Educating for integrated care
Rapid realist evidence synthesis of interprofessional education interventions with potential to support integrated care

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The University of Winchester
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Executive Summary

This evidence synthesis was commissioned by Health Education Wessex to identify educational interventions with demonstrable potential to enhance the integration of health and social care in Wessex, called for by the Better Care Fund and other integration initiatives.

The focus of the evidence review has developed across the lifespan of the project. Whilst initial interest was in identifying pedagogic approaches to Interprofessional Education (IPE) with potential relevance to the current Wessex context, latterly, the focus became more tightly centred around IPE that can be embedded within service redesign, is sustainable and offers value for money.

Following discussions at the first interim feedback meeting and the Better Care Summit, more tightly defined parameters of the requirements for IPE were drawn up by the University of Winchester, as follows:

IPE delivered or commissioned in respect of Better Care delivery should be:

1) **Transformational**: leading to culture change and facilitating service redesign around the patient/service user, through:
   a) Changing mind sets/creation of a shared vision
   b) Interprofessional input into joint planning and service redesign (e.g. through planning and implementation of joint projects).

2) **Sustainable**: ensuring transfer of learning into (and from) the workplace, with demonstrable effects over time.

3) **Value for money**: fit for purpose, with evaluation leading to further improvement and knowledge sharing.

The report makes recommendations on IPE interventions that have the potential to deliver against these identified priorities.

With reference to case study examples, the report suggests that integration is a learning process, beginning with early stages of conceiving and planning, through to testing and developing new structures and ways of working, on to more established integration. Therefore, IPE that is fit for purpose should be cognisant of the organisation’s ‘stage of integration’.

**Recommendation 1**: To be fit for purpose, IPE should take account of an organisation’s stage of integration.

In the initial stages, characterised by developing shared visions and overcoming stereotypical thinking, narrative and exchange based approaches, focused on capturing the narratives of service users and practitioners have been shown to be helpful, nationally and locally.
**Recommendation 2:** In the early stages of integration, building narratives is essential for learning and generating a shared vision.

At later stages of integration, as practitioners come together to work in new ways, the evidence shows the benefits of approaches to learning that are embedded in the workplace. These are service-led, rather than curriculum-led, responsive to patient, learner and organisational needs. Such approaches use external facilitators/researchers to capture ‘data’ from the workplace that is shared with multidisciplinary groups of practitioners and service leads engaged in integrated teams, to promote learning and stimulate ideas for change. One particular approach - that of Expansive Learning, is highlighted as particularly pertinent. This approach is theoretically underpinned, pedagogically well-defined and has been successfully implemented and evaluated within multidisciplinary environments both in the UK and internationally.

**Recommendation 3:** As new ways of working are initiated, action based approaches, based in the workplace, are of particular value.

**Recommendation 4:** An approach based on Expansive Learning, or similar, encompassing the collection of qualitative and quantitative service data, with facilitated opportunity to discuss and test new ways of working, have been implemented within a number of integrated settings and offer potential here.

Evidence from case studies, literature and feedback from the Better Care Summit, show that taking on new roles can be anxiety provoking for those involved. The work in South Cheshire Rehabilitation Teams revealed that involvement in learning workshops and focus groups provided staff with opportunity for shared critical reflection.

**Recommendation 5:** Staff should be supported to take on new roles, both in terms of increasing their skills base, but also through provision of opportunities for joint reflection. This can be encompassed as part of the design of IPE.

As well as offering potential for learning from qualitative data, the expansive learning approach offers potential for in built evaluation in terms of outcome data. It also offers the opportunity to involve participants in thinking about which data or information, can really tell the story, taking evaluation beyond the gathering of key PIs, which may or may not be viewed as relevant by those involved. In adopting an expansive learning approach, ‘performance’ information could be used as catalyst for learning, dialogue and identification of support required. In this way, the analysis and evaluation of practice can become synonymous with reflection about practice and support for individual development.

**Recommendation 6:** Evaluation that is participatory and reflective can be used as a catalyst for learning, dialogue and identification of support required. In this way, the analysis and evaluation of outcomes can become synonymous with reflection and support for individual, as well as service, development.
1. Background and Introduction

Health Education Wessex has commissioned the University of Winchester to provide a rapid realist evidence synthesis of educational interventions with a demonstrable evidence base that can enhance the integration of health and social care in Wessex.

This has been driven by the requirements of the Better Care Fund, announced by central government in June 2013. The first step of the Better Care Fund is the implementation of an operational plan in 2015/16 approved through Health and Wellbeing Boards in February 2014. These plans are characterised by proposals for pooled budgets subject to joint governance and the requirement for agreed delivery arrangements with providers to address:

- Delayed transfers of care
- Emergency admissions
- Effectiveness of reablement
- Nursing and residential home admissions, and
- Patient and user experience.

Given the limited experience of, in particular, many primary care professionals and practitioners in relation to integrated social care, Health Education Wessex intends to commission educational programmes to support Better Care in the long term, and has a dedicated central allocation for this purpose. This evidence synthesis was commissioned to provide a review of educational approaches with potential to equip staff from a range of different backgrounds, to work collaboratively together under new integrated arrangements. It was commissioned in August 2014, with interim feedback provided at a meeting with representatives of Health Education Wessex on 7th October, 2014 and via a presentation at the Better Care Summit, on 28th November, 2014. The focus of the synthesis has developed during the course of the project.

1.1 Interim report

In the interim report, presented in October 2014, an overview of approaches to interprofessional education (IPE) was presented. IPE was defined, in line with the definition given by the Centre for the Advancement of Interprofessional Education (CAIPE, 1997) as, "Occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care."

This definition formed the basis of the synthesis, although it is fully recognised that, particularly in social work and social care, much of the workforce comprises practitioners, volunteers and semi-professionals. Nevertheless, the principles of IPE still largely apply. Barr (2002: p.13) shows that IPE has been implemented to address a number of service challenges, including:
- to modify negative attitudes and perceptions;
- to remedy failures in trust and communication between professionals;
- to reinforce collaborative competence;
- to implement policies;
- to improve services;
- to cope with problems that exceed the capacity of any one profession;
- to enhance job satisfaction and ease stress;
- to create a more flexible workforce.

In the interim report, seven main pedagogic ‘types’ of IPE were identified. These were received learning, simulation based learning, exchange (including narrative) based learning, action based learning, e-learning, practice based learning and observation based learning. From these seven approaches, three were prioritised by the group from Health Education Wessex as holding the most relevance for educational interventions related to Better Care. These were narrative/exchange based approaches, simulation and action based learning. It was agreed that subsequent review would focus on investigating potential IPE interventions using these pedagogic approaches.

Along with this, an interest in uncovering information about IPE-in-practice at integrated sites developed, leading to a focus on collecting case examples of sites that have employed particular IPE strategies to enhance integration, a selection of which are discussed in section 2.

1.2 Subsequent review and Better Care Summit

During the subsequent phase of evidence review, case study examples of IPE underpinning service redesign proved somewhat difficult to uncover. This was because literature/evidence tended to focus either on issues related to service redesign/integration or on details of IPE, often with sparse detail of the service context that spawned them. However, a limited number of cases, where details of both were given, were found - and these are shared in section 2 below.

There seem to be two main reasons for this disjuncture between service and educational foci of the evidence. Firstly, whilst educational interventions may well be happening ‘on the ground’ (as was evidenced at the Better Care Summit), these are not always captured formally, or evaluated. Secondly, IPE is often something that happens within the bounds of undergraduate, or other academic courses, rather than being embedded within service redesign.

These challenges were presented at the Better Care Summit. Subsequent plenary discussions suggested that these two issues offer an opportunity to Health Education Wessex to:

- a) publish/evaluate IPE implemented along with a description of its drivers and
- b) embed IPE within service redesign, rather than as a separate academic exercise.

Reflecting these discussions, the following parameters were drawn up as a way to refine the focus of the subsequent evidence review and synthesis in light of emerging themes:

IPE delivered or commissioned in respect of Better Care delivery should be:
4) **Transformational**: leading to culture change and facilitating service redesign around the patient/service user, through:
   c) Changing mind sets/creation of a shared vision
   d) Interprofessional input into joint planning and service redesign (e.g. through planning and implementation of joint projects).

5) **Sustainable**: ensuring transfer of learning into (and from) the workplace, with demonstrable effects over time.

6) **Value for money**: fit for purpose, with evaluation leading to further improvement and knowledge sharing.

This report makes recommendations on IPE interventions that have the potential to deliver against these identified priorities. These are made with reference to:

- Case study data from integrated care sites
- Evaluation of specific IPE approaches
- Theoretical and academic perspectives on pedagogy and evaluation
- Prior experiences of research team in delivery/evaluation of IPE
2. Integrated Case Studies

In this section, four case studies are presented as examples where the activities of a range of health and care providers have been integrated around specific service drivers. The chosen examples illustrate a range of enablers and stages of integration to be borne in mind when designing and implementing approaches to IPE. Particular elements of IPE implemented within each site are described. Inclusion criteria for the case studies were:

- Relevance to Better Care in terms of service focus/integration of services
- Some detail of education/training implemented available
- Potential for learning regarding general messages, enablers, underpinning educational approaches
- Evaluated

Cases consist of 3 from within the UK and 1 from overseas. In section 6, one further case study of children's medical care in Helsinki is presented. This is used to illustrate the implementation of one particular approach to learning/service redesign, so is not included at this stage. The cases included below are:

- South Cheshire Rehabilitation Link Teams
- Torbay Primary Care Trust
- Imperial Child Health General Practice Hubs
- Health One, Mount Druitt, Sydney, Australia

Details about each are presented below in terms of drivers; service; stages/enablers; challenges (where reported); mechanisms for learning and impacts. Common messages are drawn out in section 3.

2.1 South Cheshire Rehabilitation Link Teams

| Drivers | South Cheshire, a mixed rural urban county, had a growing population of older people, aged 65 and over. As increasing longevity can be associated with disability and multiple illnesses, increasing demands and pressures on health and social care services were anticipated.

As a result of this, an 18-month pilot assessment and rehabilitation service for older people with complex needs was introduced across South Cheshire in 2000, with the aim of maximizing older people’s ability to live independently. The service consisted of three new Rehabilitation Link Teams (RLTs) drawn from health, social and voluntary agencies, based on Intermediate Care models. |

| The Service | In 2000-2 a new countywide assessment and rehabilitation intermediate care service, consisting of three Rehabilitation Link Teams (RLTs) was piloted for older people with complex needs, requiring longer term intervention and support from a range of professionals and organizations. The RLTs adopted a multidisciplinary care management approach. The teams provided older people with intensive rehabilitation/care packages, led by a care manager drawn from one of the range of health/care services. Care plans included a |
range of services including physiotherapy, nursing, homecare and occupational therapy.

<table>
<thead>
<tr>
<th>Stages/enablers</th>
<th>Evaluations of these pilot teams cited the following enabling factors:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Transformational leadership</td>
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<td></td>
<td>- Involvement of stakeholders</td>
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<tr>
<td></td>
<td>- Leadership provided clear vision for all stakeholders</td>
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<tr>
<td></td>
<td>- Whole systems thinking- awareness of contributions of people at all</td>
</tr>
<tr>
<td></td>
<td>levels of the system</td>
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<td></td>
<td>- Learning organisation – invested in members’ learning to meet new</td>
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<tr>
<td></td>
<td>challenges and to actively support their/service development and</td>
</tr>
<tr>
<td></td>
<td>deeper understanding</td>
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<td></td>
<td>- Action research approach adopted – led by two external and one</td>
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<td></td>
<td>internal researcher</td>
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</table>

| Challenges | At the end of the pilot work only two of the teams maintained the care |
|            | manager service model due to management change.                      |

| Mechanisms for learning | An action research based evaluation was undertaken by the University of |
|                        | Salford. Through involvement in this project, the following learning |
|                        | mechanisms were implemented to support staff to take on their new care |
|                        | manager roles within these multidisciplinary teams:                  |
|                        | - Feedback loops i.e. Collection of data through observations, focus |
|                        |   groups and interviews by research team, followed by regular        |
|                        |   feedback of data to teams, to identify emerging challenges and      |
|                        |   learning points                                                    |
|                        | - Supported action planning to overcome challenges                    |
|                        | - Implementation of change                                            |
|                        | - Further cycles of feedback                                        |
|                        | - Evaluation that was both formative and summative (collection of cost |
|                        |   benefit data)                                                      |
|                        | - Further training needs identified including in-house competency    |
|                        |   training, mentoring, induction programmes, job exchanges           |

| Impacts | Collection/sharing of research data created collaborative culture and |
|         | a shared organisational narrative                                     |
|         | Action research approach promoted information exchange and problem    |
|         | solving                                                               |
|         | Focus groups provided opportunity for shared reflection               |
|         | Pilot project problematic for judging cost and outcome data as teams  |
|         | were not yet operating at their full potential or carrying representative |
|         | caseloads                                                             |

| Useful references | Kneafsey, Long, Reid and Hulmes, 2004; Reid, Kneafsey, Long, Hulme, &  |
|                  | Wright, 2007                                                          |
## 2.2 Torbay Primary Care Trust

**Drivers:** Torbay is in the South West of England, and comprises the three towns of Brixham, Paignton and Torquay. At the time of this service integration/evaluation (2006), it had a resident population of 135,000, with an additional 1,450,000 people visiting the area each year. It is a popular retirement destination, with 23% of the population over 65 compared with the national average of 16%. (Figures from 2006).

In a paper describing the creation of the Care Trust, Lavendar (2006) explains that the management teams of Torbay Primary Care Trust and Torbay Council’s social services department had long recognised the potential advantages of closer working between health and social care. A number of joint posts had been established as early as 1999, including the director of public health and carers’ lead. Monthly joint management team meetings had taken place since 2003 to bring a coherent strategic direction to the delivery, partnership and integration of health and social care services.

In late 2003, following the publication of the DoH Green Paper Every Child Matters, Torbay Council established a commission, to look at potential opportunities for reconfiguration of children’s social services. The commission recognised that any changes to children’s social services would have an impact on the provision of adult social services. Amongst their findings, they recommended that the adult social services department and the PCT should be combined to form the Torbay Care Trust.

**The service** Creation of Torbay Care Trust from Torbay Primary Care Trust and Torbay Council bringing together the functions of the Primary Care Trust and adult social care. Integration based on five health and social care teams organised in localities and aligned with general practices. Each team has single manager and point of contact, uses a unified assessment process and a shared health and social care electronic record.

**Stages/Enablers** Findings from evaluation reports show the following stages and enablers as crucial to the success of the Trust:

- Initial consultation with stakeholders
- Joint management meetings taking place since 2003 to set strategic vision
- Recruitment of a Chief Executive designate
- Development of the concept of ‘Mrs Smith’*
- Installation of project manager, joint management team and implementation of project management
- Communications with existing staff via weekly, monthly, bi-monthly and quarterly bulletins and quarterly integration seminars*
- Brixham pilot site - A single zone manager was appointed to run all health and social care services in Brixham
- In the second half of 2004, the zone manager established a zone management team
- Governance documents, partnership arrangement, legal underpinning.
<table>
<thead>
<tr>
<th>Identified Challenges</th>
<th>Findings from evaluation reports the following challenges:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Time needed to achieve culture change. Issues to work through include the effects of integration on professional roles, structures, work bases, working patterns.</td>
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<tr>
<td></td>
<td>• Integration of support services complex and lengthy due to different budgets, assets, infrastructure.</td>
</tr>
<tr>
<td></td>
<td>• Governance: lengthy process to draw up partnership agreement – covering legal, financial, performance and liability aspects. This is vital though, to enshrine principles of joint working.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mechanisms for learning</th>
<th>The following mechanisms are reported to have promoted learning and to support staff through the moves to integration:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Educational visit by PCT Chief Executive, clinical leaders and senior managers to Kaiser Permanente (integrated health care system) in California</td>
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<tr>
<td></td>
<td>• Use of the ‘Mrs Smith’* concept – a fictional frail, elderly lady living alone in Brixham, having a variety of long-term health and social care needs, and receiving input from many professionals. Story constructed about the services she required, and the difficulties she faced in trying to navigate the local health and social care system. This was used to spark vision and stimulate creativity and innovation.</td>
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<td></td>
<td>• Integration seminars every quarter, for staff to hear about progress, key projects and to ask questions, discuss, dispel myths and build enthusiasm.</td>
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<tr>
<td></td>
<td>• Evaluation - Base-line work was undertaken to understand the starting position, then an ‘action research’ model was adopted. Short-term objectives were set, impact monitored and fed back to both the pilot and the management team to assess progress. Following feedback, new objectives were set, and a number of ideas emerged which were further developed and adopted by the entire organisation.</td>
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<tr>
<td></td>
<td>• Pilot work - Brixham site is recognised to have been an important driver in the development of a ‘new cultural paradigm for the Care Trust’ – workplace/action based learning.</td>
</tr>
</tbody>
</table>

| Impacts | Analysis has shown that Torbay made measurable progress in reducing reliance on acute hospitals and avoiding admissions, including reducing the average number of daily occupied beds used in both the district general hospital and community hospitals and reducing emergency bed days for people aged 65 and over. |

| Information taken from | Lavender, 2006; Thistlethwaite, 2011 and Correspondence with key professionals within the Trust. |
2.3 Imperial Child Health General Practice Hubs

<table>
<thead>
<tr>
<th>Drivers</th>
<th>The hubs were formed in response to high outpatient and A&amp;E attendances by children and young people in the local area (amongst top 20% in the country). Data showed that over half of outpatient attendances at St Mary’s could have been treated in primary care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The service</td>
<td>Four pilot Child Health General Practice Hubs have been created in 2014, comprising:</td>
</tr>
<tr>
<td></td>
<td><strong>Specialist outreach</strong> – paediatric consultants attend hub practices every 4-6 weeks to discuss cases within multidisciplinary teams. Following this meeting a joint outreach clinic held in GP hub, which can refer cases to hospital if necessary.</td>
</tr>
<tr>
<td></td>
<td><strong>Open access</strong> – same day GP appointments/paediatric advice for children and young people. GPs supported by 24 hour phone/email hotline to consultants. Cases can be referred to hospital/specialist outreach as necessary.</td>
</tr>
<tr>
<td></td>
<td><strong>Patient and Public engagement</strong> – information campaigns about A&amp;E attendance, self-management initiatives and involvement of practice champions.</td>
</tr>
<tr>
<td>Stages/Enablers</td>
<td>The Kings Fund (2014) case study evaluation of this service identified the following enablers of integration:</td>
</tr>
<tr>
<td></td>
<td>• Children’s commissioner employed by PCT and local authority instrumental in co-ordinating strategy, stakeholder involvement, funding bids and evaluation.</td>
</tr>
<tr>
<td></td>
<td>• Motivated consultants driving collaboration with GPs through relationship building.</td>
</tr>
<tr>
<td></td>
<td>• Two early pilots led to two more. Model being rolled out more broadly.</td>
</tr>
<tr>
<td></td>
<td>• Transformational leadership</td>
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<tr>
<td></td>
<td>• Communication and development of shared vision</td>
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<tr>
<td></td>
<td>• Creative and whole population approach to the design of service</td>
</tr>
<tr>
<td></td>
<td>• Pilot work and evaluation</td>
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<tr>
<td>Challenges</td>
<td>Patchwork funding and lack of single service specification</td>
</tr>
<tr>
<td></td>
<td>Difficulties with sharing information across GP/hospital systems.</td>
</tr>
<tr>
<td>Mechanisms for learning</td>
<td>Because of the extended role of GPs in this service, there has been a focus on enhancing the paediatric skills of general practitioners:</td>
</tr>
<tr>
<td></td>
<td>• Developing the paediatric skills of GPs and other health care professionals at the heart of this model – through multidisciplinary meetings and shared clinics, as well as advice via hotline.</td>
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<tr>
<td></td>
<td>• As well as this, hubs are used as placements for GP and paediatric trainees, medical students and student health visitors.</td>
</tr>
<tr>
<td>Impacts</td>
<td>Early evaluation indicates potential for: cost savings, decrease in referrals to hospital and outreach clinic, shortened waiting time, reduced emergency admission, increased patient satisfaction.</td>
</tr>
<tr>
<td>Information taken from</td>
<td>Kings Fund (2014), Specialists out of hospital case studies – Imperial Child Health General Practice Hubs.</td>
</tr>
</tbody>
</table>
### 2.4 Health One, Mount Druitt, Sydney, Australia

<table>
<thead>
<tr>
<th>Drivers:</th>
<th>Integration of GP and community health services to provide continuum of care. Improve referral process to specialist and other care services. Reduction of hospital admissions amongst target population of people with complex and chronic health needs at risk of hospitalisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The service</td>
<td>Health One, Mount Druitt, Sydney, Australia is a virtual organisation based on a hub-and-spoke model of care that operates in a socially disadvantaged area of Western Sydney based around a community health centre (the ‘hub’). The model, which began in 2006, is based on ‘virtual’ care planning and aims to improve co-ordination of care for older people with complex health needs, as well as to reduce unnecessary hospitalisations and ensure appropriate referral to community and specialist health services. General practice liaison nurses organise multi-disciplinary case conferences, co-ordinate care between various care providers, and ensure that information about the patient is provided to the GP or case manager. Practice liaison nurses link together primary care physicians, community health staff, counselling, other allied health services and hospitals. They also provide self-management support to chronic and complex patients, referred in from multiple sources.</td>
</tr>
</tbody>
</table>
| Stages/Enablers | • Service and capital planning  
• Information and communication technology  
• Governance and sustainability  
• Workforce development |
| Identified Challenges | No information available |
| Mechanisms for learning | Approaches to supporting staff development through education and training strategies include:  
• Attending formal courses, (face-to-face or online).  
• Establishing structures for clinical supervision and opportunities for informal learning  
Health One states that on-going education and professional development can have a positive impact on the workplace, by increasing staff confidence and competence and contributing to staff stability and morale, particularly in rural and remote areas. Once established, Health One NSW services may also provide clinical placements for undergraduate and post graduate medical, nursing, and allied health students. |
| Impacts | Clients feel supported/less anxious. GPs have high satisfaction. Reduced emergency room (A&E) visits and lengths of stay post-intervention. Reduced referrals to community health. |
3. Stages and Enablers of Integration and IPE

Whilst a broader review of case studies for integrated learning is beyond the scope of this report, a number of key issues are highlighted within the cases identified above. These are:

- The need for transformative leadership
- The development and communication of a shared vision
- The need for creativity and openness to new ways of thinking and working
- Involvement and equipping of staff and stakeholders in defining problems and creating solutions.

Rather than happening at specific time points, the case studies illustrate that integration occurs as a learning process, moving from early stages of conceiving and planning, through to testing and developing ways of working and infrastructures, to more established structures for integrated working (with opportunity for continued reflection and improvement).

Kneafsey et al. (2004) describe the process for staff taking up new care management roles within the South Cheshire Rehabilitation Link Teams as ‘learning care management’ (role development, learning, problem solving); ‘doing care management’ (identifying key foci to the role, attending to the ‘nitty gritty’ details, problem solving) and ‘experiencing care management’ (dealing with challenges of lack of resource, working with practitioners from different backgrounds, learning about roles and remits, feelings of anxiety and satisfaction).

Barr (2001) and Guy (1986) have identified a five stage model of integration and learning, as shown in Table 1 below:

<table>
<thead>
<tr>
<th>Stage One</th>
<th>Achieve common understanding, concepts, language, knowledge</th>
<th>Professions find (more) commonality with other professions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage Two</td>
<td>Overcome prejudice, bias and stereotypes</td>
<td>Values of trust and service shape relationships</td>
</tr>
<tr>
<td>Stage Three</td>
<td>Modify behaviour – change cultural norms</td>
<td>Team structures ‘socialise’ across professions</td>
</tr>
<tr>
<td>Stage Four</td>
<td>Reinforce common ground – combine complementary skills</td>
<td>Joint goals harness professional and bureaucratic resources together</td>
</tr>
<tr>
<td>Stage Five</td>
<td>Identify joint opportunities – agree actions</td>
<td>User outcomes demonstrably drive interprofessional contributions</td>
</tr>
<tr>
<td></td>
<td>(Barr, 2001)</td>
<td>(Guy, 1986)</td>
</tr>
</tbody>
</table>

Table 1: Stages of integration and IPE (Barr, 2001) and (Guy, 1986)

IPE that is fit for purpose will need to take account of the stage of integration the service is at, and thus, the individual and organisational requirements of IPE. It should also recognise that learning is not necessarily about the transfer of fixed and stable knowledge, rather, that as work reorganises and roles develop, practitioners are creating and developing knowledge, that has not previously existed, through a process that Engeström (2001)
describes as expansive learning. Engeström’s particular approach to IPE and support for service change is discussed in section 6.

4. IPE strategies for early stages of integration – preparing to work together

From the case studies above (reinforced by ideas shared at the Better Care Summit), it is suggested that in the initial stages of integration, (characterised by the generation of ideas and planning how new arrangements may look), IPE should be focused around the development and communication of a shared vision and awareness/openness to new ways of working and thinking. At these stages a focus on achieving common understandings of concepts, language, overcoming bias and stereotypes, developing values that shape services are important *stages one and two, in table 1 above*.

It is suggested that narrative and exchange based approaches are likely to be of particular use here, involving approaches that capture and share narratives of service users/patients and a range of stakeholders including practitioners, carers and volunteers. As in the case of Torbay’s development of the narrative of Mrs Smith, these can be used to spark creative thinking, and a desire to improve services. Two excellent examples of this were discussed at the Better Care Summit on 7th December. Wiltshire’s systems thinking approach used patient records to collate a patient journey which illustrated the fragmented and repetitive nature of one patient’s care. This was produced visually and shared with members of the team working to develop integration – providing both learning and a desire to improve collaboration for the sake of the service user. Another colleague revealed that a similar exercise within her own organisation had also been costed – providing learning and motivation for a different, but related, audience. The Isle of Wight’s ‘My Life A Full Life’ project began with consultation with stakeholders – another form of gathering patient/service narratives.

The need for an overarching narrative about what integrated care should look like has been recognised by a number of national organisations, including the Kings Fund and Nuffield Trust who have jointly stated that:

> “The most fundamental prerequisite to the development of integrated care at scale is the crafting of a powerful narrative”

The recognition of the importance of narrative has led the NHS Commissioning Board to ask National voices (the national coalition of health and social care charities and its members) to create such a ‘Narrative’ about how integrated care should look – taking the perspectives of patients, carers and other service users. Work completed by National Voices to date comprises the collation of statements by patients and service users about what person centred, co-ordinated care should provide for them. Once completed, the Commissioning Board will adopt the completed Narrative as its framework definition for integration, with support from The Local Government Association (LGA), the Department of Health and Monitor. A link to further details about this project is provided in appendix one.

**Finding one:** Integration occurs at a number of stages, and as a process, reflected in case study examples, practice shared at the Better Care Summit and frameworks by Barr (2001) and Guy (1986). Therefore, to be fit for purpose, IPE should take account of an organisation’s ‘current state of integration’ and set activities and outcomes accordingly.
**Finding two:** In the early planning stages, the use of stakeholder, and in particular, service user/patient narratives, to inform and motivate integration are key for the development of shared values and a common vision. Some of this work is being undertaken nationally by ‘National Voices’ and locally within Wiltshire, and the Isle of Wight.

5. IPE strategies for later stages: Learning through working together (stages three to five, table 1)

As identified at the Better Care Summit, project work that brings groups of professionals together to make improvements in practice offer opportunities to learn whilst embedding change. There are a number of approaches that can be adopted here, such as the one being taken by Health Education England’s Better Training Better Care, Inspire initiative. In this approach, trainees are empowered to develop and implement improvement projects with support from workplace trainers. These projects have been evaluated very successfully, and include, for example, projects to: Improve supervision in basic psychiatric training (Tees, Esk and Wear Valley NHS Foundation Trust), Serious Incident Prevention Simulation-based Training Pilot (East London NHS Foundation Trust), Avoiding Grey Wednesdays – shadowing and peer mentoring project (University Hospital Coventry and Warwick NHS Trust). An annual sharing good practice day provides trainees with the opportunity to share their projects as an oral or poster presentation. Similarly, at the Better Care Summit, Wiltshire revealed that in their 100 day project period, members of staff were given the opportunity to trial collaborative improvement projects in practice, in a spirit of openness to new ways of thinking and practicing.

Beyond the implementation of particular projects, it is relevant to consider how learning opportunities can be maximised for staff working within newly integrated services, or within pilot sites. Each of the UK cases described above used pilot sites for integrated services, which had the potential to be rolled out more widely. As practitioners come together within pilot sites and newly developed services, vital opportunities for informal and more formal workplace learning occur. This is the very enactment of workplace, action based learning, an approach that resonated with managers at the interim feedback meeting at Health Education Wessex.

This approach has also been adopted ‘on the ground’ during integration at Torbay. As one senior manager from Torbay wrote about pilot sites and newly integrated services:

‘interprofessional learning tends to play out in the common learning environment of integrated teams’

And:

‘there is a strong sense of integrated and interprofessional teams learning together in an experiential environment’. (Source: email to researcher following request for information about IPE for integration)

Opportunities to maximise naturally occurring interprofessional learning within newly developing teams offer a good fit to Health Education Wessex’s concern to embed IPE as an integral part of service redesign. Nisbet et al. (2013: p.469-470), making the case for workplace learning, suggest the benefits it offers above university based curricula:
“…workplace learning encapsulates all employees and learners regardless of whether or not they are formally enrolled in an educational programme. Learning is guided by individual, patient and organisational needs rather than a university curriculum.’

Whilst the healthcare workplace is rich with potential opportunities for IPE, these opportunities can be best realized if learning is made explicit and intentional.

**Finding three:** newly formed and developing integrated services provide rich opportunities for workplace interprofessional learning.

**Finding four:** Workplace learning is inclusive and embedded with the needs of the service, the individual and the patient.

**Finding five:** strategies to support, and make explicit the learning occurring within these contexts, are likely to enhance IPE.

6. **Expansive Learning at work**

Two of the case studies above adopted action research methodologies as a way to maximise workplace learning. For example, in the case of Cheshire’s Rehabilitation Link Teams, researchers gathered qualitative data, in the form of interviews and observations, as well as outcome and financial information. The qualitative data was fed back to practitioners in a series of workshops, and used to define problems and model solutions, which were then implemented into practice. As well as supporting change in the organisation, the opportunities for practitioners to come together to discuss and share experiences, was valued as an opportunity for reflection and support from colleagues (Reid et al., 2007). This methodology was adopted as an aid to change management, but such approaches can also be used to foster IPE –enhancing potential for the embedding of service redesign and collaboration. Gathering of hard data also acts as a means to evaluate the success of newly integrated arrangements.

In this section, a further case study is presented which provides details about how one particular action based learning approach – Expansive Learning (Engeström, 2001), was used within the context of paediatric care in Helsinki to identify, learn from and overcome existing problems with fragmentation of care. The case study of the particular intervention is presented, followed by a more detailed discussion of its theoretical and pedagogic elements. The potential relevance of this approach to the current context of preparing and supporting staff for integrated working, is then highlighted.
### 6.1 Learning Challenge in Children’s Health Care in Helsinki

<table>
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<tr>
<th>The Case: Children’s Health Care in Helsinki</th>
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<tbody>
<tr>
<td><strong>Drivers:</strong></td>
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<td><strong>The service/intervention:</strong></td>
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| **Stages/Enablers:** | - Implementation of Boundary Crossing laboratories (based on Activity Theory), facilitated by University of Helsinki  
- Key stakeholders from primary and secondary care, and patient representatives attended the sessions.  
- The sessions used patient/family narratives to present problems to be resolved  
- Through a series of workshops the problem was identified and solutions suggested and finally modelled/tested through an expansive learning cycle (Figure 2: Expansive Learning Cycle Engeström, 2001) |
| **Identified Challenges:** | Initial defensiveness about own roles and practices, therefore need for skilled facilitation. Presence of patient representatives also helped to diffuse blame shifting. |
| **Mechanisms for learning:** | - Boundary Crossing Laboratories, facilitated by external researchers  
- Collection and sharing of patient narratives as basis for learning and action  
- Solution modelling, discussion then implementation, supported through expansive learning approach |
| **Impacts:** | At the end of the expansive learning intervention, a four stage integrated approach had developed:  
- GP became co-ordinator of patient’s care trajectory  
- When a child visited a hospital more than twice a care agreement was drafted, setting out the division of care across the contributing organisations, and sent to the primary and secondary care physicians and patients’ parents for approval.  
- If any party felt it necessary, a care negotiation would be held to formulate a mutually acceptable care agreement  
- Patient’s medical record sent to all relevant providers. |
| **Information:** | Engeström 2001 |
In the UK context, expansive learning has been used by Edwards et al. (2009) in the Learning in and for Interagency Working project, to develop interprofessional collaboration to support the wellbeing of vulnerable children and young people (e.g. Daniels et al., 2007) across 5 local authorities in England and two sites in Northern Ireland. Expansive learning is a theoretically driven approach to learning, based on activity theory, which is recognised to be valuable to the design and delivery of IPE (e.g. Payler, Meyer, & Humphris, 2007 and Meyer & Lees, 2013). Through its theoretical base, it offers a number of tools to help groups of practitioners and service leaders, engaged in integrated teams, to define and think about their own work, and that of others, its challenges and potential for transformations. These are introduced briefly below.

7. Theoretical underpinnings: activity theory
The early development of activity theory is based on the work of Vygotsky (1896-1934), whose main concern was to study how relationships between humans and their environment are mediated by cultural means, tools and signs. His work helped us to understand how what we think is revealed in our actions and talk. Activity theory is an object-orientated analysis of human activity – that is, its starting point lies in understanding what people are seeking to do or change (Edwards et al., 2009).

More recently, activity theory has been developed through the work of Engeström, who has been concerned to show how it can be useful in facilitating change within and across activity systems, through joint learning and reflecting on organisational challenges. The model below shows one activity system, but the diagram can be expanded to include many more, to reflect networking and collaborative configuration of services.
Each of the labels marked on the triangle above, are a point of focus and analysis for activity theory – helping us to analyse how the subject, (here, the practitioner) makes use of tools and signs, is constrained and guided by rules, interacts with his/her community/colleagues within varying forms of division of labour – to reach the object, or outcome of their activity. Even the process of defining the ‘object’ of work can be a useful learning experience. For collaborative, integrated working, the negotiation of a shared ‘object’ or vision is important. Subjects are those undertaking the activity, the rules are those which shape the activity, such as process, guidelines, protocols, such as information sharing protocols. How we make sense of the object defines our learning and can move to include joint envisioning.

For Engeström, potential for learning and change comes from a number of features of activity systems, which he describes as:

**Multi-voicedness** – An activity system is a nexus of multiple points of view, traditions and interests. The division of labour in an activity creates different positions for the participants, the participants carry their own diverse histories and the activity system itself carries multiple layers and strands of history engraved in its artefacts, rules and conventions. This multi-voicedness increases exponentially in networks of interacting activity systems. It is a source of both tension and innovation, demanding actions of translation and negotiation (Edwards et al, 2009, p.197).

**Historicity** – Activity systems take shape and are transformed over lengthy periods of time. Their problems and potentials can only be understood against their own history, which needs to be considered not only in terms of local history of the activity and its objects, but also as the history of theoretical ideas and tools that have shaped professional activity (Edwards et al, p.197).
Contradictions – historically accumulating structural tensions within and between activity systems. To relate this to a case study example above, an example of one such contradiction within the Child Health General Practice hubs, is that whilst closer working, joint consultations and services between general practices and hospital consultants have been developed at the point of service delivery, this is not currently underpinned by shared computer systems, meaning that GPs are unable to access relevant details from the hospital system and vice versa. Contradictions may constrain practice at times, but importantly act as a driver for change through their ability to can spark a joint envisioning and collective change effort.

Expansive learning - Expansive transformation is accomplished when the object and motive of the activity are reconceptualised to embrace a wider horizon of possibilities than in the previous mode of activity. In the case of practitioners from different professional or agency backgrounds working together in integrated teams, this relates to a shift from a ‘siloed’ professional view to broader multi-professional visions. A full cycle of expansive transformation may be understood as a collective journey through what activity theorists see as the zone of proximal development of the system.

Expansive learning does not assume that practitioners are always learning to master stable, defined bodies of knowledge and skills. Instead it focuses on the kind of learning that occurs when work practices and organisational configurations are undergoing rapid change and workers are creating new knowledge and new ways of working.
8. The format for expansive learning ‘laboratories’ – or ‘mini labs’

A series of sessions is scheduled for practitioners over a number of months (in Edwards et al’s work, this was six sessions over a period of twelve months, at intervals of two months). Sessions last in the region of two hours each, and are designed to support cycles of expansive learning, through a focus on:

- Past practice – encouraging consideration of the historical development of their working practices

- Present practice – identifying structural tensions (or contradictions) in current working practices

- Future practice – working with professionals to suggest new forms of practice that might effectively support innovations in multi-agency working. (Edwards et al, 2009, p.201)

These sessions are based on the delivery of ‘mirror data’ as a stimulus to learning, reflection and planning. This consists of data collected by a research team (which consists of external researchers, but may include internal ones also) in the form of interview and observation data. Such data may take the form of anonymised cases, or discussions about practitioners’ own understandings about practice. Such data is used as an analytic tool, to facilitate learning and understanding, assist the identification structural tensions in integrated practice and the development of new solutions.

It is suggested that the implementation of this approach, for multi-professional groups beginning to work together in newly integrated ways across Wessex, offers much potential to be:

7) **Transformational**: leading to culture change and facilitating service redesign around the patient/service user, through:
   a) Changing mind sets/creation of a shared vision
   b) Interprofessional input into joint planning and service redesign (e.g. through planning and implementation of joint projects).

8) **Sustainable**: ensuring transfer of learning into (and from) the workplace, with demonstrable effects over time.

9) **Value for money**: fit for purpose, with evaluation leading to further improvement and knowledge sharing.

9. Summary and discussion
As has been outlined above, the focus of this evidence review has developed across the lifespan of the project. Whilst initial interest was in identifying approaches to IPE with potential relevance to the current Wessex context, latterly, the focus has become more tightly centred around IPE that can be embedded within service redesign, sustainable and value for money.
It has been suggested that through careful matching of strategies to integration stage (table one, above), strategies that are fit for purpose may be employed. In the initial stages, narrative and exchange based approaches, focused on capturing the narratives of service users and practitioners have been shown to be helpful in identifying current problems and developing a shared vision for collaborative improvement efforts.

At later stages of integration (stages three to five in table one), there appears to be much potential in developing approaches to learning that are embedded in work that is naturally occurring. Two of the case studies presented in section 2 above have employed action learning strategies, and one such approach – expansive learning – has been highlighted for its potential to meet current requirements and drivers. This approach has been implemented to enhance interprofessional learning and service delivery with the UK and overseas.

It is likely that practitioners will identify other educational needs as they progress in new roles. As outlined above, Kneafsey et al (2004) identified three stages for practitioners taking on new case manager roles. At each stage, different learning needs emerged, some of which will involve the need to develop clinical knowledge and skills (as in the Child Health hub case study). They suggest:

“Successful management of the transition…requires support from the key stakeholders and strong leadership within (care manager) teams. In-house competency-based training and induction programmes, and mentorship, can also play an important role, together with innovative forms of postqualifying education and training, for example, via job exchanges or an apprenticeship model” (Kneafsey et al., 2004: p.129).

As identified through the case studies above, integration is successful when staff are supported to take on new and developing roles – which is likely to require a range of educational interventions. These should be delivered in response to practitioner needs, rather than imposed by university curricula, requiring a partnership between those delivering and those receiving such interventions. It is suggested that part of the role of forums for practitioners to come together to reflect, question and envision new ways of working could be to help them articulate the support and further learning they require. In this way, a cycle of expansive learning, embedded wholly within service re-design, may be developed.

Secondly, it is also pertinent to consider how integration and educational initiatives introduced to support it, may be evaluated and shared. To build an element of evaluation into the delivery of IPE, through the collection of hard and soft data that can be used both for learning and evaluation, appears to offer much potential here, as does the opportunity to involve participants in thinking about which data or information, can really tell the story, taking evaluation beyond the gathering of key PIs, which may or may not be viewed as relevant by those involved. It is important to cognisant that evaluation or monitoring may be viewed as threatening for those under the microscope.

Here too, the expansive learning approach offers interesting potential. Clarkson (2008) suggests that in particular, social workers, who are not ‘traditionally wedded’ to ideas of measurement and routine evaluation may benefit from performance information presented as part of a more participatory environment. With this approach, performance information is presented as a stimulus for thinking about how local performance could be improved rather than a punitive measure to draw attention to those who are falling behind.
and Warburton (2006), in their study on performance indicators for practitioners working with older people, found that staff workshops, conducted to enable senior practitioners to view the performance of their teams in relation to others and the wider department, were seen as particularly beneficial. Reported benefits included the linking of activity to visible outcomes for service users, gaining an understanding of how work fitted in with other organizational priorities and the generation of informed questioning of activity Clarkson (2008, p179).

In adopting an expansive learning approach, ‘performance’ information could be used as catalyst for learning, dialogue and identification of support required. In this way the analysis and evaluation of practice can become synonymous with reflection about practice and support for individual development. Cooper (2000, p.117) suggests that this could entail a cultural shift within organizations.

“At a time when the need for a ‘performance culture’ is being increasingly invoked in social work settings, it tends to suggest that staff are being measured and judged. But imposed frameworks beg the question of where the criteria have come from and the legitimacy of those who are identified as judges and assessors. It certainly brings a tone of anxiety for all involved in a system of standards with endless possibilities for ‘failure to meet requirements’ but few opportunities for self-authorship or engagement in an ownership of development. At this stage I want to concentrate upon the need for ‘honourable engagements’ between people, or relationships, as the basis of a social work that offers potential for a reflexive process…”

And a cultural shift – in which staff are supported, through what may be anxiety provoking job changes - to put service users at the very heart of their work - is what is being sought.

**Recommendation 1**: To be fit for purpose, IPE should take account of an organisation’s stage of integration.

**Recommendation 2**: In the early stages of integration, building narratives is essential for learning and generating a shared vision.

**Recommendation 3**: As new ways of working are initiated, action based approaches, based in the workplace, are of particular value.

**Recommendation 4**: An approach based on Expansive Learning, or similar, encompassing the collection of qualitative and quantitative service data, with facilitated opportunity to discuss and test new ways of working, have been implemented within a number of integrated settings and offer potential here.

**Recommendation 5**: Staff should be supported to take on new roles, both in terms of increasing their skills base, but also through provision of opportunities for joint reflection. This can be encompassed as part of the design of IPE.

**Recommendation 6**: Evaluation that is participatory and reflective can be used as catalyst for learning, dialogue and identification of support required. In this way the analysis and
evaluation of outcomes, can become synonymous with reflection and support for individual, as well as service, development.
Appendix One: Useful resources/links for further reading

National Voices: collection of service user narratives about what integrated care should provide:
http://www.nationalvoices.org.uk/person-centred-coordinated-care

Example of narrative approach in practice:
The case of Mr Kirby – case study for inter-disciplinary teaching
https://www.youtube.com/watch?v=6QYGHXC7QMQ

Quality Use of Medicines Project: University of Newcastle, Australia

University of Oxford’s collection of video and audio recorded interviews with people about experiences of illness.
http://www.healthtalk.org/

Learning in and for interagency working website (expansive learning approach)
http://www.bath.ac.uk/research/liw/
References


