



# Enlisting interprofessional learning

The Italics are direct quotations from the Lord Darzi interview

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*“We want more integration. That is the challenge.”*

Few would disagree, but reorganising services is not enough to ensure better care. The structural fallacy was exposed long ago<sup>1</sup>. Integrated care falls short unless and until it takes into account the interplay between structural strain and personal stress for those charged with translating blue prints into practice and for maintaining services in transition; *there is a need to take account of* the way in which integrating some services invariably distances them from others, putting a premium on effective collaborative working across the fault lines<sup>2</sup>. Integrated care with interprofessional learning responds in the round to the needs of individuals, families and communities. Neither stands alone.

*“We get fixated about structures. -- if we are really going to tackle some of the challenges of the future – we need closer working.”*

Change invariably encounters resistance as Lord Darzi recalls:

*“We could see --- some of the advantages from the patient’s perspective, --- but we were much more resistant to that change as a profession.”*

Acknowledged or denied, anxiety often drives those facing change on to the defensive<sup>3</sup>, working to rule when innovation is vital and withholding cooperation when it is most needed. Interprofessional learning can mitigate adverse reactions and assemble cross-professional support on which successful implementation of future policies depends, whatever their precise form for primary care following continuing consultation.

It was first introduced into primary care some forty years ago in the midst of equally momentous reforms as teams were established and their members explored new ways to work together helped by ‘facilitators’ recruited from the cadre of freelance trainers<sup>4-5</sup>. Their successors are as active today and just as able to work with primary care teams, centres and trusts provided that they are briefed, alerted to the issues and helped in honing their skills in the light of recent research<sup>6</sup>.

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Interprofessional learning is now firmly established, grounded in evidence<sup>7-8</sup> and supported by Strategic Health Authorities, Skills for Health, the Higher Education Academy, the GMC, the BMA, the RCGP, the UK Centre for the Advancement of Interprofessional Education (CAIPE) and many of the Centres for Excellence in Teaching and Learning to name but a few. Continuous quality improvement (CQI) has been ‘imported’ from the US by the NHS in the South West in partnership with Bournemouth and other universities and done much to promote collaborative learning and practice in the process of effecting innumerable small scale improvements<sup>9</sup> Activity theory is being explored as a means to engage with

inter-agency and interprofessional collaboration on a larger scale to reshape services and improve care<sup>10</sup>. Drawing on work-based experience, interprofessional learning has been widely introduced into pre and post-registration professional education in universities building up a critical mass of former student dedicated to collaborative working and teachers ready and able to advise and assist in designing, delivering and evaluating work-based initiatives.

Interprofessional learning can:

- Allay fears and mitigate resistance
- Change perceptions by exchanging perspectives
- Challenge orthodoxy and trigger innovation
- Generate joint ownership and concerted action
- Further critical understanding of new policies
- Evaluate implications for each organisation and profession
- Devise strategies for joint implementation
- Explore ways to coordinate and improve services within new policy frameworks
- Engage patients and carers as co-learners

Taking into account:

- the redrawing of boundaries
- the redistribution of power and authority
- the reassigning of responsibilities
- the revision of roles and relationships

Interprofessional learning has no hidden agenda, no axe to grind.

Its values are transparent:

- enabling professions to learn with from and about each other
- improving the quality of care
- respecting the integrity of each and enhancing its practice
- increasing professional satisfaction
- focusing on the needs of service users and carers

It is applicable vertically and horizontally wherever collaboration is needed across public and independent sectors of health and social care for all the constituent professions including management. It relies critically on protecting time on

neutral ground where views can be ventilated candidly without fear of comeback. Given skilled leadership in a supportive environment, such learning can and does occur, implicitly or explicitly, during regular meetings of some primary care teams, but the breadth of the current policy proposals, calling for the inclusion of additional agencies such as local authority social services and additional professions such as social work, reinforces the case for dedicated learning opportunities jointly planned and led by all the interested parties.

*"If we do multi-disciplinary meeting, not on a patient but on a service redesign, -- then you will come up with some fascinating outputs ---."*

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