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Learning centres: a new approach for service improvement

The Northern Centre for Mental Health is developing new ways of learning in adult mental health services

There is little doubting the intention of this government to change the NHS and place quality at the top of the agenda. Confirmation of this can be found from two main sources: the plethora of policy papers issued since May 1997, all of which signal change to the way the health service works (eg. through the introduction of primary care trusts), and, perhaps more importantly, much clearer expectations of how things will be done (Department of Health, 1997; 1998*a*; 1998*b*). The times when clinicians could shape services on their own seems to be gone and the balance of power has shifted away from the time that a minister of health could say: "We may be sure that the progress of medical thought and method will still be well ahead of our departmental practice." (Powell, 1961) It is interesting to note that this was the minister who launched the mental hospital closure programme all those years ago. Now there seems little else from ministers but impatience at the lack of progress and blame for errors that, to many, seem unavoidable and unpredictable. Doctors find themselves in a changed and changing world, with greater central prescription challenging clinical freedom.

The causes for this are varied. Some are acts of commission (too much policy, too much politics) and some are acts of omission (not enough resources, not enough understanding). Public expectations have increased too, and nowhere more so than in mental health, where the National Service Framework (NSF) spells out vastly increased expectations of user involvement in the planning, delivery and evaluation of care (Department of Health, 1999).

Although our colleagues in physical medicine are beginning to feel the heat of public accountability in a way that is all too familiar to us in psychiatric practice, feelings of *schadenfreude* would be unworthy. One of the more recurrent themes in the modernisation project is government frustration at the failure of good practice to spread more rapidly. It is difficult to explain this state of affairs. On the one hand, there has to be a case for the slow spread of good practice being merely the proper consideration of evidence. Why change if there is no proof that the change will be for the better? On the other hand though, many of the changes that would make the greatest improvement to the quality of life for users are the things that are hard to quantify, such as swift access, choice in treatment regimes and locations and support and encouragement to get a job or find a better place to live.

If we accept for a moment that we are all reluctant to learn from each other and change familiar ways of working without good reason, we have to ask what factors might account for this state of affairs? Although the reasons are complex, some of them may be:

(a) The new service models set out in the NSF require a different set of skills. Assertive outreach, for example, operates where the client is, at times to suit him or her and in ways that meet his or her needs. How many of today's trainees are equipped to undertake present state examinations in bus shelters or cafés? How many are adept at the interpersonal skills necessary for leading a team? Leadership at local level becomes multi-faceted; developing services and managing teams and resources can make it easy to lose sight of the need to change and adapt, as the sheer pressure of competing demands overshadows the best of intentions.

(b) Organisations can be frustratingly indifferent to the new skills acquired by their staff. Most people can recount examples of how people attend training courses and return to work eager to apply new skills, only to find apathy. If organisations are not prepared to enable newly skilled staff to practise their newly acquired competence, disillusionment can soon set in. Scarce training resources will have been wasted. All

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too often, training takes place in isolated professional groups, with little shared training.

(c) It is all too easy to assume that because managers ask staff to work in different ways, they have the time, inclination and personal resources to learn how to do things differently. It must be extremely hard to confess that you do not know what people mean when they refer to innovative practice like assertive outreach or home treatment. It is harder still to do so in front of a team of junior colleagues, when your educational experience has been based on creating an aura of quiet competence.

(d) You cannot divorce your general approach to life from your approach to practice. If you do not believe that users should be involved in planning care and care systems, it will be very difficult to feel involved and committed to projects designed to do just that, much less lead or initiate such activity.

(e) The quality of team relationships can have an impact too. If teams are dysfunctional, then relationships could be damaged further by changes to practice.

(f) The lack of clear local definitions of what services are supposed to do, and how the local components fit together, can lead to lack of clarity regarding the benefits or disbenefits of any particular change. For example, there is real confusion about the contribution acute in-patient care can make to local services. It can easily become all things to all people.

These are some of the reasons why good practice may not spread quickly and why change is difficult in complex organisations. New approaches to making rapid change in health care systems are being developed in this country, with some promising results. Although these approaches are not widely available, the Northern Centre for Mental Health is piloting one new approach within the Northern and Yorkshire region. Derived from the work of a US paediatrician (Berwick, 1998), the approach seeks to cut through the usual inertia that surrounds practice development by describing the need to create learning centres. These sit conceptually between organised, course-based learning, and local development and innovation. They seek to bring people together to share experience and expertise, in such a way as to encourage more rapid focus on a quality service – 'getting it right first time'. Learning centres seek to provide opportunities for different colleagues to work together on real life problems; to address the necessary skills, knowledge and attitudes required to deliver change for improvement.

There are a number of features that characterise a learning centre:

- It is an approach, not a building. In general education the term is often used interchangeably with 'learning resource centre' to mean a place where materials, books, computers, etc. can be found. Our learning centre is strictly of the virtual variety.
- It seeks to deal with real problems; working with issues that are sensed or accepted by clinicians as being a problem. It makes little sense to ask people to devote time and effort to correct things that really do not bother them. For example, the NSF needs to be adapted to address local difficulties, e.g. problems faced by rural mental health services.
- Learning centres need to be inclusive. All those engaged with service delivery, and that includes users and carers, have to be involved in trying to make things better. This is central to the approach, and offers clinicians an opportunity to get back to the heart of decision-making through practical involvement in the change process.
- Any change has to be about making an improvement to the way things are done. It may be a relatively small change for the better, but if it improves the experience felt by the user, then it is worth it.

The essence of the learning centre approach is based on rapid cycles of change, described by Berwick (1998) as the 'plan, do, study, act' cycle. Small-scale changes are planned in an inclusive way, implemented, measured and incorporated (or not) into mainstream practice. This approach is about generating collective ownership of the problems, bringing a clinical focus to the management agenda and promoting change for improvement. The solution is not that staff should do more, it is that there should be a clearer collective view of what services need to provide with locally owned and driven changes. There needs to be flexibility about ideas, and methods, but there must be a clear grip on results. Try a small change and measure its effect, if it does not work stop doing it.

What would a learning centre do?

Learning centres should organise collaborative events or bring teams together to work on single issues. For example the Northern Centre for Mental Health, in collaboration with the Centre for Best Practice at Leicester, has initiated a project on acute in-patient care. A group of nurses, psychiatrists, psychologists and users met to identify commonly agreed standards of care. It has now been proposed that all NHS trusts in the Northern and Yorkshire region and Trent NHS region participate in a series of 1-day workshops, over a year, to assess local performance and set local targets to achieve these standards of care. Project managers working in each trust will guide the process. The opportunity for a larger number of clinicians to be working at the same time on the same agenda offers real potential for the rapid spread of ideas and of learning from mistakes.

The centre should also help to surface good practice and give some recognition to those who have been getting it right. On-site support should be provided to help manage change, through specific events or individual mentoring. It would help to provide a bridge between higher education institutes and service providers, making sure that what was provided was linked to what was needed. It could run conferences on specific topics, publish briefing papers etc. and help to establish new networks and strengthen existing ones.

A learning centre should provide clinicians with a real opportunity to engage with their colleagues to solve the very real problems they face in implementing the NSF.

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No single initiative – including learning centres – will solve all the problems. Nor will learning centres act as substitutes for careful, collective assessment of what real problems face services, or how the local systems work. But they may well signal a new era in clinical development; and if that begins to rebuild confidence in the professions, then they are worthy of attention.

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