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Sustaining interprofessional collaboration

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Summary *There has been much written about new interprofessional collaborations, rather less about established or terminated collaborations. This paper briefly rehearses well known factors that encourage and discourage interprofessional collaboration, before considering factors that may help sustain collaborations or signal that termination of the collaboration is appropriate. The Clinical Skills Initiative at St Bartholomew's in London, UK is offered as a case study of a sustained interprofessional collaboration. It will be argued that a combination of continued need to collaborate and empowerment to do so, creates favourable conditions for sustained collaboration. The composition of the interprofessional team that comprises the collaboration is also seen as key.*

Key words: *Interprofessional; sustaining collaboration; clinical skills centre.*

Introduction

Much has been written about promoting interprofessional collaboration in health and social care, less about ways to sustain it. Many collaborative initiatives are short lived, ending when initial funds are exhausted, key workers move on, or the management climate becomes less supportive. However, there is very little incentive for stakeholders to publish analyses of terminating collaboration. Satin (1987) and Ross & Tissier (1997) provide rare examples of reflection upon discontinued interprofessional initiatives.

This paper will outline some of the factors that encourage or discourage collaboration, then turn to the knotty problem of sustaining collaboration. The interprofessional Clinical Skills Centre at St Bartholomew's Hospital in London will be used as a case study to illustrate different facets of sustaining collaboration. It will be argued that continued need for collaboration and continued scope for development of the collaboration, together provide conditions in which interprofessional collaboration is likely to be sustained.

Encouragement to collaborate

While there is a common sense reasonableness about the idea of interprofessional collaboration, an impetus is required to realise the ideal. A wide variety of circumstances encourage members of different professions to embark upon collaborative initiatives. These include attempts to resolve gaps, lapses and inefficiencies in service delivery; political and ideological drivers; and local enthusiasts.

Investigations of cases where clients have received poor service have repeatedly drawn attention to failures in communication and co-operation between different professionals (e.g. London Borough of Greenwich, 1987; DoH, 1994). This spawns the search for mechanisms

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to encourage interprofessional and multi-agency working, in an attempt to reduce the future incidence of identified failings (e.g. Home Office, 1991; Lowe & O'Hara, 2000).

Striving to make best use of limited resources may encourage interprofessional collaboration. For example, the development of a joint validation procedure for preregistration programmes in learning disability nursing and social work was heralded as ideologically driven (ENB & CCETSW, 1995, p. 1)

> The need for a closer interface among professionals and among agencies concerned with health and social care is becoming more evident than ever before.

However, it was undoubtedly important that it offered resource savings to stakeholders, including the institutions providing the programmes, students and employers.

Changes in health and social policy, particularly changed management practices, have provided external drivers for interprofessional collaboration (e.g. DoH, 1989; 1990; 1993; 1996). These have often been experienced as uncomfortable pressures, as roles and boundaries have been challenged and changed, and the autonomy of the most powerful professions has been curtailed (Hopkins *et al.*, 1996; Hugman, 1995).

Interprofessional collaboration has also been encouraged by increased emphasis on centring provision around the ideologies of holistic care, and the involvement of users and carers. It has been more widely recognised that the needs of most clients are beyond the remit and expertise of any single profession. To provide a genuinely user-centred service *requires* interprofessional collaboration and effective teamwork. This may necessitate professionals setting aside historical power struggles and the protection of historical boundaries, to deliver efficient and comprehensive care which meets the needs of the client group (e.g. Sandall, 1995; West & Slater, 1996). This is quite a tall order, and interprofessional education or training is often suggested as a logical first step.

The impact of local enthusiasts should not be underestimated. Some people are particularly committed to the ideal of interprofessional working. When this is combined with empowerment to direct energy towards achieving that goal, a small number of key individuals can carry forward a collaborative initiative. Their expertise and enthusiasm can encourage others to collaborate, overcome passive and active resistance to change, and remove organisational obstacles to progress.

Discouraging collaboration

Many authors have described factors which strain interprofessional collaboration (e.g. SCOPME, 1997; Zungolo, 1994). A high proportion of published case studies draw attention to the difficulties posed by superficially mundane matters. These include the location and timing of meetings; dual (or indeed multiple) reporting structures and requirements; and increased practical problems of communication, availability and accommodation as a team increases in size and diversity (Freeth *et al.*, 1998; Hallett, 1995). In addition, interprofessional education at the pre-qualification stage is complicated by students' different prior educational experiences, levels of attainment and types of knowledge; incompatible curricula in terms of length, format, educational approach, and requirements for professional accreditation; and large numbers of students, unevenly split between the professions (Connor & Rees, 1997; Pryce & Reeves, 1997). These are real difficulties that cannot always be overcome and thus, genuinely desired interprofessional collaboration is thwarted.

However, difficulty in resolving mundane matters is inextricably linked to the complex issues of allocating limited resources, the ability and willingness to share power, gains and losses for participants, the congruence of participants' objectives, support at the policy making level, grass roots support, overcoming resistance to change, and persistently maintaining effective communication. Uncooperative stakeholders can negate the efforts of local

enthusiasts. Beattie (1995) and Biggs (1997) drew attention to the conflicting loyalties and concerns about potential loss of identity, which may trouble professionals engaged in interprofessional collaboration. Grant (1986) discussed inherent tensions in interprofessional collaboration between those at a managerial level and grass roots participants. In particular, interprofessional collaboration poses complex questions for budgetary control. Indeed, interprofessional and interagency activity may never be fully supported by managers because it is more difficult for them to control and refocus.

Sources of finance for multidisciplinary projects are few, and the competition stiff. Interprofessional collaborations can 'fall between stools' with the participating agencies not wishing to finance and service them from core funds because part of the activity and control lies outside the agency.

Sustaining (and terminating) collaboration

An interprofessional initiative may reach the point where its objectives have been achieved and sustaining that particular collaboration is no longer felt to be necessary. The initiative would not be sustained, but also would not be judged to have failed or left an undesirable void. It would be expected to leave a legacy of embedded interprofessional collaboration in its core area, and spin-off collaborations in related areas. However, too often collaborations are not sustained to this point of maturity. The difficulties outlined in the previous section can prove overwhelming, even where they have been addressed when the collaboration was initially developed. This is because circumstances change, sometimes so dramatically that the interprofessional collaboration is broken or severely diminished.

Over a decade ago Satin (1987) set out 'lessons from three failures and a success' in interprofessional education. It is an important, frank analysis of influences on sustained collaboration in a literature heavily biased towards recording positive outcomes. He argued that five factors were pivotal in sustaining successful interprofessional education:

> (1) interdisciplinary education must be a primary program goal consistent with other major goals; (2) controlling educational authorities must be committed to it; (3) it may have to exist outside the main academic structure because of its inherent conflict with that structure; (4) honesty, trust and respect are essential to the interdisciplinary endeavor; and (5) resources must be sufficient for interdisciplinary as well as traditional education. (Satin, 1987, p. 53)

Viewed like this, it would be rare to find conditions conducive to nurturing sustained interprofessional collaboration in educational programmes. Perhaps interprofessional education is inherently vulnerable: competing agendas can threaten it from all sides.

More recently, Vanclay (1996), considering collaboration between GPs and social workers, claimed that collaboration is sustained by similar factors to those important for first developing collaboration, namely: understanding of roles and responsibilities; sharing information about structures and procedures; regular face to face contact, named link social workers, joint working on local projects or specific topics; and support from senior management. Factors that were seen as threatening sustained collaboration were:

- rapid changes and conflicting organisational priorities;
- dependence on key individuals already committed to collaboration;
- lack of clarity or defined lead responsibility for ensuring collaborative development process is sustained;
- lack of responsibility for ensuring ongoing funding.

(Vanclay, 1996, p. 28)

Education and training were seen as pivotal to providing the conditions and skills required for sustained collaboration.

It seems reasonable to add to the list of threats; dissatisfaction with outcomes to date. If partners in an interprofessional collaboration benefit unequally from the collaboration, it is likely that those gaining least will become dissatisfied. If they feel unable to change the distribution of benefit, it would be natural to gradually withdraw support. Less often, all parties may come to feel that the benefits of a collaborative venture are not sufficient for the resources expended. If attempts to sustain the collaboration through replanning and innovation did not yield a viable and widely supported plan, one would expect the collaboration to be terminated.

Funding is a perennial problem for interprofessional collaboration. Even when pump-priming funds have been secured and well evaluated collaborative work developed, internal and external pressures on participating agencies can block the provision of continued funding and hence, terminate the collaborative initiative (e.g. Ross & Tissier, 1997).

Interprofessional collaborations, particularly in fields with no tradition of collaboration or worse, a tradition of enmity, may take a few years of nurturing to properly bear fruit. This is problematic with short-term funding and unrealistic expectations of what can be achieved in one or two years. Further, if an interprofessional collaboration is truly breaking new ground (and not all will or should) no one can be certain of how the collaboration will really function until it is underway. In these circumstances it is important that pressure to demonstrate beneficial outcomes is not exerted too soon or with too restricted a vision. It is imperative to evaluate process outcomes and to be alert to unexpected outcomes, because the originally anticipated terminal outcomes may have been rather limited or a little misguided. To evaluate an innovation only against its original aims and objectives is seductively logical, but may result in 'the baby being thrown out with the bath water.' Imaginative initiatives in interprofessional collaboration require imaginative evaluation to record impact at a variety of stages and levels and to capture the unexpected.

The continual change and competition for the limited resources that characterise the environments of health and social care, create conditions in which conflict is easily ignited. Drinka *et al.* (1996) drew attention to the variety of motivational styles which members of interprofessional teams may hold. They also discussed changes in the manner in which team members interrelate in 'normal' times and times of conflict. In conflict situations members' responses become more uniform and they more often employ withdrawal or avoidance as a form of self-protection. This is detrimental to teamwork and interprofessional collaboration will become strained. To sustain collaboration, conflict and responses to conflict need to be recognised and acknowledged. All team members need to be involved in creative problem solving.

The role of key individuals in encouraging interprofessional collaboration has already been noted. The passage of time inevitably involves changes in personnel. Key enthusiasts whose support, facilitation and hard work were instrumental in commencing collaboration will move on, particularly as the prevalence of short term contracts increases. The initiative may expand and thus, new people may join the team. The newcomers will not have shared the clarification of roles and objectives, the frustrations, setbacks and early successes of setting up the initiative. Without sufficient attention to induction and team building, the changed team may be less cohesive and less committed to the initiative's original interprofessional objectives. This has been noticeable in the case study presented below and also noted by Leathard (1998). In addition, Vanclay (1996, p. 10) reported respondents as saying:

> It takes a long time to build a trusting relationship with a colleague and then they move and we have to start all over again.

The enthusiasts who facilitated the launch of an interprofessional collaboration will not be sufficient to sustain its momentum after the initial implementation. Continued facilitative support and guidance will be required from senior management. The involvement of middle managers and front line participants must be secured and embedded in their professional practice.

It should be recognised that individuals who relished the challenge of translating a vision of interprofessional collaboration into a functioning initiative, may be less motivated or skilful in embedding the initiative in mainstream practice. Sustained collaboration may be more likely if the original team of participants also includes some individuals who are intrinsically motivated to iron out teething problems, dot i's, cross t's and secure the long-term future of a collaboration. Ultimately, activities that do not become integrated with mainstream systems and structures are unlikely to be sustained.

Case study: The skills centre at St Bartholomew's

Breaking new ground

The Clinical Skills Centre at St Bartholomew's Hospital in London is the physical embodiment of a vision shared by the two exceptional women who were Deans of the medical and nursing schools there in the early 1990s. Their conviction, authority and effort secured the required funding and commitment from a team of key individuals to transform the vision into working clinical and communication skills suites, shared by nursing and medicine.

An interprofessional Project Group, with equal representation from the two Schools and alternating chairmanship, initiated and supervised the design, construction and equipping of the Centre (Dacre *et al.*, 1996; Studdy *et al.*, 1994a). The Project Group was supported by a Steering Committee, chaired alternately by the two Deans. Members of the Project Group became the first academics to work within the centre and they recruited other staff. When the Skills Centre opened in 1993 it was unique in the UK. As an initiative that brought medicine and nursing together as full and equal partners, it delighted many.

The Skills Centre raised the profile of the teaching, learning and assessment of clinical skills. It provided a safe environment for students and staff to develop and reflect upon practical skills, aided by: simulation, experiential learning which could not be permitted in clinical areas, video play-back facilities, and opportunities for self-directed access for practising skills. Curriculum innovation was stimulated and assessment methods changed. Learning resources were developed, including instructional videos and interactive CD-ROMs (e.g. Dacre & Nicol, 1996; Freeth & Nicol, 1998; Nicol *et al.*, 1996; Nicol & Freeth, 1998; Studdy *et al.*, 1994b).

The Clinical Skills Initiative at St Bartholomew's was very fortunate. It had management support at the highest levels and at pertinent subordinate levels in the two Schools. Early in the project generous pump-priming funding was secured. The project addressed issues that were pressing at the time: raising standards, assessing competence, modernising curricula, interprofessional collaboration, and responding to changed expectations and changes in the delivery of healthcare. Further, the initial Project and Steering Groups contained enthusiastic and talented individuals who worked tirelessly for the project's success. Fortuitously, their enthusiasms and talents were complementary with some leading the visionary thinking and convincing doubters, while others naturally gravitated towards anticipating and solving operational problems.

However, the collaborative venture was not easy. The cultures and structures of the two Schools were very different. This sometimes created misunderstanding and always appeared to slow decision making. This was frustrating to all parties. Project members had to balance

the demands of the interprofessional venture with the demands of their separate Schools and disciplines. The collaboration coincided with major upheaval in the provision of medical and nursing education. Both Schools merged with other institutions and then integrated with different universities. In this process, key members of the original interprofessional team regretfully left the initiative when they took up new posts. The depletion of the team was uneven, with a higher proportion of the Medical School staff being lost. In addition, it proved impossible to appoint staff to some of the posts originally planned, necessitating some refocusing. Nevertheless, the Clinical Skills Initiative has continued.

The skills centre as an instrument for sustaining interprofessional collaboration

The Skills Centre as a physical location has proved to be a multifaceted instrument for sustaining interprofessional collaboration. The shared challenge of designing, equipping and opening the Centre was difficult, but a prized goal with tangible stages. Each School developed mechanisms for coping with inter-institutional collaboration. Progress towards opening the Centre was, at each stage, identifiable and motivating. The common purpose for all activities, united and sustained the interprofessional project group. A motivated and interdependent core group resulted, members of which would go on to develop subsequent phases of the interprofessional collaboration.

Following the opening of the Skills Centre, energies were diverted to the opportunities it promised for innovation and efforts to make best use of its facilities. Reflection on the learning process was sparked and curriculum development soon followed. For the original team members interprofessional collaboration was an established mode of working. Therefore, it was natural for them to aim for much of this reflection and innovation to involve interprofessional collaboration. Core members and their policy documents signalled commitment to interprofessional collaboration as the group norm to new members joining the expanding team. Most newcomers took up the message and thus, collaboration was sustained.

An original aim of developing shared modules for all medical and nursing students, as a means of nurturing competencies for subsequent professional practice in multiprofessional teams, has proved an elusive dream. Multiple barriers exist, including: split sites, rapid expansion of student numbers, different admissions cycles, separate demands for professional accreditation, different funding and staffing arrangements, and separately developed curricula. Progress has been slow, with intermittent setbacks. However, the original interprofessional ideal of the Skills Centre has continued to fuel the search for solutions to the apparently insoluble problems of bringing students and curricula together, and resourcing the educational experience. It seems doubtful that this would have been the case without the shared facilities of the Skills Centre and consequent shared responsibility for management and efficient usage.

One adopted solution to the difficulties of establishing shared modules for nursing and medical students was the development of a short course for final year medical students and recently qualified nurses (Kopelman *et al.*, 1997). This involved participants in planning the management of the changing needs of a simulated patient. They also practised some aspects of the planned care with the aid of a range of simulation techniques. The course was an example of the sustained interprofessional collaboration between staff associated with the Clinical Skills Centre. A small interprofessional team undertook the curriculum development and evaluation. The delivery of the course included team teaching from two interprofessional pairs of lecturers, and guest speakers from both professions. The desired learning outcomes heavily featured improving participants' ability to integrate theoretical knowledge, practical experience and expertise from different professions, to plan and deliver high quality, efficient, patient-centred care.

Participants evaluated the course very positively and reported increased understanding of the roles, responsibilities and needs of different members of the multidisciplinary team. Many expressed increased motivation to collaborate more extensively and more effectively in their subsequent professional practice. An aspect of the course design which it was hoped would increase the likelihood of such aspirations for sustained collaboration becoming a reality, was the selection of the newly qualified nurses from a single directorate. Some of the medical students have subsequently rotated through this directorate and thus, at least for a few months, some of the course participants have been colleagues.

The Schools' continued quest to bring students and curricula together at appropriate points has caused regular contact between educators from nursing and medicine. They sit on joint committees and planning groups. Cross-representation on certain working groups within each School has been established where previously, it is unlikely to have been thought necessary or desirable. Through shared initiatives and cross-representation, formal and informal communication channels have been opened and maintained. This supported the on-going exchange of information, cross-fertilisation of ideas, and the assimilation of interprofessional collaboration into the institutional cultures.

The process of opening the Skills Centre established a tested model for interprofessional collaboration. The way was paved for other initiatives between the Schools. The most ambitious of these is a 'training ward' (Reeves & Freeth, 2000) involving students from four professions, which drew its inspiration from the interprofessional initiative at Linköping (Wahlström *et al.*, 1997).

Sustaining the interprofessional skills centre

The initial funding and programme of activity for the interprofessional Clinical Skills Centre ended in 1999. Sustaining this particular interprofessional collaboration rested upon a lengthy sequence of decisions. First, the Schools had to decide whether they wanted to have one or more skills centres in the future. Evaluation of the Skills Centre's usage and cost effectiveness, in addition to its track record of good practice in learning and assessment, quickly yielded positive answers from both Schools. The debate about whether part or all of the Schools' skills centre facilities should be interprofessional was longer and more finely balanced. Economies of scale, and increased opportunity and motivation for interprofessional collaboration, weighed in favour of shared provision. Overcrowding, and delays resulting from shared decision-making and dual accountability, weighed against shared provision. Many other matters, great and small, were discussed. On balance, both Schools wished to retain an *interprofessional* clinical skills centre, and each was prepared to commit core funds to its running costs.

Every pre-registration student from both Schools is taught and assessed within the Clinical Skills Centre at appropriate points in their programmes of study. All are given the opportunity to book time slots and equipment for self-directed learning. Many post-registration learners make use of the Skills Centre facilities. Before pump-priming funds were exhausted, the interprofessional skills centre was firmly embedded in the mainstream business of both schools. The interprofessional collaboration is sustained by a commitment to shared funding and shared management at both strategic and operational levels. The interprofessional contact and dialogue that these commitments necessitate continue to spawn spin-off innovations in shared learning such as that reported by Freeth *et al.*, (2000), which now involves junior nurses, doctors and pharmacists.

Naturally, the future of the interprofessional Clinical Skills Centre will be reviewed periodically. If the benefits of sharing the facility continue to outweigh the disadvantages of

accountability to two institutions, with different procedures and different priorities, this interprofessional collaboration will be sustained. Some of the spin-off initiatives spawned by the skills centre collaboration now have natural 'lives' of their own. Sustaining these collaborations depends upon their separate balances of benefits over costs.

Conclusions

A multitude of factors encourage or discourage interprofessional collaboration. For collaboration to be sustained the balance of these influences must be such that each collaborating party can identify sufficient benefit to outweigh the disadvantages of interprofessional collaboration. The particular challenges of sustaining interprofessional collaboration centre around addressing: structural differences between organisations, conflicting organisational and professional agendas, resource requirements, more complex communication demands, replacing former team members, inducting and forming strong links with new team members, regular evaluation and shared planning of the team's shared goals and progress.

The Clinical Skills Centre at St Bartholomew's was discussed as an example of an initiative, which has served as an instrument for sustaining interprofessional collaboration. The shared goal of opening the centre created mechanisms for collaboration between the partner Schools of Nursing and Medicine. Enduring collaborative working relationships were formed. Once open, the Centre helped to sustain collaborative activity through: the shared responsibility for management, shared space and equipment for curriculum and assessment innovation, and regular face-to-face contact between medical and nursing educators. The Schools' decision making processes and curricula have changed in response to the existence of the Interprofessional Skills Centre. Spin-off collaborations have developed.

The Interprofessional Skills Centre has provided a continued *need* for interprofessional and inter-institutional collaboration in order to manage and make efficient use of its resources. In addition, it has been a catalyst for continued innovation in interprofessional collaboration. The two-fold motivation of need and opportunity has been a great strength. It is suggested that the coincidence of these motivators would help sustain interprofessional collaborations in other settings.

Whilst being committed to the central foci of clinical skills and interprofessional collaboration, the people who have formed the Clinical Skills Initiative have exhibited a complementary range of enthusiasms and talents. Particular facets of the collaboration have appealed more to some than to others, and there has been need for everyone's skills. It is suggested that success in encouraging and valuing an adequate range of skill and preferred focus among the people who comprise an interprofessional collaboration will help sustain the collaboration.

Eventually, sustained interprofessional collaboration becomes routine interprofessional collaboration. It no longer occurs to people that they could approach a particular task without involving members of other professions. For example, certain aspects of child protection could now be categorised as routine interprofessional collaboration (Hallett, 1995). Making something routine brings with it the problems of guarding against stagnation and complacency: further threats to effective interprofessional collaboration.

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