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Piloting Interprofessional Education

Four English Case Studies

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Forewords

Since around the turn of this 21st century the need for interprofessional education (IPE) in health and social care has been highlighted by the UK government and given prominence in the media by some tragic cases resulting from lack of collaboration between professions. It is now increasingly recognised that a good understanding of the roles and relationships between the professions and the structures to facilitate this are essential to ensure the proper protection of the public. This occasional paper is a very welcome addition to the recent literature on lessons learned from practical experience in IPE. It brings together case studies from pilot 'leading edge programmes' developed by four collaborations between Higher Education Institutions and their Workforce Development Confederations in different parts of the UK. These were commissioned in 2001 by the Department of Health with the understanding that their evaluated findings would be disseminated to ensure wider application. Three of the case studies concentrate on practice learning using different approaches, and the fourth on restructuring of all health and social care curricula to allow for integration. The juxtaposition of these different approaches enables comparisons between them. The case studies are put into context by Hugh Barr who eloquently describes the changes in professional education policies and structures in the UK over the last 10 years, untangling the new from the old names and processes of the many regulatory bodies as well as reminding the reader of the distinction between 'common learning' and 'interprofessional learning'.
IPE is high on the priorities of the Higher Education Academy Centre for Health Science and Practice, as it is for the Centres with which we collaborate closely, Medicine, Dentistry and Veterinary Medicine, and Social Policy and Social Work, and so we are delighted to have this opportunity to help disseminate the fascinating findings of these four programmes.

Professor Catherine Geissler
Director, Higher Education Academy Subject Centre for Health Sciences and Practice

I very much welcome the publication of Occasional Paper 8 focusing as it does on a detailed description of the four DH funded Interprofessional Education pilots.
I have to declare my interest as, being based at the University of Southampton, I have observed the New Generation Project tackling some immense institutional and regulatory challenges as well as their success at engaging students and academics. I was even at one stage on one of the curriculum development groups. So it is with eagerness and curiosity that I look forward to reading in more depth about all the projects. The lessons learnt section of each of the four papers will be of immediate use in a new IPE initiative. Hugh Barr states in his introduction that "the greatest challenge, at home and abroad, lies in reaching out beyond health and care as commonly understood to test the relevance of IPE in other working worlds". As part of the Integrated Children's Services - Higher Education project, a collaborative venture between five Higher Education Academy Subject Centres and the Childrens Workforce Network, we will be calling upon this publication to inform the knowledge review being undertaken to do just that - learn the lessons from interprofessional education in the health and social care arena.

Jackie Rafferty, Director, Higher Education Academy Subject Centre for Social Policy and Social Work (SWAP)

The four studies outlined here were an important and ground breaking group of projects, funded in a way designed to reach a critical mass of change and to overcome some of the logistical and pedagogic challenges faced every day by education reformers seeking to implement interprofessional education in a wide range of curricula.
Each of the four Common Learning pilot projects illustrate innovative educational approaches in order to evidence ways of mainstreaming IPE. The projects acknowledge the work of IPE champions elsewhere, in the UK and beyond, who have helped to develop our understanding of the potential of IPE to improve the quality of care for patients and their carers.

Dr Megan Quentin-Baxter, Higher Education Academy Subject Centre for Medicine, Dentistry and Veterinary Medicine

Abbreviations

CUILU: the Combined Universities Interprofessional Learning Unit (Sheffield)
CLEG: the Common Learning Evaluation Group
CLPNE: Common Learning Programme in the North East
CPD: continuing professional development
CPSM: Council for Professions Supplementary for Medicine
DH: Department of Health
ENB: English National Board for Nursing, Midwifery & Health Visiting
GMC: General Medical Council
GSSC: General Social Care Council
HEI: higher education institution
HPC: Health Professions Council
ILP: the interprofessional learning in practice course
IPE: interprofessional education
IPL: interprofessional learning
KCL: King's College London
NGP: New Generation Project
NHS: National Health Service
NMC: Nursing & Midwifery Council
NOS: national occupational standards
NWC: national workforce competences
PCT: primary care trust
PQAF: partnership quality assurance framework
QAA: Quality Assurance Agency for Higher Education
SHA: strategic health authority
UK: United Kingdom
WDC: workforce development confederation

1. The Brief

Hugh Barr

Inviting bids

In August 2001 the Department of Health wrote to Higher Education Institutions (HEIs) and Workforce Development Confederations in England inviting joint applications for funding to support "common learning programmes" for pre-registration students. Applicants had to demonstrate their combined capability to implement successfully "leading edge programmes" and to disseminate their findings to ensure wider application across the higher education sector based on evaluated success.

Proposals were expected to:

- span medical, nursing and at least two allied health professions
- build on strong progress in developing interprofessional learning
- make robust links with workforce strategies
- have a community orientation
- overcome blocks in successfully implementing interprofessional education
- make joint appointments between service agencies and HEIs
- employ innovative learning methods including e-learning
- incorporate rigorous evaluation and quality assurance
- demonstrate sustainability

The Department made clear its intention to back proposals that would be able to "break through on this complex agenda" to "effect real time change".

From a wider range of bids four proposals were accepted for funding by a national panel:

- Newcastle, Northumbria and Teesside universities with Workforce Development Confederations for the North of England and County Durham and Tees Valley
- King's College London, London South Bank and Greenwich universities with South East London Workforce Development Confederation
- Sheffield and Sheffield Hallam universities with the South Yorkshire Workforce Development Confederation
- Southampton and Portsmouth universities with the Hampshire and Isle of Wight Workforce Development Confederation.

Co-ordinating the pilot sites

Funding allocated to each 'site' and the timing of its release differed, influencing the scale, content, starting date and duration of the subsequent programmes. In addition to the formal Department of Health reporting processes, a voluntary "Common Learning Evaluation Group" (CLEG) was established (with the editor as independent convenor) to open channels for communication and mutual support between the researchers at the four sites. The design of the evaluation for each programme had already been determined as part of the Department of Health bid requirements and so were already well underway by the time CLEG was formed.

CLEG was freestanding and separate from the Steering Group convened by the Department of Health to oversee the progress of the four programmes and to maintain links with national policy developments, although it did provide a meeting point on two occasions for discussion between the hands-on researchers and officials from the Department.

Comparing the evaluations

Each of the four sites conducted its own evaluation of its programme, in accordance with its agreement with the Department of Health. The outcome is various monographs, journal articles and website entries, many of which have by now already been published.[1]

In addition, CLEG decided that it would be helpful to prepare a joint monograph comprising four case studies, one from each of the four programmes, as a means to disseminate their experience more widely. Strict comparisons would be unhelpful, given the differing scale, scope and nature of the projects but CLEG envisaged that parallel presentations would enable readers to see how each leading edge site had interpreted and developed the Department of Health's original vision. Members were much encouraged when the Health Sciences and Practice Subject Centre of the Higher Education Academy agreed to publish the outcome.

The Department of Health also commissioned an independent evaluation of the four sites by Professor Carolyn Miller and her team from Brighton University (Miller et al., 2006). They focused on the organisation and delivery of the learning at the four sites within the confines of the two years covered by their study. Their report and this offer external and internal perspectives respectively on the same programmes. They brought a greater degree of detachment and objectivity than we can claim, given the concurrent responsibilities that many of us had for the development and delivery of the programmes as well as their evaluation.

Contributors to this paper describe the genesis, evolution and operation of those programmes through to their completion, weaving in elements of evaluation and foreshadowing more to follow once additional outcome data has been analysed.

We make no further reference to evaluations in the Miller report to respect its integrity and impartiality, but urge readers in search of a rounded understanding of the programmes to compare these two reports. Assiduous readers will find it helpful to refer also to other papers emanating from the separate sites. Many have been published as listed; others are unpublished but mentioned in the case studies below and available on websites.

[1] (CUILU, 2006; Gordon, 2004; Gordon et al., 2004a&b, 2005; Gordon & Walsh, 2005; Gordon & Ward, 2005; Hean et al. 2006; Hean & Dickinson, 2005; Humphris & Hean, 2004; Marshall & Gordon, 2004; O'Halloran et al. 2006; Pearson et al, 2006).

Deconstructing the semantics
The Department of Health used the terms "common learning" and "interprofessional education" (IPE) interchangeably, although the latter has come to be used more often in line with the following definition:

> *"Occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care" (CAIPE, 1997 revised).*

The programmes came during their short lives to be known as the 'pilot sites'. This was an apt metaphor to capture the spirit in which they explored and charted unfathomed and sometimes troubled waters in search of a safe passage through which others might follow, but there was never any intention that launching other programmes should be held back pending positive findings from the pilot sites. Others were already plumbing the same depths, supported by local or regional funding, and generating valued contributions to the literature[2], contributions which we commend to readers in search of a fuller understanding of the developments of pre-registration IPE in England.

Introducing the case studies
Three of the four sites opted to concentrate on the development of interprofessional practice learning to complement existing interprofessional classroom learning, but taking different approaches.

Pauline Pearson, Claire Dickinson, Alison Steven and Pam Dawson describe an organic approach to developing and testing three models of interprofessional practice in North East England for small numbers of students, in the first instance, from seven professions at Newcastle, Northumbria and Teesside universities. All three models focused on providing students with an experience of working in teams which mimicked or shadowed actual practice. The preferred model was the 'shadow team'. This entailed, first, finding teams in which a number of practice teachers from different professions were located and each in a position to have one or more student on placement and, second, agreeing criteria for them to employ in selecting appropriate clients for interprofessional learning (IPL). Staff in some practices settings doubted whether they could deliver this model, which prompted the development of two others – 'the Peer Interprofessional Placement' and 'the Sole Interprofessional Placement'. Tidy though the distinction between these models is, Pearson and her colleagues encourage flexibility in the light of their experience and in an NHS beset by resource constraints.

Lynda D'Avray, Elaine Gill and Sam Coster describe how King's College London (KCL) and its partners rose to the challenge of introducing an IPL experience into practice placements throughout South East London for some 7,000 pre-registration students in health and social care at any one time from its three HEIs and others placed there by institutions farther afield. A way had to be found to bring as many of these students as practicable together, albeit briefly and within cost limits, with minimal disruption to predetermined, profession specific placements across many NHS trusts, local authority

[2] See for example: Barrett et al., 2003&2005; Hind et al., 2003; Hughes et al., 2004; Lindgvist et al., 2005a&b; Pollard et al., 2004, 2005&2006; Tunstall-Pedoe et al., 2003

social services departments and independent bodies. Logistics were complex, data patchy and resources constrained. The model devised enabled groups of students from different professions to follow a patient's journey through his or her eyes. The devil was in the detail. Guidelines prepared for students and facilitators reward study. The programme was piloted in one hospital before being extended to others and then to primary care. Half the target number was reached per intake within the two-year life of the programme.

Frances Gordon and Michelle Marshall describe how the two universities in Sheffield joined forces, reconciling very different prior experience of IPE, to establish a joint unit to generate interprofessional practice learning opportunities in South Yorkshire. The Unit selected five 'beacon sites' satisfying criteria that inspired confidence that they would offer students on placement experience of user centred collaborative working attuned to the NHS Modernisation Agenda. As in South East London, learning focused on patients' journeys, but the most widely acclaimed product of the South Yorkshire pilot was the 'Interprofessional Capability Framework'. This represents a significant advance on earlier attempts to formulate competency-based IPE outcomes, which others have adopted at home and abroad. The case study makes relatively brief reference to the framework but points readers towards the substantive document.

Debra Humhpris and Jill Macleod Clark describe how the New Generation Project in Hampshire and the Isle of Wight undertook a whole system of educational change across eleven professions. Whereas the other three leading edge sites focused on the development of interprofessional practice learning, Southampton and Portsmouth embarked upon a root and branch review and restructuring of all health and social care curricula for some 1,500 student per intake from all the professions included. This revised and harmonised common learning with reference to QAA benchmarking statements, enabling the integration of three Interprofessional Learning Units, one in the classroom and two subsequently in practice. The case study details structures and systems devised and implemented to manage this ambitious and complex programme whose success, as in all the other sites, has been dependent upon the commitment and goodwill of innumerable parties. A longitudinal evaluation is in progress and its findings are being made available in publication and via the University of Southampton eprints service www.eprints.soton.ac.uk.

The styles adopted by the authors are as varied as the programmes that they describe, variations which I have respected as editor save for introducing consistencies in format.

2. The Policy Framework

Hugh Barr

The turn of the Century was a watershed for IPE in England and indeed throughout the United Kingdom (UK) as 'initiatives', which had until then been for the most part isolated, ephemeral and marginal, moved into the mainstream of professional education in response to the lead given by Government. The UK administration elected in 1997 had immediately signalled its intentions to put training and education at the centre of its workforce strategy to help in improving health care. Integrated care for patients would rely on models of training and education that gave staff a clear understanding of how their own roles fitted with those of others within both health and social care professions. This accorded closely with established expectations of interprofessional education, but stopped short of making explicit reference (Secretary of State for Health, 1997).

A subsequent report put the emphasis on continuing professional development (CPD). Health professions in all health settings would need the support of lifelong learning through CPD programmes, whilst local health service employers would need to recognise the value of such programmes in an increasingly competitive labour market in attracting, motivating and retaining high calibre professionals, managers and other health care workers. Higher education providers and local education consortia (succeeded later by Workforce Development Confederations) would have key roles to play in the development of CPD, including innovative approaches to work based learning. CPD programmes would need to reconcile two objectives, matching the legitimate aspirations of individual health professionals with the needs and expectations of services and patients (Department of Health, 1998a).

The Chief Medical Officer for England (Department of Health, 1998b) put forward proposals for "practice professional development plans" (PPDP) in primary care. These plans, he said, should take into account both "uni-professional" and "multi-professional" learning needs to encourage team working, facilitate appropriate adaptability of professional roles and develop the whole primary care practice as a human resource for health care, thereby introducing IPE in all but name into the Department's case for CPD.

Proposals for radical reforms came in the subsequent NHS Plan (Secretary of State for Health, 2000), which emphasised the importance of collaboration between the NHS, higher education providers and regulatory bodies to make not only post-basic but also basic training programmes more flexible. They challenged, by implication, conventional wisdom that IPL was best left until practising professionals had found their respective identities and had experience under their belts to share, and called for a new core curriculum to promote partnership at all levels to ensure a seamless service of patient centred care. That curriculum would include joint training across professions in communications skills and in NHS principles and organisation delivered by new common foundation programmes to give everyone working in the NHS the skills and knowledge to respond effectively to patients' individual needs.

The programmes would promote:

- Teamwork
- Partnership and collaboration between professions, between organisations and with patients
- Skill mix and flexible working between professions
- Opportunities to switch training pathways to expedite career progression
- New types of workers

Educational reforms would back up Government's intent to give front-line staff with patients the opportunity to think and work differently to solve old problems in new ways and to deliver the improvements set out in the NHS plan. But education alone could not achieve these goals as Government recognised; they depended also upon a change in organisational culture by reducing hierarchies and developing self-managed teams (Department of Health, 2001a).

Successive reports reinforced the message. In future, all health professionals should expect their education and training to include common learning with other professions at every stage. All universities should put "multi-disciplinary education" at the top of their agenda for all health professionals who should expect their education and training to include common learning with other professions during pre-registration courses, in the classroom and practice, and throughout continuing professional development (Department of Health, 2001b&c). A subsequent partnership statement, agreed between the NHS Executive and the Committee of Vice Chancellors and Principals (now Universities UK) aimed "to provide a long-term, stable basis for the relationship between the NHS and higher education, including a shared commitment to the development and expansion of inter-professional education, "flexible pathways" and "joint career initiatives" (Universities UK, 2003).

The South West was the first of the NHS regions to report how it was implementing these policies in a three-year region-wide development plan piloting different models of interprofessional teaching and learning in partnership between universities (Bournemouth, Plymouth and the West of England) and 'provider agencies' at three sites (NHS, 2002).

The high profile report of the inquiry into the untoward deaths of young children during and following heart surgery at the Bristol Royal Infirmary lent weight to the Department of Health's arguments, highlighting as it did failures in collaboration between professions and arguing persuasively for IPE to help remedy the problem (Kennedy, 2001). That case was reinforced later by Lord Laming in his report into the death of Victoria Climbie, which in a markedly different context drew attention to the tragic consequences that can follow lapses in communication and collaboration between professions (Laming, 2003).

By 2004 the Department asserted that attitudes towards more flexible working were changing with "a significant appetite for developing new roles in the services" (Department of Health, 2004a), but flexible working required flexible learning. "In future, education, training and learning", it said, would be based on transferable, computer-based modules (anticipating the role of the ill-fated and short-lived NHS

University). Programmes like those funded by the Department, i.e. the four pilot sites, would achieve national coverage and "ensure that people learn together so that they may better work together in the NHS".

Framing Knowledge and Skills
Reforms had by then been set in train by the Department of Health to implement these policies including the Knowledge and Skills Framework (Department of Health, 2004b; NHS Modernisation Agency, 2004) designed to support personal development in post, career development and service development, as well as to ensure transferability of roles, for all types and grades of NHS staff. Its subsequent development rested with 'Skills for Health' under whose auspices it provided a backdrop for discussions about the organisation and regulation of the health professions.

Establishing new regulatory bodies
Concurrently, the Department of Health overhauled the regulatory machinery for the health and social care professions, setting up three new bodies for England: the Health Professions Council (HPC), the Nursing and Midwifery Council (NMC) and General Social Care Council (GSCC). At the same time, it phased out the (UK) Council for Professions Supplementary to Medicine (CPSM), the UK Central Council for Nursing, Midwifery and Health Visiting (UKCC), the English National Board for Nursing, Midwifery and Health Visiting (ENB)[3] and the UK Central Council for Education and Training in Social Work.[4]

Sustaining commitment to IPE
Strong commitment by the outgoing organisations was reiterated by their successors.

- allied health professions
Under the heading of 'professional relationships', standards of proficiency for all professions regulated by the HPC require that registrants understand the need to build and sustain professional relationships both as an independent practitioner and collaboratively as a member of a team and are able to contribute effectively to work undertaken as part of a multidisciplinary team (Health Professions Council, 2005a: 1a&b), but guidance for the conduct of visits to programmes injects a note of caution:

"Where there is interprofessional learning the profession specific skills and knowledge of each professional group must be adequately addressed."
(Health Professions Council, 2005b)

- nursing and midwifery
References to interprofessional learning and working can be found throughout the NMC standards of proficiency for pre-registration nursing education. Practice must, says the Council, reflect collaboration with other members of the care team. Practice standards set for nursing were not separate and insular professional aspirations, but linked to the wider

[3] And its counterparts for Scotland, Wales and Northern Ireland

[4] The regulatory bodies for dentistry and pharmacy were not affected, although the General Medical Council was later reformed.

goals of achieving clinical effectiveness within health care teams and agencies. It was therefore necessary that nursing standards of proficiency encompass the capacity to contribute to this wider health care agenda. Newly registered nurses should demonstrate an understanding of the roles of others by participating in interprofessional practice, establishing and maintaining collaborative working relationships with members of the health and social care team. Furthermore, they should contribute to the learning of those others by sharing knowledge and experience (Nursing and Midwifery Council, 2004: 14, 32, 34).

- social work

Informed by the government strategy for modernising of social services (Department of Health, 1998), the Requirements for Social Work Training (Department of Health, 2002: 3-4) stipulated that social work students be able to "work confidently and effectively with other professionals' by experiencing learning and assessment in partnership working and information sharing across professions and agencies'.

- medicine

These statements bear comparison with those from the General Medical Council (GMC), which requires its graduates to "know about, understand and respect the roles and expertise of other health and social care professionals" and to be "able to demonstrate effective team working skills". "Medical schools", it said, "should explore and, where appropriate, provide opportunities for students to work and learn with other health and social care professionals".

Boundaries between health care professions, said the GMC in *Tomorrow's Doctors* (General Medical Council, 2003), were increasingly shifting towards more overlap in skills and responsibilities, accompanied by recognition that many tasks previously reserved for doctors were being performed by other health care workers. Effective relationships needed to be developed beyond specific teams to include also individuals beyond the health care professions. Medical schools were responding positively to the need to prepare students for effective interprofessional practice.

This was corroborated by the Chief Medical Officer (Department of Health, 2004c) who reported that some medical schools had successfully introduced learning across professions. Consultations regarding *Tomorrow's Doctors* had, nevertheless, identified a polarity of opinion on whether its next edition should stress interprofessionalism more, although the GMC itself thought that it "might be revised to include some further support for interprofessional learning". Support for that view came from the British Medical Association (2006) which concluded that the "emerging evidence suggests that interprofessional education can, in favourable circumstances and in different ways, contribute to improving collaborative practice", although further research was needed.

Reviewing the regulatory process

Following the creation of the new regulatory bodies, the Department of Health brought together interested parties including the HPC and the NMC to develop the 'Partnership Quality Assurance Framework' (PQAF) to carry forward work which it had started with the ENB. The exercise focused on the role of Strategic Health Authorities in commissioning award-bearing programmes of learning for the nursing, midwifery and the

allied health professions in England, taking into account the role of the Quality Assurance Agency (QAA) and its formulation of benchmarking statements (see below).

Work on the PQAF fed into a review of non-medical regulation (Department of Health, 2006a) which focused on ensuring proper protection for the public. Ministers came to a number of conclusions based on the review prior to its publication of which some are especially pertinent in this context. Regulators should, said Ministers, be more consistent with each other about the standards they require for persons entering their registers for the first time. Revalidation was necessary for all professions, based on the Knowledge and Skills Framework (see above), which implied a degree of standardisation across professions. There were substantial areas in which common standards were said to be desirable. Statutory regulation would be extended to include new roles, such as that of Medical Care Practitioner, but worked remained to be done to decide whether this should be the responsibility of a single regulatory body or several with a "lead regulator". These and other decisions introduced a greater degree of control over the regulatory bodies, but arguments for their amalgamation were set aside (save for the two bodies responsible for pharmacy). Further harmonisation was, however, to be kept under review including the possibility of a further reduction in their number. A parallel review by the Chief Medical Officer dealt with the regulation of medicine (Department of Health, 2006b).

Neither of these reports made explicit reference to interprofessional learning and working, but moves in the first towards closer harmonisation of regulatory bodies can be viewed as step towards creating a favourable climate and a framework within which interprofessional issues can in future be addressed.

Formulating Benchmarking Statements

Of all the reforms, the preparation of benchmarking statements for the QAA had most impact on IPE. The QAA invited representatives from royal colleges and other professional associations for nursing and midwifery and for the allied health professions under the leadership of Professor Dame Jill McLeod Clark and Professor Michael Pittilo to participate in a series of working groups to draw up benchmarking statements to set standards for their respective pre-registration programmes. These statements were adopted by their organisations (QAA, 2001). Common benchmarking statements were then formulated and agreed to illustrate the shared context within which programmes were organised (QAA, 2004) distinct from the profession-specific statements for nursing, midwifery, health visiting, dietetics, speech therapy, chiropody/podiatry, prosthetics and orthotics, physiotherapy and radiography.

The common statements were to prove invaluable as the starting point for formulating content and outcomes by the pilot sites, while the specific statements reminded programme planners of the need to safeguard the distinctive learning needs of each profession. Benchmarking statements were also agreed for social work (QAA, 2000) and medicine (QAA, 2002a).

Most recently, the QAA (2006) has published a statement of common purpose for health and social care[5] professions based on the deliberations of a broad-based steering group

[5] Excluding social work

including, in addition to representatives the range of nursing, midwifery and the allied health professions, others from the complementary therapies, dentistry, medicine, pharmacy, psychology and social care plus the Department of Health, Skills for Health, health authorities and universities. This breadth of representation adds much to the authority of the resulting statements and the contextual understanding in which they are presented.

Many changes, said the QAA, had occurred since the development and adoption of "the emerging framework", including "considerable development" in IPE, suggesting that the benchmarking statements were in need of significant revision and re-casting to place clients' and patients' expectations of health and social care staff at the centre. Cross-professional benchmarks and statements of common purpose underpinned trends towards increasingly integrated service delivery as well as continuing growth in IPE. The challenge was not to subsume one discipline or professional activity into another but to integrate perspectives in a manner that maximised the synergies and distinctive contributions of each.

Subject benchmarking statements, said the QAA, provided:

- An external point of reference when designing and developing programmes
- General guidance for articulating programme outcomes
- Bases for variety and flexibility in programme design
- A focus on client and patient perspectives
- Creativity regarding learning in both academic and practice settings
- Information for internal and external quality assurance
- Information for prospective students
- An explication of the general academic characteristics and standards of awards across the UK

The revised statement distinguished between:

- Values in health and social care practice
- The practice of health and social care
- Knowledge and understanding for health and social care practice

They focused on students' learning to meet the needs of clients and patients within an environment that required effective team interprofessional and inter-agency working and communication, as well as expert care. They aimed to encourage shared learning between students from a range of health and social care professions, but were not to be regarded as a national curriculum for such learning.

Under the heading of "co-operation and collaboration with colleagues" the QAA statements said that health and social care staff should:

- Respect and encourage the skills and contributions which colleagues in both their own profession and other professions bring to the care of clients and patients
- Within their working environment, support colleagues to develop their professional knowledge, skills and performance
- Not require colleagues to take on responsibilities that are beyond their level of knowledge, skills and experience

National Occupational Standards

While the benchmarking statements were being developed by the QAA to set standards for qualifying programmes, national occupational standards (NOS) and national workforce competencies (NWC) were being developed by Skills for Health (www.skillsforhealth.org.uk) to provide statements of competence and good practice and measure performance outcomes. Skills for Health also envisaged that they would be taken into account when designing higher education programmes, as in the case of requirements for the social work degree where the national occupational standards developed by TOPSS[6] (now Skills for Care) along with the QAA benchmarks for social work, the GSCC code of conduct and the Department of Health requirements for social work education form the compulsory framework for the teaching and assessment of the social work qualification. NOS and NWC may also guide and inform the formulation of outcomes and the selection of content for particular sequences of study (although with 60 such statements it would be hard to monitor how each is being put to use).

Devising National Service Frameworks

Also in the arena of guiding and informing outcomes and content are the national service frameworks (see www.dh.gov.uk), published by the Department of Health, each of which sets out a long term strategy to improve a specialist area of care, with measurable goals within a set time frame. They cover (at the time of writing) coronary care, cancer, paediatric intensive care, mental health, old people, diabetes, long term care, renal, children and chronic asthmatic pulmonary diseases. Addressed primarily to managers and practitioners, each is nevertheless a rich seam to mine to inform professional and interprofessional learning and teaching.

Harmonising national, regional and local developments

These reforms constituted the national context for the four pilot programmes (to which we now turn), reforms that they endeavoured to take into account and influence, while honouring the agreements that they had made with the Department of Health at the outset. The more coherent the policy framework becomes nationally, the easier it will be to harmonise developments regionally led by Strategic Health Authorities (SHAs) and locally by universities and service agencies.

[6] Training Opportunities for Social Services

3. The Case Studies

- **Towards a common goal: Developing practice-based interprofessional education in North East England**

  Pauline Pearson, Claire Dickinson, Alison Steven and Pam Dawson

- **Interprofessional learning in practice in South East London**

  Lynda D'Avray, Elaine Gill and Sam Coster

- **Interprofessional learning in practice in South Yorkshire: the CUILU Project**

  Frances Gordon and Michelle Marshall

- **Embedding interprofessional learning in Hampshire and the Isle of Wight: The New Generation Project**

  Debra Humphris and Jill McLeod Clark

Towards a common goal: Developing practice-based interprofessional education in North East England

Pauline Pearson
Claire Dickinson
Alison Steven
Pam Dawson

Introduction

This paper presents the experiences of a team[7] involved in developing and implementing practice-based interprofessional education (IPE). We describe how the Common Learning Programme in the North East (CLPNE) initiative began, the evolution of a range of IPE models as well as some of the challenges and opportunities encountered. By sharing some of the issues that emerged and our responses to them we hope to highlight factors which may be relevant for others to consider, especially those who are thinking about introducing practice-based IPE.

Background

Two Government initiatives directed at promoting interprofessional collaboration in health care education and practice, *Common Learning* and *Meeting the Challenge* (DH 2000), were simultaneously piloted within the North East during 2003-2005. The three universities of Newcastle, Northumbria and Teesside collaborated to develop a 'partnership site' encompassing the areas of the two former Workforce Development Confederations for Northern England and for County Durham and Tees Valley.

This partnership and the joining together of common learning with the IPE strand of 'Meeting the Challenge'[8] at Northumbria University enabled the inclusion of students from pre-registration education programmes in nursing, medicine, physiotherapy, speech and language therapy, occupational therapy, medical imaging and social work. Students from nursing, physiotherapy and occupational therapy were already familiar with working together in the classroom, but the development of practice-based interprofessional learning (IPL) and the opportunity to learn alongside medical, medical

[7] The Operational Team comprised Alison Steven (Research Fellow), Anne Whitworth (Speech and Language Therapy), Claire Dickinson (Research Associate), David Teasdale (Web Developer), Hilary Abbott-Brailey (Nursing), Jeanie Molyneux (Social Work), John Stephens (Physiotherapy), Marion Grieves (Nursing), Michael McGovern (Nursing), Nick Lewis-Barned (Medicine), Samantha Shann (Occupational Therapy), Suzanne Medows (Practice Placement Facilitator), Yvonne Hindmarsh (Practice Placement Facilitator) and Pauline Pearson (Programme Manager).

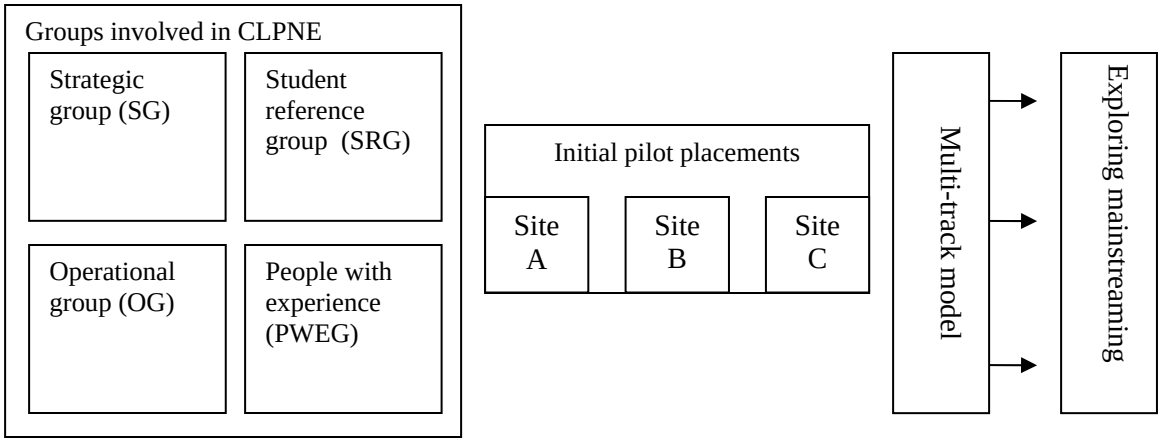
[8] Meeting the Challenge: A Strategy for the Allied Health Professions was published by the Department of Health in 2000. It focused on ways to develop and support changes in the role of the allied health professions, and specifically to make educational programmes more flexible and practice centred. One strand which was seen as important was the enhancement of opportunities for interprofessional learning in pre-registration programmes for AHPs.

imaging, speech and language therapy and social work students was a significant step forward.

The pilot programme was practice based and encouraged self-directed and enquiry based learning. The overall aim was to develop, implement and embed innovative interprofessional, work-based, practice placements which promote collaborative pre-registration learning and working in health and social care for the North East of England. Students worked in small groups, with one or more core case used as the trigger for IPL. A strong client-centred orientation underpinned the programme, which was based on students and practice educators using the learning opportunities provided by the management of existing clients, often with complex health and social problems.

The programme was developed through consultation with four reference groups: strategic, operational, student and people with experience (see Figure 1).

Figure 1. Development of the Common Learning Programme North East



The strategic group (SG) included: senior academics such as Deans and Associate Deans; service leads such as Consultant Physicians, Trust Directors and professional managers; and Strategic Health Authority representatives. The strategic group collectively monitored the development and progress of the pilot programme.

Members of the operational group (OG) included: lecturers representing different professions from across the three partner universities; practice educators or mentors; and practice placement facilitators from four participating Trusts. The operational group was responsible for facilitating the first run of the pilot programme in Site A.

The student reference groups (SRG) from Newcastle and Northumbria Universities were consulted through facilitated group discussions (with refreshments!) to determine their perceptions of the potential value and relevance of the planned pilot programme.

The ‘people with experience’ group (PWEG) was made up of people with long term chronic conditions who had experience of using health and/or social care services. They

had been recruited through advertisements in local health and community facilities. This group provided essential input regarding what constituted effective interprofessional working and what students needed to learn to become effective interprofessional workers. They also contributed directly to work with students.

For the second run, in Site B, the operational group together with a practice placement facilitator (PPF) acted as educational facilitators and supported volunteer practice mentors who came from all relevant disciplines. Subsequent runs followed this model, with some further lecturer practitioners and PPFs taking on additional roles. The eventual development of the 'multi-track model' is discussed in the next section. A total of 96 students took part in the pilot programme, with the largest proportion from nursing and physiotherapy and the smallest from social work and speech and language therapy (see Table 1).

Table 1 Year of training and profession of student participants

Profession	**Year of Training**					**Total**
	Not known	Yr 1	Yr 2	Yr 3	Yr 4	
Medicine	-	-	-	5	7	12
Nursing	3	10	2	12	-	27
Occupational therapy	4	-	6	-	-	10
Physiotherapy	7	-	13	1	-	21
Medical Imaging	4	-	10	-	-	14
Social Work	5	-	2	-	-	7
Speech & Language therapy	2	-	-	1	1	4
Unknown	1	-	-	-	-	1
Total	26	10	33	19	8	96

Model – Shadow Team

Initially we had envisaged that a group of students from the different disciplines involved[9] would be operating with relevant paper based cases – virtual clients. The example given in our original tender document suggested focusing on a person who had experienced a stroke. It was envisaged that we would focus on the care of clients with long term or chronic health problems since these are an increasing group and one for whom complex needs often require multifaceted care provision. Other patient groups we considered included people with diabetes, and those with arthritis and other joint problems. However, in discussion the operational group felt that it would be preferable for students to be working in teams which mimicked or shadowed actual practice, and with actual clients.

[9] Initially, the disciplines involved were Medicine, Nursing, Occupational Therapy, Physiotherapy, Social Work and Speech & Language Therapy. Medical Imaging was added in Phase 2 of the work.

This meant that we needed to:

- find teams (Discussion Point 1) in which a number of practice educators were located, each of whom would or could have one or more student/s on placement with them, and
- identify criteria which could be used by practice educators to select appropriate clients for IPL.

Discussion Point 1: What is a 'team'?

One of the questions to emerge was - what actually is a 'team'?

From the teams involved in the CLPNE we found that practice educators did not need to work together face to face provided that they:

- *contributed to the care of the same person or people, and*
- *were able to attend a meeting most weeks during the placement period*

You might want to consider:

- *If this is true for your settings?*
- *Whether your practice educators can offer this level of commitment?*

The first issue was to identify teams which were suitable for IPL and then, amongst them, find those in which a number of practice educators were located. The operational group felt at that stage that we should be looking for teams where there were staff from three or more disciplines working together to provide care for clients with long term or chronic health problems. In Site A, around twenty possible 'active team' locations were initially identified, but gradually thinned down to half a dozen locations which had sufficient practice educators currently in place (Discussion Point 2), of which in fact only three were taking students who would be in the practice area at the same time.

Discussion Point 2: Finding Practice educators

Different professions have different patterns of provision, training and regulation for practice educators. Some must complete specified courses. Some are in short supply and the demands of clinical practice mean they cannot always take students.

You might want to consider:

- *What the regulations and expectations are for the professions you are involved with?*
- *If any groups of practice educators are in short supply?*
- *What factors may affect the timing and availability of student placements?*

The operational group developed a set of criteria, which could be used by practitioners to select appropriate clients for IPL. The criteria outlined that:

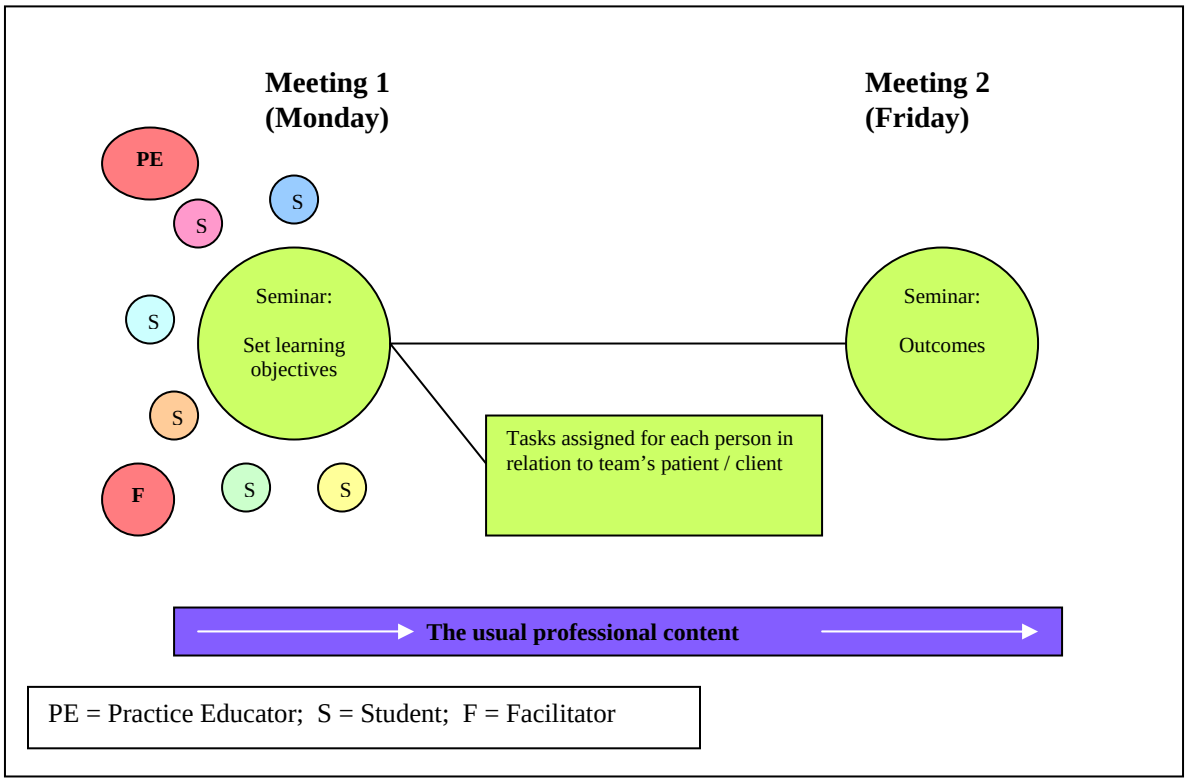
- The client (and where appropriate carers) should have given informed consent to being involved in teaching, and they should be currently referred to or receiving health and social care.

- They should have clear potential to benefit from some form of interprofessional intervention.
- Suitable people might be at a point of anticipating transfer or transition of some kind (e.g. into or out of hospital, from acute to rehabilitative care), or at a point of biomedical, social or psychological crisis.

In the initial run at Site A, practice educators were invited to an event at which we described the way in which we hoped the shadow teams would work and answered questions from those present. We envisaged that four to eight students from different professional groups would work together in one placement over a specified period, usually five or six weeks. After some induction activity involving them in reflecting on team roles using the metaphor of football, meeting with 'a person with experience', and looking at a paper case, the students would be assigned to work with one or more suitable clients cared for by the team in which they were placed. They would meet regularly with a facilitator both to plan case management and to evaluate how the team was working. This, in essence, was what happened.

In subsequent 'runs' greater attention was paid to the preparation of those in each site, in particular the recruitment of students, and the training of practice placement facilitators and practice educators to share in facilitation. As we became aware of some of the challenges of implementing the shadow team model, a 'multi-track model' was developed, which is described below.

Figure 1 Structure of a typical week in a shadow team placement



The teams

Teams originally recruited were caring for people with chronic and long term health problems and in which a number of practice educators were located, each of whom would

or could have one or more students on placement with them. The practitioners on the operational group also indicated which locations had a reputation for being an effective – active – 'team'. In reality there were good learning opportunities in most settings, but effective facilitation was important. The locations we used ultimately included a range of medical wards, a community disability team, stroke units, critical care units, an orthopaedic ward, teams within a rehabilitation centre and several care of the elderly wards. As can be seen, these were not all caring for people with chronic health problems. However, we felt that where we found practice educators who were keen to be involved and had colleagues who were also interested, we should do our best to facilitate their inclusion.

Participants' perspectives

One of the themes to emerge both explicitly and implicitly was the 'value of reality' in practice-based learning. This 'realness' took various different forms. For some it concerned working with real patients, real practitioners or working in a real setting and with a real team. Students from most disciplines apart from medicine had experience of classroom based IPE in the early part of their uni-professional courses. It was envisaged that this provided students with the theoretical grounding to take part in this initiative. Students and facilitators felt that the difference between the CLPNE and their previous, classroom based, experience of IPE was due to working with a real patient in a practical setting and being able to see the results of collaborative work with the patient.

> [The physiotherapy student] felt the difference was due to working with a real patient in a practical setting and being able to see results of work with the patient … students feel their input can be seen, and outcomes of this evaluated' (*Facilitator Nurse, reflection sheet*)

In addition some students felt that the consequences of learning in a practice-based setting related to both team working and patient care.

> "Having 'time-out' to discuss our individual roles in relation to a 'real-life' case study, rather than a written one, was also an excellent experience and should be incorporated in to students' learning as a means of breaking through stereotypes, prejudice and barriers that exist between professionals working in a healthcare setting." *(Student Occupational Therapist, reflection sheet)*

Students gained confidence in their own role as well as an awareness of what others did.

> "I felt like I was a representative of my profession and that it was nice to realise that 'you do know what to do' – it boosts your confidence" *(Speech and Language Therapy student, Focus Group)*

> "The shared learning meeting presented me with an opportunity to get to know people from other health related professions on a social level as well as a working level" *(Social Work Student, Reflection Sheet)*

For some, the relationships which they established during the CLPNE were sustained, both socially and in later encounters on placements.

Facilitators found themselves taking on a variety of roles and tasks over the course of the placements. As time went on in each group, the students tended to take on some of these tasks. However, facilitation was viewed with anxiety by new facilitators, who found it useful to work with someone else initially. Preparation sessions were organised which outlined the task, but co-facilitation enabled them to practice it in a 'safe' environment.

> "I was just so pleased that X was there because she had been there and got the t-shirt sort of thing" *(Nursing facilitator, interview)*

Facilitators could be engaged in prompting students to explain their terminology, making sure that action points and tasks were clearly agreed, facilitating group reflection, keeping to time and coordinating meetings. They also learnt from the experience of facilitation. Clinical educators participated to varying degrees in meetings. They were often inhibited by a perceived lack of time for or skills in facilitation. Where they did, they were often positive about the atmosphere and levels of participation of students:

> 'Was nice to see how inspirational students were in the session and very talkative, not scared to share information and feelings." *(Clinical Educator, reflection sheet)*

Challenges and opportunities - our responses

During the course of the programme some different challenges and opportunities were encountered. This section explores each of them and outlines our responses.

Working with reality - virtual or actual?

An important shift took place in the very earliest days of the programme, when the decision was made to move from students working with a 'virtual' case to working with a real team and an actual person. This provided important opportunities for our programme. The initial bid development took place primarily in Newcastle University, in the medical faculty, where the use of virtual cases (on paper, web or as role plays) as triggers to learning was common even when students were in practice. Virtual cases can be controlled to exhibit appropriate learning opportunities. This initially seemed to be the way forward. However, in engaging with staff from other programmes and disciplines, they were keen to follow through the implications of situating the interprofessional learning in practice. They had already established IPL in classrooms and felt that it was logical, if students were learning in practice, for them to learn through managing (under supervision) real clients. We listened to this recommendation and decided to change our original intention of using virtual cases in favour of using real clients of health and social services.

Out of this we began to understand a number of differences between the learning potential of virtual cases and of the actual clients the students cared for. Firstly, we soon found that students from different professions were more or less engaged at different stages in an individual client's care, depending on the point in his or her journey which had been reached. For example, someone recovering from a stroke might receive a lot more medical and nursing care in the first days after admission, and more therapy and social work input later on. Students could feel like observers if they had little to engage them. One solution which emerged was to seek two or more (up to four) clients at slightly different stages of care. Secondly and similarly, the range of needs of an individual client

would determine the input required. The mix of people included needed to possess a reasonably wide range of needs so that students could identify these and link them to their own and each others' contributions. Virtual cases can always be accessed. One of the most unexpected characteristics of real clients turned out to be their transience within the hospital system. Whereas in 1981 the average length of stay of an acute patient was 8.4 days in 1998 it was 5.5 days (Office for National Statistics, 1981-1998). Whilst we should have anticipated this, the impact on student learning was in some cases an experience of fragmentation. In these situations we needed to involve many more clients over the period of the attachment. Where we had anticipated potential problems with discontinuity for clients because of student turnover, in practice students experienced discontinuity due to the turnover of clients. Finally, and in our eyes most importantly, whilst dealing with virtual cases provides safe space to learn, real clients – and those who carry out their care – experience real consequences. These can be positive, neutral or negative but they appear to motivate students and to facilitate effective experiential learning about interprofessional working. Making a difference for a real person is perhaps more memorable than solving a paper puzzle correctly.

One size does not fit all

The shadow team model was developed to fit a number of practice settings. However, when members of the Operational Group began discussions with practitioners about the possibility of introducing the shadow team in their area some potential barriers were identified. Some practice settings only ever took students from two professions so they would never have a range of four to six professions as outlined by the shadow team model. Even where students from a range of professions were placed within a setting the differences in timetables sometimes meant that it was rare for the students to overlap. Thus whilst one area may have placed students throughout the year sometimes there was only ever one or two students placed there at the time of the proposed shadow team. In response to the challenges of different professional timetables and the range of professions involved in student placements a further two models: the Peer Interprofessional Placement (or PIP) and the Sole Interprofessional Placement (SIP) were developed by the CLPNE team.

PIP involved two or three students from different professions working together with common clients or on a common project. SIP operated where a student was placed with no students from other professions on site. Other professions would be identified and the student would work alongside qualified practitioners to gain an interprofessional perspective. The programme (be it in the form of a shadow team, SIP or PIP) was offered at a number of locations at specific times, each time period was described as a 'placement run' (i.e. one group of students meeting for a set of sessions over 4-6 weeks).

The demands of interprofessional facilitation

Facilitation of the interprofessional groups was perceived as a vital part of the Common Learning Programme North East experience. Facilitation during the early stages of the programme was undertaken by members of the operational group who were all experienced academics from a range of professions. As the programme developed and expanded into new areas there was a need to increase the numbers of facilitators. However, potential facilitators (from both academic and practice roles) reported feeling ill-equipped to facilitate interprofessional groups.

The main area of anxiety was confidence in their own ability to 'teach' a mixed group. Even experienced teachers who were confident with their own professional group reported anxiety over incorporating new professions into a teaching situation where they did not have the knowledge of that profession. The CLPNE team dealt with this in two ways. Firstly, a training programme was developed to introduce potential facilitators to the common learning models. An essential part of the training programme was to emphasize that students in the groups required 'facilitation' and not 'teaching'. Within the CLPNE model students were encouraged to become self-directed and as such to identify gaps within their own knowledge and discuss possible ways of addressing the gaps. This reduced some anxiety amongst potential facilitators that there would be an expectation on them to "know all the answers". The training programme also involved opportunities for role play so participants could try out some of the strategies used within the common learning groups. Materials used in the training programme can be found on the Common Learning Programme North East website: (http://commonlearning.ncl.ac.uk/). Secondly, all potential facilitators were encouraged to 'buddy up' with a colleague when facilitating. Wherever possible the buddies were more experienced and more confident facilitators who co-facilitated until the new facilitator grew in experience and confidence, gradually taking a greater role in the group whilst their 'buddy' reduced their input.

Information flow

Despite the best efforts of those involved, participants in the CLPNE reported huge difficulties in finding the right people to whom to direct information when setting up new interprofessional learning situations. The complexity of a programme that involved so many professions and both the academic and the practice situation resulted in some people not having the correct information when it was required. As a solution the operational group developed a resource pack of information sheets, flyers and posters that could be left in the practice situation. The aim of the pack was to raise the profile of the CLPNE, provide contact details and to provide a resource for practitioners and students to consult in the time between hearing about the programme and it actually starting.

Time to co-ordinate

As alluded to previously, the co-ordination of the programme was a complex and complicated process. It involved time and effort trying to locate the most appropriate individuals in the practice setting as well as pinpointing student placements. Co-ordination of the programme was seen to be a whole task itself and it was felt that if the 'burden' was removed from facilitators more practitioners would be willing to take on the role of facilitating. In order to pilot the appointment of a co-ordinator who would be responsible for the logistics of the programme, finances were used from the core funding and topped up by the local Trusts. A co-ordinator was appointed for a fixed term as a pilot scheme in one local area. His job was initially to find suitable practice settings where practitioners were interested and willing to become involved and had students. However, it was also to facilitate a culture change and develop a longer term strategy for IPE in the local patch.

The way forward for sustainability

Over the period of the original Common Learning Programme funding, the team sought to make the models used ultimately sustainable within an NHS which, even when we

began, was short of resources – human and financial - and in partnership with Higher Education which also perceived itself as under pressure. As detailed above, a time-limited post was introduced in one locality to explore how some of the organisational pressures could be addressed and take some responsibility/control in organising placements. This pilot demonstrated that systems could be created in a local patch, building on the goodwill and enthusiasm of clinicians, but that some ongoing administrative contribution and academic support would still be required. Subsequently some, but not all, of what is required locally has been facilitated by the Centre for Excellence in Healthcare Professional Education (CETL4HealthNE[10]).

The sustainability of IPE in practice is also dependent on the availability of students to work together over protracted periods of time. The CETL partners[11] aim to embed interprofessional, work-based placements to promote collaborative pre-registration learning. However, students and practitioners must be in place to achieve this. For example, the position in physiotherapy, which provided one of the largest student groups for our programme, is such that placement provision is critically short in many areas, and student numbers are likely to be cut due to a serious unemployment situation among new physiotherapy graduates. IPE initiatives like this are often short term. Education and service providers may struggle to maintain interprofessional learning in practice as a priority, given these other challenges. In this case, academics and experienced practitioners have begun to work collaboratively in the CETL to exchange ideas and develop ongoing IPE. Meanwhile partners are reviewing curricula and developing thematic approaches that embed IPE into students' prequalification experience. Nevertheless, current NHS pressures remain a concern. The partners are seeking to maintain their long-standing commitment to IPL in the classroom, while trying to create opportunities to roll out the multi-track model during a time of extreme turbulence.

To achieve sustainability across an area requires dialogue between those within Strategic Health Authorities who have responsibility for educational and workforce contracting, those in Trusts who need appropriately prepared staff and those in Universities who are responsible for delivering curricula which prepare students for effective interprofessional working. In the complex and fast changing world of education for health and social care other agencies too – for example local authorities and voluntary sector providers - may need to be involved. Agreements need to be reached on appropriate clinical and educational workloads, resource for administering practice education and levels of remuneration or buy-out for practice educators in each profession.

[10] www.cetl4healthne.ac.uk

[11] The five universities of Newcastle, Northumbria, Teesside, Sunderland and Durham, together with Northumbria Healthcare Trust, North Tees and Hartlepool Trust, North Tyneside PCT and North East SHA

Conclusions

A strategic approach that includes universities, NHS Trusts, local authorities, and Strategic Health Authorities is necessary to ensure a systematic and equitable opportunity for IPE is available to all potential participants. There is a need to be flexible as one model will not meet the needs of all programmes or professions. An 'organic' approach can be successful. Using 'real' patients, as well as real teams, settings and practitioners makes learning more powerful. Appropriate rewards and recognition are important for all participants (students, staff and people with experience), and ultimately a co-ordinated approach is needed to educational and workforce contracting. Nevertheless, even though the CLPNE took a lot of co-ordination, time and training it was worth it because the students and facilitators got so much out of it.

What this adds:

1. It is an example of how initiatives can start small and grow 'organically'.
2. It is a resource for potential IPE organisers who wish to learn from the experiences of others.
3. It contributes to a growing body of literature on the need for 'facilitation' as opposed to 'teaching'.

Things to think about:

1. Context
   There is no need to reinvent the wheel but any model will need to be adapted to the particular requirements of specific areas.

2. Participants
   Who should be involved? In IPE some important considerations are:
   a. How do you find the right people?
   b. How do you get them involved?
   c. How do you ensure they are equipped for the role?

3. Evaluation
   It is important that evaluations of IPE take account of the processes that are involved as every initiative will be different. We would suggest using an approach that goes beyond the level of simple description and enables outcomes to be linked to different contexts and processes.

4. Policy
   National and local policy change continually. We would suggest that consideration is given to the impact policies may have on initiatives.

Interprofessional Learning in Practice in South East London

Lynda D'Avray, Elaine Gill, Sam Coster

For the South East London Pilot for Interprofessional Education

Introduction and Background

In 2002, King's College London (KCL) initiated a programme of interprofessional education (IPE) in South East London that had the potential to include all pre-qualification students of health and social care. Partnerships followed in 2003 with London South Bank University, Greenwich University and the South East London NHS Trusts in order to extend the practice part of the IPE programme to all students across the sector.

Interprofessional learning had previously been introduced for KCL medical and nursing students in the academic setting. Originally these students were brought together for joint sessions on communication which was soon followed by a single session focusing on infection control and hand-washing.

This early experience helped pave the way for developing the subsequent IPE programme, which had two arms: the first was the design and delivery of a first year KCL common learning course in communication and healthcare ethics; the second was the development and implementation of a practice learning course for students in subsequent years from KCL, London South Bank and Greenwich universities who would meet and interact on placement around the care of a patient. The professional composition of each of the two arms is described within their respective discussions.

IPE in year one

The year one communication and healthcare ethics course for KCL students was set up by democratic process with representatives from all participating health schools. A committee was formed and chairperson elected. The committee met regularly to discuss and agree all aspects of year one IPE, and student representatives were invited to all meetings and sent minutes. The group fed directly into the main college and trust wide steering group.

Between 2002 and 2006 the main content of the course covered core knowledge, behaviour and skills, which included confidentiality, consent, rapport, listening, empathy, question styles, autonomy, truth telling and paternalism. These subject areas were chosen because they were considered universally applicable and transferable across all health disciplines. The course consisted of five sessions delivered in the first semester of professional courses in dentistry, dietetics, medicine, midwifery, nursing, occupational therapy, pharmacy and physiotherapy. All students were expected to interview a patient in a clinical setting following the confidentiality, consent and core communication skills sessions. This was followed up by a written reflective account to be submitted for assessment.

Funding from the Department of Health in 2002, for the first few years of the course, allowed for the appointment of a full time administrator to support the huge undertaking required to co-ordinate approximately 1,300 students and 72-84 tutors as well as attend and service all IPE meetings each year. As the communication and healthcare ethics course became an established part of common learning, this post was made substantive within KCL. Support from enthusiastic and committed key leaders and facilitators in the medical and other schools were also vital for success. Training for facilitators was delivered each year and extensive student and tutor evaluation was carried out.

In 2006 the course was redesigned on the basis of the experience and evaluation carried out over the first four years of IPE. The main reasons for revising the original course were, first, to encourage and support more enquiry-based learning (and consolidate a team approach to facilitating this) and, second, to make explicit the links between the year one course in communication and healthcare ethics and the subsequent learning in practice course. In this way the aim was to develop an integrated vertical strand for IPE based on the curriculum, as opposed to discrete courses, which would be embedded into all participating disciplines' curricula. Evaluation of the new course will be carried out to add to the body of IPE evaluation and research.

Interprofessional Learning in Practice

The second arm of the IPE programme was the design and delivery of a practice-based course whereby students would engage with each other in clinical practice. A successful bid for support from the Fund for the Development of Teaching and Learning (FDTL) of the Higher Education Funding Council enabled partners in the universities and trusts across the sector to follow the first arm of the IPE programme with the development of the interprofessional learning in practice course (the ILP course). The aims of phase-four of the FDTL were to stimulate developments in learning and teaching and to secure the widest possible involvement of institutions in the take-up and implementation of good practice (heacademy.ac.uk/html/fdtl4_projects.asp). The interprofessional learning course would offer a patient-centred learning exercise to all health and social care students in any of the acute and primary health care South East London NHS Trusts. The project was ambitious as 'the patch' had an annual intake of 2,000 students. Furthermore, as the funding was due to end in June 2006, implementation for some of the student population would lie beyond the life of the project.

This case study tells the story of the ILP initiative – how it was born, its development and its growth.

Preparatory work

Structure and management

Clear leadership and guidance was provided by a steering group of senior partners from the three universities, health service providers and the South East London Workforce Confederation. The initiative thus had the benefit of strong personal commitment from the top. The steering group's first task was to establish an infrastructure for devolving responsibility, monitoring experiences and evaluating the project. An IPE project manager was appointed to implement and evaluate interprofessional learning in practice. The heads of NHS trusts and health schools in South East London were asked to

designate individuals to become IPE representatives. These representatives and champions would be responsible for working within their locality and negotiating with the IPE Project Manager to set up the ILP course in each trust.

Locating students on placement

The second task was to find out when and where the students would be in placement. After the first pilot in Lewisham Hospital, a critical decision was made. Shared mapping of all student placements was not available. Details about nursing and medical placements were relatively easy to find, but many of the allied health professions had complicated arrangements (sometimes organised by a national body) and information about their placements was more difficult to obtain. The South East London Workforce Development Confederation (SELWDC), now the Strategic Health Authority, commissioned a feasibility study into the mapping of all student placements, but it was not practical to wait for this before implementing the ILP course. The management group therefore took the decision to set dates and plans for the exercise to take place in targeted trusts when and where students were most likely to be on placement.

Preparing the Trusts

The third task was to prepare participating trusts. Successful implementation depended upon a key employee coming forward to champion interprofessional learning in each trust. Each champion would need to find and nurture a small team of enthusiastic innovators to work with him or her to raise the profile, plan and execute delivery, and negotiate problems. The ILP project manager would work with and support trust champions, grooming and guiding them and other ILP activists throughout the planning and the implementation process. This was predictably a complicated business. Although the trusts had contractual links with local higher education establishments for training professional staff, they each had their own individual tradition, reputation, structure, organisation, specialist practices, staff and clients.

Not only were the trusts in the area providing practice experience to the overwhelming majority of students from the three universities located in South East London, they were also hosting a smaller number of students from particular disciplines studying at universities outside the patch. All student placements from whichever university were organised individually by each profession through negotiation between each school and trust staff. Trust champions were needed for locating clinical educators for the release of students from established commitments in order to attend ILP sessions. Champions would also need to negotiate with ward managers and other practice staff, creating opportunities for building yet further connections.

Training Facilitators

The fourth task was to build from scratch a team of trained ILP facilitators. For this purpose half-day training sessions were set up at a minimum of one per month in varying locations throughout the sector in order to recruit people from both the trusts and the universities. To ensure consistency, the same two project leaders carried out all the training sessions. In the second year a half-day workshop was provided, which would take place every six months, for those who had facilitated ILP sessions to enable them to reflect together on their experience in a supportive environment.

It was anticipated that two facilitators would be required for every group of between seven and ten students for the three consecutive two-hour sessions. This would ensure support for new facilitators and would cover attrition in a fluctuating workforce. Consistency over the three sessions was expected in order to get to know and develop trust with the students, who would also remain within the same group. Facilitators were free to sign up to as many or few rounds as their diary would allow. Apart from the training half-day, there was no preparation and no marking.

Students and assessment

The sheer numbers of students to be included in the ILP initiative presented a challenge. Over the three years of the project 3,900 students from KCL and a further 2,000 from London South Bank University and the University of Greenwich would be eligible. Rolling out the initiative on this scale would not be possible in one go with the given resources. Therefore, instead of a sector-wide plan for implementation, one trust was selected to set the ball rolling by hosting a pilot, which would help with developing the optimum system of delivery.

The students themselves constituted a diverse group including many who were mature with children, many from minority groups and a preponderance of women. Their educational background was similarly diverse, from those who were admitted to higher education though an access programme and those with prior qualifications that ranged from General Certificate of Secondary Education to degree. Not only were they studying different professional courses leading to different registration and levels of qualification, they were also studying in different schools, in different universities and were following different pathways with client groups in placements located on different sites. School structures within the same university also varied with different styles of teaching, monitoring and mentorship. Their courses of professional study were delivered in many forms over varying time spans. It was striking that some students were familiar with being in practice almost from day one of their training, but others did not normally meet a service user until near qualification. Their varying educational needs and aspirations would therefore constitute a challenge to any facilitator.

As a general rule individual professional curricula were designed separately and did not easily support interprofessional learning. Designing a summative assessment that would be acceptable across universities, schools and examination boards proved to be impractical, but other steps were taken to reinforce learning. Opportunity for individual and facilitator assessment was provided and learning from the ILP experience would provide evidence for portfolio type assessments and knowledge that students would need for completing written examinations and Objective Structured Clinical Examinations.

Developing the initiative

The course content was built on process mapping, an exercise that has been used in business and industry to look at the total customer experience, and in the NHS to monitor patient pathways and throughput. The one thing that all students could relate to was the patient. Constructing a process map of a patient's perspective of an episode of health care was something with which all students would be able to engage. This gave the exercise a clear patient focus. Working together in practice and on the process map provided the interprofessional learning. (See text box for details of the process mapping exercise).

Interprofessional Learning in Practice (ILP)
Three sessions of two hours each:

Session 1: constructing a process map
In mixed groups of 7 to 10, students were linked with a clinical area from which they selected a typical client or patient experience they would like to explore. With minimal guidance from their facilitator they devised a map of stages in the patient's journey. Inevitably there were gaps and misunderstandings in their knowledge about the patient journey and about the responsibilities and practice of professional and lay carers. Questions arose from the process mapping exercise that could best be answered by visiting the practice area to enquire. Therefore towards the end of the session facilitators helped students assign responsibilities to each other and made arrangements to meet them in the clinical area to track the client or patient experience in the next session.

Session 2: visiting practice
With help from their facilitator and ward staff, pairs of students from differing disciplines talked to patients and carers, who consented to being interviewed, about the care they received and how it might be improved. They explored professional responsibilities by interviewing staff from different disciplines and reviewing documentation and patient records. Some of them also looked at client literature, and procedures and protocols that were practiced in the clinical area. Some students also opted to track the client or patient pathway beyond this by visiting outpatient clinics or specialist units. Students based in primary care worked in a similar way but more advanced planning was required for client and practitioner contact.

Session 3: analysing the patient's journey, making recommendations and presenting their findings
Students met again and discussed what they found in practice by analysing the journey from the patient's point of view. They considered what the patient said and, on the bases of the patient's negative and positive experiences, they suggested changes that could be made for their benefit. Finally, they presented critically constructive feedback to students in other groups, together with recommendations for improving the patients' experiences of care. Members of the clinical areas were welcomed and encouraged to attend. Recommendations from all the groups were passed on by the trust ILP champion to hospital or primary care management to be fed back to staff.

Assessment

Learning from the ILP experience provided evidence for portfolio type assessments and knowledge for incorporating into written examinations and OSCEs. Other measures have been introduced to reinforce and reward student commitment: a KCL Certificate of Attendance; a facilitator signature for each session in their professional development document, e.g. logbook (medical students) and core skills document (nursing students); monitoring by their uniprofessional tutor.

Piloting Interprofessional Learning in Practice

Staff in University Hospital Lewisham agreed to pilot the first ILP sessions. The local champion was one of the early ILP pioneers and had been involved in developing the learning exercise. The project manager spent time in the Trust with the champion helping to prepare for the first round of ILP by attending meetings with senior staff, providing information to Trust employees and raising the profile. Student programmes were compared to find dates and times that students shared in the Trust. Meetings were set up with medical registry, nurse placement teams and clinical educators. The first timetable was worked out around the availability of medical and nursing students and a smaller number from the allied health professions. Facilitators were recruited and trained, rooms booked and students invited to attend. Preparation in the pilot trust proved to be a useful template for the delivery in the trusts that followed.

Lewisham ILP was piloted as a series of four separate consecutive process-mapping sessions for students of the adult pathway. It was soon modified to three separate consecutive sessions to improve attendance and then extended to other sites across South East London. During the second year of the project King's College Hospital and Greenwich Primary Care (plus a pilot at Lewisham Primary Care) were added, thus extending the ILP course beyond the acute setting to students on placement in primary care. This presented the opportunity to broaden the client group and add pathways in the care of the child.

In its third and final year, with stronger administrative support in place, Guy's and St Thomas' Hospitals were ready to join the project. The trust was keen to provide ILP to each and every student on placement throughout the year. Bromley Hospitals and Bromley Primary Care would be the last trusts to join before the project ended, and they opted for the three sessions to be delivered in a one-day event to students of both adult and child care. The final year also included a plan for a pilot in the South London and Maudsley Trust, which would for the first time include students from mental health pathways. With these trusts on board half the South East London health student population would be covered.

Evaluation

A research fellow was recruited to help co-ordinate research and evaluation in interprofessional learning. This included the management of a longitudinal panel survey designed to explore how students' interprofessional attitudes developed during their pre-qualification studies by using three validated scales: the professional identity scale (Brown 1986), readiness for inter-professional learning scale (Parsell & Bligh 1998) and health-care stereotypes scale (Carpenter 1995). Students from eleven professions starting their healthcare studies in 2002 and 2003 at three London Higher Education Institutions were invited to participate.

Approximately 3,000 students have been surveyed annually on their attitudes towards their own profession, other professions and towards interprofessional learning. The first cohort of students has already graduated, and the second is due to leave the study in 2006. It is hoped that findings from this longitudinal project will help inform the planning of future interprofessional initiatives.

During the second year of the ILP course, a smaller formative evaluative study was undertaken in one selected trust. The objectives of the study were to identity the processes of interprofessional learning occurring during the ILP course, and to determine the perceived impact of the course on students and facilitators. In addition to the observation of sessions, a number of students and facilitators were interviewed about their views and experiences. Data were analysed thematically. Some of the information from this evaluation has already been utilised in discussions on ILP course development.

Development and Delivery

On-going internal and external evaluation and reporting provided opportunities for discussing feedback from students, facilitators, health schools and trusts so that changes could be made where necessary. For example in the second year, in order to concentrate rather than dissipate limited resources the decision was taken to deliver fewer ILP rounds in a smaller number of trusts. Well-organised and effective delivery was found to be particularly important for IPE in order to ensure that each student had a positive learning experience. Rolling out the programme across South East London was therefore not seen as the immediate priority. It was important first to concentrate on developing and delivering the intervention to its best in those trusts that were committed to ILP.

This approach paid off and as the course gained support and recognition, more trusts that might have been previously unsure or hostile to ILP came forward. The roll out subsequently picked up speed and, with the addition of the next round of participating trusts (in Bromley), the overall capacity of the Project by 2006/7 will be 930 student experiences per annum. This will cater for nearly 50% of the 2,000 students in the annual intake for medical and health care at the three HEIs (1,300 KCL, 700 London South Bank and Greenwich universities). Provided that support continues for the project, projected work over the forthcoming period will take this to 100%.

An administrator was recruited to work with the IPE project manager, IPE steering group and the trust champions on implementation. Funding for 18 months was provided by the SELWDC. The administrator helped with organisational logistics of the roll-out which required new administrative systems that could cope with effective planning and delivery, student and facilitator participation and evaluation.

Trusts

Each participating trust required considerable support to get the course going and for every round of ILP students there were administrative tasks and organisational challenges that lay beyond the capacity of the local trust team. For instance, strategic planning across all trusts required central organisation that could not be left to individual trusts; information about student placements, their names and contact details came from a variety of sources, mainly outside the trusts; and facilitator training required central resources.

The ILP team needed to be flexible to accommodate the style of delivery preferred by each trust. The main variation was in the delivery of the middle session in practice. In this session students in mixed professional pairs visited an area of practice in order to find out about the experience of patients in their chosen pathway. Champions and staff in Lewisham Hospital had permitted students to go unaccompanied to the ward of their

choice. Larger trusts preferred to select practice areas for student to visit and for them to be accompanied by one of their facilitators. The middle session also required a different approach in primary care. Advance planning and negotiation with practice staff was required for the students to be able to tap into local networks and services that clients use in the community.

At the beginning of the project the recommendations made by students for improvements in patients' care tended to be too general and global to have much influence. With help from practice staff and facilitators, recommendations became more specific and practical, with the result that they were more likely to be taken up. One trust has since reported that the painting and decorating of a heavily used unit will be carried out more frequently, following student feedback from patients. In this way users of the health service became involved with the students' education and clients' voices had a chance of being heard.

In the third and final year Lewisham Hospital opted to deliver the course during a whole day instead of the usual three consecutive sessions spread over three weeks. This provided several advantages: there was no drop-out between sessions; students were able to spend their coffee and lunch breaks together thus increasing the time for social contact; enthusiasm was better maintained between sessions; students found it easier to negotiate release from their other practice commitments for a day rather that just two hours; and it was easier to manage administratively. The main concerns were that there would be less time to reflect between sessions and that the facilitators might find it hard to take a whole day out of their busy diaries. It remains to be seen whether the concerns outweigh the advantages.

Overall the trusts successfully hosted the ILP course, supplying facilitators, practice visits and rooms. Trust champions proved to be a vital source of contact for locating clinical educators for the release of students from established commitments in order to attend sessions. Gradually, as a result, new lines of communication developed between academics and practitioners from different disciplines, many of whom had not met before.

Delivery was helped when the job-description for the Placement Development Managers was revised to include IPE. However, some clinicians and educators remained unconvinced of the value of the exercise with some genuine concerns, such as the brevity of uniprofessional placement experiences for students and the pressing requirement for students to succeed in knowledge-based examinations. For some trust members IPE was just not regarded as a priority or it was seen as already included in the uniprofessional curriculum and that students would inevitably meet each other in the normal course of practice anyway.

Students

Out of a total of 850 invited students, 610 (72%) participated in at least one session in the project up to the end of June 2006. 255 were invited and 182 attended at University Hospital Lewisham, 284 invited and 193 attended at King's College Hospital, 213 invited and 171 attended at Guy's & St Thomas'. Three were invited all of whom attended in Primary Care Practice in Hillyfields Health Centre in Lewisham PCT and a further 43 of whom 29 attended, in the Eltham locality in Greenwich PCT.

Over the life of the project the number of students completing the course in the larger trusts, after attending session one, ranged from 68% in King's College Hospital to 80% in Guy's and St Thomas' as shown in the following table:

Table showing overall student attendance, up to June 2006, by NHS Trust

Trust	Invited	Attended session 1 n (%)	Did not attend session1 %	Completed after session 1 %	Drop out after session 1 %
University Hospital Lewisham	255	182 (71)	28	79	21
King's College Hospital	284	193 (68)	32	77	23
Guy's & St Thomas' Hospital	213	171 (80)	20	89	11
Lewisham PCT	3	3 (100)	0	100	0
Greenwich PCT	43	29 (68)	32	86	14
Bromley Hospitals	52	32 (62)	38	100	0
Total	850	610 (72)	Mean 25%	Mean 89%	Mean 12%

There were two main potential drop-out points, between initial invitation and attending session one, and between attending session one and not finishing the course. It is interesting to note that although a mean of 25% invited students did not attend the first session, once students had come along to session one, subsequent non-attendance fell to a mean of 12%.

The number of invited students who did not attend the first session has fallen from 30% to 25% (December 2005) as a result of administrative improvements. Each student now receives a personalised written invitation (by e-mail or by hand) and is asked to confirm in writing his/her availability. As the course becomes better known within the sector, student and staff expectations are being raised.

It is also hoped that embedding the course within the core curricula for each constituent professional programme will assist improvement. Attendance has been encouraged by the introduction of a KCL certificate of attendance, a facilitator signature for each session in students' professional development document, e.g. logbook (medical students) and core skills document (nursing students) and monitoring by their uniprofessional tutor.

Professions included were diagnostic radiography, dietetics, medicine, midwifery, adult and child nursing, occupational therapy, pharmacy, physiotherapy, podiatry and

therapeutic radiography. Work was in hand towards the end of the project to add clinical measurement, clinical psychology, mental health nursing and operating department assistants. The project only included pre-qualification students, but there is scope to include qualified staff. The catchment could, with advantage, also be widened further to include non-professionals who come into contact with patients, such as clerical and ancillary staff.

Interviews with students, following their ILP experience, showed that overall the ILP course was a positive experience for them. Some reported changing their practice as a result of the exercise. Some were exposed to practice for the first time. Some learned about aspects of patient care that they would not have seen in the normal course of their training. They learned about the importance to patients of staff identifying themselves and that there are differences in how much information patients would like. They were critical of the use of jargon. Overall they were encouraged to focus on the patient and care delivery. Hopefully being asked to make recommendations on how care could be improved helped them feel more engaged with the care-giving organization and gave them a sense of having a potential influence on the delivery of care. Overwhelmingly they reported enjoying working with each other.

Facilitators

A total of 228 facilitators were recruited and prepared by December 2005, of whom 40 actively delivered the course in participating trusts. Facilitator training sessions are in hand to raise this figure. Of the 228 trained staff, 132 came from the three universities (90 from KCL, 31 from London South Bank and 11 from Greenwich) and 96 from six NHS trusts. Across all the trusts and universities, 15 facilitators were trained from medicine, 171 from nursing, 32 from the allied health professions, and 10 non-clinical.

Of the 40 active facilitators who came forward many were from senior levels, particularly in the trusts. The majority came from nursing and from the trusts, which was not surprising considering that the exercise took place within the practice placement, that nurses outnumbered the other staff in the trusts and appeared to have more flexible teaching commitments. In the early days many came forward for training who did not take a student group. Subsequently potential trainees were required to sign up for both, or postpone their involvement until they could put the training into practice.

Those who did not become active facilitators may have feared that being a facilitator with students from other professions would threaten their professional credibility or that the ILP course required unique approaches to teaching. This was not born out by the experience of those who participated. The point of the interprofessional learning exercise was not to provide technical or clinical knowledge but to draw out different experiences and approaches to the educational task. Expert knowledge was not required, but facilitators found that awareness of nuances within the group, and an ability to deal with diversity, were essential. Many facilitators reported that ILP improved their own knowledge and practice in the light of their experience in guiding students through interprofessional networks.

Critique

Students

Although student evaluations indicated that the stated objectives of the ILP course were met, several weaknesses can be identified:

a) In the various professional curricula, the course featured as only a very small part of a student's education.

b) Not all students were routinely prepared by their uniprofessional courses for the ILP experience. Some were unfamiliar with the reasoning behind the need for IPE and saw it as an added extra and not integral to their professional learning.

c) This sometimes led to reduced attendance.

d) Most professional courses emphasised the pursuit of factual information and it was not clear to all students how a course built around reflective interaction was going to benefit them in the context of their need to succeed in knowledge-based examinations.

e) The support students received from their teachers and mentors was mixed and some staff questioned the value of interprofessional learning. Despite the ILP course counting in students' accumulated practice hours, some found it difficult to get permission to be released from their placement.

f) Students were not formally rewarded for their ILP work. They received a certificate of attendance but no credits or marks.

g) Students expressed a wish for more time to spend on looking at each other's roles.

h) Although values were often discussed this was not an express objective of the course.

It is doubtful whether points a) to d) can be countered by the project alone because they result from the general attitude amongst staff towards IPE in professional education. However, with continued implementation the ILP course has enjoyed increasing respect and a higher profile, which may in the long run lead to improvements. In developing the course it should be possible to consider ways to address points e) to g).

Facilitators

The recruitment of some professions, particularly in medicine was disappointing. Although doctors were represented amongst the key leaders on the steering group very few found the time to volunteer for ILP facilitation. Those that became involved as facilitators were consultants and several GPs also attended facilitator training in Greenwich PCT. They enthusiastically supported their staff running the course, but they did not come forward to act as facilitators themselves. So far the project has not been successful in recruiting registrars or house officers.

Service Users

Although it would have been beneficial to involve service users in the design or delivery of the course this was not felt to be possible at the time. The fact that students met with patients in the practice session to obtain feedback about their experience of health care was one way that the patient's voice was heard. It should be possible to build in the opportunity for more service user contribution to the course in future implementation and development.

Successes
The design of the ILP course has shown sensitivity to three core aspects of important policy changes. Working from the service user's perspective, providing relevant skills and improving interprofessional working all feature in the course and reflect the requirements of various National Service Frameworks in the context of modernising the NHS.

Student evaluations indicated that the stated objectives of the ILP course were met. Students report overall satisfaction with the course, particularly their consistent enthusiasm for meeting each other and for studying the patient pathway. As a result of the course, uniprofessional teachers have anecdotally reported small changes to aspects of student practice and some staff reported changing their own practice. Students have also been able to influence service delivery to a small degree.

Where they were prepared for interprofessional learning, there was good attendance and students came with positive expectations about the ILP course. Attendance and value for the course was also improved by monitoring from the uniprofessional teachers. Medical students were closely monitored and their teachers wanted to know who had not attended and the reasons why from the student. This is an example to follow and it is hoped that by involving nurse and other programme leaders more in delivering the course, it will encourage them to monitor student attendance as part of student practice assessments, which will have a positive influence on attendance.

The course has required little modification, apart from variations in the delivery of the middle session in accordance with the requirements of each trust. It has worked well in many settings: in acute and primary care trusts; in adult and child pathways; with students from different professions; in different trusts; with facilitation from staff in different professions with both academic and practice backgrounds in the universities and trusts. It has proved to be replicable and lends itself to further extension and development. Uptake has been improved during the life of the project through organisational changes, more effective administrative systems within the ILP team and improved collaboration across the schools and institutions.

The ILP exercise has proved to be deliverable. This may have been helped by its modest size. A more ambitious programme might have been too costly in terms of resources to implement and too difficult to sustain in the face of competing demands for professional attention.

Lessons learned
Concentrating on developing a robust intervention delivered to a few positively motivated trusts was helpful in building trust and collaboration between the separate health schools and between the professions in the trusts. The mid-term decision to ensure that the intervention was robust before extensive implementation meant that teething problems could be dealt with and the roll out could gather pace later.

The established and separate structures of the individual professions that any exercise in IPE must straddle presented enormous logistical problems. A few academics and practitioners from different professions initially designed the learning exercise, but

management for change required outside intervention from the project manager and the small project team, who worked with enthusiastic staff within the sector. But the course would have been a non-starter had not the team been able to influence yet another layer of staff who were needed to help with finding students, acting as facilitators and helping students in the practice session.

The size of the project team meant that it had to involve and rely on local staff to carry through the delivery of the programme. This led to new forms of collaboration between a wide cadre of university and trust staff, which put them in a position where they themselves were influenced by the implementation process. Organising the ILP course put people together who had not met before and thereby had an influence on the teachers and staff involved.

Efficient and effective organization of the course was essential. The slightest problem lent opportunity for criticism of IPE and could have led to reinforcement of negative stereotyping between students and staff both about other professions and about the efficacy of IPE. Three elements proved critical to the success of ILP, in any of the trusts: at least one local trust champion for raising the profile with senior managers and clinicians within the trust; someone with a dedicated remit for clinical education, such as a Practice Development Manager, to establish links with those who manage students in each profession; and central administrative support without which the sessions would have been impossible to organise.

Future success will depend on extending the project to all the trusts in South East London, embedding the ILP course in the professional curricula, transferring more responsibility from the project team to the health schools, especially student preparation, and continued administrative support. The programme has been and continues to be highly innovative. It has been hard to establish it as a mainstream activity and sustaining it at this point will not be possible without continued input and support.

The ILP course, in the fullness of time, will have the capacity to cater for all health and social care students from the three universities in South East London. While it is not possible to prove that patient care will benefit from this particular course, when they qualify all health students will be expected to work with other professions in practice. It seems likely that early exposure to each other in the context of some of the realities of practice would help in preparing them for that future.

Interprofessional Learning in Practice in South Yorkshire

Frances Gordon & Michelle Marshall

For the Combined Universities Interprofessional Learning Unit (CUILU)[12]

Introduction and background

The Combined Universities Interprofessional Learning Unit (CUILU) between the University of Sheffield and Sheffield Hallam University started work in January 2003. Its aim was to embed an emerging practice-based interprofessional learning pedagogy into curricula for students of health and social care across both universities.

The collaboration took into account very different approaches to interprofessional learning (IPL) in the two universities. Students following professional programmes in the School of Health and Social Care[13] at Sheffield Hallam University undertook a core curriculum entitled interprofessional learning throughout their three year courses. This core comprised six modules across academic levels four, five and six bearing a total of 90 academic credits. The learning associated with this curriculum involved students from nine professional groups learning with each other: nursing; occupational therapy; physiotherapy; social work; diagnostic radiography; oncology and radiotherapy; operation department practice and paramedic practice.

Students from dentistry and its allied professions were the only students at the University of Sheffield who undertook IPL as part of their formal curriculum, although the Faculty of Medicine in which that learning occurred included schools of Medicine and Biomedical Sciences, Nursing and Midwifery, Clinical Dentistry, Health and Related Research and the Department of Human Communication Sciences. There had, however, been a number of earlier interprofessional educational (IPE) interventions on a project basis between medicine and nursing including: shared history taking; 'buddying' between students from both professions gaining paediatric experience; and a three week placement for medical students called the Intensive Clinical Experience comprising three separate weeks with a nursing, medical and social work team.

The systemic approach to IPL at Sheffield Hallam meant that students there shared a common approach to learning, making it relatively easy for them to understand the nature and content of their campus based preparation. There was no shared approach at the University of Sheffield across schools comprising the Faculty and students might or might not have had the opportunity to participate in one or more of the IPL initiatives. But a scoping exercise conducted in the early stages of the CUILU project, taking into account documentary analyses of the curricula across both universities, found that theoretical concepts thought to underpin learning that promoted collaboration between

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[13] Later to become part of the Faculty of Health and Wellbeing.

professions were studied by all students at some stage in their programmes, albeit at different levels and to different extents. This was a key finding that informed decision making during the project.

Decision-Making and Governance

A management structure for the project was agreed at the outset. A steering group was instituted and met twice yearly with an independent chair from a nearby Strategic Health Authority. Members included pro-vice chancellors, finance officers and senior academics from both universities plus representatives from the South Yorkshire Strategic Health Authority. A management group comprising the project team and a senior academic from each university oversaw day-to-day operations and a Public and Patient Advisory Group provided the lay perspective.

Oversight of the project was supportive and light-touch, with a strong element of trust invested in the team. The steering group's remit was to receive progress and financial reports, sanction project objectives and provide advice, leaving the project leader with responsibility for determining the direction of the project. This enabled the team to be creative, to follow unpredicted opportunities as the project unfolded allowing, we believe, for a different, richer result than if the enterprise had been more pre-determined, controlled and tightly project-managed.

Decision making by the team was nevertheless careful, considered and based on evidence if available, whilst adding to the evidence when possible. Pivotal decisions in the early stages were to determine the scope and setting of the project, and the questions that needed to be addressed. Having established that all students in both universities had in some way studied underpinning interprofessional concepts and experienced practice-based learning during their programmes, we conducted another scoping exercise which confirmed that interprofessional learning and working was of interest, and engaged in actively to a greater or lesser degree, across the South Yorkshire health and social care practice settings where students gained their experience. This finding, reinforced by the interprofessional literature, led to the first major decision: to base the project in interprofessional practice learning.

Preparing the Field

Five 'beacon sites' provided the practice environment for much of the work:

- Barnsley District General Hospital NHS Trust (children's services)
- Doncaster and Bassettlaw NHS Trust (emergency and critical care services)
- South East Sheffield Primary Care Trust
- Sheffield Teaching Hospitals NHS Foundation Trust (communicable diseases services)
- Rotherham General Hospital NHS Trust (stroke unit on Rockingham Ward)

Criteria applied in selecting these sites were their ability to provide:

- students with patient/client centred collaborative learning experiences
- working opportunities to heighten motivation and develop students' skills and knowledge

- environments in which students could experience the thrust of the government's modernisation agenda
- integrated service for service users and their carers.

Students would then be able to discover the nature of these rich learning environments through observation, exploration and implementation.

Preparing these sites by the project team took different forms, but always included:

- repeated information giving sessions with all staff and students
- meetings with students to sensitise them to learning opportunities available
- working with staff to develop 'patient journeys' that focused on the type of care provision available at that site
- plotting student placement patterns to negotiate the timing of seminars with site staff
- planning those seminars with staff who agreed to participate
- preparing staff and students to participate in interviews and to keep records

Key Questions

Questions that the team came to see as important to address during the project were:

- What is the nature of practice-based learning environments that promotes the development of collaborative skills?
- What is it that students need to learn in order to become collaborative workers?
- How can students be supported in these environments?
- How can practice-based interprofessional learning and teaching strategies be conducted?
- How can lay involvement effectively and meaningfully be promoted in student learning?

Methods employed in the search for 'answers' were:

- documentary analysis
- curriculum mapping
- qualitative interviews conducted with educators, students and lay participants
- measurement of student attitudes to their own and other professional groups
- evaluation of teaching/learning sessions in practice-based interprofessional seminars
- collection of data to validate the Interprofessional Capability Framework using a tool for service user/carer assessment of student learning
- students' self-assessment of their emerging interprofessional capability
- mentors' views regarding assessment of student achievement of capability.

Process evaluation was also employed, i.e. examination of the actual activities carried out within the programme (Lazenbatt, 2002).

Question 1
What is the nature of practice-based learning environments that promotes the development of collaborative skills?
Insights regarding the role that the practice-based learning environment plays in promoting and developing collaborative working among students were drawn through analysis of practice in the beacon sites offering students pragmatic 'real world' learning opportunities, where Utopian 'brave new world' working (Trevillion & Bedford, 2003) can be compared with pragmatic perspectives (Gordon et al., 2004).

Learning points:
Insights gained regarding the nature of effective collaborative learning environments for students were that:

- The practice context is such that the service users and carers are placed at the centre of the organisation of care and are recognised as partners in decision making;
- The culture of the practice context is one of sharing and collaborative team working in which the contributions of all members of the team are recognised, understood and valued in the interests of providing high quality, integrated care for service users and carers;
- Students are welcomed as future practitioners and enabled to practise safely as student members of the team;
- Practitioners across disciplines work together to ensure all students are supported and their learning needs attended to.
- Students are given opportunities to learn together within the practice context;
- Students are enabled to learn from and about all members of the team and the roles each plays in the care of service users and their carers;
- Success in implementing robust IPL structures within the practice area seems dependent on champions and motivated individuals.

An attitude scale based on the work of Carpenter (1995a&b) was employed in order to determine whether exposure to the beacon site interprofessional learning environments resulted in changes regarding students' identification with their own professional group and attitudes towards other professional groups. The schedule was administered to the students at the beginning of their placements and again at the end.

Forty-one students completed the schedule at the outset (nine from medicine, 25 from nursing, three from occupational therapy, three from physiotherapy and one from social work student). Twenty four completed the schedule at the end of their placements (six from medicine, 15 from nursing, one from occupational therapy and two from physiotherapy). There were 20 matched completions at the beginning and end (five for medicine, 13 for nursing, one for occupational therapy and two for physiotherapy). Numbers were too small to demonstrate statistically significant differences, although some trends, albeit indicative only, are interesting.

Learning points:

- Students demonstrated positive attitudes towards their own profession at baseline. Little change was detected at follow up but, where change did occur, positive attitudes were intensified.
- Expectations at the outset about working on a placement alongside practitioners and students from other professions were positive for almost two thirds with little change at the end of the placement.
- At the outset students held positive views regarding the ways in which professions work together. There was little change in the proportions responding positively or negatively to these statements by the end, although some tended to agree that competition between professions had decreased.
- The proportion of respondents ascribing high importance to stereotyping for each professional group changed on certain measures.
- Positive change towards being more likely to recognise leadership, breadth of life experience, being a team-player and decisiveness as important qualities in other professions were recorded following placement
- The perceived status of other professions was rated 'high' or 'very high' and this intensified by the end of the placements, except for social work and for speech and language therapists.

These data revealed a high baseline of positive attitudes in students beginning their experience at the beacon sites. Few statistically significant changes were demonstrated, although the findings do suggest that their practice learning experience sustained or enhanced students' own professional identity and positive attitudes towards other professions. This supports suggestions that IPL has a role in at least maintaining positive attitudes during student's qualifying programmes.

Question 2

What is it that students need to learn in order to become collaborative workers?

IPL outcomes reported so far for undergraduate students have tended to be intuitive or 'common sense', addressing topics such as teamwork, communication and understanding the roles of other professions. Learning outcomes specific to interprofessional working have yet to be articulated, which will entail describing the components of such working. The project therefore needed to devise a systematic approach to generate IPL outcomes that also indicated what interprofessional working involved. This would need to take into account demands on practitioners in contemporary health and social care agencies to focus on service users and patients and to be more responsive to their needs and expectations. But client-centred goals (save for the most basic) cannot be met by any one health or social care profession in isolation from the others. Nor can any one agency meet them in isolation from others in the network of modern services. This complex world demands competence in collaborative working relevant to all the professions participating in the project achievable on placement in the workplace.

Questions have been raised regarding the adequacy of concentrating on 'competence' alone in preparing practitioners to respond effectively to the complexity of contemporary health and social care practice (Wilson & Holt, 2001; Fraser & Greenhalgh, 2001). As Heron and Murray (2004) note, assessment of 'competence' does not address complexity,

merely the performance of task. Assessment of 'learning' needs also to be about understanding and applying a range of theories, concepts and ideas in practice.

The need to equip students for "changeability, improvability and responsiveness" (Fraser & Greenhalgh, 2001:780) prompted us to think how we might develop a framework of learning to guide students to acquire the skills, knowledge and attitudes that underpin effective collaborative working, leading us to conclude that the construct of 'capability' offered a more productive way forward than 'competence'. Fraser and Greenhalgh (2001:801) differentiate between competence as "what individuals know or are able to do in terms of knowledge, skills and attitudes" and capability as the "extent to which an individual can apply, adapt and synthesise new knowledge from experience and so continue to improve their performance". The concept of capability, therefore, overcomes some of the limitations imposed when the conceptualisation of work performance is reduced to a set of 'competencies' by taking into account the many-layered and multiple processes that professionals are expected to perform (Barr, 2002).

This prompted us to devise the 'Interprofessional Capability Framework' during Phase 1 of the project, using benchmarking statements for undergraduate programmes in medicine, dentistry, professions allied to medicine, nursing and midwifery and social work from the Higher Education Quality Assurance Agency (QAA, 2000; 2001; 2002a) to guide its formulation. We considered these an appropriate data source as they contain significant indicators of the attributes and capabilities that those possessing health and social care qualifications should be able to demonstrate and provide general guidance for articulating the learning outcomes associated with the programmes (QAA, 2002b). Grounded theory (Glaser, 1992) was employed to analyse the benchmark statements and generate a framework that conceptualised the nature of interprofessional learning for interprofessional working. We selected grounded theory because of its emphasis on generating theory that offers explanations of social phenomena (Glaser and Strauss, 1967). A detailed description of how the Interprofessional Capability Framework was formulated is reported elsewhere (Walsh & Gordon, 2004, Gordon & Walsh, 2005).

It has sixteen interprofessional capabilities, each having three incremental learning levels contained in four domains of interprofessional practice: knowledge in practice; ethical practice; and interprofessional working and reflection (learning). We validated the Framework during Phase 2 with practitioners and students working in the beacon sites.

Learning points:
The validation processes generated the following learning points:

The Framework provides a statement of what students need to learn. The capabilities and learning outcomes contained in the Framework were recognised as appropriate and relevant to the participants' own and other professions' learning. This supports its use to provide learning outcomes that are common to and relevant for all students.

The Framework draws attention to learning opportunities that promote interprofessional working. The learning outcomes within the framework sensitise its users to interprofessional aspects of the learning opportunities available in the practice context. This therefore carries the potential for developing the interprofessional focus of the

practice context by extending consideration of a learning opportunity as a topic to be learned, such as a clinical skill, to a wider view of interprofessional and collaborative working.

Service organisations can limit learning opportunities. Although the beacon sites were recognised as areas where interprofessional working took place, the success in facilitating it for students seemed to depend upon how well integrated the organisation and student support were. Where barriers to IPL seem to be in operation, it was not because of lack of opportunities for such learning, but its management in profession-specific contexts. Student groups learnt in the same setting, but in isolation from each other. The lack of integrated structures within the organisation, communication difficulties between professions both in practice and the university, and streaming educational funding were also cited as reasons for failures in integrating student learning fully.

The Framework had potential to advance interprofessional practice. Cross-professional learning objectives tended to be set at a level that the 'visiting' student could reasonably achieve, i.e. at a lower level than that set for the 'host' profession. This reflected the assumption that a student could not be expected to have any proficiency in another profession's skills or knowledge. Invoking the Framework allows all students to access the same learning opportunities on an equal basis to achieve incrementally more challenging IPL outcomes.

The Framework brings the patient to the foreground. Focusing on interprofessional capability not only emphasises the centrality of the patient for students' learning and assessment, but also reflects how interprofessional working occurs when services are structured around the patient. The Framework, by drawing students' attention to the multidisciplinary team at work for the patient, facilitates greater understanding of the changing roles of different professions and how they impact on the care received.

Despite general agreement that the capabilities and learning achievements contained in the Framework were appropriate and reflected the realities of interprofessional working, some practitioners found certain statements complex. The development of the Framework from the QAA benchmarks indicates the level of practice that students emerging as qualified practitioners should have attained. This raises issues concerning expectations of newly qualified practitioners and the responsibility they can be given as students in order to learn and prepare for qualified roles. It may also indicate the need for staff and service development in order for students to be appropriately supported. The learning levels within the Framework seek to provide a graduated progression towards the achievement of the capabilities.

The Framework facilitates assessment. Practice-based assessors, service users and carers, and students were able to use the framework as a basis for assessment of emerging collaborative skills and knowledge. See the CUILU final report (CUILU, 2006) for a more detailed discussion of these findings.

Question 3

How can students be supported in these environments?

There remains a paucity of literature concerning interprofessional facilitation or 'mentorship', although it is clear that the health and social care professions are seeking to understand and develop such roles to support student learning (DOH, 2000; ENB & DOH, 2001; BMA, 2004). Interprofessional mentorship and the mechanisms involved in undertaking interprofessional student support and assessment were explored in the CUILU project by analysing the qualitative data collected from students and practice-based facilitators of learning (see Marshall & Gordon, 2004).

Learning points:

Facilitation of interprofessional working can and does happen in the practice arena, but the culture and environment can impact both positively and negatively on its breadth and scope.

A range of teaching processes facilitate IPL. These include 'shadowing' other professions, attending multidisciplinary meetings and attending shared seminars.

Students benefit from the facilitation of their learning by other professions. However, the interprofessional mentor does not replace the uni-professional mentor who retains overall responsibility for the student learning whilst on placement.

Interprofessional knowledge is the focus of interprofessional mentorship. This applies to both students of the same and different professions.

The evaluation of interprofessional encounters/learning is already taking place within practice. This can be further developed using the Framework.

Education and training needs of practice-based facilitators need to be addressed for interprofessional mentorship to become a generalisable reality.

Question 4

How can practice-based interprofessional learning teaching and learning strategies be conducted?

Teaching and learning strategies that support the development of collaborative working remain poorly understood. But the literature suggests that IPL is most successful when, according to Parsell et al. (1998), it uses adult learning theory, small group experience, interactive facilitation with multi-professional participants in a comfortable safe environment and, according to Baxter (2004) it is practice based, active and patient centred.

The seminar programmes were delivered in four of the beacon sites. Each comprised four sessions, each constructed around one of the following learning tasks:

- the identification of interprofessional care goals for the service user
- the writing of interprofessional philosophies and mission statements for the practice sites
- the formulation of stem questions through which service users may be enabled to evaluate interprofessional aspects of their care

- the enabling of students in a simulated practice scenario through role play, working together with service users and their carers.

Each programme was based on a patient 'story' or case study produced in partnership with practitioners. At one site service users and carers also contributed. Each story involved a series of scenarios concerning a service user whose characteristics and problems were typical for the client group being cared for. Although the story offered an integrated approach to the programme, the individual seminars could stand-alone. This ensured that each seminar was meaningful for those only able to attend one or two sessions as well as those able to attend the whole programme.

The overall purpose of each programme was to enable students to reflect on practice through engaging in set learning tasks or exercises and identify how such learning could assist them to meet the interprofessional capabilities set out in the Framework. It was anticipated that taking part in the seminars would enable participants to:

- Share professional values and understandings and learn about those of other participants
- Identify and include the perspective of service users/carers in a given learning exercise
- Work collaboratively to produce designated learning 'products' relevant to the practice area
- Reflect on personal learning gains towards becoming interprofessionally capable

Students undergoing practice experience in the practice sites came together to attend the seminars conducted either in the practice area or a simulation venue. This resulted in a mix of students from different professions and seniority within their respective programmes.

Students groups attending came from diagnostic radiography, dietetics, medicine, nursing, occupational therapy, physiotherapy, social work, speech and language therapy and therapeutic radiotherapy.

Learning points:

The centrality of the patient/service user. An important aim of interprofessional education is to improve practice (Barr, 2000). By placing the patient/service user at the centre of the learning process, as is required in the caring processes of modernised services, attention is focused on the needs of patients/service users and their carers.

Making it real. In order to ensure that the students' learning is embedded in 'real world' practice, a partnership approach in formulating the patient story is required. This collaboration should be with expert practitioners, educators and wherever possible patients/service users. Such approaches make the learning meaningful for students and are motivating.

Facilitate student reflection. The learning encounter must be supportive, appropriately confidential and structured around students being able to consider learning gains and learning needs. An important point for the practice based teacher, is that the strategies of

facilitating students' reflections are equally appropriate when considering actual, rather than simulated or role play events, and will advance and enhance the learning students have gained through their engagement in practice.

Promote interprofessional capability as an outcome. The learning activities should be focused on helping students become interprofessionally capable and learning outcomes that are about interprofessional working should be made transparent to the students.

Take a team approach. An interprofessional teaching team overcomes barriers to IPL that are presented by students not yet being confident in their own professional role in that they are able to draw on the insights of more experienced practitioners.

Make the learning active. The learning should be interactive and engage students in shared tasks and should be facilitated in a supportive and non-threatening way that encourages students to be open about their learning needs.

See 'mistakes' as both understandable and opportunities for learning. The point of role-play and simulations is to enable students to learn from 'mistakes' in a positive, non-blame culture and to identify and build upon their current levels of knowledge and skill.

Question 5

How can lay involvement effectively and meaningfully be promoted in student learning?

Involvement of service users and patients has been regarded as a key vehicle for the promotion of interprofessional learning. This reflects the current move toward patient and public participation in all facets of health and social care delivery. Work with patients/service users, students and educators in planning patient/service user participation in interprofessional student learning was a central theme of the CUILU project. This work focused on exploring the experience of lay participation in student learning from the perspective of students, lecturers and service users and carers; exploring approaches to involving patient and service users including issues around sharing stories and experiences, patients as assessors, problems around involving 'hard to reach' or 'difficult to engage' groups; developing guidelines for good practice in such initiatives and 'testing' the guidelines in one of the beacon sites where they were used to support the involvement of service users and carers in the seminar programme. Key principles of Collaboration, Preparation, Communication, Support and Debrief for both students and lay participants were revealed as essential for successful patient/service user involvement in education.

Learning points:

Time and resource implications to support student learning from good practice should not be underestimated.

Closure was important. It facilitated positive disengagement where individuals no longer wish to, or were unable, to participate and paved the way for continued involvement.

Student evaluation indicated that the involvement of service users provided high impact, interprofessionally focused practice learning.

Service user evaluation indicated that the Good Practice Guidelines comprising collaboration, preparation, communication, support and debriefing enabled a positive and empowering experience of involvement

These five questions allowed the findings of the project to be presented as an integrated whole. The insights gained suggest what it is that students could or should learn through interprofessional education; the nature of the practice-based environment that supports such learning; how students can be supported to optimise that learning and its facilitation, including the role of service users and carers.

Recommendations
The findings of the project generated recommendations, including the following pertinent to this paper:

Clear learning outcomes accessible to assessment and common to all students should be utilised in order to take a strategic approach to managing IPL across all professions.

Preparation for the interprofessional aspects of the role of individuals who support students both in university and in practice may be undertaken as part of uni-professional preparation for those roles, but should preferably be interprofessional.

Service user involvement should be pivotal to IPL, but must be carefully planned, managed and adequately resourced.

Students' placement learning arrangements should be an integral part of service development. This should involve the identification of a champion or co-ordinator of all students to ensure that profession specific learning is addressed in conjunction with the IPL.

Adequate resource must be committed in order to sustain change in the educational culture with respect to IPL.

Attention should also be paid to structures and processes in the management of education to facilitate interprofessional teaching and learning, and its assessment, in both HEIs and the service providing agencies offering students practice experience.

The role of performance indicators, in both educational commissioning and quality enhancement, should be explored to support the development of interprofessional learning.

Some Personal Reflections (Frances Gordon)
The outcomes of the CUILU project have been reported in various publications including the Final Report (CUILU, 2006) that can be accessed at www.sheffield.ac.uk./cuilu. These publications carry much more detail of methods, processes and findings than outlined above as well as related issues that considerations of space preclude from discussion in this paper.

The team's overall approach to the evaluation of the project was qualitative. In keeping with this, members tried to be as reflexive as possible in their day-to-day work. Some of us kept diaries or field notes of our feelings and impressions during the project. Although not constituting formal data for the project, these records did serve as reminders and a focus for discussion from time to time when we wanted to make sense of our experience.

At the end of the project we met and recorded a discussion about the experience that was CUILU. This did not seem as satisfactory as we had hoped. There were no revelations, no aha! moments. I think that we had gained more successful insight in spontaneously reflexive moments when going about our daily business. This reflection is of course from my perspective, not speaking for colleagues. They may not agree with everything as I have perceived it. That is the risk and liberty I have taken. I trust they will forgive any misrepresentation.

So what did we bring as a team? We were employed by different institutions, although working as an integrated team. This caused no problems within the team, and in fact was enriching, but we were always aware of the potential for difficulties when working in the university where team members were not employees. Our backgrounds were diverse. Four of us are nurses (Frances Gordon, Michelle Marshall, Claire Walsh and Fiona Wilson), but I think that any notion that nursing is an homogenous profession is questionable to say the least, and as far I can tell as a nurse, we did not come to the project with a common focus. Tim Hunt came from social work and Carol Kay was the administrator with a teaching background. Our two senior academics, who provided support and guidance, came from backgrounds of speech therapy (Pam Enderby) and podiatry (Linda Lang).

Some of us had strong education practice, research and/or management backgrounds. Others had more clinically focused research backgrounds, while Claire Walsh and Tim Hunt joined the project directly from professional practice. This diversity, I think, offered certain perspectives to the project. It was certainly not a 'pure' research project, although a frequent explanation we gave to staff in the beacon sites was that we wanted "to describe what you do here". In some ways this probably gave the impression to some people that we wanted to go along and collect data and take them away for our own purposes. Naturally any evaluatory activity has an element of this, but the educational drivers and practice orientation that we all carried also led us to be quite interventionist and wanting to 'experiment' ourselves with practice-based education approaches and in involving service users in these approaches. These 'experiments', conducted through the seminar programmes, relied on the diversity of background in the team and this was widened further when practitioners from the beacon sites participated in the seminars and when we initiated a rolling programme of interprofessional projects with (interprofessional) teams of educators across both universities.

We do not know how things would have turned out if diversity had been less of a factor, or indeed more, but one reflection on this seems to be that the diversity meant we had to feel our way around the project. I consider this was a positive development. We did not come to the project with one mind, or one perspective of what its shape and processes should be. We had to negotiate around what we felt was important and feasible and to follow leads and individual interests as the project unfolded. As the project leader this felt

pretty risky to me from time to time, but in the end perhaps more ground was covered than if we had devised a tight inflexible schedule overly ruled by Gant charts (we did have one, but I can't remember looking at it much). So an insight that is not particularly groundbreaking but worth emphasising: interprofessional education and/or research feels more 'right' if it is conducted interprofessionally.

What needs to be mentioned, however, is that working interprofessionally with diversity takes effort and perseverance. Initiating IPE is time consuming, can be frustrating and at times even demoralising. A sense of humour is essential. It seemed to take a worrying amount of time to get the project off the ground, although, once preparatory work had been done, things moved very quickly, and this seemed to have a cyclical pattern of delay and then rapid development. The team was generally not consciously aware of the pace and scope of the project until it was highlighted by Fiona Wilson who, on return from maternity leave, reported herself amazed by how much had happened in a relatively short space of time. However, frustratingly frequent delays and barriers were a feature of our experience and although a pressing factor, this wasn't just confined to NHS research ethics approvals. Our weekly team feedback was characterised by reports of long waits for key meetings due to the higher priority commitments of NHS and social service staff; or that required information about student placement patterns was not available so complicating onward planning; or the fact that information giving sessions for beacon site staff had to be rearranged or repeated, proving to be quite resource intensive. The logistics of setting up the seminar programmes proved to be extremely difficult, and in one site became impossible. This was despite concerted effort of all concerned both within the team and of staff within the beacon sites. Our reflections on this is that this is partly a function of project work – outsiders to the organisation, albeit ones with responsibility for the education of students gaining experience within that organisation, have additional difficulty in logistical arrangements for students coming, not only from different schools and faculties, but also from different institutions. This seemed to be based on issues of ownership and regulation in that navigating the organisation whilst not employed by it, is an extremely complex task.

Although still problematic, things were markedly easier where the practice based staff were in a position to actively participate in, and carry some ownership for, the seminar programmes, hence the finding of this project, and without doubt of others, that champions within organisations are pivotal to success. But the success we feel most important is not necessarily that of the project but in terms of systemic organisational commitment and requirement for IPE to support collaborative working to be a feature of professional preparation, ongoing professional education and service development. Champions, therefore, perhaps should not be required after the work of embedding principles and practice is done. IPE should be such an integral part of what we do, that its 'special' status (which carries of course the opportunity for dismissal and opting out on grounds of irrelevance or of not applying) will diminish. Projects come, and projects come to an end. We hope that the CUILU project produced some insights into how practice –based IPE can be taken forward and embedded into the preparation of collaborative workers for the NHS and social care.

Embedding Interprofessional Learning in Hampshire and the Isle of Wight: The New Generation Project

Professor Debra Humphris and Professor Dame Jill Macleod Clark

1. Introduction and background

The New Generation Project was launched in 2003. It involves a partnership between the University of Southampton and University of Portsmouth and health and social care providers. The underlying principles reflect a commitment to expose all health and social care professional students to significant interprofessional learning opportunities throughout their undergraduate studies. The New Generation Project comprises three interprofessional learning units (IPLUs), which are mandatory and assessed and embedded within all pre-qualifying health and social care programmes.

This ambitious programme developed out of a long history of small scale interprofessional initiatives at the University of Southampton. These focussed in areas such as palliative care and had evolved out of the close interaction between academic Schools within the University including Medicine, Social Work, Health Professionals and Rehabilitation Sciences and Nursing & Midwifery. This interaction was facilitated by the existence of a unique health related multi professional Faculty structure.

This history of pioneering interprofessional learning (IPL), coupled with emerging policy directives from the Department of Health, become powerful drivers. This resulted in the strategic decision made by the University of Southampton to develop IPL as a key feature of the Interprofessional Learning portfolio. In 1999 the then Vice Chancellor (Howard Newby) and Dean of the Faculty (Eric Thomas) appointed a new Deputy Dean of Faculty and Head of School of Nursing and Midwifery (Jill Macleod Clark) with a specific remit to take corporate leadership for the development of IPL. This led to the development of a macro, whole systems approach to embedding IPL throughout all undergraduate health and social care professional programmes. In 2001 colleagues from the University of Portsmouth, who provide programmes in pharmacy, social work and radiography, approached the University of Southampton to explore the possibility of collaborating with the New Generation Project. Following considerable discussion it was agreed by both Vice Chancellors that this would be an appropriate and positive step forward.

In 2001/2 the Department of Health made funding available via a national bidding process to support the development of its policy commitment to see the introduction of IPL within all pre-registration programmes by 2004[14]. The New Generation Project, by then a collaboration of both universities and the Hampshire Isle of Wight Workforce

[14] Department of Health (2001) Working together, learning together. Department of Health. London

Development Confederation, bid for significant resources to take forward its ambitious plans for IPL.

This case study tells the story of the development, delivery and growth of the New Generation Project

2. Preparation and infrastructure

In 1999 an Inter Professional Learning Committee was formed within the Faculty of Medicine, Health & Biological Sciences chaired by the Deputy Dean of Faculty Professor Dame Jill Macleod Clark. The group membership included Heads of Schools involved in the preparation of health and social care practitioners and student representatives. The plan was to maximise the integration of interprofessional learning within the curriculum. The scale and complexities of this initiative was such that it evolved into a specific project which was titled the New Generation Project. The Faculty committee made bids for matched pump priming from the University of Southampton strategic development fund, the Postgraduate Deanery and the Nursing and Midwifery Education Consortium. These funds supported the appointment of a Project Director (Professor Debra Humphris) in November 2000 with the remit to deliver major curriculum change by 2003.

The New Generation Project Steering Group came into existence in December 2000 and superseded the Inter Professional Education Committee. Its membership was broadened to include senior colleagues from key service provider organisations to ensure that the development of interprofessional learning in the classroom and in practice would be undertaken in partnership. In 2003 after the launch of the NGP programme the Steering Group evolved to became the New Generation Project Strategy Group, which is charged with the remit to:

- set and steer the strategic direction for the medium to long-term (3-5 years) development of interprofessional education in health and social care at all levels (pre- and post-qualifying), in response to university, key stakeholder and policy drivers

- influence policy at local and national levels to support the development of interprofessional education

- convene task groups as appropriate to take forward innovative workforce developments in response to the agreed strategic direction

- ensure that appropriate resources are secured in support of common learning

- receive and respond to the Common Learning Management Forum's annual quality improvement plan

3. Curriculum development and planning

A key aim of the New Generation Project was to provide opportunities for pre-registration students from health and social care professions to learn together in order to improve their collaboration and teamwork skills with the aspiration that this would, over

the longer-term, contribute to an improvement in the quality of care provided by future graduates to patients and clients.

The development of the curriculum model has been described extensively elsewhere[15] but is summarised below. At an early stage of the curriculum development process it was vital to agree terminology. The use of the words "common learning" was taken to provide an umbrella term to denote any opportunity for students to engage in learning that was shared in some way with other health and social care professionals. The term interprofessional learning was used in line with Barr's[16] definition of opportunities to learn 'with, from and about each other'. The focus of the curriculum model reflected a commitment to provide interprofessional learning experiences for students in order to enhance collaborative practice and the teamwork skills of future professionals.

The curriculum development was designed to embrace students undertaking pre-qualifying programmes in audiology, diagnostic radiography, medicine, midwifery, nursing, occupational therapy, pharmacy, physiotherapy, social work and therapeutic radiography. This resulted in a potential combined intake of around 1500 students per year from across both the University of Southampton and University of Portsmouth.

The first stage of the development process was to identify from each separate professional curriculum where students were learning the same things or were aiming for the same learning outcomes. This painstaking process was informed by triangulation with the results of an analysis of the academic and practitioner standards available at the time from the Quality Assurance Agency, along with current curriculum documents and comments from local and national stakeholders and expert groups. As a result of this process areas were identified that could provide students with an opportunity to explore their contributions to improving collaboration between health and social care practitioners. These topics areas formed the basis for the three Inter Professional Learning Units, referred to as IPLUs, which were developed and integrated within the individual programmes. There were also topics that had been identified that most students would need to study but the consensus view was the benefits to be gained from joint teaching did not warrant significant curriculum change. These areas were labelled 'learning in common.' They are related to IPLU units but are delivered within the uniprofessional elements of programmes.

The three IPLUs were categorized as IPLU1 'early in programme', IPLU2 'middle in programme' and IPL3 'late in programme' and were designed to be delivered at the appropriate stage in each of the programmes in which they are integrated (See Fig 1.). The programmes in the New Generation Project vary in length from two to five years in duration. So, for example, IPLU3 takes place in the final year of any programmes, so students may be in the third year of a degree in physiotherapy or the fifth year of a degree medicine, but for all students the unit is taken close to the completion of their programmes.

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[15] O'Halloran, C., Hean, S., Humphris, D. and Macleod-Clark, J. (2006) Developing common learning: the New Generation Project undergraduate curriculum model. *Journal of Interprofessional Care*, 20, (1), 12-28. (doi:10.1080/13561820500471854)

[16] Barr,H. (2000) Interprofessional Education:1997-2000 a review. London. CAIPE

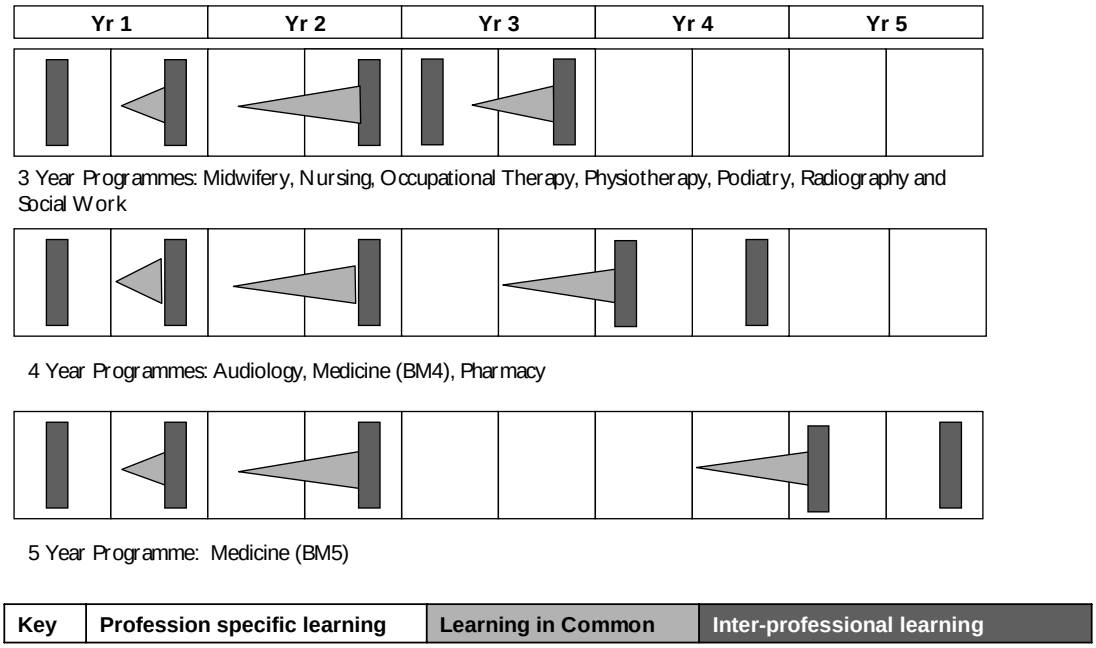

Fig 1. Phasing of Inter Professional Learning Units and learning in common

A model of learning and teaching was identified to underpin the development of the whole curriculum change process. This model is rooted in experiential learning and is based on the belief that exposing students to learning experiences involving a range of students from other professional groups and by constructing learning conditions to support collaboration and learning, students will be able to achieve the learning outcomes. The model is known as Facilitated Collaborative Interprofessional Learning (FCIL) and combines three pedagogies - guided discovery learning, collaborative learning and interprofessional learning[17].

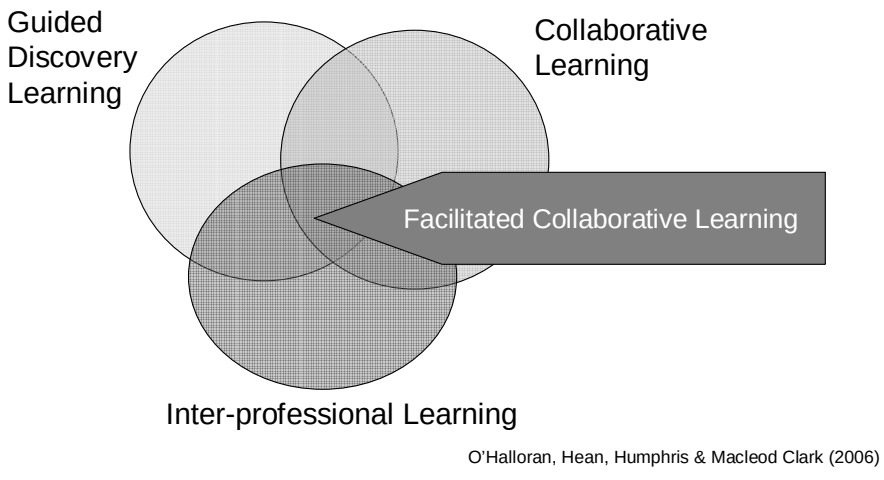

Fig 2. Facilitated Collaborative Interprofessional Learning (FCIL)

[17] See O'Halloran, et al 2006

The aim of the IPLU's is to help students recognise their own and other professionals' contribution and role within a team based approach to care delivery. They should also recognise opportunities for new patterns of service delivery to enhance their teamwork skills and refine the contribution their own profession can make to care. Co-producing knowledge as part of the learning group activities projects was seen as a mechanism to enhance the individuals understanding of themselves as an independent practitioner and as a member of a team. The outcomes identified for common learning are set out below:

Common Learning is the mechanism through which we will enable students to learn about, and assess their ability to:

Respect, understand and support the roles of other professionals involved in health and social care delivery.

Make an effective contribution as an equal member of an interprofessional team.

Understand the changing nature of health and social care roles and boundaries.

Demonstrate a set of knowledge, skills, competencies and attitudes which are common to all professions, and which underpin the delivery of quality patient/client focused services.

Learn from others in the inter-professional team.

Deal with complexity and uncertainty.

Collaborate with other professionals in practice.

Understand stereotyping and professional prejudices and the impact of these on interprofessional working.

Practice in a patient centred manner.

Throughout the curriculum development process a close working relationship with colleagues in practice has been essential. IPLUs 2 and 3 are delivered in practice and provide an opportunity for students to work in a group on an element of the audit of services (IPLU2) or a complex problem arising from practice such as an ethical dilemma or service redesign (IPLU3). All of these opportunities are facilitated by senior practitioners who have identified the topic on which the students will work. The Facilitated Collaborative Interprofessional Learning model is based on a small group of 10 to 11 students from at least five different professions in each group.

Inter Professional Learning Unit 1 - Collaborative Learning
This unit introduces students to the concept and practice of collaborative learning and team working and develops their knowledge management and IT skills needed to participate in collaborative learning supported by on-line methods.

Inter Professional Learning Unit 2 - Interprofessional Team Working
This unit provides students with an opportunity to apply their team working and negotiation skills in an interprofessional context focused on the audit of practice against evidence based standards.

Inter Professional Learning Unit 3 - Interprofessional Development in Practice
This unit will help students examine interprofessional working in modern health and social care services from a personal, professional and organisational perspective focused on service redesign

The process of integrating the three IPLUs was handled within the quality assurance frameworks of both universities and in all cases required either programme revalidation or 'minor changes' under University regulations. The units carry academic credit and contribute towards progression and award classifications. They are compulsory. Overall these units comprise between 8 to 12% of the pre-registration programmes and to date have been incorporated within 17 different professional programmes.

4. Academic management
The overall academic management for the IPLUs is based on a Unit Team and Unit Leader for each IPLU. The Unit Leader is an academic member of staff from one of the two universities and the Unit Team comprises members of staff from a range of schools and from practice organisations. The Unit Teams are accountable to a Common Learning Management Board. This Board is made up of all the senior educational leaders from each of the schools involved. The board has responsibility for the overall academic and quality oversight of the IPLUs and is responsible for providing an annual quality report to the Schools and to the New Generation Project Strategy Group.

Common Learning Management Board: Terms of reference

- To oversee the management of Common Learning (Learning in Common and Interprofessional Learning Units)
- To plan and respond to timetabling and resource issues
- To review the CLP learning, teaching and assessment strategies for congruence with Schools', Faculties' and Universities' learning, teaching and assessment strategies
- To receive and respond to programme evaluations and relevant Quality Assurance and Enhancement reports including the External Examiner's Report
- To oversee the continuing improvement of Common Learning.

The assessment of the three units is the responsibility of the Common Learning Assessment Sub Board, to which there are two dedicated External Examiners. The decisions made by the Sub Board then form part of each schools overall assessment processes, therefore student IPLU work is assessed and ratified by the Sub Board and then forms part of each school's overall assessment decisions.

5 Partnership Working

5.1 Partnership with Professional Regulatory Bodies

From an early stage of the Project, engagement with the relevant professional regulatory bodies was identified as crucial. To this end a Regulators Group was convened involving the General Medical Council, the Nursing and Midwifery Council, Health Professions Council, the Royal Pharmaceutical Society of Great Britain, the General Social Care Council and the Regulatory Unit from the Department of Health. Contributions were also made by the Chartered Society of Physiotherapists, the College of Occupational Therapy, and Society of Radiographers.

The purpose of the discussion with the regulators was to engage them in the both the debate and the development of interprofessional learning. In taking forward the New Generation Project their contribution was wholly positive and there was strong support for the proposed changes. Minutes were made of all of the discussions of the group and once agreed they were published on the Project web site to help inform wider debate. This group was particularly helpful in exploring the complexities that programme revalidation might have presented. It became evident that the scale change proposed could legitimately be handled under internal university regulations. However in the spirit of collaboration all the bodies involved were party to revalidation.

5.2 Partnership with Students – Student Reference Group

As part of the project development phase two reference groups were formed, these played a vital role in the scrutiny and direction of the project. The establishment of the Student Reference Group was central to the development process. This group was made up of student volunteers and its role was to review and contribute to every aspect of the project development process. The chair of the SRG was an automatic member of the New Generation Project Strategy Group.

All stages of the curriculum development process were scrutinised by the Student Reference Group and from this process a number of curriculum innovations were developed. One of these was the development of peer assessment within IPLU 2 and 3 to strengthen the emphasis on team working. Students were also involved in the appointment process for the Inter Professional Learning Coordinator posts.

Many of the initial members of the group continued to be involved after they graduated to the point that the group was renamed the Student & Newly Qualified Reference Group. In 2004 the group was superseded by a Student Liaison Group, this group is made up of nominated student members from each of the School involved in the New Generation Project. The students are then responsible for systematically linking with their home schools Student Staff Liaison Group.

5.3 Partnership with wider community – External Reference Group

The second group that was formed to support the development process was the External Reference Group. This group was made up of a range of senior individuals from the health, social care, education and voluntary sector, including the Department of Health. Their role was to act as ’critical friends’ in shaping the outcomes and project

development. As with the Student Reference Group all of the proposed developments were taken to this group for scrutiny and review.

5.4 Partnership with practice

A critical element of the New Generation Project has been the partnership with service provider organisations. The whole emphasis of the Project has been to develop a new generation of practitioners able to contribute to effective teamwork and enhance collaboration to improve quality of care. Therefore providing students with appropriate and meaningful learning opportunities within the practice of health and social care is pivotal. The development of our model of learning necessitated a transformation of learning in practice to a group based approach. To support this, a significant amount of the Department of Health funding was utilised to establish eight Inter Professional Learning Coordinator posts. The post holders were employed by local NHS organisations and one social service department. The posts formed part of what we believe is a vital infrastructure to support practice based learning. The posts were for a fixed time period of two years and focused on creating the conditions needed to support the delivery of IPLUs 2 and 3. From the outset this was a time-limited investment. However, the debate about these posts, and other profession specific posts, has now been located within the wider context of how the Strategic Health Authority supports an infrastructure to support the delivery of learning in practice.

In 2003 the Workforce Development Confederation responsibilities for all practice based learning were taken on by a new Practice Based Learning Development Board chaired by the Director of Nursing, Southampton University Hospitals NHS Trust. As a result it was agreed that, rather then running parallel arrangements, the responsibility for developing the practice based capacity to deliver IPLUs would be taken on by the Practice Based Learning Development Board as part of the overall pre registration placement capacity agenda.

6. Taking a Project focus for IPLU

The project focus for all of the IPLUs provides students with a catalyst for developing and strengthening a team based approach to learning. IPLUnit 1 introduces students to the concept and practice of collaborative learning and team working. All students undertaking a pre-registration health or social care programme at the two universities come together at the start of their programmes to participate in common learning and undertake a health related project. In the case of this Unit the students explore the local community and develop a position paper on a controversial topic they have discovered from their community exercise. The quality of the work produced by the students in their first year is illustrated on the next page.

In March 2006, a team of first year students from the Universities of Southampton and Portsmouth, as part of their first Interprofessional Learning Unit, explored the lack of access to NHS dentists in the Shirley area of Southampton.

Their facilitator, Peter Coleman, Professor of Psychogerontology, was so impressed with what the students had achieved in just one week that he sent their position paper to the Faculty.

The Dean of the Faculty of Medicine, Health & Life Sciences, Professor Williams, a distinguished dental surgeon, responded by thanking the students for such an excellent report, "It is an absolutely first class paper, drawing attention to a very significant public health issue. As (the) students point out, there are areas of real deprivation in Hampshire where levels of dental decay are very high and access to services is poor. This is a fact which is not widely appreciated, because Hampshire is perceived generally to be rather affluent." Professor Williams also suggested that their work should be shared with the Director of the Workforce Development Directorate at the Strategic Health Authority.

Jo Grobbelaar, BSc Physiotherapy student and member of the IPLU1 group said "We were very excited about our project and by our newfound awareness of this issue". Shipu Zaman, BM5 Medical student felt 'the team gelled together really well and that's what made the difference in producing such a high standard paper'.

IPLU 2 &3 take place in practice and here the project emphasis has enabled practice provider organisations with the opportunity to both enable students to meet their learning outcomes and to allow the organisations to gain the value from the student project. To explore the extent to which these IPLU projects add value to organisations a study is underway to follow-up all the IPLUs in practice to date (See under Research & Evaluation) to explore the extent to which the practiced based project may make a difference in practice.

7. Training the facilitators

Along with the investment in the Inter Professional Learning Coordinators the Department of Health funding was invested in creating a staff development programme to support individuals who were going to take on the role of facilitator either in University (IPLU1) or in practice (IPLU 2 &3). A two-day facilitator workshop was designed, along with supporting materials and all facilitators took part in the programme. Since 2002 we have run over 57 facilitator training workshops. 743 people have booked places and over 658 people have attended and received a certificate for completing the training

Access to workshops is organised via an online booking system, developed specifically, and materials to support the workshops are available in both hard and electronic copy. The number of workshops has now reduced to a maintenance level of around 5 or 6 per year. The workshops are interprofessional and multi-agency in nature and evaluation data indicates they are of high quality.

8. Delivery of IPLUs

The delivery of the IPLUs went live with programmes which commenced in academic year 2003/04. IPLU 1 ran for the first time in 2003/4, IPLU2 in 2004/5 and IPLU3 in 2005/6. Given the varying lengths of programmes, it will not be until 2007/8 that medical

students who commenced in 2003 on the five year programme will take part in IPLU3. The complete roll out will have taken five years from the start point in 2003. Over the past four academic years over 1000 IPLUs have been delivered across university and practice settings. Each IPLU would have involved at least one facilitator and have required space in which to deliver the experience.

Academic year	IPLU 1 (Nov & Mar)	IPLU 2 (Mar)	IPLU3 (Nov)
2003/4	160		
2004/5	160	132	
2005/6	155	130	111 [18]
2006/7	128	(Mar 07)	102

The first IPLU in practice ran in 2004/05 and since that time over 370 IPLU placements have been supported across Hampshire, West Sussex and East Berkshire. We have worked with over 35 different organisations across health, social care, the independent and voluntary sector as well as the Police and Local Authorities. From an analysis of IPLU2 and 3 in the past year (2005/06) it is evident that 72 facilitators hosted both an IPLU2 and IPLU 3 placement, often following through on a common area of service audit and change.

9. Evaluation and research

The project team has developed a robust research and evaluation framework to encompass the educational change processes related to Common Learning. Evaluation data are routinely collected on students' experiences of each IPLU unit. Data are also collected from facilitators.

A key aim of the New Generation Project Longitudinal Study is to examine the impact of the common learning curriculum on pre-registration students from eleven health and social care programmes. It provides a unique opportunity to investigate large cohorts of students and to explore the influence of IPL on students' attitudes and professional identity as well as to compare those who received common learning with those who did not. Data collection commenced in 2002 (cohort one – the comparison group) followed with data collection from the 2003 (cohort two - the intervention group). There are three data collection time points planned – at the beginning of each undergraduate programme (T1), by the final year of each programme (T2) and approximately 18 months post qualification (T3). The New Generation Project Longitudinal Study findings to date are available through the publication of papers and presentations and can be accessed via the eprints facility at the University of Southampton http://eprints.soton.ac.uk/

A further evaluation is being undertaken of the impact of the IPLU 2 and 3 projects on practice. This evaluation is designed to follow up with facilitators and co-ordinators within host organisations to explore the actions taken as a result of the IPLU projects. It will provide valuable information concerning the level of uptake of project outcomes and

[18] The figure includes 72 facilitators in practice who had been involved in an IPLU2 project earlier in the same year.

the identification of factors which can facilitate or detract from this process. It is anticipated that the evaluation team will put together a number of case studies, which can be used to feed back to practice organisations and students and can act as examples for facilitators and students of future cohorts. The study will be reported in March 2007.

Centre for Excellence for Learning and Teaching: Interprofessional learning across the public sector (CETL: IPPS).

In 2004 the University of Southampton was awarded a grant to establish a Centre for Excellence for Learning and Teaching, the focus of which is interprofessional learning across the public sector (CETL:IPPS). Pedagogic research focusing on interprofessional learning in continuing professional development will explore the influences of context, task and mediation on practice-based interprofessional learning. Using case study techniques the relationship of the student experience, the facilitators and the practice-based placement will provide valuable feedback about the pedagogic model used in the New Generation Project (Facilitated Collaborative Interprofessional Learning). Interviews have taken place and analysis is now underway. The findings from this study will complement the New Generation Project Longitudinal Study. This qualitative pedagogic research into aspects of undergraduate IPL will also inform the future development of interprofessional learning approaches for continuing professional development for post-qualified students.

10. Quality Assurance Agency/Department of Health Major review
Over the past year all of the 17 professional programmes commissioned by the Strategic Health Authority have been subject to major review. In all of these reviews common learning and the IPLUs have been strongly praised. Copies of the full reports are available on the Quality Assurance Agency website.

University of Portsmouth Allied Health Professions February 2005
http://www.qaa.ac.uk/reviews/reports/health/uniofportsmouth05.pdf

University of Southampton Allied Health Professions November 2005
http://www.qaa.ac.uk/reviews/reports/health/unisouthampton05.pdf

University of Southampton Nursing & Midwifery March 2006
http://www.qaa.ac.uk/reviews/reports/health/southampton06.pdf

11. Educational innovation – blended learning
Given the differing virtual learning environments in use in the two universities it become necessary from the outset to develop a bespoke web space, www.commonlearning.net

Addressing the logistical challenge of handling the submission of assessments by more then 1500 students at any one time has resulted in the development of an electronic assignment handling and marking system. This is based on the models used by many peer-reviewed journals. The e-assignment handling system has been developed and built by the e-learning staff involved in the project. The use of such a system presents a number of cultural challenges for academic and practice staff in relation to the assessment process. However, the system is effective and enables the handling and

marking of large numbers of assignments without a single piece of paper moving. It also enables clear structured feedback to students on their assignments. The work of an entire cohort can also be stored and retrieved from a single DVD at the end of each academic year. Access to the system is also provided to the External Examiners and they can view the system at any time.

The project has made considerable use of a blended learning environment in line with the pedagogical underpinning of Facilitated Collaborative Interprofessional Learning[19], providing a comprehensive range of learning resources on line. From the outset the concept of students forming an online learning community within their group is promoted. As part of the assessment of IPLU1 students are required to demonstrate their active and appropriate online collaboration as part of the group task. To support this each IPLU group is provided with a personalised forum to enable group interaction and the exchange of work. The facilitator is included as part of the group and is able to contribute to them when they see fit. The involvement of a University Librarian as part of the NGP team proved a vital element in creating these resources.

We have made use of the web to provide extensive learning resources in support of each of the IPLUs. Facilitators from practice and the university are provided with user names and passwords to be able to access these resources. Alongside the development of an electronic system to support assignment handling we have also developed a system to store and present information about all the placement projects and settings. The success of this facility has been such that it is now, in effect, used as the site that provides information about all placements whether uniprofessional or interprofessional across the university.

12. National and International connections

Over the past four years the team involved in the New Generation Project have provided a focus for considerable international interest from health authorities, Universities and Governments across the globe that are facing the challenges of developing team based approached to care. The project team has hosted a large number of international and national visitors and acted in an advisory and consultancy role to a wide range of Universities and Health Departments. Universities from Australia, New Zealand, Canada, the United States of America and Japan have visited and made requests to establish collaboration with the project. The project Director, Professor Debra Humphris is regularly involved in supporting and advising universities, health departments and professional bodies across developed health care systems on approaches to developing similar initiatives in varying settings and contexts. The central driver of this work is the context of the very considerable workforce challenges faced by most developed health care systems across the globe.

13. Sustainability

One of the major tensions with project funding is how to move to a point of operational sustainability once the development phase is complete. The IPLUs form part of all the professional programmes, they are not an added extra, and as such funding for the small core team that supports their delivery has been agreed with each of the schools. A Service

[19] See O'Halloran, et al 2006

Level Agreement is now in place with all of the schools with an agreed cost per student per programme to include the 3 IPLUS. This provides sustainable funding to support the small core staff. It does not, however, include the ongoing costs of our commitment to the research or to any future roles in practice.

14. Interprofessional Learning in a wider context

Across the globe developed health care systems are facing similar workforce challenges. In that context the NGP was never designed to simply develop and implement IPL within pre qualifying programmes. The Project has resulted in the development of an interprofessional approach to raising the awareness of potential students to the range of health and social care programmes available. The FE2HE interprofessional summer school has now been running successfully for the past four years, with support from the Sutton Trust and with outstanding evaluations by the participants. Many former FE2HE participants have now taken up places across the universities, some of whom now act as student mentors for the FE2HE summer school. It is vital that potential students are aware of the wide range of potential careers that health and social care can offer.

15. Common Learning and Foundation Degrees

As the role of the intermediate workforce expands so the composition of teams in practice will broaden to include the Associate Practitioner role. Under Agenda for Change the preparation for these roles is seen as via a Foundation degree. Given the projects wider commitment to workforce innovation the students undertaking the Foundation degree in Health and Social Care, delivered by the Health Care Innovation Unit at the University of Southampton, have IPLU1 integrated within their programme. The students have successfully taken part with the rest of the pre qualifying students for the past two years. This has now been expanded to include students on the Foundation degree in Paramedical Science at the University of Portsmouth. The reality of workforce innovation is not just about the existing professionals learning together to work together better but how new forms of practitioner are also included.

16. Key Lessons learned

16.1 Staff development and learning environment

A critical element of the New Generation Project has been the emergence of a new model of learning in practice. Practice settings provide the ideal environment in which to create the conditions required for students to develop the skills to work as part of an effective team. The ongoing challenge is to work with the Strategic Health Authority and placement provider organisations to ensure that a team based model of learning in practice is sustained. The rate limiting factor in providing students with the experience to learn to work in effective multi professional teams is the availability of placements in practice.

The investment in staff development, both within university and in practice, has been, and remains a vital element of delivering a sound student experience. The quality of facilitation in either setting is the key factor that can make or break the student and staff experience

16.2 Logistics

The logistical realities of working with around 5500 students and their related facilitators has presented a considerable number of challenges to systems, cultures and processes within both Universities. The delivery of a small group model of learning is dependent not only on the availability of facilitators but also of appropriate spaces. The pressures and challenges faced by information and facility management systems have been brought in to stark relief by the scale of the project.

16.3 Service user involvement

One area where there remains considerable scope for the development is the involvement of service users in ongoing curriculum development. As IPLUs in practice have developed so these have provided some opportunities, but we need to increase these.

16.4 Partnerships

The development and delivery of the New Generation Project has been, and remains based on the critical interdependency between education and practice. To deliver the workforce reform commitments made by the Department of Health will continue to require a constructive and creative relationship between the two sectors. For the delivery of IPL to be meaningful and to help shape the practice of future practitioners it is vital that there is a commitment to supporting IPL in practice. The NGP has transformed the model of learning in practice to a team based approach supported by multiprofessional facilitation, and as part of the legitimate practice experience of all the professions involved.

17. Conclusion

An overview of some of the achievements and challenges associated with the New Generation Project has been presented throughout this chapter. The NGP was, and is, ambitious, but we have clearly demonstrated that it is possible to embed interprofessional learning into undergraduate programmes on a large and complex scale. The challenges have been stimulating and at times frustrating. Achieving major cultural and pedagogic changes is never easy and there is still much room for improving processes and mechanisms and focus. Conversely, the achievements have been highly rewarding. Positive evaluation from students across the board, as well as constructive criticism, has created suggestions for improvement which are being actively considered. Perhaps most pleasing has been the positive impact of engaging in IPL on facilitators, particularly those in practice.

Examples of unsolicited facilitator feedback

1. Can I just say that I have been allocated a fantastic group of students. I have not received any of those blank faces that have been present in previous groups and their enthusiasm for the project should be commended. They are working extremely well as a group and are very professional in their approaches to staff and service users despite their anxieties about being placed in a mental health setting. They are a credit to their professions and the University.

2. This is the first time I have facilitated an IPL Group and can honestly say that they are making my life very easy. They are using the forum extremely well; communicating with each other. They all turned up on time and have been very enthusiastic. They seem to have embraced our project and a huge amount of work is being done. Thank you.

3. Myself and my colleague xxxx would like to add to the praise of groups. Our team seems to be working really well together and have already done a huge amount of work for the project; they are also using the forum brilliantly. They obviously have had a good briefing from the universities as to what they are expected to achieve, well done all!

4. I would just like to say that this group is very professional and supportive to one another. The 155 hits on their discussion forum show how they are working together as a team and everyone is contributing. I am converted to IPL groups already and feel very strongly that this team will produce the goods!

However, we are not complacent. There is a need to further extend the concept of IPL within the undergraduate programmes but perhaps more importantly, routinely into post-registration programmes. At the same time, there is a need for continued investment into research which evaluates the impact of IPL over time on the students themselves, the quality of health care delivery and the effectiveness of team working.

Appendix 1

New Generation Project Strategy Group: Membership

Name	Position
Mr Derek Adrian-Harris	Head, Centre for Radiography Education, University of Portsmouth
Dr Jeanette Bartholomew	Head, School of Health & Social Work, University of Portsmouth
Mr John Beer	Director of Social Services, Southampton City Council
Mr Mike Branicki	Learning & Development Adviser, Hampshire County Council
Professor Roger Briggs	Head, School of Health Professions and Rehabilitation Sciences, University of Southampton
Professor Ian Cameron	Head, School, School of Medicine, University of Southampton
Professor Clair du Boulay	Post Graduate Dean, Wessex Institute
Mr David Eccles	Director of Human Resources, Portsmouth Hospitals NHS Trust
Professor Alison Fuller	School of Education, University of Southampton
Mr Denis Gibson	Director of HR, South Central SHA
Mrs Judy Gillow	Director of Nursing, Southampton University Hospitals NHS Trust
Ms Sally Gore	Head of Organisational Development, Hampshire Partnership NHS Trust
Professor Debra Humphris	Director, New Generation Project
Mr Peter Johnson	Expert Patient Project and service user
Mrs Rosalynd Jowett	Director of Learning & Teaching School of Nursing & Midwifery, University of Southampton
Professor Mark Lutman	Head, ISVR Hearing & Balance Centre, University of Southampton
Professor Dame Jill Macleod Clark (Chair)	Deputy Dean of Faculty of Medicine, Health and Life Sciences and Head, School of Nursing & Midwifery, University of Southampton
Dr David Paynton	Southampton City PCT
Jackie Powell	Social Work Studies, University of Southampton
Dr John Wong	Head, School of Pharmacy and Biomedical Sciences, University of Portsmouth
--	Chair, Student Liaison Group

4. Rolling Out

Hugh Barr

Pilots perhaps, but the notion that experience gained by the four sites would be 'rolled out' across England for others to pick up was misleading from the outset. Parallel developments had begun at much the same time, augmented by others during the years under review. Researchers and teachers from the pilot sites therefore offer their case studies as contributions to the growing, collective understanding of pre-registration IPE to be compared and combined with that gained by colleagues plumbing those same depths elsewhere.

Opportunities nevertheless abound to roll out the lessons learned, opportunities to which the pilot sites and others are responding. IPE, albeit taking hold rapidly throughout health and social care across the UK, has yet to be introduced everywhere. Nor are its precepts and practices, born of experience and increasingly corroborated by evidence, universally understood and applied.

The momentum behind IPE is also accelerating in other countries throughout the English speaking world, notably Australasia, North America and the Nordic Countries, generating opportunities to share experience and to learn from each other. Establishing comparable collaboration in the so-called developing countries is more challenging, constrained as they all too often are by lack of resources to evaluate and report IPE initiatives, to travel and to participate in international exchange.

But the greatest challenge, at home and abroad, lies in reaching out beyond health and care as commonly understood to test the relevance of IPE in other working worlds where collaboration between professions can be no less problematic. IPE has indeed been introduced into wider fields during the years under review. That trend continues, most dramatically as education, care and health services for children, young people and their families are reconfigured and the need for IPE becomes apparent to enhance collaboration between the parties. IPE also took root, but briefly, in the built environment field, with support from the Higher Education Funding Council for England while its activists enjoyed periodic exchange with their fellows in health and social care (www.bettertogether.ac.uk). Yet the scope of collaborative education and practice remains relatively narrow in developed countries compared with that in many developing countries where it may embrace economic and community development. That all professions carry a collective obligation to work together for the common good may well become the ultimate goal.

The challenges know no limits, emphasising the need to focus on realistic objectives adequately resourced. Three of the four pilot sites secured funding for Centres of Excellence in Teaching and Learning (CETLs) putting them in an advantageous position to respond. CETL4HealthNE in Newcastle most closely retains the focus of the pilot sites, but spreading developments throughout its region. The Centre for Inter-Professional E-Learning (CIPel) is a joint project between Sheffield Hallam and Coventry universities, working with their faculty to produce wide-ranging interprofessional e-learning materials.

The CETL for Interprofessional Learning across the Public Sector (CETL: IPPS) in Southampton, as its name suggests, explores scope for the wider extension of experience gained from the NGP.

But top priority for each of the four sites must be to replace, secure, protect and, where possible, augment funding to sustain developments started during the pilot phase, at a time when resources for professional education, including interprofessional education, have come under threat.

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