


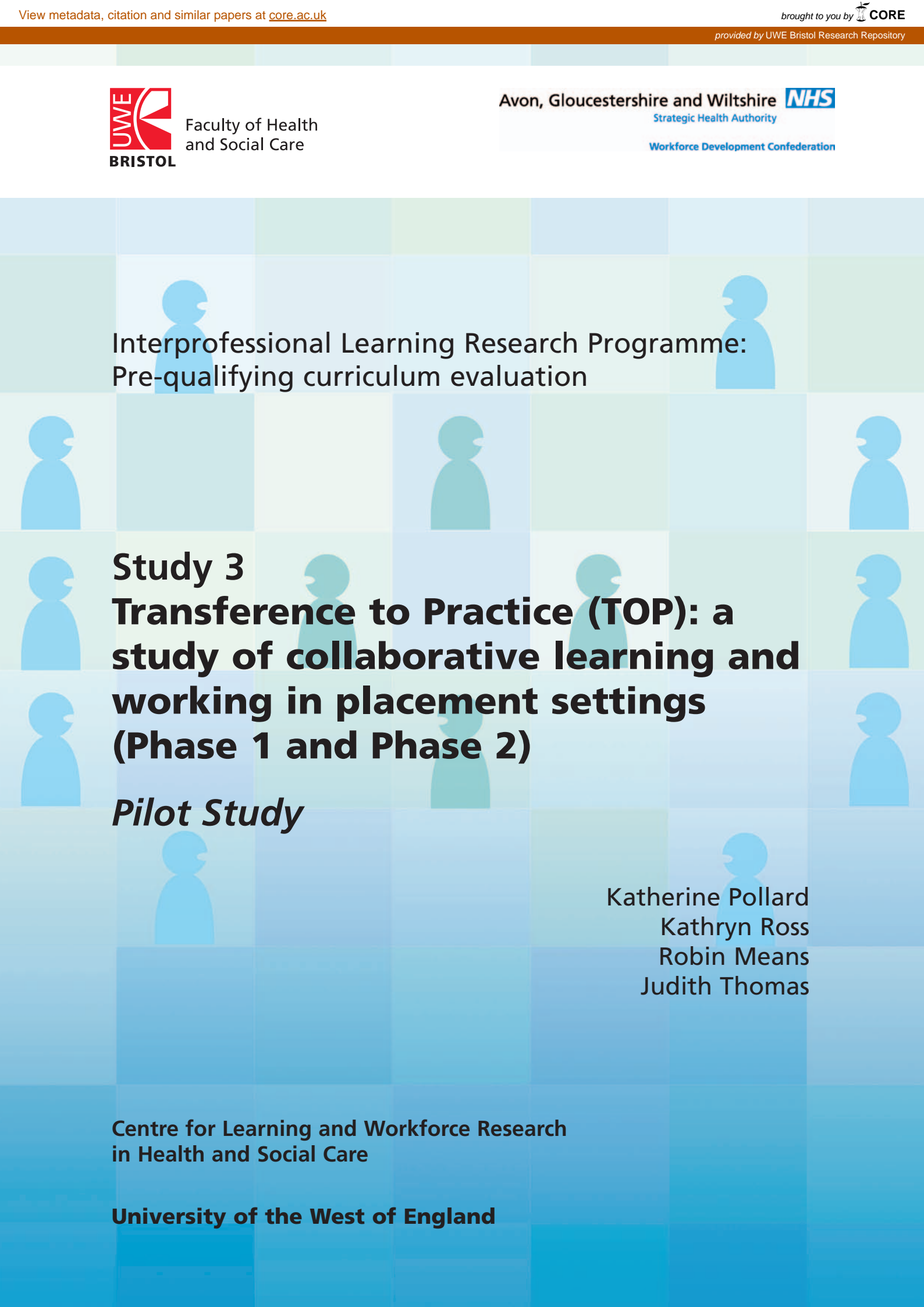


Faculty of Health
and Social Care

Avon, Gloucestershire and Wiltshire 

Strategic Health Authority

Workforce Development Confederation



Interprofessional Learning Research Programme: Pre-qualifying curriculum evaluation

Study 3

Transference to Practice (TOP): a study of collaborative learning and working in placement settings (Phase 1 and Phase 2)

Pilot Study

Katherine Pollard
Kathryn Ross
Robin Means
Judith Thomas

Centre for Learning and Workforce Research
in Health and Social Care

University of the West of England

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Steering Group for the Research Programme

Gill Barrett, FHSC, UWE

Dr Brenda Clarke, FHSC, UWE

Dr Kevin Foreman, FHSC, UWE

Rosemary Greenwood, FHSC, UWE

Diane Hawes, FHSC, UWE

Dr David James, Faculty of Education, UWE

Professor Robin Means, FHSC, UWE

Dr Margaret Miers (Project Manager), FHSC, UWE

Professor Steve Onyett, Mental Health South West

Katherine Pollard, FHSC, UWE

Professor Kath Ross, FHSC, UWE

Julie Thomas, AGW WDC

Suzie Ventura, FHSC, UWE

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Executive summary

This report details the findings of a nine-month pilot study exploring health and social care students' experience of collaborative learning and working in placement settings. The aim of the pilot study was to test and refine the research methods which will be used to conduct the main study, which is scheduled to commence in January 2004. This study is a component in a larger research programme evaluating the pre-qualifying interprofessional curriculum offered by FHSC, UWE, which is being conducted by a research team based in the Faculty.

The Faculty's interprofessional curriculum was developed in response to a continuing emphasis on the need to improve service delivery in health and social care in the UK, and the belief that effective interprofessional working is key to service enhancement. It has been widely assumed that interprofessional learning will facilitate interprofessional working, although there is little evidence to support this assumption. The debate continues about the optimum timing of interprofessional learning, that is, pre- or post-qualification.

In order to contribute to the evidence base, a multi-method research programme is being conducted by FHSC to evaluate its interprofessional curriculum. The programme comprises a number of studies, three of which are collecting new data (Studies 1, 2 and 3). These three studies are being funded by AGW WDC, and focus on student attitudes to, and student experience of, collaborative learning and working in both academic and placement settings.

This report focuses on the pilot study for Study 3. The aim of Study 3 is to explore the opportunities for collaborative interprofessional working that arise for students over a range of placement settings. In view of the complexity of the issues being investigated, it was decided to conduct a pilot study to test and refine the methods of data collection and analysis before commencing the main study.

Senior personnel from a number of NHS Trusts in the AGW WDC area were asked to suggest areas in which they considered interprofessional working to be effective, and in which the pilot study could be conducted. Three sites were chosen for this purpose:

- a stroke rehabilitation unit
- a hospital-based mental health liaison service
- an acute medical ward for older people.

It was not possible to conduct the pilot study within a social care setting, due to time and logistical constraints.

Ethical approval for the pilot study was gained from three Local Regional Ethics Committees, as well as the University Ethics Committee and the Faculty Ethics Subcommittee. The Research and Development Committee in each selected NHS Trust supported the study. The process of gaining ethical approval took a number of months, and the study was therefore conducted in two phases:

Phase 1 – consultation with placement staff about the interprofessional nature of their practice;

Phase 2 – the study of students' experience of interprofessional working in placement settings.

Data were collected between November 2002 and June 2003.

In Phase 1, a self-completion questionnaire was developed to explore placement staff's opinion about the nature of interprofessional working in their practice area. The questionnaire was based on a number of existing instruments found in the literature.

In Phase 2, key interprofessional events in each setting were observed: these included case conferences, discharge planning meetings and goal setting meetings. A criterion sheet based on a concept analysis of collaboration was used as an aide-memoire for members of the research team to structure observations, which were recorded in field notes. Follow on individual interviews were conducted with some staff who were present at the observed meetings. These interviews were taped and transcribed.

The number and range of staff involved in interprofessional working varied between sites. The pool of professionals involved in the mental health liaison service comprised only medical and nursing staff, and was much smaller than those at both the stroke unit and the ward for older people. Both the latter areas had teams consisting of nursing, medical, therapy, and social work staff.

36 questionnaires were completed by a range of staff across the three sites. The results indicated that most respondents were positive about the interprofessional working in their area, although some junior staff reported difficulties with issues of control and relationships with senior staff from other disciplines. All the respondents thought that they understood the roles and responsibilities of their colleagues from other professions; however, a third of the respondents felt that their own roles and responsibilities were imperfectly understood by other professionals.

7 key events were observed across the three sites, involving 34 staff members, 8 students and 3 service users. The research team observed effective interprofessional collaboration during all these events; however, this mostly involved senior personnel from each discipline. Junior staff tended to contribute to discussion only when asked to do so. Individual interviews were conducted with 6 staff members. Interview data supported the finding that the quality of interprofessional working in the practice areas was dependent to a significant degree on the characteristics of the senior medical personnel involved.

In many of the key events, student experience of interprofessional interaction appeared to be limited mainly to observation. This applied to all the nursing students observed, both pre- and post-qualifying. However, this was not the case with an occupational therapy student in the stroke rehabilitation unit, who was actively involved in some of the key events observed.

Observational data supported the questionnaire results, and it was decided that the original multi-method approach should be maintained for the main study. However, the results indicate that some changes to the instruments and methods are advisable.

Although the questionnaire was found to be generally suitable for its purpose, feedback indicated that it needs to be shorter, and that the balance between negatively- and positively-worded questions could be reviewed. Other issues raised were the lay-out, and the need to allow for responses relating to different professional groups

The observation of key interprofessional events and subsequent individual interviews provided a substantial amount of valuable data concerning interprofessional working in

the pilot settings; however, due to time and other constraints it was not possible to obtain the same depth of data from each setting. In addition, it was difficult to evaluate students' experience, or to predict their presence at events, using the approach adopted. In view of these facts, the research team has decided to alter the timing of interviews and observations and the selection process for key events in the main study.

The pilot study to test the methods for Study 3 proved to be a valuable exercise. It allowed the research team to

- refine the staff questionnaire;
- test the consistency and effectiveness of observational and interview methods among the team of researchers;
- devise a suitable semi-structured interview guide for use with students;
- identify the weaknesses in the initial research design, in particular, the difficulty of predicting student attendance at key events; and the problems of capturing a true picture of student experience where students are passive observers of events.

It is clear from data from other studies in the research programme that students are learning about interprofessional working in placement settings. However, it is not clear what they are learning, or how that learning takes place. The pilot study enabled the research team to identify a range of important themes and issues, and thus provided a good basis from which to move forward, so that deeper understanding of these issues can emerge.

Chapter 1. Introduction and background

1.1 Interprofessional learning in health and social care

The last decade has seen a continuing emphasis on developing interprofessional working in UK health and social care services in order to enhance care provision (DoH 1994; 1996; 2000). Incorporated in this drive towards effective interprofessional working has been the move to establish interprofessional learning for health and social care professionals, both at the pre- and post- qualifying stages (DoH 1999; 2001).

Across the country, educational institutions have attempted to introduce an element of interprofessional learning into their curricula for health and social care students. However, most initiatives reported in the literature have been implemented at the post-qualifying stage (Freeth et al 2002). Over the last few years, there has been an increasing drive to develop curricula that will provide pre-qualifying learners with interprofessional experience and awareness.

1.2 Interprofessional learning in placement settings

Most interprofessional learning has taken place in academic settings; there are only limited numbers of initiatives which have managed to take structured interprofessional learning into placement settings (see for example, Reeves and Freeth 2002). Nevertheless, most health and social care students learn in a multiprofessional environment, where interprofessional working occurs with varying degrees of effectiveness.

1.3 Interprofessional learning at University of the West of England, Bristol

In response to the increasing emphasis on interprofessional working and learning, the Faculty of Health and Social Care, UWE, introduced an interprofessional pre-qualifying curriculum in September 2000 for all health and social care professionals studying in the Faculty. The Faculty already had a history of developing shared learning across professional groups and offered interprofessional learning opportunities for post-qualifying awards.

The pre-qualifying curriculum framework incorporates three elements: uniprofessional pathway modules; shared learning modules; and an interprofessional strand.

The interprofessional strand comprises the following:

- Interprofessional modules in which “two or more professions learn from and about each other to improve collaboration and the quality of care” (United Kingdom Centre for the Advancement of Interprofessional Education (CAIPE) 1997);
- Interprofessional learning outcomes within professional pathway modules;
- Interprofessional working as an element of supervised practice.

The Faculty is in an excellent position to offer and to evaluate interprofessional learning, given the unusually broad range of professions educated within it (all four branches of nursing, midwifery, social work, occupational therapy, physiotherapy, radiotherapy and diagnostic imaging). The Faculty received funding from the then NHSE to fund a programme of staff development to support the development and delivery of the interprofessional curriculum.

1.4 Interprofessional research programme

Whilst there is intuitive logic in interprofessional learning having the potential to improve (inter)professional practice and thus service delivery, to date there is little robust evidence of the benefits of interprofessional learning at pre-qualifying level. In their review of evaluations of interprofessional learning, Freeth et al (2002) included only two UK studies (Carpenter 1995, Parsell et al 1998): in both these cases, the educational initiative being evaluated lasted only one to two days.

In order to contribute to the evidence base, the Faculty started a research programme to evaluate the curriculum in September 2001. The aim of the programme is to gain an understanding of the effects of a pre-qualifying interprofessional curriculum on the collaborative learning and collaborative working of health and social care students.

New data is being collected through three studies in the programme:

- Study 1: A longitudinal quantitative study of students' approach to learning and to collaborative working as students and qualified staff, comparing scores on collaborative learning and working scales over time and between cohorts;
- Study 2: A longitudinal qualitative study of small groups of students' experience of interprofessional learning in the academic environment;
- Study 3: A multi-method study of collaborative learning and working in placement settings.

This report concerns Study 3 in the programme.

1.5 Study 3 - Transference to Practice (TOP): a study of collaborative learning and working in placement settings.

Students' educational experiences in placement settings have been identified as a factor influencing their preparedness for collaborative working (Russell and Hymans 1999, Hilton and Morris 2001). Study 3 aims to explore the opportunities for collaborative interprofessional working that arise for students over a range of placement settings. Specific points of interest for the research team are to identify settings where students are exposed to 'good practice', where they have shown ability to use collaborative skills, and have been supported in doing so. Models of 'good practice' may contribute to enhancing the quality of the students' learning experience.

1.6 Study 3 - pilot study

In view of the complex task facing the research team, it was decided to conduct a pilot study on three sites to test the methods of data collection and analysis, before proceeding to the main study. For logistical reasons, including the gaining of approval from the various ethics and NHS Trust committees within a specific time frame, the pilot study was carried out in two phases:

Phase 1 - consultation with staff in identified placement settings about the interprofessional nature of their practice;

Phase 2 - the study of students' experience of interprofessional working in identified placement settings.

Data were collected between November 2002 and June 2003.

Chapter 2. Methods

The purpose of this chapter is to describe the methods used in the pilot study.

2.1 Research approach

Following a review of the available literature, it appeared that Study 3 would be best supported by a design that incorporated both quantitative (Phase 1) and qualitative (Phase 2) methods. This approach accorded with the recommendations issued jointly by CAIPE and the British Educational Research Association (BERA) (Barr et al 2000).

2.2 Settings

As the purpose of conducting the pilot study was to test the methods, the research team decided that it was important to collect data in sites with comparable levels of interprofessional working. A number of NHS Trusts in the AGW WDC area were asked to suggest sites where they considered 'good' interprofessional working to be established. Three sites were identified for the pilot study:

- a stroke rehabilitation unit
- a hospital-based mental health liaison service
- an acute medical ward for older people

It was not possible to include a social care setting in the pilot study in the specified time frame.

2.3 Ethics

Ethical and locality approval was gained from three Local Regional Ethics Committees, as well as from the FHSC Ethics Sub-committee and the UWE Ethics Committee. The Research and Development Committees of the institutions involved all supported the pilot study.

2.4 Data collection

Phase 1: a questionnaire was used to explore professionals' opinion of the interprofessional aspects of their practice (see Appendix 1). This tool focused on professionals' self report of their skills for collaborative working, as well as their perception of the nature of interprofessional collaboration in their practice settings.

Phase 2: qualitative data were collected through observation and interview. Two or three key events in each placement setting were observed: these included case conferences, team meetings, and discharge planning meetings. Events for observation were selected in negotiation with senior staff in each area. The research team was particularly interested in the interaction that occurred between those attending these events. Criterion sheets with specific collaborative behaviours identified were used for structuring observations (see Appendix 2).

Follow through open interviews with individuals at the key events were used to explore the interpretation of these observations. This allowed the research team to gain more in-depth understanding of the relevant issues from the perspective of some of the participants. Each interviewee was sent a summary of the interview for verification and comment.

2.5 Sample

Phase 1: all professional staff who worked in the three settings were asked to complete the questionnaire. Questionnaires were distributed by the nurse managers/nurse consultants in charge of the areas.

Phase 2: all staff present at the selected key events were recruited to the qualitative phase of the study. In two of the three settings, some attendees were then interviewed individually. Logistical obstacles prevented interviews being conducted on the third site.

Not all key events involved students, however this was consistent with the purpose of the pilot study. In the main study, the data collection and analysis methods will be applied in the same way to both qualified staff and students.

2.6 Data analysis

Phase 1: data from the survey were initially analysed in terms of descriptive statistics, in order to construct an interprofessional profile of each placement setting in terms of staff's perceptions.

Phase 2: the criterion sheets used for observation provided the framework for preliminary data analysis. Additional data from field notes and interview transcripts were analysed by means of thematic content analysis, incorporating categorical aggregation (Burnard 1991, Creswell 1998)

After commencement of Phase 2, data from Phase 1 were analysed concurrently and triangulated with data from Phase 2.

Chapter 3. Results and emerging themes

In this chapter, a profile of each setting in terms of interprofessional working will be presented, together with the findings emerging from pooling all the data.

3.1 Phase 1: questionnaire

36 questionnaires were returned. It was difficult to estimate the response rate for the questionnaire, as it was not always clear exactly how many professionals were involved in each setting. However, the purpose of the questionnaire was to provide a broad frame of reference regarding interprofessional working in each setting, rather than manipulable statistics. The pool of responses obtained therefore comprised a valuable source of information.

3.2 Phase 2: observations and interviews

Observations involved 34 members of staff, 8 students and 3 service users. Individual interviews were conducted with 6 members of staff. Conditions and opportunities to spend time with staff varied between settings: these were a function of differences in structure and organisation, as well as of logistical problems co-ordinating researcher and practitioner timetables. These variations were reflected in the different numbers of staff interviewed in each site.

3.3 Stroke Rehabilitation Unit

The unit has 15 beds. There are various criteria for admission, the most pertinent being that service users must be medically stable, as the unit is approximately 10 minutes away from an area where acute care is available. The focus of the unit is on rehabilitation aiming for discharge into the community.

Data were collected by a contract researcher with a midwifery background.

3.3.1 Questionnaire data

13 qualified staff and 1 healthcare assistant completed questionnaires (Table 1).

Profession	Number	Base
Healthcare assistant	1	Stroke unit
Medical staff – registrar	1	Hospital
Nursing staff	4	Stroke unit
Nursing staff – specialist	2	Community and hospital
Occupational therapist – senior	1	Stroke unit
Occupational therapist	1	Stroke unit
Physiotherapist – senior	1	Stroke unit
Physiotherapist	1	Stroke unit
Social worker	1	Community and hospital
Speech and language therapist	1	Community and hospital

Table 1. Stroke rehabilitation unit – number of respondents to the questionnaire by profession and base

From the questionnaire data, it appears that interprofessional working occurs within the unit to varying degrees between the following professional groups (presented in order of most to least frequently reported contact):

- hospital nursing staff
- physiotherapists
- occupational therapists
- social workers
- medical staff
- speech and language therapists
- dietitians
- community nurses
- other community staff
- pharmacists
- radiographers
- radiologists

The data painted a picture of an environment with good interprofessional communication. All the respondents felt that they understood other professionals' roles (q9); however, representatives of some nursing specialisms, social work and speech and language therapy did not feel that their roles were well understood by their colleagues from other disciplines (q10). There were mixed opinions about the clarity of channels of communication and about whether different professionals held a common view of the goals of interprofessional collaboration (q17, q21, q22, q44, q45, q46).

Some difficulty with interprofessional collaboration was reported by junior staff regarding issues of control and relationships with senior staff from other disciplines (q15, q16, q20, q36, q55). A small number of nursing staff (including a nursing specialism) reported feeling that their expertise was not valued, and that support and trust were lacking between the professions (q33, q34, q35). However, all the respondents felt that they benefited from interprofessional working in the unit, as did service users and their colleagues from other professions (q39, q56, q57, q58).

3.3.2 Observations and interviews – staff experience

15 members of staff (nursing, medicine, social work, physiotherapy, occupational therapy), 5 students (nursing, occupational therapy) and 3 service users were observed during 3 meetings: a weekly meeting to discuss service users, a discharge planning meeting, and a weekly goal-setting meeting. Individual interviews were conducted with the nurse manager in charge of the unit, the superintendent physiotherapist, a junior physiotherapist, and the senior occupational therapist.

From the interview data, it appears that the forging of an interprofessional team has been an explicit goal and process on the unit over the last four to five years. Strategies to this end have included changing the therapy staff's base, and establishing regular meetings, such as the goal-setting meeting.

The observational and interview data gave the impression of a closely-knit interprofessional team operating in the unit, in which physical proximity undoubtedly plays a part, as most members of the team know each other very well. In fact, this was

raised on two occasions as sometimes being problematic for new members of staff and students. This team does not, however, include the medical staff or the social workers. As far as the former are concerned, this appears to be mainly a logistical problem, and the nurse manager reported that at times in the past it had been better, when a doctor was assigned to the unit for 1 year (not currently the case). The social workers are not based in the unit.

Medical staff were present at only one of the observed meetings. This was overtly interprofessional: all the senior staff were involved in, and obviously used to, making collective decisions. The consultant physician, nurses and therapy staff had all worked together for a long time, and obviously had a good understanding of each other's roles and responsibilities.

However, this meeting was noticeably more hierarchical and more formal in tone than the other two meetings, with no input from junior staff or students. It was also noted that the consultant was addressed as 'Dr', while everybody else was on first name terms (the only other doctor present at the meeting was a senior house officer, who was addressed only by the consultant).

When no doctors were present, there was no obvious hierarchy, except between the nursing students and qualified staff. Decisions were arrived at jointly, and contributions were both solicited and welcomed from the physiotherapy assistant and the occupational therapy student. During the goal-setting meeting, it emerged that both the nursing staff and social worker occasionally found working with the mental health team problematic (there was no mental health representative present, and no mention of this discipline occurred in the questionnaire data).

During the discharge planning meeting, the service users appeared comfortable. Exchanges were informal, with plenty of opportunity for all present to ask questions, volunteer information and voice concerns. The staff actively sought the service users' perspective, and negotiated decisions with them.

The nurses, occupational therapists and physiotherapists are physically based in the unit, so there was a definite sense of their 'belonging' to it. Although social workers were

present at all the meetings, and actively involved in them, there was no sense of them being thought of as integrally part of 'the team' – rather as visitors with whom the other staff collaborate. In interview, when other staff talked about everyone being a team, only nursing and therapy staff were mentioned. It appears that physical base was a highly significant factor influencing whether individuals were perceived to be 'in' or 'out' of the team.

The overall impression of the interprofessional nature of the unit was of a cohesive nursing and therapy team, collaborating effectively with medical staff and social workers on the fringes. In interview, it was intimated that relationships with the medical staff were constructive, but dependent to a significant degree on the consultant's good will. The effect is a multi-layer system of interprofessional working, with varying degrees of involvement between the different disciplines.

3.3.3 Observations and interviews - student experience

It seems that students on the unit have varied experiences and are exposed to different levels of interprofessional working.

Interprofessional relationships involving medical staff appeared to be generally positive. However, they probably reinforce the status quo for students, judging by the contrasting behaviour displayed in the meetings with and without medical staff present. The most noticeable issue concerned the behaviour of the occupational therapy student – when the consultant was present, she did not speak, nor was she asked to do so; in the other two meetings, she took the lead in contributing information about service users, which went towards informing decisions taken.

There was a difference noted between this student's position and that of the nursing students, in that the latter were not observed to participate actively at any point in any of the meetings. Communication between them and qualified staff was only initiated (always by the staff, and usually as an aside) when there appeared to be a need for something to be explained to them. It was not clear what stage of their professional programmes they had reached. The occupational therapy student was near to

qualification, however, and so could be expected to contribute to discussions about service users in whose care she was involved.

In general, however, there appeared to be very good interprofessional practice between all disciplines on the unit, and exposure to these role models could be expected to be beneficial for any students placed there.

3.4 Hospital-based Mental Health Liaison Service

A nursing/medical team provides a mental health assessment and short-term intervention service to individuals who present to a general hospital setting with a range of mental-health related difficulties. The team is co-ordinated by a G grade liaison nurse, with the involvement of other professionals, for example, social workers, as appropriate. There are 6-7 daily contacts with service users.

The researcher was an academic with a social care background.

3.4.1 Questionnaire data

5 professional staff completed questionnaires (Table 2).

Profession	Number	Base
Medical staff – consultant	1	Community and hospital
Medical staff – senior house officer	1	Hospital
Medical staff – senior house officer	1	Community
Nursing staff – consultant	1	Mental health liaison service
Nursing staff	1	Mental health liaison service

Table 2. Hospital-based mental health liaison service – number of respondents to the questionnaire by profession and base

From the questionnaire data, interprofessional working occurs to varying degrees between the following professional groups (presented in order of most to least frequently reported contact):

- mental health nurses
- psychiatrists
- social workers
- general nurses
- other medical practitioners
- occupational therapists
- psychologists
- physiotherapist
- speech and language therapists

The questionnaire data intimated that there was good interprofessional communication in this area, with the respondents agreeing that colleagues from different professions routinely consulted each other about service delivery (q13, q14, q30, q31). While all the respondents felt that they understood their colleagues' professional roles, some of the mental health nurses and medical staff did not think that this was reciprocated (q9, q10).

Opinions about the clarity of channels of communication varied, and there were mixed views about whether different professionals shared a common understanding of the goals of interprofessional collaboration (q17, q21, q22, q44, q45, q46). Not all the respondents felt that there were always mutual respect and co-operation between the different professions (q18, q34, q36, q48). However, all the respondents felt that they benefited from interprofessional working in the service, as did service users and their colleagues from other professions (q39, q56, q57, q58).

3.4.2 Observations – staff experience

8 members of staff (psychiatry, mental health nursing) and 3 students (mental health nursing, medicine) were observed during 2 weekly team meetings held between the mental health team and the psychiatric team. It was not possible to interview any individuals in this setting, due to time constraints.

The meetings observed centred around the presentation of cases by mental health nurses and by senior house officers. They followed a common pattern of starting with the events leading to a referral, going on to consider past mental health history and more general background, followed by the outcome and future prognosis. The meetings were chaired by the nurse consultant, who explored decisions taken or assumptions made, with the support of the consultant.

Examples of real learning were identified in the observations. A senior house officer was challenged in the first meeting on the difference between behaving in a manipulative manner and being a manipulative person, and she acknowledged the importance of this distinction during the next observed meeting. A detailed discussion took place with another senior house officer about the inadvisability of claiming that a risk assessment has been completed when a service user is drunk, irrespective of pressure from senior medical staff wishing to remove someone from a bed in the accident and emergency department.

The style of the meetings was friendly and inclusive, but two caveats need to be made. First, some members only contributed when it was their turn to present a case. Second, social workers, not being core members of the mental health liaison team, were absent. However, case presentations often referred to the centrality of the social work input: sometimes this was praised, but at other times considerable frustration was expressed.

The overall impression was one of good quality interprofessional working, which was, however, confined to some extent to established patterns of interaction between senior and junior staff, with the nurse consultant emerging as a key player in developing egalitarian links between the disciplines at a senior level.

3.4.3 Observations - student experience

A further caveat concerning the style of the meetings concerns student experience. There was one student present at the first observed meeting, and two at the second. At the first meeting, the student was not invited to comment. The students at the second meeting were asked what questions a GP should ask if a service user was threatening suicide. They both seemed very unconfident about being asked to contribute, and

struggled to come up with suggestions. It is not clear what these students gained from the meetings in terms of interprofessional awareness and experience.

3.5 Acute Medical Ward for Older People

This ward has 20 beds. The service user group are older people who are admitted through medical ‘takes’ with acute medical conditions. Many of the service users have complex medical and social problems and require a full health and social care team to contribute to their care. The focus from the point of admission is planning for their discharge. This ward is complemented by another ward that focuses on stroke cases and longer-term rehabilitation. The median length of stay is 10 days, although a significant number of service users stay for longer than 3 weeks. Service users with acute infections who are frequently discharged after 48 hours lower the median.

The researcher was an academic with a nursing background.

3.5.1 Questionnaire data

Questionnaires were completed by 15 professional staff and 2 healthcare assistants (Table 3).

Profession	Number	Base
Healthcare assistant	2	Acute medical ward for older people
Medical staff – consultant	1	Hospital
Medical staff – senior house officer	1	Hospital
Nursing staff	4	Acute medical ward for older people
Nursing staff	1	NHS Professionals
Nursing staff – specialist	2	Community and hospital
Occupational therapist – senior	1	Hospital
Physiotherapist – senior	1	Hospital
Social worker	2	Community and hospital
Speech and language therapist	1	Hospital
Speech and language therapist	1	Community and hospital

Table 3. Acute medical ward for older people – number of respondents to the questionnaire by profession and base

From the questionnaire data, it appears that interprofessional working occurs between the following staff groups to varying degrees (presented in order of most to least frequently reported contact):

- medical staff
- occupational therapists
- physiotherapists
- social workers
- hospital nursing staff
- community staff
- specialist nurses
- dietitians
- speech and language therapists
- radiographers
- pharmacists
- mental health nurses
- psychiatrists
- dentists

All the respondents to the questionnaire agreed that there was good interprofessional communication and consultation on the ward (q14, q23, q26, q30, q31). All the respondents felt that they understood other professionals' roles, but representatives of social work, physiotherapy, and nursing did not feel that their role was well understood by colleagues from other disciplines (q9, q10).

Respondents' views varied as to the clarity of channels of communication, and as to whether different professionals had a common understanding of the goals of interprofessional collaboration (q17, q21, q22, q44, q45, q46). A small number of nursing and therapy staff felt that their expertise was not valued, and that respect, trust and support were lacking between professions (q18, q33, q34, q35). However, all the

respondents felt that they benefited from interprofessional working on the ward, as did service users and their colleagues from other professions (q39, q56, q57, q58).

3.5.2 Observations and interviews - staff experience

11 members of staff (nursing, medicine, social work, physiotherapy, occupational therapy) were observed during 2 weekly meetings held to discuss service users on the ward. Individual interviews were conducted with the consultant physician and the occupational therapist assigned to the ward.

From the interview data, it emerged that the consultant and the nursing team had enjoyed a long-term relationship, and consequently had clear understanding of each other's roles and responsibilities. This was also the case with the social worker, although she was due to retire. The physiotherapist and occupational therapist were not permanently based on the ward, and rotated out of the area after a period: this was seen to be less satisfactory than a previous arrangement, whereby the area had dedicated therapy staff.

The 2 meetings observed appeared to follow a well-tested procedure. The illness episode was the initial trigger for interprofessional interaction. As a result of this, early patterns of interaction seemed to centre on the senior nurse and the senior medical staff (the latter occasionally coaching more junior doctors). The meetings were led by either the consultant or the registrar, depending on who had been conducting the earlier ward round, with frequent participation by the senior nurse. However, there were many occasions when representatives of other disciplines contributed to discussions on their own initiative, rather than only responding to direct questioning. The increased participation by all group members seemed to relate directly to the length of the meeting, with more spontaneous interaction occurring later on. The complexity of the cases being discussed also seemed to have an effect, in that the more complex the needs of the service user, the more engaged all those present became. Decisions were reached collectively, and there was evidence of mutual respect between all the disciplines. Despite the evidently constructive nature of the open interprofessional relationships on the ward, it was noted that they were dependent on the characteristics of the senior medical staff. In this way, it could be seen that the medical hierarchy framed positively

the nature of the interprofessional working in the area to a significant degree. In addition, the interview data suggested that social workers were not always easily able to operate on the ward, and that the personality of an assigned social worker was seen as crucial to the success of interprofessional collaboration involving the health professions and social work.

3.5.3 Observations and interviews - student experience

No students were present during the observations. However, in interview, qualified staff made it clear that both occupational therapy and physiotherapy students were expected to attend and to contribute to these meetings. It was reported that on some occasions, even junior therapy students deputised for therapy staff. This did not appear to be the case with the nursing students, who were reported as more likely to play a passive role at these meetings.

Medical leadership within the multiprofessional meetings occurred in a context of general awareness of good interprofessional practice and the engagement of the full range of staff on the unit. It was considered that students could benefit by being placed in this environment.

3.6 Emerging themes

When considering the data from all three settings, a number of themes emerged. In considering these themes it should be stressed that these were all secondary or specialist health care settings, so cannot be assumed for primary health or social care settings.

3.6.1 Medical dominance/leadership

Professionals may all work together, but the medical hierarchy still appears to dictate the nature of interprofessional working on the ground. In two of the settings, it was explicitly stated that the disposition of senior medical staff determined to what effect other staff could implement interprofessional working.

3.6.2 Delineation of professional roles

Much modern interprofessional working is based on a clear view of different professional roles, rather than a blurring of roles (Booth and Hewison 2002). In this context, it is interesting to note that every respondent to the questionnaire claimed understanding of other professionals' roles, while a third of professionally qualified respondents (11/33) felt that their own role was not well understood by their colleagues from other disciplines.

3.6.3 The role of nurse consultants/nurse managers

There is considerable scope for nurse managers/nurse consultants to take on leadership roles across disciplines in the modern NHS. In all the areas observed, it was noticeable that the nurse managers/nurse consultants were key players in implementing and developing interprofessional working, at different levels, and with a variety of both professional and non-professional staff.

3.6.4 Absent friends

Key players may still be absent from important interprofessional events. This was noticeable in the mental health liaison service, where social workers were not included in the weekly meetings between the mental health team and the psychiatric team; and in the stroke rehabilitation unit, where medical staff did not attend the discharge planning meeting. Where frustration or concerns were expressed, these were more often directed at those not present at the meeting.

3.6.5 Health professionals and social workers

Tensions remain between health professionals and social workers in relation to hospital discharge and mental health. Two of the three social workers who completed the questionnaire reported that health professionals did not understand their role, and that issues of respect and control were at times problematic.

3.6.6 Limits to inclusivity

A meeting that is very inclusive for some may not be for all. Interprofessional interaction that reinforces the underlying hierarchical structure does not appear to be conducive to active participation by junior staff and students.

3.6.7 Eligibility

Much interdisciplinary working remains focused on users' eligibility for resources. At all three types of meeting observed, considerable time was spent discussing which resources were available, and whether service users were eligible for them. Misunderstanding of why different agencies/professions have different priorities and eligibility criteria remains a potential source of tension in interprofessional working.

3.6.8 Long-term relationships

Good working relationships across disciplines appear to be built up through trust over time. This was particularly noticeable in the both the stroke rehabilitation unit and the

acute medical ward for older people, where patterns of interpersonal and interprofessional communication had been established over a number of years.

3.6.9 Physical proximity

It appears that good working relationships across disciplines are facilitated by routine physical proximity. This was illustrated by the relationships between the nursing and the therapy staff on the stroke rehabilitation unit. In addition, the fact that the therapy staff were no longer based on the acute medical ward for older people, as they had been previously, was seen by some staff there as a retrograde step in terms of effective interprofessional collaboration.

3.6.10 Culture and atmosphere

The interprofessional events observed had been part of practice in each setting for some time and were seen by staff as being 'normal' or routine, rather than new or innovative practice. Consequently patterns of communication and leadership were well established and not questioned or challenged. The atmosphere was generally relaxed with occasional moments of humor shared by the group. There was little obvious conflict between those attending meetings or disagreement about the ways forward.

3.6.11 Content and process

Discussions focused mainly on the management of service users, their diagnosis and the sharing of information. This took precedence over discussions about how members of the team worked together or any explicit consideration of how the different professional roles complemented each other to the benefit of the service.

3.6.12 Previous role modeling

From interview data, it would appear that previous models of conducting multiprofessional events affected the way in which the observed events were conducted, as well as the degree to which interprofessional working would or could be effective in the participating sites.

3.6.13 Student experience

Student experience appears to vary with discipline and setting. Nursing students did not participate in observed events, unlike the therapy student in the stroke rehabilitation unit. However, participation also seemed to be dictated by the degree to which traditional hierarchical structures were supported during the key events. In interprofessional terms, students' status or needs as learners did not appear to have any significant attention.

Chapter 4. Discussion and conclusion

The main purpose of the pilot was to test the research methodology. However, some of the findings raise interesting issues concerning the nature of effective interprofessional collaboration and student learning.

4.1 Settings

In all the settings the provision of care was overtly enhanced by the closeness with which the various members of the different professions worked together. However, as mentioned above, it should be noted that these were dedicated institutionalised settings, where concentrated specialist care was provided to clearly defined groups of service users by teams with a highly-motivated core membership.

This was particularly the case in the stroke rehabilitation unit and the acute medical ward for older people, where the routine working practices reflected both the long-term relationships and the physical proximity enjoyed by many of the key players. It is therefore not clear from the pilot what other factors may enhance interprofessional collaboration, particularly in settings where the working structures are less cohesive, and the membership of interprofessional working groups is less stable over time. There is evidence to suggest that personal motivation and attitude are key factors in this regard (Gerrish 1999, Cook et al 2001). A focus of the main study will be to gather data over a range of settings, so that deeper understanding may be gained of the wider issues affecting interprofessional working in general, as well as the opportunities available for student experience.

4.2 Staff experience

Questionnaire data showed that staff were generally satisfied with the quality of interprofessional working in their area, with some caveats about control and communication between senior and junior staff from different disciplines. These data triangulated well with the qualitative data; additionally, where there was an opportunity to interview staff, interview and observational data triangulated well. The practitioners who participated in Phase 2 engaged in interprofessional interaction to varying degrees during the observed key events. The dynamics of this interaction appeared to differ depending on whether there were medical staff present or not.

4.2.1 Interprofessional working with medical staff

Those who appeared to engage most were those who had sufficient seniority to have comparable status with professionals from other disciplines and who could also be viewed as enjoying 'ownership' at some level. For example, the setting could be seen as 'belonging' to senior staff who were permanently based there: this applied to senior nursing staff in all three settings, and to senior therapy staff in the stroke rehabilitation unit. The senior medical staff, on the other hand, could be said to 'own' the service users, as the latter were formally admitted under the care of designated medical personnel, whose authority was required for processes such as discharge.

It was noticeable in most events observed that the majority of the interprofessional interaction that occurred was between senior medical staff and senior nursing staff. Junior staff usually only spoke when directly addressed, if at all. These findings reflect the concerns that inequality of status can hinder interprofessional interaction (Hudson 2002).

4.2.2 Interprofessional working without medical staff

Where medical staff were absent, seniority became less of an indicator for participation in interprofessional interaction. The concept of 'ownership' was still operating, in that it was those practitioners who were permanently based in the setting, that is, to whom it

'belonged', who engaged most noticeably. However, this did not apply where practitioners had only been in post for a short while, so length of service also appeared to be implicated.

It must be noted that key events without medical staff were only observed in one setting, so that this phenomenon may be an isolated case.

4.2.3 Professional groups without 'ownership'

In all the settings, certain professional groups, such as the social workers and the community liaison practitioners, appeared to occupy a position on the margins of a more tightly-knit interprofessional working group. Their contribution to discussions and their ability to interact interprofessionally on behalf of service users was seen always to be appropriate, but there was no sense of their 'owning' either the setting or the service users. With particular regard to the social workers, these findings may reflect the longstanding divisions that existed between social work and the health professions until relatively recently (Dalley 1993).

4.3 Student experience

We know that students' experience in placement influences their interprofessional working at later stages of their careers (Russell and Hymans 1999, Hilton and Morris 2001). It is important to discover what those influences are, and how they operate.

In many of the key events, student experience of interprofessional interaction appeared to be limited to observation, with some coaching from qualified staff as an aside to the main business at hand. This applied to all the nursing students observed, both pre- and post-qualifying. The exception was the occupational therapy student in the stroke rehabilitation unit, who was actively involved in 2 of the 3 key events observed.

Students placed in the pilot site settings had the opportunity to observe a range of good interprofessional practice, such as needs assessment, clarifying diagnoses, joint planning, sharing of information, problem solving and reflection on critical incidents in practice. However, it is not clear how effectively the potential learning from exposure to

such experiences was supported and enhanced. It may be that students discuss such learning opportunities with mentors, supervisors and FHSC-based staff, but there were very limited examples of students being explicitly encouraged to reflect critically on what they were learning about interprofessional working. It was unfortunately not possible to interview any of the students in these settings. This raises a question-mark about whether the methodology employed in the pilot can effectively capture student experience.

4.4 Methodological issues

As the purpose of conducting the study was to test the data collection and analysis methods, the limitations of the pilot methods are of key importance.

4.4.1 Questionnaire

The questionnaire was found to be generally suitable for its purpose. Feedback from practitioners, health and social care academics and a focus group of social care professionals highlighted the following points:

- the questionnaire needs to be shorter
- some questions are redundant/repetitive
- some questions are ambiguous
- more questions need to be negatively worded, to effect an even balance between the questionnaire items
- the lay-out could be more user-friendly
- there is a need to allow for responses relating to different professional groups

These criticisms have been taken on board, and the questionnaire is being revised for the main study.

4.4.2 Observations and interviews

The observation of key interprofessional events and subsequent individual interviews provided a substantial amount of valuable data concerning interprofessional working in

the pilot settings; however, due to time and other constraints it was not possible to obtain the same depth of data from all three settings. There is also a concern that it was difficult to evaluate students' experience, and that their presence at events was unpredictable.

In view of these facts, the research team has decided that the aim of the study will be better served by starting with individual student interviews midway through a placement, which will focus on their perceptions of their interprofessional experience in that placement setting. A concern of the researchers is consistency of data collection. There are differences in the way in which individual researchers conduct interviews, even with an agreed focus: a semi-structured interview guide, informed by the pilot findings, will be devised for the main study.

Students will be asked to identify key events or critical incidents involving interprofessional interaction. These will then be observed, and follow on interviews will be conducted with staff, service users and students, as appropriate. The researchers will also observe discussions between students and their mentors.

Again, in the interest of consistency, it is important that Study 3 has an aid to observation, as there will be a number of different researchers involved in data collection. It was felt that the criterion sheet was not completely suitable for this purpose, and will accordingly be revised in light of the findings.

4.4 Conclusion

The pilot study to test the methods for Study 3 has proved to be a valuable exercise. It has allowed the research team to:

- refine the staff questionnaire;
- test the consistency and effectiveness of observational and interview methods among the team of researchers;
- devise a suitable semi-structured interview guide for use with students;

- identify the weaknesses in the initial research design, in particular, the difficulty of predicting student attendance at key events; and the problems of capturing a true picture of student experience where students are passive observers of events.

It is obvious from data from other studies in the research programme that students are learning about interprofessional working in placement settings. However, it is not clear what they are learning, or how that learning takes place. The pilot study has enabled the research team to identify a range of important themes and issues, and has thus provided a good basis from which to move forward, so that deeper understanding of these issues can emerge.

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Appendix 1. Questionnaire for health and social care professionals about interprofessional working in their practice area

The literature identified a range of research tools that have been used to survey professionals' understanding of their collaborative skills in practice (Weiss and Davis 1985, Anderson and West 1998, Millward and Jefferies 2001, Geller 2002). These were adapted, in conjunction with a concept analysis of collaboration by Henneman et al (1995), to produce the questionnaire that was used in the pilot study.

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Research No. _____

Questionnaire for Health and Social Care Professionals

Interprofessional Research Programme Faculty of Health and Social Care, University of West of England, Bristol

Definition of Interprofessional Work: The part of professional practice that fully engages the expertise and co-operation of other practitioners and/or agencies to support effective, quality care for clients/service users.

Background information

1. Where do you work (e.g. health centre, social services office, hospital setting, etc.)?

2. What is your job title? _____

3. What is the job title of your line manager? _____

4. What staff do you manage? _____

5. What staff do you mentor? _____

6. What type of students do you mentor? _____

7. Did you have experience of interprofessional working prior to your current post? (Please tick one box).

Yes

No

If yes, please give details:

8. Please use the grid below to identify the types of health, social care or other professionals you work/liase with as part of your job. Please include **all** other professionals with whom you interact, even if that interaction is irregular or infrequent.

Professional	Employer	Frequency of interaction	Nature of work/liason

Section 1. Regular interprofessional working

The following section contains statements about your colleagues from other professions with whom you work/liaise with **closely and/or on a regular basis** (at least once a month).

For each of the following statements please circle the number of response that **best** reflects how you feel or behave. **Please circle one number only.**

1 = *Strongly Agree* 2 = *Agree* 3 = *Disagree* 4 = *Strongly Disagree*

9. I have a good understanding of other professionals' roles.

1 2 3 4

10. My colleagues from other disciplines have a good understanding of my professional role.

1 2 3 4

11. I know where my professional role overlaps with those of other professionals.

1 2 3 4

12. I am able to contribute to a discussion of a service user's care with other professionals.

1 2 3 4

13. I find it difficult to discuss areas of professional disagreement with other professionals.

1 2 3 4

14. I am able to negotiate constructively with other professionals when necessary.

1 2 3 4

15. I find it difficult to justify my professional viewpoint to more senior colleagues from other disciplines.

1 2 3 4

16. I feel comfortable taking the lead in interprofessional working.

1 2 3 4

17. As professionals, we have a shared view about what interprofessional collaboration should be trying to achieve.

1 2 3 4

18. We regard each professional perspective as equally important.

1 2 3 4

19. There is a lot of give and take among the different professionals.

1 2 3 4

20. Different professionals try to control each other.

1 2 3 4

21. There are agreed methods for communication between all the different professionals.

1 2 3 4

22. Communication channels between the different professionals are unclear.

1 2 3 4

23. I regularly communicate with other professionals.

1 2 3 4

24. We keep each other informed about work-related issues.

1 2 3 4

25. As professionals, we co-operate in order to help develop and apply new ideas.

1 2 3 4

26. I negotiate with other professionals to establish responsibilities for planning and delivering a service to users.

1 2 3 4

27. We discuss the degree to which individual professionals want to be involved in planning aspects of care for service users.

1 2 3 4

28. I tell other professionals when, in my judgment, their suggestions seem inappropriate.

1 2 3 4

29. I inform other professionals about areas of practice that are unique to my professional discipline.

1 2 3 4

30. When planning care for service users, I ask for input from other professionals.

1 2 3 4

31. When planning care for service users, other professionals ask for my input.

1 2 3 4

32. Where I work, the capabilities and skills of all the professionals are fully utilised.

1 2 3 4

33. My professional expertise is valued by the other professionals I work with.

1 2 3 4

34. As professionals, we are supportive of each other.

1 2 3 4

35. As professionals, we trust each other.

1 2 3 4

36. I feel at ease with the other professionals.

1 2 3 4

37. When interprofessional working succeeds, I feel pleased for everyone involved.

1 2 3 4

38. I am confident in putting forward new ideas to other professionals.

1 2 3 4

39. Where I work, interprofessional working has damaged the relationships between members of different professions.

1 2 3 4

Section 2. Occasional interprofessional working

The following section contains statements about the professionals from other disciplines with whom you work/liaise with **on an occasional basis** (less than once a month).

For each of the following statements please circle the number of response that **best** reflects how you feel or behave. **Please circle one number only.**

1 = *Strongly Agree* 2 = *Agree* 3 = *Disagree* 4 = *Strongly Disagree*

40. I find it difficult to communicate effectively with professionals whom I don't know well.

1 2 3 4

41. I find it easy to discuss areas of professional disagreement with these professionals.

1 2 3 4

42. I am able to negotiate constructively with these professionals when necessary.

1 2 3 4

43. I find it difficult to contribute to a discussion of a service user's care with these professionals.

1 2 3 4

44. As professionals, we have a shared view about what interprofessional collaboration should be trying to achieve.

1 2 3 4

45. I have agreed methods for communication with all the different professionals.

1 2 3 4

46. Communication channels with different professionals are unclear.

1 2 3 4

47. We keep each other informed about work-related issues.

1 2 3 4

48. As professionals, we co-operate in order to help develop and apply new ideas.

1 2 3 4

49. I negotiate with these professionals to establish responsibilities for planning and delivering a service to users.

1 2 3 4

50. We discuss the degree to which individual professionals want to be involved in planning aspects of care for service users.

1 2 3 4

51. I tell these professionals when, in my judgment, their suggestions seem inappropriate.

1 2 3 4

52. I inform these professionals about areas of practice that are unique to my professional discipline.

1 2 3 4

53. When planning care for service users, I ask for appropriate input from these professionals.

1 2 3 4

54. When planning care for service users, these professionals sometimes ask for my input.

1 2 3 4

55. I find it easy to approach other professionals, even if I don't know them well.

1 2 3 4

Section 3. Effect of interprofessional working

56. Do you think that interprofessional working benefits the service users where you work?
(Please tick)

No Please explain why not: _____

Yes Please explain how: _____

57. Do you think that interprofessional working benefits you in your work?
(Please tick)

No Please explain why not: _____

Yes Please explain how: _____

58. Do you think that interprofessional working benefits your colleagues from other professions? (Please tick)

No Please explain why not: _____

Yes Please explain how: _____

Thank you for taking the time to complete this questionnaire.

Appendix 2. Criterion sheet for structuring observations

The development of the criterion sheet was based on the concept analysis of collaboration conducted by Henneman et al (1995). The criterion sheet was not designed as a rigid framework for recording observations; rather, its aim was to provide an aide-memoire for the interviewer while collecting qualitative data.

Henneman EA, Lee JL, Cohen JI (1995) Collaboration: a concept analysis *Journal of Advanced Nursing* 21 103-109

STUDY 3 - TRANSFERENCE TO PRACTICE

OBSERVATION SENSITISING SHEET

	Evident	Not Evident
Evidence of Joint Venture		
Full inclusion of all present		
Dialogue between those present		
Joint goal setting/shared planning		
Shared problem identification and solving		
Shared problem analysis		
Joint evaluation of overall performance		
Co-operative endeavour		
Willing and active participation		
Understanding and acceptance of one's own role and expertise		
Contribution of expertise		
Willingness to explore each other's role		
Non-hierarchical relationships		
Recognition of boundaries of one's discipline		
Inclusive approach		
Interdependence of activity		
Communication		
Excellent communication skills		
Evidence of respect		
Evidence of trust		
Conflict strategies		
Negotiation skills		
Observation Record , eg conversation mapping, specific interaction, observed outcomes/ consequences		

Centre for Learning and Workforce Research in Health and Social Care

Faculty of Health and Social Care
UWE Bristol
Glenside Campus
Blackberry Hill, Stapleton
Bristol BS16 1DD