

PRACTICAL ADVICE

Setting Up an Innovative Masters Course in Interprofessional Health and Welfare Studies

AUDREY LEATHARD

South Bank University Faculty of Health, London, UK

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Our new Masters course started memorably on Thursday the 27th September 1990. The key questions to be addressed in retrospect are:

- **why** was such a venture undertaken?
- **how** did we approach setting up such an innovative development?
- **what** were the main features of the programme and their outcomes?
- **where** did the early initiatives eventually lead?

1. Why did we set up an M. Sc in Interprofessional Studies?

First, the nature of the work in our Department of Community Health and Nursing was particularly appropriate for interprofessional developments. By 1987, we were running courses at Diploma, Degree and Postgraduate level for nurses, district nurses, health educators, social workers, nurse educators and health visitors (qualified nurses with specialised training/experience in child health, health promotion and education). The range was then extended to include midwives, occupational therapists and occupational hygienists. We were therefore keen to respond to the needs of students and to those staff members who were interested to further interprofessional education. Importantly, we were fortunate in having a Head of Department, Dr. Val Chapman, who was very supportive of our proposed initiatives. Given the tight resource commitments of any Polytechnic in those days, the support of both the Head of Department and the relevant Faculty was essential. (Up to 1992 prior to university status, Polytechnics

Address for correspondence: Professor Audrey Leathard, Visiting Professor of Interprofessional Studies, South Bank University Faculty of Health, Erlang House, Borough Road, London, SE1 OAA, UK.

were lead educational institutions which specialised in diploma, degree and Masters courses with an emphasis on the practical and applied nature of the topic).

Secondly, outside developments were increasingly pointing the way forward for action to further interprofessional studies. Both the CNAA (Council for National Academic Awards) and NHSTA (National Health Service Training Authority) were seeking to encourage interprofessional initiatives. By 1988, key reports: regarding health: the Cumberlege Report (1986); welfare: the Griffiths Report (1988); and child care: the Butler Sloss Report (1988)—all strongly recommended the case for a more collaborative approach amongst the professional workers involved.

2. How did we set about putting Aims into Action?

Elements of practical advice can be traced, as we sought to make sure that our assessment matched the mood of the market.

(a) A *market research survey* was undertaken, in the spring of 1988, to seek advice from numerous professional bodies and employers in the field of health and welfare in Britain. Our initial ideas about launching a Masters course in interprofessional studies were also discussed with the (then) Department of Health and Social Security, with the relevant training bodies and with students to gauge an appropriate level of fees.

The response was both encouraging and positive. The pathway for action was reflected in the demand for a flexible part-time Masters course which students could combine with ongoing employment. Students were thus enabled to choose different sequences of study units to suit their own programme requirements; the length of course could also vary accordingly up to a defined limit of time overall.

(b) *Contacts* were made with relevant departments in Polytechnics and Universities to see whether any comparable course was available across Britain. Together with subsequent guidance from Dr. John Horder's invaluable knowledge of interprofessional developments (as CAIPE chairman: see below), we then discovered from these investigations that:

- From 1980, Exeter University's Department of General Practice had set up the first course in multidisciplinary education in Britain. Subsequently, the programme was expanded to include an M. Sc course for GPs and allied health professionals (Jones, 1986). Amongst others, Dr. Rita Goble was a lead member of these developments but who valuably introduced us to EMPE (the European Network for the Development of Multi-professional Education).
- A Centre for the Advancement of Interprofessional Education (CAIPE) was established in 1987 to further the topic area through a national

council, academic work, research and conferences, based on the vehicles of regular bulletins and organizational contacts.

- At the Marylebone Centre Trust in London, Dr. Patrick and Marilyn Pietroni had also been involved in promoting various initiatives in interprofessional work which, by 1993, led onto an MA in Community and Primary Health Care: Towards Reflective Practice—eventually to be based at the University of Westminster.

So how far did these developments influence the thinking in shaping our Masters course? As can be seen from the timing, much of our planning and course construction were well on the way to completion before we made our discoveries. The disadvantage was that we could not gain from others; the advantage was to strike out on our own, while encouraged to see how increasingly important this field of work was likely to be.

(c) *Course Planning* By 1988, three staff members formed a planning group: Dr. Alan Prout, Senior Lecturer in Health Studies but who left in July 1989; to be replaced by Dr. Don Dawson, Senior Lecturer in Health Education Research; Dr. Tony Leiba, then a Senior Lecturer in Community Health Studies with an interest in the sociology of the professions; and myself with a background in social policy but applied to health and social services. Of significance was the fact that this founder group did not come from any one profession which made planning an interprofessional venture open to all relevant angles with no domination of any one professional view. To strengthen our views, we then set up a wider Departmental Working Party whose members would become responsible for particular Units.

(d) *Advice received at the planning stage* We sought views from staff members more widely in order to represent inputs from a broad span of disciplines, expertise and professional backgrounds, both from our own Department and from other Faculties across the Polytechnic. As we aimed to introduce highly innovative topics, at that point in time, such as information technology, we also turned to individuals in the City of London who valuably contributed to the early courses. Furthermore, drawn from internal and external advisers across the health and welfare professions and management, an official Course Planning Committee was also set up in December 1988 to advise on the Course Statement required for all proposed new courses at South Bank Polytechnic. The purpose was to verify the aims, objectives and rationale; entry requirements; course content; assessment; and resource implications, alongside views from the Departmental Working Party, our Head of Department and the Faculty Dean. From February to May 1989, meetings were held where helpful advice was received and amendments made accordingly. One point of interest revolved round the title “interprofessional” which suggested to some that “professional” could appear to exclude informal carers, the voluntary and private sectors and unemployed people. After careful consideration, the M.Sc team decided that the term “interprofessional” still had the advantage of a clear identity of a Masters course for health and welfare professionals to enable those from all the above differing backgrounds to learn and

work together. Interestingly enough by the mid-1990s, new terms had gained ground which obviated any unease over the concept of ‘professionals’ learning together, such as: partnership working; collaboration; integration; teamworking; and joint working. However, all terms have different shades of meaning.

3. What were the Main Features of the Programme and their Outcomes?

The course planning outcome established the purpose of the M. Sc as seeking:

- to encourage the development of reflective practice in the health and welfare field;
- to focus on the interface between academic and professional work;
- to enhance existing professional knowledge and identity; and
- to promote opportunities to develop integrated, interprofessional, perspectives.

The proposed 2 year, part-time (one afternoon/early evening) programme, was planned to provide a first year foundation, grounded in research, to lead onto a second year which would concentrate on interprofessional work. The assessment programme varied according to the needs of each Unit but an emphasis was placed on encouraging students to work together in groups. To enable flexibility, students could stop at a Postgraduate award by completing Units 1 to 4 only; or extend the M. Sc from a minimum of 2 to a maximum of 5 years’ attendance.

The Programme for the M. Sc in Interprofessional Health and Welfare Studies

| <i>Year 1</i> | <i>Credits</i> |
|---|----------------------------------|
| Unit 1: <i>Research methodology</i> | 15 |
| Unit 2: <i>The management of health and welfare</i> | 15 |
| Unit 3: <i>Social aspects of health and welfare</i> featuring: change and discrimination within a multidisciplinary context; health and welfare abroad | 15 |
| Unit 4: <i>Information technology</i> | 15 |
| <i>Year II</i> | |
| Unit 5: <i>Interprofessional workshops</i> | 15 |
| Units 6,7,8: <i>Dissertation preparation</i> | 75 |
| | <i>Credit total at “M” level</i> |
| | 120 |

In setting up this innovative programme, we had the supreme advantage of starting from a blank sheet which enabled new thinking and creativity.

Educational Methodology

Following Schon (1988), the philosophy of the reflective practitioner was to form a central core. An emphasis was therefore to be placed on the development of critical and analytical skills to enable reflection on interprofessional health and welfare developments as well as on the relationship between theoretical input and practice in the workplace. A wide variety of teaching methods and learning activities were selected which included: lectures; seminars; tutorials, conferences; directed reading; debates; independent study; practical workshops; visiting lecturers; group work and tutorials; and individual supervision for the M. Sc dissertation.

After rigorous verification and monitoring procedures (Leathard, 1992), on 12 February 1990, the Masters course in Interprofessional Health and Welfare Studies was officially validated. From course planning to validation, the time taken was roughly 18 months which, in Polytechnic parlance, was fast work for a completely new course, achieved due to staff commitment and support as well as the excitement of a new venture.

Outcomes: Underlining Practical Advice for Innovation

Any innovative venture must be underpinned by effective publicity. Our Department could only afford a limited expenditure on advertising so we sought other ways of spreading the news of our new Masters course, such as: publishing articles and contacting British Councils abroad as we wished to build up an international base.

A special occasion is also needed. On the 23 March 1990, the Minister of Health, Mrs. Virginia Bottomley officially launched the Masters course, when we could thank many health and welfare professionals, employers, students and colleagues who had helpfully supported the developments.

The outcome was encouraging. By the following autumn, although our initial numbers were set at 15, 29 students were eventually enrolled for the first intake for the 2 year part-time course. The professional backgrounds were also widely covered from the fields of health and social care which enabled a truly interprofessional intake. Student entry was achieved by individual application, followed by an interview with two staff contributors to the course. Student demand came from various sources: as a result of advertisements and contacts; by word of mouth; through articles published and, especially through the interest of past students who wished to upgrade their qualifications through a wider, innovative sphere of work in health and social care. By the following year, the course had been so well received and evaluated that we were inundated with applications, so we had to call a halt at nearly 40 students; whereupon we established a waiting list.

The success of the venture was significantly underpinned by a highly qualified and committed staff team led by champions i.e. individuals who were totally committed to promoting interprofessional learning and education.

The course was run by someone like myself who, usefully, had management experience. In the first 2 years, along with the few other Masters courses at South Bank, we organized all our arrangements except fee payments which were more appropriately handled by our finance office. We were fortunate in only having to pay a relatively small cut off fee to the Polytechnic (25%) for the support given overall. The result was that, although our target was a break-even cost schedule, we actually made quite an amount of money which was valuably ploughed back into improving elements of the course, facilities and staff development.

The two negative features were, first, our failure to attract doctors. Despite our endeavours to overcome the barriers, the medical profession had little time for Polytechnics as this sector was not part of the university programme nor, in any way, involved with medical schools where doctors were essentially based for their training and practice. In contrast, because the early developments at Exeter University were located in a Department of General Practice, a level of medical involvement could be secured. However, by the mid-1990s, the medical profession (more particularly general practitioners) gradually became engaged with interprofessional education and activities, as the New Labour government encouraged partnership working amongst other relevant initiatives. Secondly, we could not match the programme at the University of Linköping, Sweden, led by Professor Nils-Holger Areskog, where all undergraduates studied together for the early part of their education whether in medicine, occupational therapy, nursing, physiotherapy and social care, linked to community training networks on an interprofessional basis.

University developments: however, all was to change radically in 1992 when South Bank became a university. Although gaining in prestige, fundamental changes were made to Masters courses whereby the administrative arrangements were largely centralized. Our self-standing Masters course was folded into a much wider postgraduate/M. Sc network which provided more choice of units for students but curtailed some of the interprofessional identity and direction.

Student and staff outcomes: the annual evaluations were very positive about the M. Sc. with points made which led on to useful amendments in the arrangements for the following year. Further, over the years, students have secured increasingly senior posts both in academic and professional work who, in some cases, have become leaders in their field of work. Interprofessional developments abroad have also taken place, via our past students, especially in Greece, Ghana and Japan. With regard to staff members, most of the original contributors have all moved on. In my case, the need to publish the first major book on the topic area, together with a team of authors (Leathard, 1994), became an imperative which led me to work on a part-time basis. By 2003, together with an international team of contributors, we have moved the interprofessional debate on into the 21st century (Leathard, 2003).

4. Where did the Early Initiatives eventually lead?

From the mid-1990s onwards, interprofessional course developments have moved apace across the country both at Masters and undergraduate levels. As M. Sc university fees have escalated, the main outcome today has been to observe interprofessional work inserted as part of pre-registration or undergraduate courses (as at South Bank University); although a few interprofessional courses, in their own right still continue elsewhere. Other developments include multidisciplinary practitioner-based courses where students are linked to placements in the community (such as the programme at the Centre for Studies in Community Health Care, University of Leicester).

Publications have also encouraged debate and support such as the *Caipé Bulletin* and the *Journal of Interprofessional Care* together with at least a dozen books on the topic. Various bodies are now actively promoting important angles on interprofessional education such as: the LTSNs (Learning and Teaching Support Networks) in various fields; the Learning for Partnership Network; and the Association for the Study of Medical Education, amongst other developments. However, much wider issues are afoot than in the early 1990s, such as organisational integration and mergers; quality assurance; professional regulation and evaluation, to mention a few of the key issues at stake today.

Conclusion

What were the key lessons which emerged from setting up an innovative, interprofessional Masters course in 1990? First, timing is crucial: our new course responded to the needs of students and professional developments at the right point in time. Secondly, an assessment of market forces, the competition elsewhere and the external arena more generally were all key factors. Thirdly, it was advantageous to have a neutral founder group so that no particular section among health and social care professionals was seen to dominate the whole, although the arrangements sought to draw advice and involvement from all relevant quarters. Fourthly, effective publicity is essential—for example, a big event to launch the start; as well as an appropriate course title to further the initiative. Above all, enthusiasm, compelling interest, enjoyment and commitment are all needed to engage both staff and students. Despite the achievement of all these factors, once the management of the original Masters course was folded into a much wider M. Sc matrix, with the 1992 reorganization for South Bank University, so the impetus had both advantages (larger numbers) and disadvantages (less interprofessional identity). However, as Handy's (1994) management analysis has shown, for organisations to survive, change is an essential ingredient without which initiatives, failing to respond, face possible

extinction. Reflecting the pathway of ever faster change, so interprofessional education has sought to meet the needs of the day to enable the original strands to continue in newly fashioned ways.

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