

# the beacon

A review of the School of Health & Social Care



**How to  
achieve  
wellbeing  
in the  
workplace**



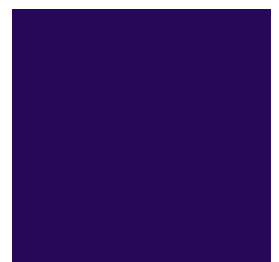
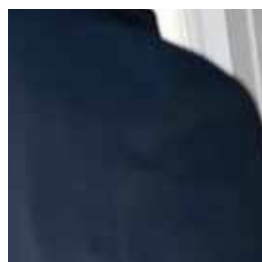
**Developments  
in mental  
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**Improving  
dementia  
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general  
hospitals**



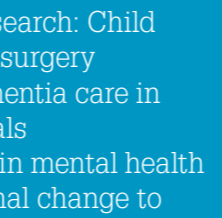
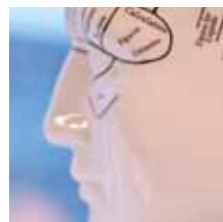
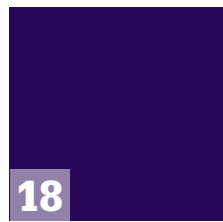
**Education  
programme  
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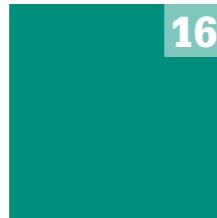
# Welcome

Welcome once again to the Beacon, the annual publication by the School of Health & Social Care at Bournemouth University. This year we have selected a variety of our activities and successes to share with you, to demonstrate the commitment we make to working with partners in our academic endeavour. We hope you find these interesting and stimulating.

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Professor B Gail Thomas  
Dean of Health & Social Care and Applied Sciences

This is a somewhat turbulent time in the worlds of both healthcare and higher education. The imminent changes to Strategic Health Authorities and Primary Care Trusts, the move towards the establishment of Health Education England, and the introduction of Skills Networks and GP Commissioning Consortia all have implications for the School. We are endeavouring to work in partnership with colleagues in Dorset and surrounding areas as the transition takes place, to ensure your local University can offer facilitation and support as appropriate.

The new Vice-Chancellor at Bournemouth University, Professor John Vinney, has emphasised the importance of the student experience as paramount in the strategic plan for BU. The School of Health & Social Care is totally committed to an enriched learning environment, underpinned by strong research, practice development and enterprise activity, in order to provide the very best learning opportunities for our students and all our partners.

The changing landscape for higher education with the increased graduate contribution also has implications for some of our provision. As the financial investment involved in pursuing study at University increases, our emphasis is on enhancing quality to ensure an optimal student experience.

# Editor's welcome

Welcome to the latest edition of the Beacon. The purpose of this publication is to share a flavour of the work of our academic staff with partners and colleagues in health and social care, and to reach and inform those who may be interested in linking with our endeavours. We welcome any feedback or comment on this publication or interest in areas of work that are highlighted.

Universities are facing changing times, as the editorial on the previous page sets out. In this shifting landscape we would like to share a range of activities with you.

One theme is the increasing use of blended approaches to learning. Colleagues in practice have been using the Bournemouth University Resource Pack to enhance breastfeeding practice. Internally, we have developed an internet resource to strengthen understanding of the evidence that guides practice, supported by professorial lectures delivered to over 600 undergraduates across many different professions. A further article about education sets out the vision and purpose of the role of University Practice Learning Advisors, who are critical to the support and guidance of the mentors supporting our undergraduate students.

A second theme is that of research. Developing new knowledge and disseminating that learning to students, practice-based colleagues and other academics is intrinsic to the work of a university, and that is reflected in this edition. A flavour of our research is

presented in two ways: firstly, through a commentary, largely displayed in images, on the International Qualitative Research Conference held last year; and secondly, through a powerful exposition of research in social work, spanning child abuse to neurosurgery.

We hope this edition of the Beacon gives you an insight into the work of colleagues in the School of Health & Social Care, and raises your curiosity to explore working with academics in the School and wider University.

## Clive Andrewes

Associate Dean, Practice Development  
Editor of the Beacon  
candrewes@bournemouth.ac.uk

# News

## Strengthening collaboration with Memorial University in Newfoundland

Professor Steven Ersser, Director of the Centre of Wellbeing & Quality of Life at Bournemouth University and Professor of Nursing Development, has visited Memorial University in Newfoundland to strengthen research collaboration in the areas of health and wellbeing. The trip was funded through a Bournemouth University travel award.

Professor Ersser met with interested faculty members in both the Schools of Nursing and Medicine to discuss the possibilities of collaborative research. Memorial and Bournemouth University have a formal Memorandum of Understanding which supports joint activities such as research and teaching.

During his visit Professor Ersser presented to internal medicine residents on 'Psychosocial issues and the development of effective support for people living with psoriasis'. He also met with dermatology clinic staff in Eastern Health to discuss clinical and research issues, and presented a paper on 'Dermis to design in a neglected



clinical speciality: A research agenda for skin care/dermatological nursing' within the School of Nursing.

Professor Ersser is an Adjunct Professor to Memorial University, and Professor Sandra Lefort from Memorial University, Professor of Nursing, has recently been appointed as Visiting Professor at Bournemouth University. She will be linked with the Centre for Wellbeing & Quality of Life to collaborate on wellbeing and self-management studies for those living with long-term conditions (Profs Ersser and Carr and Dr Cowdell).

This is an exciting and developing relationship, and we expect the collaboration to grow over the coming years.

## Supporting health research in Nepal

Bournemouth University is partnering a project to support and enhance health research in Nepal. Working with the Universities of Sheffield and Aberdeen, as well as the Development Resource Centre in Kathmandu, BU's School of Health & Social Care is a key member of the Partnership on Improving Access to Research Literature for Higher Education Institutions (PARI) in Nepal.

Funded by the British Council and the UK government's Department for International Development, PARI aims to build research capacity in Nepal over a three-year period. The British Council's grant is made through the Development Partnerships in Higher Education (DELPHE) programme, which supports nine project grants in Asia. PARI is the only project in Nepal funded under this particular scheme.

"We must raise the profile of health research in Nepal and share its expertise across developing countries," said Professor Edwin van Teijlingen from BU. Professor van Teijlingen's overseas research is largely based in Nepal, where he is a Visiting Professor at the Manmohan Memorial Institute of Health Sciences at Purbanchal University in Kathmandu.



Mr Bhimsen Devkota of the Development Resource Centre added: "PARI will contribute to the development of a research culture in higher education in Nepal."

Now in its second year, PARI is actively encouraging higher education institutions in the country to access and assess research-based information in disciplines such as medicine, pharmacy, nursing and public health.

As part of a new project entitled 'Improving Access to Research Literature for Higher Education', PARI is organising five international workshops on access to health research and evidence-based practice. The workshops are aimed at university and college teachers, with a separate session for college librarians and information specialists. They are informed by a curriculum review of all health-related courses at the major universities in Nepal and a needs assessment of lecturers, librarians and students of the country's major universities. These two studies, conducted earlier this year as part of PARI, helped to identify gaps in knowledge and skills around the capabilities of gathering existing research information.

The partners hope to move university lecturers in Nepal away from textbook teaching by making them aware of the vast resources available online, and supporting them in becoming more critical of them. By changing attitudes towards the importance of research-based or evidence-based practice, PARI aims to strengthen research capacity in Nepal, encouraging talented people to stay in or return to the country to make their own research contributions.

## High standards lift Centre to national award

**Bournemouth University's renowned Centre for Post Qualifying Social Work has won a prestigious 2010 National Training Award (NTA). As both a National and South West Regional NTA Winner for Providing Education and Training, the Centre was one of a handful of applications this year distinguished as 'truly outstanding and exceptional'.**

The award recognises the Centre's excellent work in rapidly developing and delivering a new course for social workers which allowed employers throughout the UK to meet a crucial deadline for new statutory requirements.

Accredited by the General Social Care Council, the Centre will now await the NTA's 2011 UK ceremony in London on 1 December to find out whether it has been named the overall 'Winner of the Year'. The Centre previously won the national NTA in 2005 and the Chartered Institute for Personnel and Development special prize for the best example of Continuous Professional Development Education in the UK.

"This is a great honour for the Centre and for Bournemouth University," said Professor Keith Brown, Director of the Centre. "My colleagues thoroughly deserve this recognition for responding so quickly and professionally to the needs of our profession and setting such high standards in providing effective specialist training for social workers throughout the UK."

Through training provided by the Centre, social workers are equipped to take on the role of Best Interest Assessor (BIA), a responsibility introduced in the Mental Capacity Act 2005 and Mental Health Act 2007. This responsibility allows them to provide legal safeguards for people who lack the capacity to make informed decisions or consent to treatment in hospitals or care homes. These are known as Deprivation of Liberty Safeguards. The Best Interest Assessors are responsible for deciding whether a person is being deprived of their liberty, whether that's in their best interests, and how long a Deprivation of Liberty authorisation should last.

Because of ongoing consultation and legal processes, final training requirements were not issued by the Department of Health until November 2008. But the legislation set out that by April 2009, health and



social care employers must have enough staff trained and assessed in this area by a university. Employers were therefore under pressure to identify suitable staff and put them through an intensive course in less than six months.

Before the introduction of the training, no one in the UK was qualified as a BIA or BIA trainer. The Centre at BU therefore had to design and deliver a course for the local authorities and NHS trusts – located mainly in the South West, Thames Valley and South London – using its other courses. The goal could not be missed, since it involved a new statutory professional role and was a legal duty of these employers.

Professor Brown had advised the Department of Health during the specification of the professional requirements of the role. Thus the Centre was able to work fast, starting in September 2008, to write and validate a new course, prepare teaching materials and train teaching staff ready to start work as soon as the draft guidance was published.

The course content was completely new, since it covered new legislation and a

professional role that had not previously existed. To ensure that content was relevant, the Centre tapped into its networks of service users and carers. It drew on its experience of using third-party testimonies and case studies to ensure and verify safe and competent practice both for the employer and, ultimately, society.

Trainees who pass the course have developed the skills and confidence to collect, evaluate and analyse complex evidence and differing views, and weight them appropriately when deciding whether to deprive someone of their liberty.

The course lasted three days, and was supported by high-quality learning materials and electronic support. A cost of £545 per student covered teaching, materials, tutorial support, assessment and administration, making this one of the most efficient courses in terms of cost and length, due to the excellent support materials available. Candidates unsuccessful at their first assessment were given unlimited email and telephone tutorial support for a second

attempt. Workshops were organised across the country so that students could attend a venue close to their workplace.

The Centre expected to train up to 100 students in the first year. Demand for training was so high, however, that by April 2009 it had trained 365 candidates from 45 local authorities, just over 30% of all candidates nationwide. Some 84% passed, 8% failed or withdrew, and 8% were still continuing their studies as of 31 March 2009.

They also wrote and published the key textbooks in this field, which have been used extensively throughout the country as vital sources of information for professionals.

Piers Tetley, Senior Workforce Development Manager at Devon County Council and joint Chair of the South West England Learn to Care Social Work Employers Forum, felt the Centre's achievements could be underestimated. "The director, Keith Brown, sits on the most influential government and non-government social work bodies," he said, "and is simply outstanding at translating governmental policies and initiatives into knowledge exchange/transfer initiatives which employers need and value. In this ever increasingly complex business context, Keith Brown and his team provide employers like mine with an absolutely invaluable service."

"It is not unreasonable to say that without the Centre many employers would simply not know where to turn for advice and guidance," Piers continued. "Their materials, partnership arrangements and flexible approaches to meeting employers' workforce development needs are widely acknowledged as the best in the country, and are driven by their desire to ensure the best possible social work practice is available to the most vulnerable in our society; more critical than ever at this time due to the recent high-profile cases and public scrutiny of social work practice. Their work with regard to Best Interest Assessors is a clear example of this."

## Professor's award for patient-focused innovations

**Bournemouth University's School of Health & Social Care is celebrating a major award for one of its Visiting Professors. Professor Gary Smith was named 'Innovator of the Year' at the prestigious NHS Leadership Awards for 2010.**



Professor Smith (red bow tie) receives his award from guest host Sue Perkins.

A Consultant in Critical Care at the Queen Alexandra Hospital in Portsmouth, Professor Smith is a Visiting Professor to the University's Centre of Postgraduate Medical Research & Education. His Innovator of the Year award recognises a series of innovations and co-inventions he has introduced that focus on improving hospitals' recognition of and response to patient deterioration.

In addition to his involvement in national educational initiatives to improve the recognition and management of sick patients, Professor Smith has introduced a number of innovations to tackle the problem of patient deterioration including:

- The development of ALERT (Acute Life-threatening Events: Recognition and Treatment), a one-day course for general ward staff which now runs in over 200 centres worldwide
- The promotion of a consultant-led, multidisciplinary approach to critical care and the introduction of a philosophy of early intervention by ICU staff for acute illness on general wards
- Leadership of the team that co-developed a handheld computer-based system (VitalPAC) for the early recognition of patient deterioration, now in use in other NHS hospitals
- The planning and development of the Portsmouth Training, Education and Assessment by Medical Simulation (TEAMS) Centre, one of the early UK clinical simulation training centres

- The co-development of ViEWS (VitalPac Early Warning Score), being used as a basis for a national early warning score for detecting patient deterioration by the Royal College of Physicians
- Co-development of the RSVP (Reason-Story-Vital Signs-Plan), a system to assist staff in communicating patient deterioration
- The invention of the Chain of Prevention – a paradigm for assisting hospitals to structure their care processes to prevent and detect patient deterioration and cardiac arrest.

"It is a great honour to receive this award," said Professor Smith. "Patient deterioration is a major problem and failure to recognise or act upon the signs of deterioration is a worldwide patient safety problem resulting in many deaths and other adverse patient outcomes."

Professor Gail Thomas, Dean of Bournemouth University's School of Health & Social Care, praised Professor Smith's contribution to providing new solutions for solving significant problems related to patient deterioration: "We're very pleased to endorse Professor Smith's status as a leading innovator, whose achievements to date have brought countless positive results for patients and professionals in healthcare in the UK and around the world. We are delighted that he is committed to working with us at Bournemouth University."

# Bournemouth University Resource Package (BURP)

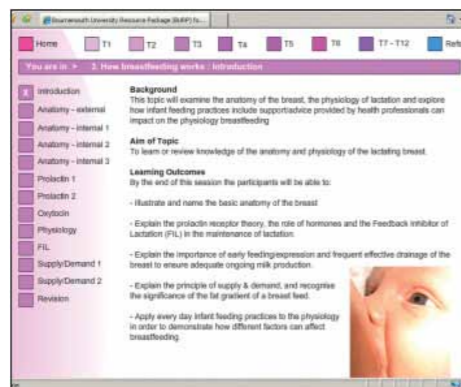
# Education programme for End of Life Care

Since 1994, maternity units in the UK have been encouraged to implement the 'Ten Steps to Successful Breastfeeding'. Created by UNICEF as part of the UK Baby Friendly Initiative (BFI), the steps are designed to ensure that high standards of care are maintained for pregnant women and breastfeeding mothers and babies.

The BFI sets rigorous standards and requires all staff in maternity units and community care settings to undertake training designed to equip them with the skills and knowledge needed to implement best practice standards. The initiative was further endorsed by the 2006 National Institute of Health and Clinical Excellence guidelines for postnatal care, which recommended the BFI as a minimum standard.

Although a few units across the UK have now gained full BFI accreditation, including Salisbury District Hospital, the majority have not. In the changing context of the NHS, it seems it is increasingly difficult to release staff for training due to financial pressures and a shortage of midwives. Whilst it is recognised that face-to-face teaching is essential for some of the training, particularly the practical skills required to support breastfeeding women, it is also apparent that flexible learning opportunities are needed to enable staff to be trained in a timely and effective manner without impacting on staffing levels on the ground.

As a result of this, Alison Taylor and Catherine Angell, Midwifery Lecturers at Bournemouth University, have developed an online training programme for healthcare trusts. The programme is comprehensive, flexible, user-friendly and, most importantly, will meet BFI best practice standards. The development team also included Andy Pulman, Web Team Leader, who has expertise in developing web-based materials. BU is well placed to produce these resources, with extensive experience in developing online breastfeeding packages grounded



in research previously undertaken at the University (Taylor and Hutchings 2010).

The development of the Bournemouth University Resource Package (BURP) has been specifically designed to be used in conjunction with the UNICEF UK BFI Three-day Breastfeeding Management Handbook (2008), designed to prepare practitioners for a practical breastfeeding workshop facilitated by individual healthcare trusts.

BURP is an innovative online resource divided into 13 topics, containing a variety of multimedia materials. These are designed to enhance practitioners' understanding and knowledge of the theory of breastfeeding and how it is applied to practice. In order to comply with UNICEF BFI standards, each topic of the curriculum has been carefully developed using a comprehensive lesson plan detailing the aim and learning outcomes for the topic, and a breakdown of how each learning outcome will be addressed and achieved. The use of multimedia within the package includes audio and video clips produced by BU in

order to combine cognitive and affective learning, thus promoting a transformative learning process (Taylor and Hutchings 2010). It also introduces a wide range of resources freely available on the web to support practitioners in everyday practice.

The online resource is accompanied by a workbook, which includes activities designed to ensure all practitioners engage and learn from the package, and are fully prepared for the practical workshop. By undertaking the package and workbook, practitioners will revise key aspects of support for breastfeeding women. They will learn new concepts, reflect on practice and think of new ways to support breastfeeding women more effectively by applying BFI best practice standards. The workbook is considered as an additional complimentary resource, and is valued by practitioners as it provides a tangible reminder of the course that can be referred to again at a later date. It is also invaluable to the trusts implementing the training, as submission to the facilitators prior to the workshop enables them to assess whether the work has been completed to a satisfactory standard, and to prompt further discussion and resolution of challenging issues.

Since the development of the resource pack, one hospital trust has already purchased a licence and is using the package, and other trusts have also expressed an interest.

**Alison Taylor and Catherine Angell**  
Midwifery Lecturers

A grant of almost £50,000 has been secured to deliver and evaluate an End of Life Care (EoLC) education programme for care home managers in West Sussex. Dr Janet Scammell from BU's School of Health & Social Care worked in partnership with Jenny Buckley of St Wilfrid's Hospice, Chichester and Sue Nash, an independent consultant from Action Learning Teams, to obtain the £49,000 grant for the two-year project. The grant was awarded by the Frances and Augustus Newman Foundation, a charitable trust which supports a variety of medical research projects in the UK and overseas.

It has been proposed that suboptimal End of Life Care in care homes may result from inadequate staff education (Department of Health 2008). Training is complex, as palliative care derived from a cancer care model may not be directly transferable to those dying in care homes. It is therefore important to work closely with care homes to ensure that education is not only tailored to their situation but is also sustainable.

St Wilfred's Education Centre has provided study days for this sector for many years but it has become apparent that it takes more than a good knowledge and understanding of EoLC to positively impact on practice. Care home managers also need highly developed interpersonal skills and management expertise to be able to cascade this knowledge to front-line staff, and embed these standards within day-to-day care. Effective leadership skills are required to ensure changes in practice are sustained in the care home environment, and developed in conjunction with multi-disciplinary and multi-agency partners such as general practitioners and district nurses.

## Project aims

The project will build on successful pilot work conducted in 2010. The grant will be used to fund the programme, enhance its content and extend the number of participants, and to conduct a rigorous evaluation to assess suitability for wider use at a national level.

### The project aims are therefore to:

- Improve End of Life Care (EoLC) in care homes through education of care home leaders
- Develop a sustainable educational model for wider use
- Evaluate programme outcomes.

The workshops aim to empower participants to cascade the knowledge, skills and attitudes highlighted from their training needs analysis and self-evaluation against the core EoLC competences (Department of Health (DOH) 2009). The action-learning element of the programme seeks to enable participants to support and challenge each other in putting into practice the

theory they learn about End of Life Care. Participants coach each other in handling difficult situations arising in practice, including staff issues. The programme is delivered via ten study days over a period of 12 months.

The evaluation will involve mixed methods including confidence questionnaires and a pre and post comparison of training needs, enriched by the collection of focus group data immediately post-programme and six months later. A content analysis of participants' self-assessment will also be conducted against EoLC competencies.

The project team believes the programme will not only benefit the participants involved but also the care home staff they subsequently train and manage. It will therefore ultimately improve the quality and standards of EoLC for clients in those care homes. In the longer term, if the educational model is found to be successful then there is the potential to disseminate this approach to the care home sector more widely.

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End of Life Care Strategy. London: HMSO.

### Department of Health (2009)

Core competences and principles for health and social care workers working with adults at the end of life. London: HMSO.

# A change is as good as a rest

Formerly known as University Locality Co-ordinators (ULCs), University Practice Learning Advisers (UPLAs) have now gained a new title, but the role remains unaltered. As such, we felt it an appropriate time to outline some of our key functions.

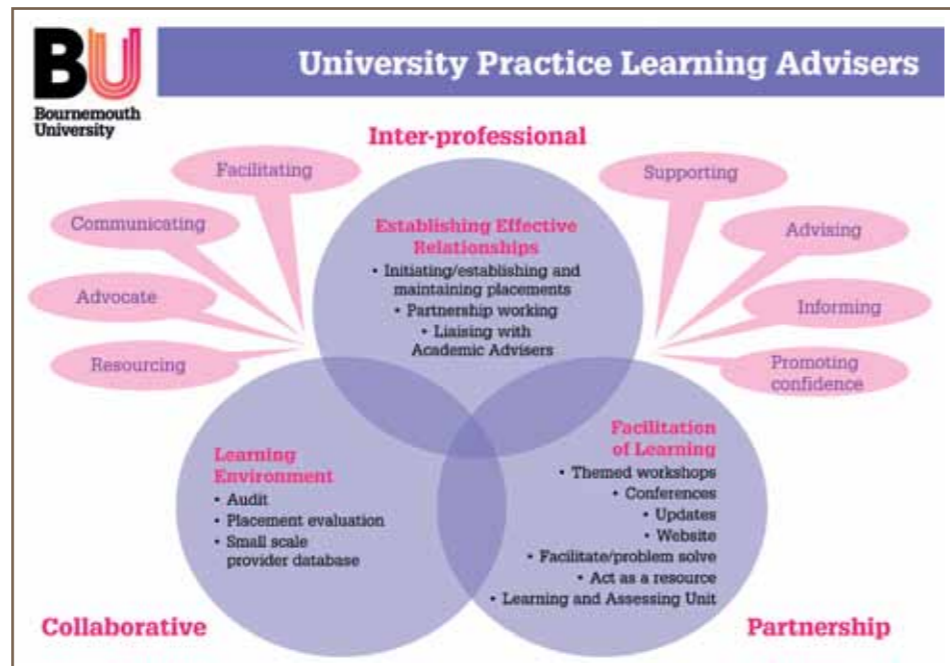
Our main purpose is to establish and sustain a culture of learning within placement settings by working in close collaboration with a variety of partners, incorporating both NHS organisations and the independent sector. We endeavour to create an atmosphere of trust and mutual respect in order to provide quality practice placements for students.

University Practice Learning Advisers serve as communication channels between practice and the higher education institute to promote collaborative working. The joint aim is to ensure students develop evidence-based, competent practice which is reliably assessed.

## To clarify:

Academic Advisers (AA) → Student issues and support

University Practice Learning Advisers (UPLA) → Practice Assessor issues and support



The University Practice Learning Advisers' focus is around the foundation of learning that develops creative and flexible approaches to inter-professional practice assessor education. An opportunity to share knowledge and experience with other healthcare professionals is considered helpful in expanding the assessor's repertoire of skills. These innovative approaches to mentor education have motivated practice assessors to confidently engage in their role, thereby promoting rigour in assessment and improving the student experience.

The value of ongoing development for practice assessors is recognised by the professional bodies (Nursing and Midwifery Council (NMC) 2008, Health Professions Council 2009). Nursing annual updating is a mandatory requirement to promote effective learning and assessment (NMC 2008).

Lee (2000) and Fisher (2000) recognised that motivation, empowerment and mentorship are interdependent. Research undertaken by members of the team identified how a variety of educational approaches empowered practice assessors to engage more fully in their roles.

The University Practice Learning Advisers are also responsible for the delivery of the Learning & Assessing Unit, and two of the team are unit leads. As we are already involved in ensuring support for mentors in their role on the pre-qualifying programmes, this teaching allows us to draw on these experiences, enabling the unit to be practice-based, incorporating group work and case studies.

The role is multi-faceted and at times complex. However, with the team's dynamism and enthusiasm it continues to evolve, with the ultimate vision of maintaining and enhancing the practice learning experience.

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**Fisher, K, 2000.** Leading self-directed work teams. A guide to developing new team leadership skills. USA: McGraw-Hill.

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Standards to support learning and assessment in practice. 2nd ed. London: NMC.

## The University Practice Learning Advisers team:

**Belinda Humphries**  
Bournemouth and Poole  
**Email:** bhumphries@bournemouth.ac.uk  
**Mobile:** 07545 420727

**Claire Uren**  
Somerset and North Dorset  
**Email:** curen@bournemouth.ac.uk  
**Mobile:** 07545 420728

**Jo Hirdle**  
Bournemouth/Christchurch and New Forest  
**Email:** jhirdle@bournemouth.ac.uk  
**Mobile:** 07545 420729

**Paula Shepherd**  
West Dorset  
**Email:** pshepherd@bournemouth.ac.uk  
**Mobile:** 07545 420730

**Amanda Watson**  
Poole/Blandford/Purbecks  
**Email:** amandaw@bournemouth.ac.uk  
**Mobile:** 07545 420731

**Zoe Cowie**  
Salisbury/New Forest/Southampton  
**Email:** zcowie@bournemouth.ac.uk  
**Mobile:** 07545 420732

**Group email:** UPLA@bournemouth.ac.uk

# The medium is the message:

## 2010 Qualitative Research Conference

In line with a core theme of the 2010 Qualitative Research Conference, the photographs here display something of the rich range of experiences of the people who attended.



The venue for the eighth 2010 Qualitative Research Conference was Bournemouth University's Talbot Campus. 209 delegates from 23 countries and 78 universities attended. Keynotes and presentations included themes focusing on Performative Social Science, whereby tools from the arts and humanities are drawn upon to research and/or disseminate the rich complexities of human experience, as well as the Humanisation of Health & Social Care (see previous article in the Beacon issue 12: [www.bournemouth.ac.uk/hsc/beacon](http://www.bournemouth.ac.uk/hsc/beacon)).

The photographs on these pages give a flavour of how delegates responded to a call from Dr Kip Jones, leader of the Performative Social Science Group at Bournemouth University. Dr Jones challenged delegates to "connect with their audiences in order to establish a dialogue of engagement and emotion through the use of alternative dissemination methods." Possibilities included, but were not limited to performance, film, video, audio, graphic arts, new media, poetry and so forth.

These alternatives to more standard conference presentations attracted media attention from both the BBC national arts correspondent ([www.bbc.co.uk/news/uk-11396474](http://www.bbc.co.uk/news/uk-11396474)) and the Times Higher Education newspaper ([www.timeshighereducation.co.uk/story.asp?storycode=412959](http://www.timeshighereducation.co.uk/story.asp?storycode=412959)).

A short film was also produced by MA students from The Media School, which tells the story of the Qualitative Research Conference by representing the activities linking events and the inter-connectedness of these in-between spaces. The delegates at the conference turn out to be the subject of the film, which can be viewed at [vimeo.com/14923222](http://vimeo.com/14923222)

Professor Les Todres, Director of the Centre for Qualitative Research, commented: "The photographs you are looking at do not only show an interesting range of activity, but also portray some of the moods of the conference, best seen in faces and postures." The photographs were taken by Dr Kip Jones.

# How to achieve wellbeing in the workplace

**Dr Ann Hemingway and Dr Paul Stevens from Bournemouth University's Centre for Wellbeing & Quality of Life are managing the development of a new wellbeing and humanisation consultancy package for commercial and public sector businesses and organisations, drawing on the expertise of academics from across the University. Here they explain the rationale for the scheme, and advise employers on how they can achieve wellbeing in the workplace.**

The importance of taking health and wellbeing into account when developing public policy has been internationally recognised over the last decade (Diener and Suh 1997; Helliwell 2006; Kahneman and Krueger 2006).

The UK government has prioritised wellbeing in the policy agenda, illustrated in reports by the Whitehall Wellbeing Working Group, the DEFRA Committee on Wellbeing and the Sustainable Development Commission among others (Dolan and White 2007). This has been supported by extensive research showing that promoting health and wellbeing in the workplace improves the working environment and is beneficial for companies and employees alike (European Network for Workplace Health Promotion 2010). Since wellbeing has been operationalised in a number of very different academic and policy fields (eg. medical science, psychology, economics, sociology, social policy, management science, human resource management, organisational behaviour and environmental science) it is important to draw upon a range of expertise in developing robust models for public policy and consultancy.

'Wellbeing and humanisation in the workplace' refers to two related ideas. Promoting wellbeing in the workplace is a well-established concept internationally, while the humanisation agenda is emerging from Bournemouth University's Centre for Qualitative Research as a developing concept, one that is informing public



policy in areas such as the health service by examining the personalisation of care to enhance the quality of services.

Humanisation focuses on the importance of person-centred processes to support wellbeing and a concern with helping people feel human. There is an increasing suggestion that people are starting to question interactions with organisations that leave them feeling they are treated as numbers and statistics rather than valued individuals (Patients' Association 2009).

**Several important dimensions of humanisation have been identified (Todres, Galvin et al 2009):**

- **Agency:** finding ways to enhance people's sense of being active in an organisation
- **Insiderness:** connecting with people's 'inward sense' of how they are: avoiding interactions and strategies that make people feel excessively like 'objects'
- **Uniqueness:** finding ways in which a person can feel that they are being seen for themselves and not just how they fit into a category

- **Togetherness:** finding ways that can enhance our need for belonging; to find familiar interpersonal connections so that our sense of isolation is reduced
- **Personal journey:** finding ways to help people connect with a sense of historical continuity
- **Sense-making and loss of meaning:** exploring ways to communicate so that people don't just feel like a 'cog in a wheel'; rather, that what is being offered makes sense and is fair to them
- **Sense of place:** providing a sense of security and belonging in the places we inhabit which adds to our wellbeing
- **Embodiment:** helping people to connect to 'wellbeing resources' beyond themselves, a quality that makes life and work worthwhile and meaningful. Embodiment means a 'reaching out' and connecting meaningfully to what is 'out there'.

An enterprise niche which links the two related perspectives of wellbeing and humanisation together provides a creative, original and distinctive framework for consultancy, focusing on processes, perspectives and outcomes related to both concepts. These two perspectives underpin the development of this consultancy package, which enables organisations across the public, private and charitable sectors to focus on wellbeing for their staff and customers/clients in a holistic manner. Employers can consider the way they work and where they work, and put wellbeing at the heart of what they do.

Organisations are more dependent on well-trained, highly qualified and motivated employees than ever before. In addition, the study of workforce health and wellbeing has enabled us to achieve a new understanding of health at work, which encompasses both physical wellbeing, mental wellbeing and the social determinants of health. We believe our specific expertise and unique enterprise opportunity is in integrating and applying some novel wellbeing and humanisation theories with empirical research evidence within the workplace.

Below are some key ways in which the evidence shows us that organisations can improve the wellbeing of their employees:

## 1. Recognising that employees are people

Underpinning everything is what we at Bournemouth University are calling 'humanisation' - focusing on how people feel as human beings. Finding ways to enhance people's sense of being active in their organisation, avoiding interactions and strategies that make people feel excessively like 'objects', and providing them with a sense of control, security and belonging are just some of the approaches that organisations could take. The work of Professor Yannis Georgellis has shown that an individual who is satisfied with their job is likely to be more motivated and productive.

## 2. Provide an appropriate physical working environment

Certain physical features can induce a stress response: a lack of natural lighting and non-opening windows; close-packed uncomfortable seating that invades personal space; or bland,

monochrome colour schemes and harsh linear features to name but a few. Once stressed, the individual is primed to respond badly to any subsequent events, making increased errors or reacting with irritability to situations normally well within their capabilities. Simple changes to the workplace can help alleviate the stress. Dr Paul Stevens tells us that studies show natural views through the window have a beneficial effect on health, reducing illness and increasing positive mood; even plants on desks can improve concentration at a task, reducing errors and fatigue, as well as improving air quality.

## 3. Provide an appropriate social working environment

It is well established that people with supportive friends (both in and out of work) deal better with stress. But human beings react to any interpersonal interaction as a social process, so the organisational structure of the workplace needs to be carefully considered. Whether in person (ie talking to a colleague) or symbolic (ie the perceived



level of responsibility and control within a role), how we are treated and how enabled we feel has a direct effect on wellbeing. Strict adherence to timetables or procedures that in reality rely on factors out of the control of staff, or feeling that you are not being listened to when you have concerns, can result in high levels of sustained stress and in the long term, can predispose us to physical illnesses such as coronary heart disease.

#### 4. Encourage environmentally friendly behaviour

Most measures designed to improve pro-environmental behaviour also have a direct positive impact on wellbeing. These include self-organised work structures; more flexible working hours allowing for avoidance of inefficient rush-hour traffic; using carbon-neutral, natural materials that decrease levels of harmful chemicals, both in the manufacturing process and in the office; natural lighting and ventilation that reduce energy bills and the pollutants used in the operation and manufacture of air-conditioning and lighting units; and naturalistic planting schemes to improve air quality. As a rule of thumb, environments that are better for humans are those that are ecologically healthy and beneficial for our wellbeing on a local and global scale. This means that organisations can not only reduce their carbon footprint but also use local products in their buildings and furnishings and within their food and drinks provision.



#### 5. Simple strategies for building a healthier work community

Many companies provide employees with information on healthy lifestyles. Companies can also integrate healthy messages into communications such as employee magazines or their intranet. Other suggestions from Associate Professor Heather Hartwell include organising seminars where information on healthy nutrition and physical activity

is provided, offering healthy dietary options at the canteen, and distributing free fruit and vegetables among employees to increase consumption. Organisations may encourage/incentivise employees to be more active, such as subsidised gym memberships and the creation of fitness facilities such as on-site showers and bike sheds. Another strategy is to organise activities in which employees may participate; lunchtime walking or running groups are good examples of these.

This initiative is bringing together disciplines across many aspects of health and wellbeing in a new and unique way that will enable organisations to rethink how 'everyone' in a workplace can join together to promote their own and others' wellbeing. The new consultancy package will be launched in October 2011 at an international conference hosted by Bournemouth University's Centre for Wellbeing & Quality of Life entitled 'Resources, Capital or Personnel? Perspectives on Wellbeing at Work'.

In addition to this, the new Wellbeing Centre has now been completed and is the nexus of our integrative, whole-systems approach, acting as a multipurpose office, meeting and events space across the Lifespan, Green Knowledge Economy and Digital Media networks. This collaborative research space is a practical demonstration of an interior environment designed to:

- 1 Minimise common stressors in the workplace
- 2 Enhance wellbeing by careful use of various perceptual cues shown to promote relaxation, improve concentration and reduce fatigue and error-making
- 3 Where possible, make use of sustainably sourced materials that minimise negative local and global environmental effects.

We hope we have created a workplace that is psychologically restorative; one that is comfortable and appealing to the senses but also practical, whilst being achievable within standard procurement and financial procedures. Contrary to popular belief, this approach is not substantially more expensive than 'standard' materials. Some materials have a higher initial cost but longer operating lifetimes, while others are cheaper. If end-of-life disposal and environmental costs are factored in, many of the materials used may well turn out to be the most cost-effective options in the future.

For more information please contact  
Colin Hewitt-Bell  
[chbell@bournemouth.ac.uk](mailto:chbell@bournemouth.ac.uk)  
01202 962251  
[www.bournemouth.ac.uk/cewqol](http://www.bournemouth.ac.uk/cewqol)

# Social work research: Child abuse to neurosurgery

**Social work is concerned with the inter-relationship of individuals, families and society, demonstrated in this brief exploration of the development of recent research, ranging from outcome studies of social work's contribution in reducing the extremes of child abuse, truancy and delinquency to the value of a social science approach in 'high tech' neurosurgery. By combining qualitative and quantitative methodologies we can indicate the value-added impact of a social work-type service on health and social care outcomes across disciplines.**

## Social work outcomes – micro studies

Richard Williams and Colin Pritchard evaluated a Home Office prospective controlled study which aimed to reduce truancy, delinquency and school exclusions in a school-based social work service. Compared to the matched control schools, the schools featured in the study had significantly better outcomes and were cost-effective, yielding a 'surplus' of £145,000 pa from the fewer numbers of school exclusions, reduced levels of delinquency and court appearances<sup>1</sup>.

At the invitation of the chief officers, we explored the outcomes of a five-year cohort of adolescents who had been permanently Excluded-From-School (EFS). It was noted that amongst the 215 males, now aged 16-24, 20% were also young men who were both 'Looked-After-Children' (LAC) and excluded. To everyone's surprise, the young men who were both LAC and EFS had significantly better outcomes than the EFS – only men. This led to us comparing the total five-year cohort of 438 former LAC males<sup>2</sup>.

Research on former LAC usually compares people against those in the general population, ignoring the psychosocial disadvantage they invariably carry. However, here was a natural control study, in effect, of two groups of relatively psychosocially disadvantaged groups, one of which had continued social work support, the LAC, and one of which, the EFS young men, had no statutory right to subsequent support.

The results were dramatic. On virtually all measures, LAC did significantly better than their EFS peers, with far fewer crimes, and 72% of the LAC men predicted by

the Home Office to reoffend did not do so. The Home Office predictions were accurate for the EFS, meaning that in effect hundreds of thousand pounds were saved in reduced crime and its sequel. However, we also found that many of the EFS had 'deteriorated', as two thirds entered a criminal career.

This is not surprising. As educational under-achievers, they are almost unemployable in a competitive market. More worrying was that out of the 215 men, three had committed murder, which is more than a thousand times that of the general population, and two EFS men committed suicide at a likelihood of 190 times that of their age peers<sup>2</sup>. The National Children Bureau (January 2011) expressed interest in these results, as it is clear that former EFS require comparable LAC social work support after being excluded, not only to seek to integrate them into society but to reduce the toll of their continued disturbed and disturbing state.

## Social work outcomes – macro studies

A major 'political' concern is about child-abuse related deaths (CARD), reflected in the high-profile tragedies of Victoria Climbié and Peter Connelly ('Baby P'). Taking the post Maria Colwell inquiry 1974 as a baseline, and using the latest confirmed WHO CARDS, we compared England and Wales with the other major Western countries. Our research showed that in the 1970s, the Anglo-Welsh were amongst the highest child assailants but today, England and Wales are either fifth or third lowest of 20 countries (dependent on whether we included all 'possible' rather than probable deaths in the CARD calculation) and had one of the biggest reductions of CARD

amongst Western countries<sup>3</sup>. Research is often inter-connected, as one idea sparks off another. This led us to explore the implicit hypothesis in the UNICEF (2001) statement that "children's mortality rates are an indicator of how well a nation meets the needs of its children". We found that between 1979 and 2005, the USA had the highest rates of child (0-14 years) mortality in the Western world<sup>4</sup>. Rates in every country fell substantially over the period, and in the USA by 46%, but in the UK they fell by 57%, an improvement that was significantly higher than the USA and six other countries.

That the USA had the highest child mortality might be surprising, as over the period their GDP Expenditure on Health (GDPHE) averaged 12.2%, compared to the UK 7.1%, with only two countries spending less<sup>4</sup>. However, we found that there was no correlation between countries' GDPHE and child deaths, but a massive positive correlation with relative poverty. Based on income inequalities, the gap between top and bottom 20% of incomes ie the USA (8.5 times), Portugal (8.0) and the UK (7.2) had the worst 'relative poverty', and occupied the top five child mortality rates. Conversely, Sweden, Finland, Norway and Japan who had the narrowest inequality also had the lowest deaths, half that of the USA.<sup>4</sup>

This poverty-GDPHE inconsistency has led us to ask new questions about 'who kills children' and a current reanalysis shows that against expectation poverty is NOT related to CARD, which has fascinating practice implications. However, this study is not yet accepted and is under review by a national journal.

## Crossing Boundaries 1 – Neurosurgical outcomes

A Wessex neurosurgical nursing sister asked the question: 'If subarachnoid-haemorrhage (SAH) patients, a type of life-threatening stroke, are technically cured, why is it they keep coming back to the unit?'

Conventional wisdom said this was due to major brain trauma but this was challenged when, in an unusual approach, we viewed the neurosurgical patient as expert and asked them to identify their problems and make recommendations to resolve them<sup>5</sup>.

More than half of SAH patients are aged under 54, thus at the peak of their family and professional responsibilities, so an SAH creates major disruption for patients and families. The initial two-year cohort attracted 142 patients (78% response rate) who identified that problems were mainly post-discharge but recommended that a 'Specialist Neuro Vascular Nurse' (SNVN) to provide family-specific support would be a solution. Their recommendation was implemented and evaluated in a two-year controlled prospective study to find major psychosocial and fiscal benefits for families and the NHS. The SNVN support saved at least £145,000 pa above the cost of the project<sup>6</sup> and was one of the first studies in neurosurgery to use Patient-Related-Outcome-Measures (PROM).

## Crossing Boundaries 2

In 2007 the Chief Medical Officer (CMO) of England recommended that consultants should be re-validated and the assessment criteria should include PROM, which led to my involvement with the Royal College of Surgeons (England) research sub-committee on re-validation.

Emerging from this experience, it seemed there was an over-focus on weaknesses in the NHS, which ignored the recent fact

that the NHS relatively 'achieved more with proportionately less', as evidenced in a study with Professor Tamas Hickish, which showed that the UK had a greater reduction of cancer deaths.<sup>7</sup> This challenged other work which concentrates on survival rates (ie living five-years post diagnosis), which are methodologically weaker<sup>8</sup> than confirmed mortality<sup>7</sup>, as the UK outperformed the USA over the last five years<sup>8</sup>.

However, when the CMO's concerns about 'adverse events' in operating theatres were raised, we realised that there was no research at a national level asking surgeons their views. John Brackstone from BU and Hull's Professor of Surgery John MacFie therefore undertook what is still the largest survey of general surgeons (549), to repeat our qualitative method by asking surgeons what are the problems that contribute to an 'adverse event', where a patient is actually harmed, and what solutions do they recommend<sup>9</sup>.

In terms of numbers of 'adverse events' (AE), we found that over a two-week period 19% of respondents were involved in an AE, which was higher than what was reported by the CMO. Based on the numbers of operations carried out, this was 0.3% of all operations, although if it is you or your relative this is 100%. Yet compared with the as-yet best meta-analysis of studies on AEs, mainly from North America<sup>10</sup>, our respondents, the Association of Surgeons of Great Britain & Ireland, had half the rate found in North America.<sup>10</sup>

## Crossing Boundaries 3

The earlier PROM studies<sup>5,6</sup> aroused further interest and BU's Dr Malcolm Cox and other colleagues were invited to re-evaluate the Society of British Neurological Surgeons national study of subarachnoid haemorrhage (SAH) patients. The research team projected the Wessex results onto the national sample of 2,380 SAH patients,

to estimate what savings there might be if there had been a Specialist Neuro Vascular Nurse in all 34 neurosurgical units<sup>11</sup>.

Cautious estimates showed that a family-specific psychosocial support service for neurosurgical patients saved the NHS £2.49 million and £8.1 million for families, mainly from the patient re-establishing family functioning earlier, and they and their carers returning to work earlier than patients from a standard service<sup>11</sup>. The study has a parallel paper which focused on areas of psychosocial improvement<sup>12</sup>.

Moreover, we highlighted a feature often ignored by politicians when speaking about the 'cost of the NHS', who forget that for those returning to full-time work, many continue to contribute to the wider economy. In our study, 72% of people of work age 24-64 returned to work, yielding an estimated £688 million<sup>11</sup>, enabling it to be said that not only does neurosurgery 'save lives' but with an integrated service is even more cost-effective.

Hopefully this brief exploration of a series of linked research projects in the School of Health & Social Care shows not only the academic value of an inherently interdisciplinary social work approach but more importantly, might contribute to improving an evidence-based practice.

### Professor Colin Pritchard

Centre for Social Work & Social Policy

Professor Pritchard was recently elected as an Academician of the prestigious Academy of Social Sciences, one of two at Bournemouth University and 700 worldwide

<sup>1</sup> Williams R & Pritchard C (2006) Breaking the cycle of Educational Alienation Open University Press.

<sup>2</sup> Pritchard C & Williams R (2009) Does Social Work Make a Difference? A Controlled study of Former Looked-After-Children and Excluded-from-School Adolescents Now Men Aged 16-24: Subsequent Offences, Being Victims of Crime and Suicide. Journal of Social Work 9, 285-307.

<sup>3</sup> Pritchard C & Williams R (2010) Comparing possible child-abuse-related-deaths in England & Wales with the major developed countries 1974-2006. British Journal of Social Work. 340, 197-210.

<sup>4</sup> Pritchard C & Williams R (2011) Poverty and child (0-14 years) mortality in the USA and other

Western countries as an indicator of "how well a country meets the needs of its children" (UNICEF). International J Adolescent Med Health 2011; 23(3).

<sup>5</sup> Pritchard C, Foulkes L, Laing D, & Neil-Dwyer G (2001) Psychosocial outcomes for patients and carers after aneurysmal subarchanoid haemorrhage patients. British Journal of Neurosurgery. 15. 456-463.

<sup>6</sup> Pritchard C, Foulkes L, Lang D & Neil-Dwyer G (2004) Two year prospective study of psychosocial outcomes and a cost-analysis of 'Treatment-As-Usual' versus an 'enhanced' (specialist liaison nurse) service for aneurysmal subarchanoid haemorrhage [ASAH] patients and families. British Journal Neurosurgery 18: 347-356.

<sup>7</sup> Pritchard C & Hickish T (2008) Changes in cancer incidence & mortality in England & Wales and cancer deaths compared with the Major Developed Countries 1979-2002 in context of GDP expenditure on health. European Institute of Oncology. ECancerMedicalScience. 2, 80, 1-18.

<sup>8</sup> Autier P & Boniol M (2011) Caution needed for country specific cancer survival. Lancet, 377, 99-101.

<sup>9</sup> Pritchard C, Brackstone J & MacFie J (2010) Adverse Events and Patient Safety in the Operating Theatre; perspective of 549 surgeons. Annals of Royal College of Surgeons (Eng). Supplement 92. 1-4.

<sup>10</sup> de Vries EN et al (2008) The incidence and nature of

in-hospital adverse events: A systematic review. Quality & Safety of Health Care. 17, 216-223.

<sup>11</sup> Pritchard C, Cox M, Foulkes L & Lindsay K (2011) Re-evaluating the National Subarachnoid Haemorrhage study (2006) from a Patient-Related-Outcome-Measure Perspective: Comparing Fiscal Outcomes of Treatment-as-Usual with an Enhanced Service. British Journal of Neurosurgery, 25. In press

<sup>12</sup> Pritchard C, Cox M, Foulkes L & Lindsay (2011) "The Patient's Voice in Neuro-surgery. Psycho-Socio-Economic Benefits of a Patient-Designed versus Standard service following treatment for a Subarachnoid Haemorrhage". Journal of Social Care & Neuro-disability. 2 In press.

# Improving dementia care in general hospitals

**In response to the National Dementia Strategy 2009, funds were allocated from the Somerset Strategic Services Improvement Fund to improve dementia care in Somerset's general hospitals. This project began on 1 April 2010 and was a secondment opportunity for two members of staff from the Somerset Partnership NHS Foundation Trust, working 19 hours per week for a year.**

The project was guided by a steering group comprising representatives from NHS Somerset, Alzheimer's Society, Somerset Partnership NHS Foundation Trust, the acute and community hospital trusts and Bournemouth University. Somerset is a rural county in the South West of England, with fifteen hospitals across 1,332 square miles. Our objective from day one was to make the project valuable, realistic and achievable.

The Tipping Point Theory of Change (Shapiro 2003) suggests that when implementing change you should first work with the Advocates, then move to the Incubators, Apathetics and Resistors, so we decided to look for like-minded people who were passionate about good dementia care and looking to develop practice. We started with the Dementia Leads in each organisation, then encouraged individuals at ward level.

We decided on a three-pronged approach, which included Awareness Raising, Introducing Ward-Based Projects, and Creating a Sustainable Network across Somerset.

In a bid to engage with as many staff as possible, we designed an hour-long awareness-raising session. The main

purpose of the session was to encourage staff to feel what it may be like to have dementia, and to consider what challenges the sufferer may experience coming onto their ward.

We achieved this in two ways. We began the session with a visualisation exercise, outlined by Brooker and Surr (2005). During this exercise participants were encouraged to consider the sights, sounds, feelings and frustrations that could be experienced on their ward. Time was given afterwards to explore their feelings and discuss possible solutions. We asked for feedback on a post-it note exit. We received the following in response to the question: 'What area of good practice will you either continue or begin following this session?'

- Know that somebody with dementia, age etc probably had a busy successful life... and is still alive!
- Smile and create a calm approach
- Talk to family and friends to get a better picture of the patient's needs
- I will give a patient more time to try and gain information on their own routine, likes, dislikes to make them feel more settled in their unknown environment

- Give more time to sit and chat to patient. Speak to staff who have already engaged with the patient
- Try and have more time and not be in a hurry
- We all need to remember everyone, everyone has a past, present and future.

## Ward-based projects

In order to engage on a practice level with ward staff we devised a number of ward-based projects, based on our reading of national papers and articles. The Dementia Champions/Leads in each hospital encouraged individual wards to engage with specific projects. Projects offered were on Environment, Involving Carers, Person-Centred Care, Occupation and Nutrition. We felt that in order for projects to succeed, it was important that the individual wards took ownership of their project.

We ran an introductory session on the ward with a cross section of staff. At some of these sessions we were joined by 'Sue', who cares for her mother and had first-hand experience in both district and community hospitals. The usual format for these sessions included discussing a person-centred questionnaire, which we

devised based on the eight dimensions of 'The humanisation of healthcare: A value framework for qualitative research' (Todres et al 2009). We shared some of our learning related to the specific project eg. the use of colour, positioning of furniture, signs etc within the physical environment, and the consideration of the social environment. The participants were given a task which would inform their action plan for the ward.

Throughout these sessions we encouraged staff to consider little things that may make a difference eg having all the clocks on the ward telling the same time, contacting a patient's loved one/carer as soon as possible following admission to discuss their usual routines and abilities, and to start to establish a relationship with them.

Wherever possible we engaged a carer in these sessions, as they were invaluable in giving first-hand insight and suggestions. We also advocated the use of life stories and introduced the 'This is Me' document produced by the Alzheimer's Society 2010.

## Creating a sustainable network

In collaboration with our colleagues from the Strategic Health Authority, we devised a workspace on Huddle.net, an online platform. The Somerset Collaborative for Dementia Care Workspace is accessed by invitation only, and comprises three areas:

1. Files containing national papers, training opportunities and individual folders related to each ward-based project
2. A discussion forum, where members of the group are encouraged to post discussion topics related to dementia care, such as:
  - Is it the hospital's role to address bio-medical issues in isolation?
  - Or is it the hospital's role to address the person's overall needs?
  - Or we are trying to establish a relationship with loved ones/carers as soon as we are aware that the patient is suffering from a memory difficulty – has anyone does this successfully?
3. A whiteboard for members to post events/occasions related to dementia care, which may be of interest to other members.

Invited members include members of the steering group and Dementia Champions/Leads from individual hospitals, including staff involved in ward-based projects and from Bournemouth University.

## Evaluation and reflection

In addition to the post-it note exit, we were involved in a more formal evaluation led by our colleagues from Bournemouth University. It took the form of questionnaires and personal interviews. Everyone who attended the Lived Experience Session was asked to fill in a questionnaire related to their learning, using the humanising strategies ie Agency, Sense of Place, Sense of Journey, Togetherness, Uniqueness, Sensemaking, Embodiment and Insideness (Todres et al 2009). We designed specific questionnaires for staff who were involved in a ward project, concentrating on their personal learning in relation to that project. We asked for volunteers to be interviewed by the researcher, and interviewed members of the Steering Group to ascertain their expectations and assessment of the project.

## Reflections were as follows:

- One of the most rewarding aspects of the project was to hear staff talking about changes needed in the culture of care, in relation to people with dementia
- The project enabled highly motivated staff in the general hospitals to take forward some of their good ideas to improve dementia care in their environment
- The collaborative working between seven organisations enabled face-to-face contact, developing good working relationships and blurring inter-organisational barriers
- We tried to encourage staff from different organisations and wards to contact others in similar situations and share their experience and frustrations
- We were indebted to 'Sue', our carer, who gave up her time to help facilitate training sessions, share her experiences and keep us grounded in the possible

- There is still a long way to go to develop the 'perfect patient experience' for people with dementia, but we have seen examples of staff willing to develop their knowledge in this area, looking objectively at their environments, involving the loved ones/carer at the earliest possible stage and considering how a patient's routines could fit into the hospital structure.

## Collaborative team:

Jan Seewooruttun, Jason Weetch, Marilyn Cash., Kate Galvin, Les Todres

## Further resources

1. 'This is me' document produced by the Alzheimer's Society. [www.alzheimers.org.uk](http://www.alzheimers.org.uk)
2. **Brooker D (2006)** Person Centred Dementia Care: Making Services Better. Jessica Kingsley Publishers.
3. **Pool, J (2008)**. The Pool Activity Level (PAL) Instrument for Occupational Profiling: A practical resource for Carers of People with Cognitive Impairment. Jessica Kingsley Publishers.
4. **Todres L, Galvin K and Holloway I (2009)** The Humanization of Healthcare: A value framework for Qualitative Research. International Journal of Qualitative Studies on Health and Well-being 4(2), 68-77.
5. **Department of Health (2009)** Living Well with Dementia, A National Dementia Strategy. DoH, London. [www.dh.gov.uk](http://www.dh.gov.uk)

# Developments in mental health

The academic year 2010/11 has seen significant developments in the area of mental health within the School of Health & Social Care (HSC). In the autumn of 2010, the University received confirmation that Dorset Healthcare University NHS Foundation Trust (DHUFT), one of our key NHS partners, had been granted University status.



University commented: "This very pleasing change is the result of hard work to demonstrate the strong commitment on behalf of both organisations, with the ultimate aim being to improve care for patients and service users. The Trust's new title reflects strong partnership working in the areas of research, education and practice development with our NHS colleagues. This will be of benefit to staff and students but, more importantly, to those in need of high-quality, evidence-based care."

Becoming a University Trust enables Dorset Healthcare University NHS Foundation Trust to continue to maintain a balance between a business approach, with its long-standing emphasis on continuous staff professional development, and its prime focus on providing high-quality care and support for local people.

The affiliation with Bournemouth University will offer the opportunity to develop new undergraduate and postgraduate programmes, high-quality clinical placements and inter-professional learning and practice. It will also bring together clinical and academic staff to undertake research which will underpin the development of practice and aid in the recruitment and retention of high-calibre staff with the right skills and qualifications.

In order to put these key principles into practice, the University Department of Mental Health has been established. The UDMH was developed through close collaboration between DHUFT, HSC and DEC, and brings together academic staff and clinicians from a range of disciplines working within mental health, including psychology, nursing, psychiatry and occupational therapy. The primary aim of the UDMH is to improve professional practice and the care for service users and carers.

The following aims are key to achieving this goal:

- Enhancing human wellbeing and engagement in life through research and scholarship
- Engagement with service users and carers
- Increasing clinical standards through education, research, enterprise and practice development
- Attracting and retaining high-calibre staff
- Continually educating the mental health workforce with an emphasis on inter-professional learning and practice
- Fostering inter-professional funded research programmes, leading to high-quality, evidence-based practice, recognition externally, dissemination of findings through conferences and publications
- Adding value to the Trust through the process of BU-led 'practice development unit' accreditation, a rigorous auditing and service improvement process.

The Department is led by Professor Sue Clarke, Consultant Clinical Psychologist with DHUFT, working closely with Dr Andy Mercer, Professional Lead for Mental Health in HSC. The UDMH will be based on the third floor of Bournemouth House, on the University's Lansdowne Campus; additional premises will be developed within DHUFT at St. Ann's Hospital, Canford Cliffs.

Professor Sue Clarke is a Consultant Clinical Psychologist at Dorset Healthcare University NHS Foundation Trust. Dr Andy Mercer is the Professional Lead for Mental Health in the School of Health and Social Care.

**Dr Andy Mercer**  
[amercer@bournemouth.ac.uk](mailto:amercer@bournemouth.ac.uk)  
[www.bournemouth.ac.uk/hsc/university-department-of-mental-health](http://www.bournemouth.ac.uk/hsc/university-department-of-mental-health)

In parallel with this welcome development, the University Department of Mental Health (UDMH) was established, as a collaboration between the School of Health & Social Care, the School of Design, Engineering & Computing, and Dorset Healthcare University NHS Foundation Trust. This exciting collaboration will support a range of education, practice development and research initiatives in the field of mental health and learning disability.

University status will enable Dorset Healthcare University NHS Foundation Trust to further develop mental health services, by continually improving clinical standards through research and development. The Trust and the University will continue to work closely to promote better treatment and care for service users and their carers through education, practice development and research initiatives. This close working relationship will further enhance the involvement and participation of service users and their carers in the development of local mental health services, particularly in the areas of research and education.

"We are delighted to have gained University Trust status," said Roger Browning, Chief Executive, Dorset Healthcare University NHS Foundation Trust. "It has been a key strategic aim of ours and one that we have been working towards since 2007. The relationship between the Trust and the School of Health & Social Care at Bournemouth University has been well established over four decades and is both positive and productive."

Professor Gail Thomas, Dean of the School of Health & Social Care at Bournemouth

# Transformational change to enhance learning

The School of Health & Social Care (HSC) at Bournemouth University is developing a collaborative lifeworld-led transprofessional curriculum for health and social work disciplines by harnessing technology to connect learners to humanising, evidence-based practice.

The purpose is to increase the use of technology-enhanced learning, release staff potential, and expose students to the research undertaken within HSC. The project is supported by the HEA Discipline-focused Learning Technology Enhancement Academy through the Subject Centre for Social Work & Social Policy.

Our goal is to capitalise on the School's expertise and scholarship in using a range of evidence around lifeworld service user and carer stories in the form of clips from television and radio programmes, films, podcasts, poetry, drama and narrative case studies. We will also use associated evidence from journal articles and policy documents to immerse health and social care students in the lifeworld of the people they may encounter in their future professional roles.

A key feature of the project is to raise students' awareness of a range of evidence, including narratives and material from the arts and humanities, to consider how practice can be guided from there. In this way we wish to introduce students to evidence in a situated way, embedded in practice, and to make explicit transprofessional learning.

As the diagram demonstrates, at the heart of our philosophy and underpinning the educational resource is an opportunity for students to integrate understandings about different kinds of knowledge for practice, conventional evidence, understandings about an individual's experience and the student's personal insights that come from imagining 'what it is like' for the person on the receiving end of human services (Todres, Galvin & Dahlberg 2006, Todres 2008, Galvin 2010, Galvin & Todres 2010).

This project builds on the development of Wessex Bay, a virtual community of case scenarios representing different service user and carer perspectives, used within our interprofessional education curriculum as problem-based triggers to engage students in learning activities relating to the residents (Scammell, Hutchings & Quinney 2008; Pulman, Scammell & Martin 2008; Quinney, Hutchings & Scammell 2008; Hutchings, Quinney & Scammell 2010).

## Stakeholders

The key beneficiaries of this initiative will be our students and ultimately, the service users and carers they meet within the course of their professional lives.

The focus is on creating a transprofessional unit to be delivered to over 600 students from social work and community development, nursing, midwifery, occupational therapy, physiotherapy, operating department practitioners and paramedics.

## The experience of the person

### First person accounts



Personal resources  
Life resources

Technical knowledge  
Research evidence

The scale of transformational change is considerable, given that all the professional groups in the School are participating. Approximately 40 staff are taking part as academic developers, champions and facilitators as their roles shift, from unit teachers and research staff to resource developers, or from uniprofessional programme leads to transprofessional champions, or from research-focused professoriate to unit facilitators.

**For further information about the project, please contact the Project Team:**

**Professor Kathleen Galvin**  
 Chair in Health Research  
 Curriculum Unit Leader  
[kgalvin@bournemouth.ac.uk](mailto:kgalvin@bournemouth.ac.uk)

**Dr Maggie Hutchings**  
 Academic Lead E-Learning and Educational Enhancement  
 Project Leader  
[mhutchings@bournemouth.ac.uk](mailto:mhutchings@bournemouth.ac.uk)

**Professor Les Todres**  
 Professor of Qualitative Research  
[ltodres@bournemouth.ac.uk](mailto:ltodres@bournemouth.ac.uk)

**Andy Pulman**  
 Web Team Leader  
[apulman@bournemouth.ac.uk](mailto:apulman@bournemouth.ac.uk)  
[andypulman.wordpress.com](http://andypulman.wordpress.com)

**Anne Quinney**  
 Senior Lecturer Social Work  
[aquinney@bournemouth.ac.uk](mailto:aquinney@bournemouth.ac.uk)

**Peter Atkins**  
 Service User/Carer Forum representative  
[patkins@bournemouth.ac.uk](mailto:patkins@bournemouth.ac.uk)

**School of Health & Social Care**

Bournemouth University  
Royal London House  
Bournemouth  
Dorset UK  
BH1 3LT

**Tel:** +44 (0)1202 962114

**Fax:** +44 (0)1202 962131

**Email:** [hsc@bournemouth.ac.uk](mailto:hsc@bournemouth.ac.uk)

**Web:** [www.bournemouth.ac.uk/hsc](http://www.bournemouth.ac.uk/hsc)

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