qualifications and experience compare with the expected characteristics?
- What familiarization has been implemented, for what specific purpose(s), how and by whom?

Recruitment of the participants

- How were they recruited (selected) and by whom?
- How did their qualifications and experience compare with the anticipated characteristics?
- What changes, if any, will be made in the design of the initiative, if the actual characteristics do not match those on which the design was based?

- What information have the participants been given about the purpose, logistics and design of the initiative?

Organization for the implementation of the initiative

- Has a detailed timetable of all educational and supporting activities been prepared, annotated with details of who is to be responsible for the respective activities?
- Who is responsible for ensuring that the timetable is implemented?

IMPLEMENTATION

Record of activities and progress

- Does the main organizer's diary identify which activity in the timetable was *not* carried out (at all, in time, satisfactorily)?
- Do the teachers/facilitators' diaries record what they did and how the participants responded, as well as any reasons for any lack of satisfaction?
- Did all who were involved (including the participants and any patients and carers) keep a record of time, energy, resources expended in preparation for, during and after the initiative?
- How was progress towards achievement of the purpose of the initiative monitored; what evidence was collected; how did this information change the design and delivery of the initiative?

Collection of perceptions and factual records

- What methods were used to obtain the perception of all who have been involved in the initiative?
- What was done to ensure an adequate level of validity and reliability of the responses, including representative sampling and adequate response rate?
- What method(s) were used to establish the attainment of the purpose of the initiative -at the end of the initiative? (See Protocol for Outcome Evaluation and Appendix B. Checklist for Outcome Evaluation.)
- Were an adequate number of records made in relation to expenditure of time, effort, resources?

Recording of records of responses, factual data and analysis

- Has all the information been organized in relation to the steps within each phase of the initiative?
- Has the information been examined for its validity and reliability?
- Have the data been related to each other, in order to identify cause and effect?
- Have conclusions and recommendations been categorized by acceptability, effectiveness and efficiency?
- Have conclusions and recommendations for future improvements been passed on to all who will be involved in the improved design and its implementation?

APPENDIX B

Checklist for Outcome Evaluation of an Interprofessional Education Initiative

[See Table 1 on Page 16]

Aspects to be evaluated as outcomes

- *Which competences* for collaboration, separately or in combination are to be assessed prior to the initiative, immediately after the conclusion of the initiative, one month later, long term?
- How, and in which context are the competences to be assessed?
- What level of validity and reliability is to be accepted?
- *Which indicators* are to be investigated, in order to evaluate the effect of collaboration (in relation to change in the acceptability, effectiveness, efficiency of collaborative practice, change in satisfaction by professionals/patients, carers, managers; change in health status)?
- When are they to be investigated (prior to the initiative, immediately following the initiative, one month later, long term)?
- How, with whom and in which context are the effects to be assessed?
- What levels of validity and reliability are to be accepted?

Conclusions

- What is the relationship between the outcomes and the purpose of the initiative?
- What insights have resulted from a comparison of the outcomes with the information obtained during the audit - the monitoring of the ongoing initiative?
- What are the recommendations of the evaluator for consideration by those who may wish to decide whether to continue, amend or abort the whole or specific parts of the initiative?

APPENDIX C Some Resources

Poulton & West (1994) developed a primary health care **questionnaire** to detect changes in team processes as a result of team-building workshops. Participants complete this before and after the workshops. It examines:

- clarity of team objectives (the extent to which members understand and value team objectives);
- team participation (frequency of interaction and the extent to which individuals feel their views are taken into account in decision making processes);
- task orientation (the extent to which the team has a shared concern for quality of task performance by setting, monitoring and evaluating standards regularly);
- support for innovation (the extent to which the team is open to and responds to new ideas);
- role understanding (members perceptions of the extent yo which colleagues make appropriate use of their skills, rating of the level of understanding of the knowledge to carry out colleagues' roles and the extent to which individuals value the roles of their colleagues);
- review processes (the extent to which the team discusses and updates objectives and working practices);
- social relationships (the extent to which members support each other during times of stress).

Pearson & Spencer (1997) suggest that four key indicators of effective teamwork are:

- agreed aims, goals and objectives;
- effective communication;
- patients receiving the best possible care;
- individual roles are defined and understood.

Based on the experience of five test sites, Funnell et al (1995) suggest that alliance working can be evaluated using five process indicators - commitment, community participation, communication, joint working and accountability - and six output indicators - policy change,

service change, skills development, publicity, contact and change in knowledge, attitude or behaviour.

National Occupational Standards are currently being developed by the Care Sector Consortium. Standards on collaborative practice and on training and development are included. The standards outline work expectations and consist of descriptions of elements of competence, performance criteria and the knowledge, understanding and skills required for key roles. Once finalised, they could be used inform the development of criteria for evaluating the impact on practice of interprofessional education.

The Newcastle **Clinical Audit Toolkit**: Mental Health (Balogh et al., 1996) includes a literature review, learning materials and exercises, specimen letters and audit tools. Much is on computer diskette, so it can be amended locally. Considerable guidance is given on all aspects of the audit. All professions involved in the team would together undertake the audit of care. Collaboration would be audited in terms of the quality of liaison. The criteria, suggested as components of the appraisal of care, include admission and assessment, home comforts, empowerment, treatment, information, staff, and overall organisation of service provision. Several scales to assess the quality of care and patient dependence are outlined.

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