Combined Universities Interprofessional Learning Unit Final Report

Introduction

The Combined Universities Interprofessional Learning Unit (CUILU) is a joint initiative between Sheffield Hallam University and The University of Sheffield, was funded by the Department of Health and the South Yorkshire Workforce Development Confederation and is one of four national leading edge pilot sites for Interprofessional Learning.

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This document is available at **www.sheffield.ac.uk/cuilu.**

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Executive Summary

Health and social care policy and workforce strategies during the past fifteen years have focused on improving services for those who use them. Central to this endeavour is the promotion of effective collaborative working between agencies and with patients/service users in order to provide an integrated service for service users and their carers. This agenda, rather than diminishing, is gaining impetus and calls for education and training that is genuinely multi-professional and enabling of professionals within and across services to work together effectively

This report describes the work and findings of a Department of Health funded project - The Combined Universities Interprofessional Learning Unit (CUILU) - that aimed to implement and evaluate educational strategies that promote capabilities for collaborative working among undergraduate students of health and social care. The funding of a number of similar projects demonstrates the government's investment in supporting projects to help inform the modernisation agenda:

The DoH has already funded joint programmes in IPL … these programmes will achieve national coverage as we ensure that people learn together so they better work together (The NHS Improvement Plan, 2004: 6.8)

CUILU is one of these projects and key learning points, conclusions and recommendations are presented here.

Section 1

The Interprofessional Learning Environment

1a. The Beacon Sites

Selected beacon sites offered the project differing levels of engagement with respect to collaboration and participation in the project. A pivotal aspect to how far the beacon site was able to engage depended on the presence of 'champions' to help in the co-ordination and promotion of the project activities in the sites.

Through analysis of the beacon sites, insights were generated regarding the nature of practice-based learning environments that promote and develop interprofessional capability in the workforce of the future.

Key points:

- The practice context is such that the patients/clients 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 the team are recognised, understood and valued in the interests of providing high quality, integrated care for patients/clients 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 play in the care of patients/clients and their carers.
- Success in implementing robust interprofessional learning structures within the practice area seems dependent on champions and motivated individuals.

1b. Change in Student Attitudes During Their Experience in the Beacon Sites

The major concepts examined through the administration of an attitude scale related to how students perceive their own profession and the attitudes they held towards other professions.

Key points:

- The students demonstrated positive attitudes towards their own profession at baseline. Little change was detected at follow up. However, where change did occur these positive attitudes were intensified following placement.
- Student expectations about working on a placement alongside members and students from other professions were positive for almost two thirds of the students, and there was little change in this attitude at Time 2.
- At baseline 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. One exception to this was the proportion tending to agree that there is an atmosphere of competition between professions decreased.

- The stereotyping of other professions was confronted through the scale. The proportion of respondents ascribing high importance to specified qualities for each professional group did change on certain measures. A positive change towards respondents being more likely to recognise leadership, breadth of life experience, being a team-player and decisiveness as important qualities in other professions following placement.

- The perceived status of other professions was rated at high or very high and this intensified at Time 2 for all professions except Social Work and Speech and Language Therapists.

These data revealed a high baseline of positive attitudes in students commencing experience in the beacon sites. Few changes that were significant in a statistical sense were demonstrated, however the findings suggest that experience in the beacon sites sustained or enhanced students' professional identity and positive attitudes towards other professions. This supports suggestions that interprofessional learning has a role in maintaining positive attitudes during the course of the student's programme of study to qualification.

1c. The Interprofessional Learning Practice Placement Audit Tool

This section discusses the development of an interprofessional placement audit document as a means of identifying and monitoring the quality of interprofessional learning environments. The Interprofessional Learning Practice Placement Audit Tool is the result of collaborative work between the CUILU project and the Sheffield Hallam University Forging Ahead project and was based on original collaborative work between the nursing departments of the University of Sheffield and Sheffield Hallam University. Interviews were conducted with key personnel in four voluntary organisations to explore the tool's utility in identifying potential placements opportunities in non-traditional settings of which the voluntary sector provides a good example.

Key points:

- The Interprofessional Learning Practice Placement Audit Tool could serve a purpose in exploring the Voluntary Sector's potential to offer interprofessional student placements. The Voluntary Sector would welcome the use of such a tool and consider they are in position to bring expertise and experience to bear in order to be in a better position to provide such placements.

- Use of the tool could potentially strengthen links between placement providers and Educational Departments by putting in place stronger monitoring arrangements that would benefit communication.

- Voluntary Sector agencies are potentially rich learning environments for students across health and social care. Nursing and medical students who have accessed these agencies on a voluntary or elective basis have fed back positively on the experience.

- Although the tool proved useful in identifying interprofessional learning experience and support, more work would be required in considering the identification and quality monitoring of uni-professional focused placements.

Section 2

What students need to learn in order to develop interprofessional capability

An emphasis of the CUILU work was on formulating learning outcomes to guide the development of the skills and knowledge that enable students to become effective interprofessional workers. To date, interprofessional learning outcomes for undergraduate students have tended to be set largely on an intuitive or 'common sense' basis and often address topic areas such as teamwork, communication and understanding the roles of other professions. The specific outcomes of learning for interprofessional working therefore needed to be articulated and this necessarily involved describing the components of interprofessional working. It was necessary, therefore, to employ a systematic approach to generating interprofessional learning outcomes that also served a purpose of indicating what interprofessional working involves. These outcomes had also to be not only suitable for undergraduate students and relevant to all professions, but practice orientated and achievable in the workplace.

2a. The Interprofessional Capability Framework

This resulted in The Interprofessional Capability Framework being devised in Phase 1 of the project and then validated in Phase 2 with practitioners and students working in the beacon sites. The Interprofessional Capability Framework has sixteen interprofessional capabilities, each having three incremental learning levels contained in four domains of interprofessional practice: Knowledge in Practice; Ethical Practice; Interprofessional Working and Reflection (learning). The validation processes of the Framework revealed the following key findings.

Key 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 the use of the framework as providing 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 sensitises its users to interprofessional aspects of the learning opportunities available in the practice context. This 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 the topic as an interprofessional and collaborative working issue relevant to interprofessional learning.

- **Service organisation can limit interprofessional learning.** Although the beacon sites were recognised as areas where interprofessional working took place, the success in facilitating interprofessional learning for students seemed to be positively related to how integrated the service organisation and student support in the beacon sites was. Where barriers to organising interprofessional learning seem to be in operation, it is not because of lack of learning opportunities, but a function of the students' experience being managed in profession-specific contexts. This results in students learning, in the same setting, in isolation from each other. Non-integrated structures within the organisation, communication difficulties between professions both in practice and in

the university context, and educational funding stream issues were also cited as reasons for not integrating student learning fully.

- **The Framework's potential to advance interprofessional practice.** When organising learning opportunities across professions for students, learning objectives tend to be set at a level that the 'visiting' student could reasonably achieve, and will be at a lower level than their profession-specific objectives. This is because the student could not be expected to have proficiency in another profession's skills or knowledge. Such objectives, however, do not reflect the complexity of the 'other' profession's role, nor it could be argued, particularly advance the student's own professional understandings. The use of the Framework allows students to access these valuable opportunities but with a purpose of achieving incrementally more challenging interprofessional learning outcomes, thus raising the student's level of achievement, rather than regressing it.

- **Capability brings the patient to the foreground.** The NHS Improvement Plan (2004) underlines the need for the National Health Service to be 'patient driven'. A focus on interprofessional capability through use of the Framework 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. Students' attention being drawn through the Framework to observing the multi-disciplinary team at work for the patient. Such attention to the needs of the patient also facilitates greater understanding of the roles and changing roles of different disciplines and how that impacts upon care provision.

- **The complexity of the Framework.** Despite a general agreement of the capabilities and learning outcomes contained in the Framework being appropriate and reflecting the realities of interprofessional working, some practitioners commented on certain of the statements being overly complex. The Interprofessional Capability Framework was developed from the QAA benchmarks, thus indicating the level of practice that students emerging as qualified practitioners should attain and the learning levels within the Framework attempt to provide a graduated development. However, this issue highlights the tensions concerning the expectations of newly qualified practitioners in respect to skill level, and the level of responsibility seen as appropriate for them to have been given as students in order to learn and be prepared for qualified roles. In turn this may indicate the need for staff and service development in order for students to be appropriately supported as student practitioners.

2c. Student Self-Assessment of Interprofessional Capability Achievement

Students were asked to make a self-assessment on their level of achievement against the learning outcomes contained in the Framework. This was mediated through the students completing a grid against which to rate their perceived level of competence and through discussion in qualitative interviews.

Key points

- Students were able to recognise and assess their interprofessional learning whilst in practice and grade their level of achievement against the learning outcomes contained in the Framework.

- Students were often able to apply and transfer or integrate the theoretical context of interprofessional learning which had been learned within the classroom, to the practice based learning experience. This linking of theory to practice enabled students to progress their learning and achieve higher levels of capability.

- Students were able to discriminate between the levels of achievement. Interestingly where students placed themselves on the Framework was related not to their seniority in terms of years of study or by profession, but depended on the length of experience they had in practice.

2d. Assessment of Capability by Practice-Based Assessors

An Interprofessional Capability Assessment Tool (ICAT) was devised to assist in the consideration of how accessible the learning outcomes contained in the Interprofessional Capability Framework were to assessment by practitioners/ interprofessional mentors. The ICAT was developed as a pilot tool to structure assessment of learning outcomes from within one domain of the Interprofessional Capability Framework. Practitioners who had been involved in supervising students' practice-based learning were asked to reflect on the experience and use the ICAT to make judgements about students' achievement of the learning outcomes.

Key points:

- Practitioners found the ICAT's structured approach helpful and the tool generally user friendly. They believed it could have a practical application in assessing student interprofessional learning in practice areas although issues around language and terminology could present some barriers and may need to be addressed.

- The ICAT provoked consideration of the perspective of the professional background of the student and practitioners felt that they needed to have confidence in their knowledge and understanding of the roles of the interprofessional team in order to assess students from another profession.

- The practitioners considered that the tool reflected the dimension of interprofessional working and indicated that it validated by their own interprofessional practice.

- The use of a tool that addresses the capabilities of all professions to interprofessional working provides a focus for assessing students from another profession during an interprofessional mentoring encounter.

- The use of an interprofessional assessment tool common to all students, was considered to have the potential to ensure equity for students and would motivate students to fuller engagement when being provided with interprofessional learning opportunities.

Section 3

Interprofessional Mentorship

The term 'mentor' was used within the CUILU project to encompass the myriad terms used across the professions to describe the process of teaching, supporting and assessing students in practice environments. There remains a paucity of literature concerning interprofessional mentorship and exploration of the concept of the interprofessional mentor has been central to the work of CUILU.

Interprofessional mentorship and the mechanisms involved in undertaking interprofessional student support and assessment were explored by analysing the qualitative data collected within the project.

Key points:

- Facilitation of interprofessional working is already happening 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 are currently employed within practice that facilitate interprofessional learning. These include: 'shadowing' other professions; attending multi-disciplinary meetings and case conferences; attending shared seminars and attending ward rounds.

- Interprofessional mentorship is already happening and students benefit from the facilitation of their learning by other professions. However, the interprofessional mentor does not replace the uni-professional mentor who takes overall responsibility for the student learning whilst on placement.

- Interprofessional knowledge is the focus of interprofessional mentorship and this applies to both students of the same profession and students of different professions

- The evaluation of interprofessional encounters / learning is already taking place within practice and this can be further developed through use of the Interprofessional Capability Framework.

- There are education and training needs that need to be addressed for interprofessional mentorship to become a more generalised reality.

Section 4

Interprofessional Learning and Teaching Strategies

Teaching and learning strategies that support the development of integrated working remain poorly understood. The CUILU team implemented and evaluated a series of interprofessional seminars in each of the beacon sites in collaboration with practice staff and, in one site, lay participants.

Key points

- **The centrality of the patient/service user.** An important aim of interprofessional education is to improve care. 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 interprofessional learning 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.

Section 5

The involvement of Patients and Service Users in Student Learning and Assessment

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.

5a. Good Practice Guidelines

The CUILU team worked collaboratively with lay participants, students and educators to explore issues concerning how service users and patients can be supported to positively engage in student learning. Good practice guidelines were developed as a response to issues around five main themes central to patient and service user participation in teaching and assessing. The five themes that emerged are: Collaboration, Preparation, Communication Support, Debrief. These themes highlight the commitment required to engage students and service users/patients in learning initiatives which are mindful of the needs of all those involved – students, and service users/patients and the guidelines were developed to address these issues (the guidelines are posted on the CUILU website **www.sheffield.ac.uk/cuilu**).

Key points:

- The time and resource implications of supporting good practice should not be underestimated.

- Closure was identified as an important aspect of good practice, not only to support opportunities for continued involvement following the completion of initiatives, but also to consider strategies for positively supporting disengagement where individuals no longer wish to, or are unable to participate, or where particular participation no longer meets learning needs, (for example in curriculum change).

- Student feedback indicated that the involvement of service users and patients provided high impact and IPL focused learning.

- Service User and Patient evaluation indicated that the Good Practice Guidelines involving collaboration, preparation, communication, support, and debrief enabled a positive and empowering experience of involvement

5b. Service User and Patient Involvement in Student Assessment

An interprofessional 'patient' assessment tool (IPAT) was developed in order to facilitate patient or service user involvement in assessing the inter-professional capabilities of students. The IPAT was further refined through a collaborative process with the CUILU Public and Patient Advisory Group. Members of a Rotherham Stroke and Disability Support Group used and evaluated the tool with students attending interprofessional learning seminars in one of the beacon sites.

Key points:

- The collaborative work with the lay participants to develop the IPAT emphasised the findings related to developing the Good Practice Guidelines described above. This process emphasised that the five themes from the guidelines need to be addressed for successful participation in student assessment.
- Following preparation by the CUILU team, the lay participants found the IPAT tool easy to use and generally accessible.
- The use of a structured tool for IPL assessment by patients, service users or their carers provides a vehicle for active engagement in the students' education, other than merely 'telling their story'.
- The lay participants felt comfortable in their roles as assessors as they felt the perspective of the patient was paramount as a recipient of the service.
- The involvement of service users or patients in student assessment carries the potential to address power differentials in health and social care and enhances the status of the role played by lay participants.

Section 6

The promotion of positive interprofessional learning environments

The project brought together representatives from departments across Health and Social Care in both the University of Sheffield and Sheffield Hallam University to participate in a workshop programme designed to disseminate information about the promotion of positive interprofessional learning environments. A second purpose was to facilitate and support the participants working together to develop programmes of their own in order to cascade insights about interprofessional learning. Evaluation of the CUILU facilitated workshop programme offered a number of insights into how a positive culture around interprofessional learning may be promoted.

Key points

- Champions for interprofessional learning emerged from this process. These individuals, in interdisciplinary partnership, were able to achieve a high level of success through their initiatives. However issues were raised about sustainability of actions following withdrawal of the champions' input and support.
- Giving opportunities for collaboration across institutions and disciplines enabled colleagues to create positive interprofessional learning environments. Both students and educators reported gaining a great deal from the process, and found it enjoyable.
- Participating in the programme gave participants a greater understanding of IPL and built positive relationships across the institutions and disciplines.
- New insights and innovative approaches to learning can be generated by disciplines that do not normally encounter each other working together.

- Change can be achieved when it receives focussed support in terms of financial input and access to expertise as in this workshop programme, but sustainability may be difficult as support is withdrawn.

Section 7

Conclusions and Recommendations

1. The Beacon Sites involved in the CUILU project enabled a description of the learning environments that promote the acquisition of interprofessional capability. It seems that the more integrated a service is in terms of organisational structure and management of student experience, the more conducive the environment is to effective interprofessional learning. Pivotal to the successful organisation of interprofessional learning is the presence of co-ordinating 'champions'.

   Recommendation: As services modernise and become more integrated, student placement learning arrangements should be considered as 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 interprofessional learning required by all students.

2. Non-traditional placement areas, which may or may not be appropriate to provide profession-specific experience for students, may nevertheless offer rich opportunities for students to meet the learning outcomes contained in the Interprofessional Capability Framework, thus raising the potential for expansion of placement capacity. The use of the Interprofessional Learning Practice Placement Audit Tool was seen as an appropriate method for identifying such placements and monitoring and enhancing their quality; and as a vehicle for enhancing communication between service organisations and Higher Education Institutions.

   Recommendation: Attention should be given to the potential of non-traditional placements to offer very rich and valuable learning experience for students of all professions. This process should be mediated through formal quality monitoring and enhancement procedures such as those offered by the Interprofessional Placement Audit Tool.

3. The Interprofessional Capability Framework contains interprofessional capabilities and incremental learning outcomes that are 'common' to all professions and rather than being an 'optional extra' are required aspects of the professional preparation of all students of health and social care. The Framework defines the domains of interprofessional working and guides students and educators to what students need to learn in order to become interprofessionally capable. The Framework was seen as relevant and appropriate to the students and practitioners referring to it, and the learning outcomes were seen being able to be assessed by students, practitioners and lay participants in the project.

   Recommendation. Clear learning outcomes that are accessible to assessment and common to all students should be utilised In order to take a strategic approach to managing interprofessional learning across all professions. The Interprofessional Learning Capability Framework offers one methodology for this, acknowledging that others may be available and appropriate.

4. Although there has been to date a lack of conceptualisation of interprofessional mentorship, CUILU have identified that aspects of interprofessional mentorship already takes place in the beacon sites. CUILU contends that the purpose of interprofessional mentorship is

to develop students' development as interprofessional workers though facilitation, supervision and assessment of students' interprofessional learning. This process is conducted with students from the mentor's own profession as well as students of other professions. The interprofessional mentor does not replace the uni-professional mentor, but nevertheless develops important skills and knowledge common to all professions. The interprofessional mentor assists students to understand: professional demarcations and the roles of various professions; where individual contributions of the care team are collaborative in nature and where roles and functions may overlap in order to provide the best possible care for the individual and his or her carers.

Recommendation. Preparation for the interprofessional aspects of the role of individuals who support students both in university and in practice should be undertaken either as part of uni-professional preparation of individuals in these roles, but preferably as an interdisciplinary endeavour.

5. Patient and service user involvement on student learning is seen as pivotal to interprofessional learning and students perceive such contact with patients, service users and their carers as a rich and enhancing source of learning. The perspective of lay participants as part of the learning and assessment process emphasises the centrality of the patient and provokes consideration of service arrangements. However, such participation is not without its problems and difficulties for all stakeholders in the process and the resource demand to ensure effective participation can be overlooked.

   Recommendation. Participation in student learning by lay participants must be carefully planned, managed and adequately resourced. The CUILU Good Practice Guidelines can assist educators to consider the issues.

6. The active promotion of positive inter-professional learning environments is a fruitful way of commencing a culture change process and embedding interprofessional learning into the educational ethos of both practice and university contexts. However, implementing such culture change and logistical organisation is extremely challenging. Pivotal to success this process is the presence of enthusiastic individuals to take forward the process and acting as champions for interprofessional learning. This raises issues of resource and where projects are funded and champions are in place progress can take place, this is true also in placement areas where champions take forward inter-professional learning, but if funding or support is withdrawn the initiatives subside. The workshop programme facilitated by CUILU demonstrated that where resource was made available for individuals to take part, extremely interesting and important results were achieved.

   Recommendation. In order to sustain change in the educational culture with respect to interprofessional learning, commitment of adequate resource must be obtained.

   Recommendation. Strategic embedding of interprofessional learning cannot rely on the activity of champions alone, however vital they will remain to be. Attention needs to be given to structures and processes in the management of education to facilitate interprofessional teaching, learning and assessing both in the context of the Higher Education Institution (HEI) and the service providers that provide student experience in partnership with the HEIs. Performance indicators both in educational commissioning and quality enhancement procedures also have a potential role in supporting the development of interprofessional learning.

An executive summary of this report has been published separately (ISBN 1843871424) and is available at **www.sheffield.ac.uk/cuilu** or in hard copy from the named contacts above.

Introduction to the Project

The Combined Universities Interprofessional Learning Unit (CUILU) is a joint initiative between the University of Sheffield and Sheffield Hallam University, and is the result of a successful bid to the Department of Health to become one of four national leading edge pilot sites for interprofessional learning. The original title of the bid was 'Hub and Spoke'. The South Yorkshire Workforce Development Confederation provides additional funding to the unit. The aim of the unit was to act as a 'hub and spoke' project to facilitate interprofessional learning through close collaboration with local educational and professional agencies.

Goal and Objectives

Goal

The goal of the project was to build multi-method; practice based interprofessional learning in South Yorkshire, specifically related to the needs of the patient/client and, through this, to develop health care professionals who can engage in effective interdisciplinary service teams.

Objectives

1. Map curricula of health and social care courses in both universities
2. Draw together initiatives currently being undertaken separately
3. Stimulate change in the use of existing and new resources to promote new approaches
4. Train and support academic and clinical staff as facilitators of student learning, using a multi method approach
5. Evaluate the interprofessional learning outcomes
6. Embed interprofessional learning within the current curricula
7. Research further developments in interprofessional learning outcomes
8. Disseminate good interprofessional learning practice methods and materials through conference communications, publication, reports and through the internet
9. Explore, inform and facilitate meaningful patient and public involvement in interprofessional education that meets the needs of service users, students and educators

The philosophical orientation of the project

The main work of this project took place in the practice environment of identified 'beacon sites' (see below). The findings have been generated through the active involvement of its participants with the lay people, students, practitioners and educators involved being conceptualised as collaborators in the project and contributors to its outcomes. This philosophical orientation drew on understandings suggested by the research

approach of co-operative inquiry. Co-operative inquiry that can be said to be a prime example of what is termed new paradigm research. New paradigm research is a synthesis of naive inquiry (our day-to-day thinking that is prone to error and bias) and objective research (that, in its efforts to control subjectivity and error, loses the meaningful human aspects of knowledge generation). New paradigm research is an approach that is systematic and rigorous but places the participant and his/her perspectives at the centre of the research (Rowan and Reason, 1981). This model of co-operative inquiry is based on a belief that individuals as social actors (lay people, students, practitioners, educators, project team members) or organisations as social actors (social services, hospitals, universities, health authorities) are continuously involved in informal 'inquiry in action' on their own performance in order to function more effectively. The researcher engaged in co-operative inquiry seeks to harness this inquiry in action but works more with and for the participants as co-researchers, than on or about them as subjects (Heron, 1996).

Congruence of this approach to project activities

This approach is congruent with the aims of this project in that the participants were asked to contribute their understandings to help drive the direction of the project; to share their experiences to identify areas to consider and address; to reflect, through the medium of loosely-structured interviews on the learning environment; to participate in process evaluations; to contribute as curriculum designers, teachers, learners and evaluators in the teaching/learning activities undertaken as part of the project.

Background

This section introduces some of the literature drawn upon in the early stages of the CUILU project. In keeping with qualitative research approaches, further literature is introduced in the findings sections to illuminate the findings.

Definitions of interprofessional learning

There is a lack of clarity surrounding the use of language in the literature with the terms interprofessional, multidisciplinary, shared, common or collaborative being used interchangeably. CUILU has adopted the definitions used by the Centre for the Advancement of Interprofessional Education (CAIPE). Interprofessional education is defined as:

> *Occasions when two or more professions learn from and about each other to improve collaboration and the quality of care.*

and multiprofessional education as:

> *Occasions when two or more professions learn side by side for whatever reason. (Barr 1997)*

Impact of interprofessional learning

Although long-term impact on service delivery is still speculative, interprofessional learning is considered a key component of the government's modernisation agenda and is encouraged as a mechanism to break down the barriers and enable effective teamwork in the NHS (Kennedy, 2001). A Cochrane Review, (Zwarenstein et al 2002) concluded that studies completed thus far highlighted the need for more rigorous methods in understanding the potential impact of interprofessional learning on professional practice and health outcomes especially in light of clinical governance. Little evidence that meets the EPOC (Effective Practice and Organisation of Care) criteria used in Cochrane review is available.

However, positive outcomes have been noted on the process and outcome of interprofessional learning i.e. reactions to the learning experience; changes in attitude or perception; the acquisition of knowledge and or skills and the effects on patients or clients. Importantly, Zwarenstein and Reeves (2000) indicate that interprofessional working (specifically the nurse-doctor relationship) has positive patient outcomes. Also there is emerging evidence (West et al, 2002) that encouraging staff to work in teams may be a positive factor in reducing patient mortality (at least in hospitals).

Opportunities for interprofessional learning

From these reviews and the work completed by bodies such as CAIPE and the Learning and Teaching Support Network (LTSN) emerging themes begin to establish the principles of interprofessional learning (CAIPE, 1996; Barr 1997) including: placing service users at the centre of interprofessional learning; promoting collaboration between service users, carers, communities and organisations. The delivery of interprofessional learning should employ a repertoire of learning methods; be rigorously evaluated by systematic evaluation; validation and approval and continue to disseminate findings to inform future developments. With respect to the context of learning, Barr (2000) found that work-based interprofessional learning was markedly more likely than college-based teaching to improve the quality of service and/or bring direct benefits to patients (generally in student's experience lasting for longer than 2 weeks).

Sheets-Cook (2002) and Schmitt (2001) both reported that students completing interprofessional and multiprofessional learning valued sharing the programme with other health students. This form of education can have some effect on addressing negative stereotyping that impedes successful collaboration (Parsell et al 1998) and enhance students' teamwork skills, (Van der Horst et al 1995). However there is also evidence that enthusiasm diminishes over time unless learning is regularly reinforced (David & Smith 1987). There is a general movement in education for students to become more self-directed, critical thinkers and reflective practitioners, able to function as members of teams, be good communicators and adaptable to change; the intention being that these features carry through to their post-registration careers and support better patient care.

Patient involvement

The drive toward user involvement emerges from a number of strands including an increase in lay knowledge and consumerist approaches (embodied in key documents such as the *Citizens Charter,* 1991) which encourage active patient/client/service user participation in shaping services, and a general trend toward patient/client centred approaches within professional groups themselves (see Ovretveit, 1997). One of the keystones of interprofessional learning and partnership working is therefore the positioning of patients/clients as a central force in enhancing quality care. This positioning is reflected in various Department of Health initiatives including the 1999 White Paper *Saving Lives: Our Healthier Nation* and the subsequent *The NHS Plan* (DoH 2000). Additionally *The Expert Patient: A New Approach to Chronic Disease Management* (DoH 2002) carries forward the concept of the expert patient with key recommendations which recognise that 'the knowledge and experience held by the patient has for too long been an untapped resource' and argues that patients should 'be part of the process of developing professional education'.

The move toward interprofessional learning and patient partnership is reflected in current education programmes. For example, the curriculum guidance for the new pre-registration nursing programmes in England reinforces the importance of service users in developing client centred education and health care (Le Var 2002). Such initiatives indicate a cultural shift in the delivery of health and social care, and if these are to be successful in facilitating user centred partnership, then such moves must be orchestrated across all professional groups, to forge a strategic approach to planning user/carer involvement in all curricula and the development of a culture where this is the norm (Morgan & Sanggaren 1997). Thus the involvement of patients/clients in professional education can in itself unify interprofessional working (Mathias 1997) and the proliferation of consumer groups represents a desire for users to be directly involved in the formation of service delivery. However, a number of commentators note that engaging service users in professional education presents a number of challenges, including consideration of practical, ethical and legal issues (Sayer et al 2002).

Barriers to interprofessional learning

Sheets-Cooke (2002) identified reluctance in lecturers to teach across disciplines and Morison *et. al.* (2003) comment that the implementation of interprofessional learning brings enormous logistical and practical problems. These problems include issues around curriculum timetabling across different academic institutions; inequality between student numbers; course validation issues; professional requirements of practice; accountability to stakeholders and a lack of reward structure for students attending interprofessional learning initiatives.
Such initiatives can present challenges for educators in terms of when to introduce programmes of interprofessional learning into the undergraduate curriculum. Barr (1996) summarises this dilemma when he indicates that early introduction of interprofessional learning programmes can be demanding for tutor and

learner in the sense that learners new to their education and training programmes are less likely to have a strong knowledge base, which is required as a foundation for sharing experience and working flexibly within an interprofessional team and learning environment. However, later introduction risks learners becoming entrenched in a specific uniprofessional strategy and approach which can lead to prejudice and negative stereotyping.

Interprofessional stereotyping is considered to present barriers to effective working relationships. It is suggested that collaborative team working could be enhanced by the fostering of more positive stereotypes (Barnes et al, 2000). Interprofessional education has been shown to effect a diminution of negative stereotyping (Hewstone and Brown 1986, Hewstone *et al* 1994, Carpenter 1995 a and b, Barnes et al, 2000) and is encouraged as a mechanism to break down the barriers and enable effective teamwork in the NHS (Kennedy, 2001).

Practice as a source of educational evidence

Problems of communication breakdowns for which health and social care services have been criticised in the past, continue to exist today (Kennedy, 2001; Laming, 2003). Although it is evident that services need to change, it remains unclear how students need to be educated for participation in evolving interprofessional services. These issues point to a problematic theory-practice gap in interprofessional learning and working, in that the processes involved in preparing students to become effective interprofessional workers, and how this may directly benefit patients and clients, remains poorly understood.
This carries an implicit but clear objective to contribute to the evidence base for interprofessional learning including the development of educational theory (Cooper *et al*, 2001). The approach of the CUILU project was that such theory should be generated through practice.

This was based on a value system that sees practice itself as a source of knowledge (Ramprogus, 2002). Conventional understandings of the theory practice gap emerge from traditional perspectives in which theory is *imposed* on practice (Schön, 1983). Such impositions fail to acknowledge the existence of the epistemologies, i.e. *ways of knowing* about practice. These ways of knowing about practice arise from the practitioner's need to respond to the uncertainty, uniqueness, value conflicts and instability that are a feature of interprofessional practice and in which 'formal' theory may not always be helpful, relevant or even exist.

This approach supports Polkinghorne's (1992) ideas about the way that expert practitioners (and for the purposes of CUILU, students and lay participants) describe their practice, and is based on the belief that practitioners are capable of generating a body of knowledge *through* their experiences. He claims that as practice experience accumulates, the individual's thinking evolves, helping him/her to develop knowledge gained from working with patients/clients until all elements of new situations are related into a meaningful whole. This is particularly important in relation to emerging and changing environments where the practitioner has to adapt to multi-layered complexity, such as in interprofessional learning.

The CUILU team considered that some of the answers regarding the effective education of future practitioners lay in an exploration of the practice arena itself. Practice-based beacon sites were identified to participate in the project. It was considered that the beacon sites offered high quality, professionally focused learning environments along with an enriched perspective of interprofessional learning and had the potential to include public and patient participation.

The beacon sites:

- 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 (Rockingham Ward

Conclusion

Evidence is emerging that more positive patient outcomes are attained by collaborative interprofessional teams (e.g. West *et al,* 2002). The current policy and workforce strategy to promote effective collaborative working between agencies and with patients/service users calls for education and training that is genuinely multiprofessional (see The NHS Plan (DoH 2000a); the Bristol Enquiry Final Report (Kennedy, 2001); Victoria Climbié Report (Laming, 2003) and the Expert Patient (DoH, 2002). The thrust of the government's agenda to modernise health and social care services is to provide an integrated service for service users and their carers, a central recognition being that professionals within and across services require to work together effectively (DoH, 1999 and b; DoH, 2001).

Key policy documents published during the course of the CUILU project (Wanless 2004, Department of Health 2004a, Department of Health 2004b, Health 2004c) re-emphasise the government's continuing drive towards an agenda for modernisation and improvement in health and social care services. The view that interprofessional learning can help bring these aspirations to fruition is reinforced in these documents and the government has invested in supporting projects to help inform the agenda:

> ***The DoH has already funded joint programmes in interprofessional learning … these programmes will achieve national coverage as we ensure that people learn together so they better work together (The NHS Improvement Plan, 2004: 6.8)***

CUILU is one of these projects and key learning points, conclusions and recommendations derived from the project are presented in this final report.

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Method

An overall qualitative approach was taken within the project and its ethos and processes were underpinned by the theoretical perspective of the 'contact hypothesis' (Amir, 1969; Rothbart and John, 1985; Hewstone and Brown 1986; Carpenter 1995; Carpenter and Hewstone 1996). This perspective was considered useful in that it is recognised that barriers to effective multidisciplinary working relationships are presented by negative interdisciplinary stereotyping.

The contact hypothesis, drawn from social psychology, proposes that properly managed contact between groups can change attitudes and foster more positive stereotypes, so enhancing collaborative team working (Barnes et al, 2000). Hewstone and Brown (1986) elicited the importance of the following variables to the success of the contact:

- Institutional support for the learning activities
- Recognition of equal status among the participants
- Positive expectations regarding the outcomes of the activities
- A co-operative atmosphere in the learning endeavour
- An understanding of both the differences and the similarities in professional roles
- The participants working together as equals
- The participants seeing 'others' as typical, rather than exceptions of their professions.

These variables have been shown to promote success in the outcomes of interprofessional learning. Previous work in interprofessional education, where these variables have been ensured, has been shown to effect both a diminution of negative stereotyping and the promotion of a more positive professional identity among participants (Hewstone et al 1994, Carpenter 1995 a and b, Barnes et al, 2000). The CUILU project has endeavoured, along with working with the philosophical and methodological approaches of collaborative, action-orientated inquiry, to ensure the presence of these variables in not only the teaching/learning strategies employed, but in all processes of the project.

Design

The project design was developed from the Hub and Spoke bid and planned in two phases. Phase 1 involved background work to inform the design and conduct of Phase 2 of the project.

Objectives of the project

The key objectives for phase 1 were:

1. To develop interprofessional learning outcomes by mapping the curricula of health and social care programmes across the two universities and by analysing the Quality Assurance Association Benchmarks related to these curricula.

2. To conduct a scoping exercise in order to identify interprofessional learning initiatives being undertaken across the South Yorkshire region.

3. To undertake preparatory work, including reference to the literature and the conduct of qualitative interviews, to inform the development of the Phase 2 activities.

Key decisions made regarding Phase 2 of the project informed by the findings of Phase 1 were:

1. Phase 2 of the project would focus on practice-based interprofessional learning and consider:
   - the validation of interprofessional learning objectives devised in Phase 1
   - the evaluation of practice-based interprofessional learning teaching/learning strategies
   - an exploration of the role of practitioners who support student learning (the interprofessional mentor)
   - a description of practice-based learning environments that support interprofessional learning
   - the utility of an Interprofessional Learning Practice Placement Audit Tool in non-traditional placement areas
   - a workshop programme to promote the development of positive interprofessional learning environments

2. Lay involvement in student learning and assessment would be explored and best practice guidelines regarding lay involvement would be formulated.

The key objectives of phase 2 were:

1. To design, implement and evaluate a framework of interprofessional teaching/learning practice in collaboration with key participants.

2. To determine student attitudes towards their own professional group and other participating groups both prior to and on completion of the programme / placement.

3. To explore the role of public patient participation in interprofessional learning and develop good practice guidelines with respect to this.

4. To describe the nature of rich interprofessional learning environments.

Research strategies: data collection and analysis

The strategies employed to meet the objectives of both phases of the project were: documentary analysis and curriculum mapping, process evaluation strategies and measurement of student attitudes to their own and other professional groups.

a. Documentary analysis

In order to articulate the dimensions of interprofessional working and the learning outcomes regarding the skills and knowledge to enable interprofessional working, an analysis was undertaken of the Higher Education Quality Assurance Agency (QAA) (2000; 2001; 2002) benchmark statements relating to the undergraduate programmes of medicine, dentistry, the professions allied to medicine and nursing, midwifery and social work. These were considered 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, also providing general guidance for articulating the learning outcomes associated with the programmes (QAA, 2002).

Following Glaser and Strauss's (1967) and Strauss's (1987) assertions that grounded theory approaches can be employed on diverse data sources including, for example, interview transcripts, dairies, letters, questionnaire answers and even statistical data, it was decided to analyse the various benchmark statements above using grounded theory strategies of: theoretical sensitivity, constant comparison and coding and categorising the data.

Glaser (1992) describes theoretical sensitivity as the researcher approaching the data with an awareness of their subtleties. Constant comparison is the principal approach to data analysis in the development of grounded theory and is used throughout the analysis to compare each incident within the data to the next, to integrate categories and eventually delimit the theory (Glaser and Strauss, 1967). The purpose of coding and categorising is to conceptualise and identify patterns within the data and begins the initial process of theory development (Charmaz, 2000). These processes include applying conceptual labels to data, sorting these data into groups and clustering these groups to generate conceptual domains within and arising from the data.

The CUILU team were sensitive to those aspects of practice that are thought to underpin interprofessional working and also the subject areas that tend to be taught under the rubric of interprofessional learning through their close involvement in teaching and researching interprofessional learning, The documents were approached using these 'antennae' of theoretical sensitivity. Each of the guideline statements across all the documents was compared and labelled (coded) and resulted in the isolation of items that could be related to interprofessional issues. These items were analysed for similarity and common meanings and further analytic operations of sorting, grouping and categorising the codes (Strauss and Corbin, 1998) resulted in the emergence of four domains labelled as: Knowledge in Practice, Ethical Practice, Interprofessional Working and Reflection.

At the stage of coding and grouping items within and across the QAA benchmark statements, the coded items were grouped according to their common meanings. From these groupings it was possible to conflate the data and state them in the form of learning objectives – later to be articulated as capabilities.

b. Curriculum mapping exercise

The generated domains were used as a mapping tool to check for and ensure that the topic areas suggested by the domains and learning objectives were addressed in all of the undergraduate curricula.

c. Process evaluation strategies

The work described in the report is founded on policy drivers and the findings may contribute to decision-making about the nature, organisation and delivery of educational provision in health and social care. Gray (1997) indicates that many decisions made in the health service are influenced by values held by the decision makers in the context of resources, and therefore opinion-based. Gray indicates, however, that there is a move towards more evidence-based decision-making and Clarke (2001), suggests that evaluation studies can provide information that allows better informed decision making. A number of process evaluation strategies were undertaken during the conduct of the project. Process evaluation refers to an examination of the actual activities carried out within a programme (Lazenbatt, 2002). The evaluation strategies employed in the project included: evaluation of teaching/learning sessions in the practice-based interprofessional seminars; the collection of evaluation data around the validation of the Interprofessional Capability Framework including through the use of a tool for patient/carer

assessment of student learning; the use of student self- assessment of their emerging interprofessional capability and mentors' views regarding assessment of student achievement of capability.

d. Measurement of student attitudes to their own and other professional groups

Data collection

In order to determine whether exposure to enhanced interprofessional learning environments would result in changes in attitude with respect to the stereotyping of other professional groups and identification with own professional group, permission to use an attitude scale based on the work of Carpenter (1995a and b) was obtained. The scale was administered to the students within the CUILU beacon sites at the commencement of their placement/allocation/attachment and re-administered on the completion of their experience.

Sample

Students of the health and social care professions allocated to the beacon sites in order to gain practice experience were asked to complete the questionnaire on commencement and completion of their placement. The sites selected for the study host a variety of student groups across the health and social care professions from both universities. The sites selected for the study host a variety of student groups across the health and social care professions from both universities and fifty two students completing experience of more than four weeks were allocated to the sites during CUILU activity in phase two of the project. Forty one students agreed to complete Time 1 of the scale and twenty four students returned Time 2.

Analysis

Data collected were analysed in keeping with the work conducted by Barnes et al (2000). Statistical analyses were conducted using the Statistical Package for Social Sciences (SPSS). Non-parametric approaches were used as sample sizes were relatively small. Differences between individuals over time were calculated and analysed using the Wilcoxon signed ranks test. The results of these analyses are presented in section 1.

e. Process evaluation

Qualitative interviews and focus group interviews

Loosely structured interviews were undertaken in both Phases of the project and focus group interviews were conducted in Phase 2. A paucity of qualitative studies has been identified by a critical review of evaluations of interprofessional learning (Freeth et al, 2002) who pointed to a need for participants and particularly learners', reactions to interprofessional learning initiatives be more widely reported. In order to respond to these issues qualitative interviews were conducted in both phases of the project.

Qualitative interviews

Qualitative interviews hold the purpose of providing in-depth narrative that address the perspective of the participants. The resulting data are rich and detailed from samples that are not required to be large. Powney and Watts (1987) have described such interviews as 'informant', where the researcher's purpose is to allow the interviewee freedom to express his or her own ideas or perceptions. The intent of interviews of the CUILU project was to enable the participants to discuss their experience in-depth. Yow (1994:5) explains that such interviews,

> *…… enable the researcher to give the subject leeway to answer as he or she chooses, to attribute meanings to the experiences under discussion, and to interject topics.*

The interviews could be described as loosely structured in that interview schedules were prepared, partly to provide a guide as more than one interviewer was involved in the data collection and partly to focus the interview

around the project interests. The questions in the schedule, however, were open and the interviewers used the schedule as a guide rather than in a tightly structured format, being free to pursue interesting threads raised by the participants. The interviews, depending on the time the participants had available, lasted between thirty minutes and an hour and were audio tape-recorded and transcribed verbatim.

ii. Focus group interviews

In Phase 2 of the project, focus group interviews were conducted with lay practitioners. Focus groups are interviews with a small number of participants, facilitated by a researcher and centre on a specific topic. They generate primarily qualitative data by capitalising on the interaction that takes place in the group setting (Sim and Wright 2000). The Focus group approach was seen as particularly relevant to the CUILU project as these interviews are noted for being able to bring together a group of people to discuss a topic of mutual interest to both themselves and the researcher (Morgan ,1996). The focus group interview is a method that provides immediate feedback about how others respond to our ideas (Kruegar 1994). The focus group interviews conducted in this study, were facilitated by a researcher through providing triggers to start the discussion and by facilitating all group members to participate and also by following up interesting threads by probing and asking for further clarification. A co-facilitator recorded key points on a flip chart, thus enabling participants to further discuss and agree the emerging perspectives. The focus group interviews lasted between an hour and hour and one and a half hours and were tape recorded and transcribed verbatim.

Sampling decisions

Morse (1991) suggests that within qualitative research the sample should be 'purposeful' in that the participants are intentionally selected according to the needs of the study. This can conflict with notions of bias and objectivity and Chenitz and Swanson (1986) indicate that all sampling procedures are based on the notion of representativeness. Representativeness in qualitative work, however, is taken to mean that the data related to a phenomenon are collected from those who best know it (Creswell, 1998). In this study the sample of participants were specifically asked to participate in Morse's terms, purposively, either in person or in writing due to their acknowledged familiarity with the phenomenon in question.

In Phase 1 of the project, the phenomenon of interest with respect to the interviews was previous experience of being involved in interprofessional learning initiatives, or in the case of lay advisors being involved in any type of student learning and/or curriculum development. Eleven students participated, these students had been involved in either the core interprofessional learning curriculum at Sheffield Hallam University or a project involving medical and nursing students at the University of Sheffield. Eleven university teachers across both universities who had experience of interprofessional teaching/learning and three lay advisors to the project agreed to be interviewed.

In Phase 2, the phenomenon of interest moved to be more specifically related to the activities of the project. Thirty-eight students who were gaining experience in the CUILU pilot areas agreed to be interviewed (medical n= 7; nurses n= 22; social workers n= 3; occupational therapy=2; physiotherapy = 4).

Twenty-two practitioners working in the pilot areas and who were in some way involved in supporting students also agreed to be interviewed (medical n= 3; nurses n= 8; social workers n= 5 occupational therapy n=2; paramedic = 1; dietician = 1; NHS Trust executive = 2).

Four focus group interviews were conducted during Phase 2 of the project with members of

the CUILU Public and Patient Advisory Group and members of the Rotherham Stroke and Disability Support Group.

Analysis

The data collection and analytic operations used in this study were in keeping with the qualitative imperatives of maintaining a commitment to the participant's point of view; acknowledging the participation of the researcher in the research and conveyance of an understanding of the phenomena of interest by reporting in a literary style rich with the participants' commentary (Streubert and Carpenter, 1995). The aim of the analysis of the transcribed interviews was to identify themes emerging in the data and to report these from the perspective of the participants. In order to be able to manage effectively the large amount of data generated, a computerised software programme QSR N6 NUD*IST was employed. This programme lends itself to a qualitative content analysis approach (Priest *et al* 2002). Content analysis strategies arose from the quantitative paradigm where data are pre-structured by the response categories built into the data collection instruments.

In qualitative research where the structure of the data is not pre-determined and the meanings within data are context-bound, content analysis can carry the limitation of over-reducing the data with a resultant loss of the contextual meaning grounded in the data. Care was, therefore, taken to ensure that the use of the software programme was primarily driven by the need to manage the data in that the original context was retained in the analytic procedures, but the computer enables a switching back and forth between analytic material and the original data (Fielding and Lee, 1998) and that the qualitative imperative of context-bound interpretation was not lost.

In some exploratory studies the main analytic categories are to some extent pre-determined and are reflected in the formulation of the questions set in the data collection instrument. These categories are created as master codes into which the data are sorted through the computer programme (Priest *et al*, 2002). In this study, a priori themes or categories had not been assumed and the interview transcripts were read several times in order to derive the master codes (categories within the data) arising within the topics of interest explored in the interviews. These master codes were entered into the programme and the researcher would undertake first level coding of all texts and ascertain the master codes and sort data into them. Thereafter second and third level coding would identify core themes within the categories. Interpretation of meanings within these themes was undertaken and to illustrate the source of these interpretations, participants' actual quotes would be offered as 'evidence' of the researcher's interpretations being grounded in, and derived from, the data.

Trustworthiness of the project

Credibility, transferability dependability and confirmability (Lincoln and Guba, 1985) rather than validity and reliability are widely accepted concepts against which to evaluate the trustworthiness of qualitative research approaches. Other writers have taken up these issues (for example Miles and Huberman 1994) but here Lincoln and Guba's work (1985) will be used as a framework to discuss how issues of trustworthiness were attended to.

Credibility, according to Lincoln and Guba, refers to the 'truth value' of the findings. Activities that make it more likely that credible findings and interpretations are produced are: prolonged engagement to learn the culture and gain the trust of the participants and persistent observation in order to identify those elements in the situation most relevant to the research interest. It is considered that the CUILU team's familiarity of the context through being health and social care professionals themselves and through their interactions with the lay advisors and students and staff in the beacon sites through regular

meetings, visits and discussions go some way to meeting this imperative.

Other issues concerning credibility include: peer debriefing to provide an external check on the processes of inquiry and member checking to provide a direct test of findings and interpretations from the participants. In the present study peer debriefing was undertaken through regular team meetings to discuss the processes of the project activities, and as analysis of data took place, for the analyses conducted by individual team members to be checked for plausibility and evidence of being grounded in the data by other members. Fielding and Lee (1998) suggest that the use of computer software enhances the acceptability and credibility of qualitative research by the ease in which the analytic procedures can be audited within the team or by external auditor. Member checks have been facilitated by the sharing of analyses within focus group discussions and the use of newsletters to the beacon sites and lay advisory panel.

Transferability, according to Lincoln and Guba refers to whether the findings arising from the context studied can be transferred to another context. The CUILU team makes no claims for the project's context-bound interpretations being generalizable, and aims only to provide sufficient descriptive data, through the presentation of participant quotes and other data, for decisions to be made whether it is possible for the findings to be transferred to other contexts.

Dependability is the qualitative researcher's equivalent of 'reliability'. Lincoln and Guba contend that there can be no dependability without credibility, but nevertheless consider that a study's dependability should be established along with its credibility. Both the dependability and the confirmability of a study may be addressed by an audit trail, which is available through the records kept of the processes of the project and the analytic operations.

Research governance and ethical clearance

Ethical approval

As this research sought to engage with NHS staff from around South Yorkshire and University staff and students based at both Sheffield Hallam University and the University of Sheffield, it was necessary to gain NHS ethical approval and research governance.

Phase 1 of the study involved undertaking interviews with practitioners and clinical educators based within the Sheffield Teaching Hospital NHS Foundation Trust, and lecturers from both of the universities. Therefore, an application for ethics approval was submitted to the North Sheffield Local Research Ethics Committee. Approval was granted and at this point reciprocal approval was sought from the South Sheffield Research Ethics Committee. Additionally, copies of the application and letter of approval were registered with both the University of Sheffield and Sheffield Hallam University Ethics Committees. An application for research governance was successfully submitted to Sheffield Teaching Hospitals NHS Foundation Trust and Letters of Authority were provided by Sheffield Teaching Hospital.

Phase 2 of the study involved interviews with practitioners based within the CUILU beacon sites, as well as students from Sheffield Hallam University and the University of Sheffield, along with the administration of the Carpenter Attitude Scale. As the pilot sites were situated within five different NHS Trusts across south Yorkshire, ethical and research governance approval was successfully applied for from Barnsley Local Research Ethics Committee (LREC), as the primary LREC. Subsequent applications were submitted to Doncaster LREC, Rotherham LREC and South Sheffield LREC to seek reciprocal approval, which was granted. Details were also registered with the Sheffield Hallam University and the University

of Sheffield ethics and research governance committees. Applications for research governance approval were submitted to Barnsley District General Hospital NHS Trust, Doncaster and Bassettlaw Hospitals NHS Trust, Rotherham General Hospitals NHS Trust, Sheffield Teaching Hospitals NHS Trust and the Sheffield Health and Social Research Consortium. Letters of Authority were then issued by each of the aforementioned Trusts and the South East Sheffield PCT.

As the study progressed, two smaller studies were included within phase two of the project. Interprofessional Capability Assessment Tools (ICAT and IPAT) were devised to explore the assessment of interprofessional capability. As this involved working with practitioners and lay participants in the Rotherham pilot site, a significant amendment application was submitted to Barnsley LREC (as the primary LREC). On receipt of approval, reciprocal approval was successfully granted from the Rotherham LREC and research governance approval from Rotherham General Hospitals NHS Trust.

The exploration of the voluntary sector's potential to provide interprofessional student placement, using the Interprofessional Learning Practice Placement Audit Tool, involved interviewing staff from within these services. As this work did not involve NHS staff, successful applications for ethics and research governance approval were granted by the Sheffield Hallam University Ethics and Research Governance Committee.

Ethical issues

Issues of power differential, particularly in the case of students and lay participants, were of paramount importance in this study. All participants were fully informed of the aims of the project and the processes of the study in order for their consent to participate to be as informed as possible. Interviewees were requested to provide signed consent for their engagement with the study. The participants were assured that they could withdraw from the study and/or terminate their involvement at any point without penalty. The confidentiality of interviewees was be secured with all contact details, tapes, transcripts, student-completed questionnaires and other paper and electronic documentation being kept securely either in identified locked cupboards or under password control. Names and other identifying features were obscured or changed in the reporting of the interviews, field notes and other observational data in order to protect the privacy of participants. All audiocassette tapes will be destroyed at the close of the study. To enable the tracing of differences between individuals over time, students were asked to enter their name, student cohort and professional group on the professional stereotyping questionnaire. This information was coded for data analysis.

The risk of stress or other harm to interviewees was minimised as far as possible throughout the study. Students were reassured that the uni-professional focus of their placement would not be affected, in fact it was considered that the educational enhancement would assist students to meet their uni-professional learning outcomes. Qualitative interviews carry a potential closeness to the therapeutic interview (Kvale, 1996) and in some situations participants may find it easy to disclose information they would not normally share. All participants were reassured that any information they did not wish to be reported or tape-recorded would be respected. It was not anticipated that the subject matter of the interviews would cause any undue reactions, however, in the unlikely event of any participant becoming distressed, the project workers were all experienced researchers and health professionals and planned to spend time debriefing the participant if necessary. This event did not arise. It was planned that such matters, with the permission of the participant, would be referred to course tutors in the case of students, senior colleagues in the case of NHS staff and appropriate support agencies/responsible clinical staff in the case of lay participants.

The findings of the strategies employed in the project will be described in sections 1 - 6.

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Section 1

The Interprofessional Learning Environment

This section is concerned, through reference to the CUILU beacon sites, with describing learning environments that promote the acquisition of interprofessional capability. Findings related to the measurement of the attitudes of students to their own profession and their attitudes towards other professions during the course of their gaining practice experience in these sites will also be discussed. The final part of this section concerns the findings of interviews with personnel employed in the more non-traditional environments with respect to student learning. These interviews focused on the potential of an Interprofessional Learning Practice Placement Tool to identify areas that could contribute to placement capacity expansion.

The overall aim of taking a practice-based approach in the CUILU project was to explore student experience of learning in the reality of the workplace. However, there was an additional intention that these workplaces should at the same time offer environments that are innovative and motivated, thus the strategy of identifying beacon sites of interprofessional working and learning. The practitioners in the beacon sites identified to participate in the project work at the forefront of practice, dealing with the complexities and dynamism that more traditional classroom or simulation approaches to interprofessional learning, are trying to reflect.

Classroom learning, of course, has an important role in preparing students for interprofessional learning through study of the underpinning theoretical concepts that students apply to practice. Trevillion and Bedford (2003) have conducted an analysis, through the philosophical lenses of utopianism and pragmatism, of how professional courses address interprofessional issues. They describe how these two different value systems have underpinned quite distinct approaches to devising curricula. Utopian approaches consider that students are being educated for the future: 'a brave new world', and that this type of education is about developing a new kind of practitioner who emerges at the same time as a new social order. With respect to interprofessional learning, this stance proposes that a future holistic approach to service provision is envisioned, where complex needs will be met in partnership with the individuals receiving that service.

They go on to describe pragmatic approaches to education. These are about educating for 'real world working' in that the curriculum is designed to help students navigate relatively unresponsive services. In the case of interprofessional learning for example, learning is planned to give attention to the work of other professions and the importance of partnership. In can be argued that this approach endorses a negative motivation through concentrating on what can go wrong, as identified for example by The Bristol Inquiry (2001) and The Victoria Climbié Inquiry (Laming,

2003) rather than on the more positive aspects of enhanced services for patients and clients. Nevertheless, the pragmatic approach is usefully concerned with the employability of graduates and preparation for their effective operations in the practice world.

The students participating in the CUILU project were following various curricula by virtue of more than one university being involved and the multiple courses that students gaining experience in the sites were following. However, the interest that CUILU had in practice based learning, was through the acknowledgement that practice based learning enables students to participate in the working environment dealing with the very problems and dilemmas that cross-boundary and collaborative practice throws up for the individual professions (Ovretveit, 1997).

The CUILU team worked collaboratively with practitioners and students in the field by accessing and constructing narrative accounts, through qualitative interviews, about interprofessional learning and working. It is considered that narrative accounts generated through the CUILU interactions in the pilot areas provide a rich source of information about the nature of interprofessional learning. These insights include knowledge about learning opportunities students find helpful; the ways and means of developing interprofessional capability; the nature of interprofessional learning support for students and aspects of effective interprofessional working. Whilst these findings will be reported throughout the other sections of the report, this section considers the environments from which the narratives were constructed.

The basis of selection of the CUILU beacon sites

Billingsley and Lang (2002) consider that the development of interprofessional learning in the undergraduate curricula of health and social care professions may provide a key to enhancing patient/clients' experience of care and of enriching professional fulfilment. They acknowledge, however, that these learning approaches are also seen as a threat to professional identity. Hudson (2002) also takes up this point and reminds us that interprofessional learning is far from being universally accepted as a 'good thing'. He argues that some of the barriers to the provision of effective interprofessional learning environments, both in practice and the classroom, can be understood as arising from the 'pessimistic' position. He suggests that this position not only militates against the development of the interprofessional curriculum but can also present barriers to interprofessional working through beliefs that:

- Professionals need to protect their own interests, leading to discordance between professionals about patient/client care, and "the scale and intensity of disagreement" (Hudson, 2002:8) affects the interprofessional relationship.

- Status differentials between groups can make collaborative working difficult. The hierarchy of professions has been determined historically, in both status (whether one is a full or semi-profession) and perceptions about individual knowledge base. These issues inform professional groups' constructs of other professions.

- The complex interrelationship between uni-professional discretion, accountability, and the exercise of judgement create a specific professional knowledge base. This influences how practitioners are able to exercise professional accountability whilst managing the complexities of team working.

Despite these barriers to the interprofessional working and learning agenda, Hudson does see

some reason for optimism in that there is evidence that being socialised into a working team can override professional hierarchies and negative attitudes towards other professions. According to Davidson and Lucas (1995), such exposure to, and experience of, collaborative practice facilitates the development of students' team functioning on graduation.

The selection of beacon sites has enabled the CUILU project to provide environments in which the thrust of the government's modernisation agenda to provide an integrated service for service users and their carers could be experienced by students. Furthermore, it was anticipated that such learning environments bridge the philosophical perspectives of interprofessional curricula described by Trevillion and Bedford (2003). The utopian view of new frontier approaches is realised in the beacon sites in that practitioners are at the leading edge of interprofessional practice and engage in collaborative working that puts the patient/service user at the centre of the service. Because the 'utopian world' is already in existence in these sites, the pragmatic values of 'real world' working, service delivery and employability can also be realised. The optimistic position is to the fore, with students being exposed to how the innovative thinking of those working there, allows the exploration of new ways of working that fly in the face of existing constraints to the realisation of a 'brave new world'. These optimistic and utopian ideals operate at the same time as a pragmatic contemporary 'real world' level that focuses on the roles; relationships and activities at work in the area.

Features of interprofessional learning environments that provide a bridge between pragmatic and utopian perspectives:

- The practice context is such that the patients/clients 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 the team are recognised, understood and valued in the interests of providing high quality, integrated care for patients/clients 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 play in the care of patients/clients and their carers

Student perceptions of the beacon sites

Students generally recognised the interprofessional focus of the beacon sites. Below are a selection of typical quotes from student interviews regarding their experience of learning across the beacon sites.

> ***Physiotherapy student 4:*** *Here, it's really, actually, been probably the most interprofessional place I've worked in. It's like when you see your patient, it's very rarely you're there just as a physio, you've got your*

occupational therapist there too ……. It's the first place I've really worked that is so multidisciplinary in that sense.

Occupational Therapy student 1: *I've been given as many opportunities as I would like to actually sit in with other disciplines when they're seeing clients. They're more than happy to discuss with me what they've been doing and why they've been doing it … so I've been able to see my own client with a different profession and then it, the learning, sort of maps across and I can involve joint working sessions into my treatment programme as well.*

CUILU: *Do you think you learned much about other people's roles within the team? (When attending team meetings)*

Nurse student 5: *Yes, because you see what the social worker will say about what they're doing and physios will say what their part to play is and what they're going to do next and then what the nursing team are going to do. It's like everybody saying what their role is and it gives you a wider insight into what's going on*

Occupational Therapy student 2: *Interprofessional learning happens if you're working on a placement where you're actually talking to other people other than just your supervisor, but it's not always possible. My last placement I didn't meet anybody who was not an OT, in this placement I've had a much, much better view of how it will be when you work together, how it should be.*

Social Work student 3: *..... it was good (meeting and learning together in the beacon site), in that sense, with having the medical students, it's good to kind for them to understand that, you know, it's not just the medical stuff that's important, it is the social stuff and it's other things that might affect, you know, could affect their health, So, and it's important, I think, that, you know, the medical teams and medical services are aware of that so that, you know, that they can pick up on it when they're seeing people, which, which they tend to do, on the whole (on this site) you know. We had a very good working relationship with them.*

Change in student attitudes

Hudson's assertions that students being socialised into a working team can override professional hierarchies and negative attitudes towards other professions are reflected in the work of other writers (Hewstone *et al* 1994; Carpenter 1995 a and b; Barnes *et al*, 2000). In order to determine whether exposure to the beacon site interprofessional learning environments would result in changes regarding identification with own professional group and any stereotyping of other professional groups, an attitude scale based on the work of Carpenter (1995a and b) was employed. The scale was administered to the students within the beacon sites at the commencement of their placement and re-administered on the completion of their experience.

The sample of students completing the scale was 41 students completing Time 1 (T1) (medical students n=9; nursing students n=25; occupational therapy students n=3; physiotherapy students n=3; social work student n=1) and 24 completing Time 2 (T2) (medical students n=6; nursing students n=15; occupational student n=1; physiotherapist student n=2). Matched completions of both time 1 and 2, was 21 (medical students n=5; nursing students n=13; occupational student n=1; physiotherapist student n=2). It is acknowledged that these are small numbers and statistically significant differences are difficult to demonstrate. However, some of the trends in the findings are interesting.

Findings

Table 1 summarises the responses to section 1 of the schedule, both prior to and immediately following placement. The underlying concepts relate to how students perceive their own profession. The table indicates positive attitudes towards the respondent's own profession at baseline, with a large proportion indicating strong sense of belonging, identification and feeling of importance. Little change was detected at follow up. However, where change did occur these positive attitudes were intensified following placement. Notably at follow up respondents were less likely to state that they made excuses for belonging to their profession (from 78 per cent to 91 per cent), less likely to feel that they criticise their profession (from 68 to 54 per cent) and felt stronger ties with their profession (66 per cent to 80 per cent).

Table 1: Responses to statements regarding professional identity at time 1 and time 2 (all respondents).

	Time 1			Time 2		
Statement	**Seldom or never**	**Sometimes**	**Often/very often**	**Seldom or never**	**Sometimes often**	**Often/very often**
I am a person who identifies with my profession		7.1	92.9		8	92
I am a person who makes excuses for belonging to my profession (T1).	78	17.2	4.8	91.7	8.3	
I am a person who feels held back by my profession (T1).	90.5	9.5		88	12	
I am a person who considers my profession important (T1).			100		4	96
I am a person who criticises my profession (T1).	54.7	40.5	4.8	68	32	
I am a person who is glad to belong to my profession (T1).		4.8	95.2		4	96
I am a person who sees myself belonging to my profession (T1)		9.5	90.5		4	96
I am a person who is annoyed to say I'm a member of my profession (T1).	95.2	4.8		96	4	
I am a person who tries to hide belonging to my profession (T1).	95.2	2.4	2.4	96	4	
I am a person who feels strong ties with my profession (T1).	4.8	28.6	66.7	4	16	80

Table 2 shows the results of statistical testing for these data (Wilcoxon Signed Ranks Test), no significant differences were detected (p>.05).

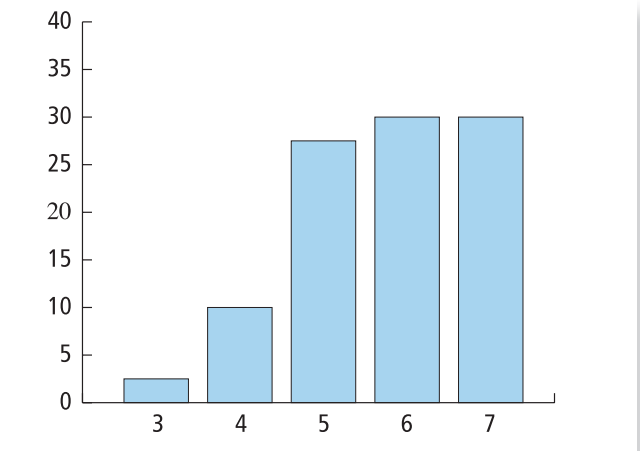
Table 2: Results of Wilcoxon Signed Ranks Tests comparing T1 and T2 (complete data only).

Statement	P value
I am a person who identifies with my profession (T2).	0.25
I am a person who makes excuses for belonging to my profession (T2).	0.73
I am a person who feels held back by my profession (T2).	1.0
I am a person who considers my profession important (T2).	0.7
I am a person who criticises my profession (T2).	0.47
I am a person who is glad to belong to my profession (T2).	0.25
I am a person who sees myself belonging to my profession (T2)	0.71
I am a person who is annoyed to say I'm a member of my profession (T2).	0.25
I am a person who tries to hide belonging to my profession (T2).	1.0
I am a person who feels strong ties with my profession (T2).	0.31
Expectations	0.24
There are similarities between allied health professionals (T2).	0.65
Differences between allied health professionals has been emphasised (T2).	0.36
Professions work together (T2).	0.29
The atmosphere between members of professions is co-operative (T2).	0.54
The atmosphere between professions is competitive (T2).	0.36
Members of the different professions tend to stick together (T2).	0.05
Members of the same profession tend to stick together (T2).	0.86

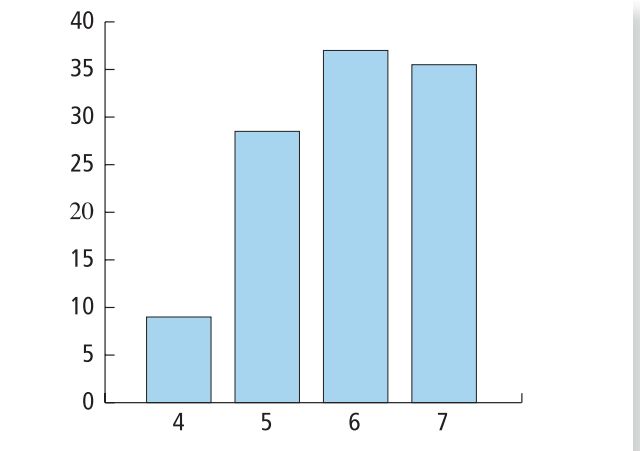
Table 2 above indicates one significant difference between T1 and T2. The significant difference detected for the statement relating to members of different professions sticking together.

Bar Charts 1 and 2 show responses to a statement about student expectations about working on a placement or allocation alongside members and students from other professions (1 very negative, 7 very positive). Almost two thirds were positive about this prospect (62 per cent recording a 6 or 7) at T1 and there was little change in this attitude at T2 (68 per cent at T2). This difference was not significant (p>.05).

Bar Charts 1 and 2



Bar Chart 1: Expectations T1



Bar Chart 2: Expectations T2

Table 3 below moves us away from how respondents view their own profession towards a set of statements regarding the ways in which professions work together. Again it is apparent that these respondents held positive views in regard to these issues at baseline. The table also shows that there was little change in the proportions responding positively or negatively to these statements. One exception to this can be noted with a decrease in the proportion tending to agree that there is an atmosphere of competition between professions.

Table 3:

Responses to statements regarding team inter-professional working at T1 and T2 (all respondents)

Statement		Not at all			Not sure			A great deal
There are similarities between health professionals	T1			2.4	9.8	34.1	39.1	14.6
	T2		4		16	24	44	12
Differences have been emphasised	T1		2.4	7.3	46.3	29.3	14.6	
	T2			8	32	48	12	
Professions work together as equals	T1	9.8	12.2	29.3	9.8	17.1	14.6	7.3
	T2	4	16	24	4	16	32	4
The atmosphere between professions is co-operative	T1			17.1	4.9	36.6	26.8	14.6
	T2			8	4	48	32	8
The atmosphere between professions is competitive	T1		26.8	17.1	12.2	29.3	4.9	9.8
	T2	4	8	28	28	32		
Members of different professions stick together	T1	4.9	14.6	19.5	29.3	17.1	9.8	4.9
	T2	4	8	16	32	20	16	4
Members of the same professions stick together	T1		2.4	2.4	9.8	19.5	29.3	36.6
	T2			4	16	20	36	24
You have experienced successful joint working	T1		2.4	2.4	7.3	29.3	36.6	22
	T2	4		4	8	20	36	28
You have experienced teams relating to each other	T1			4.8	14.3	35.7	19	26.2
	T2			4	8	44	24	20

Table 4 below addresses that section of the schedule that confronts the matter of professional stereotypes. The table shows the proportion of respondents ascribing high importance to each quality for each professional group at T1 and T2. It is here that noteworthy change is apparent. In the domains of leadership, breadth of life experience, being a team-player and decisiveness a change in attitudes can be detected, with respondents more likely to recognise these as important qualities in other professions following placement. Furthermore, this is particularly true for the attitudes concerning Radiographers, Occupational Therapists, Physiotherapists, Dentists and Speech and Language Therapists. These data were also exposed to statistical testing (Wilcoxon Signed Ranks Test) with just one change being significant (Occupational Therapists and Decisiveness).

Table 4:

Proportion ascribing high importance (6 or 7) to each quality for each professional group at T1 and T2 (all respondents).

		Social Worker	Rad	Dentist	OT	Nurse	Medic	Physio-therapy	SLT
Academic Rigour	T1	46.4	73.2	85.4	56.1	70.7	97.6	78	65.9
	T2	54.2	75	91.3	58.4	68	95.8	83.4	62.6
Interpersonal Skills	T1	90.5	33.9	59.6	90.4	100	90.4	80.5	78.6
	T2	83.3	29.2	47.8	75	100	87.5	83.3	66.6
Professional Autonomy	T1	54.8	50	76.1	69	66.7	88.1	66.7	61.9
	T2	62.5	54.2	60.9	75	66	87.5	70.8	66.6
Leadership	T1	47.6	28.6	54.8	19.1	69	89.1	47.6	31
	T2	62.5	39.1	72.8	65.2	72	91.7	70.9	54.2
Practical Skill	T1	42.9	83.3	95.2	88.1	97.6	83.3	92.9	64.3
	T2	33.4	78.2	90.9	91.3	100	95.8	91.7	58.4
Breadth of life experience	T1	73.8	9.6	16.6	35.8	52.4	50	33.3	23.8
	T2	70.8	30.4	35	56.5	72	66.6	41.6	33.4
Professional Competence	T1	92.8	92.8	95.3	90.5	95.2	95.2	100	90.4
	T2	75	91.3	100	91.3	92	100	100	83.4
Team Player	T1	76.2	42	30.9	76.2	97.6	88	76.2	64.3
	T2	70.9	52.1	40.9	91.3	100	95.8	91.7	58.4
Decisiveness	T1	86.2	59.5	78.6	71.4	90.5	100	81	64.3
	T2	75	69.5	90	91.3	92	100	83.8	62.5

Table 5:

Proportion who ascribe high or very high status for each profession at time 1 and time 2 (all respondents)

		Social Worker	Rad	Dentist	OT	Nurse	Medic	Physio-therapy	SLT
Status	T1	26.8	24.4	65.9	17.5	61	100	51.2	24.4
	T2	26.1	39.1	72.8	26.1	82.6	95.6	60.8	26.1

Table 5 reports the proportion of respondents at T1 and T2 who rate the status of other professional groups as high or very high. In all but two cases (Social Work and SALT) the perceived status of other professions increased at T2.

It should be noted that the sample size (n= 41 at T1 and n=24 T2) may have contributed to the lack of statistically significant differences detected. Also it should be emphasised that the strength of feeling towards most of the statements at baseline meant that there was a reduced prospect of further positive change to occur at Time 2.

Key points:

- The students demonstrated positive attitudes towards their own profession at baseline. Little change was detected at follow up. However, where change did occur these positive attitudes were intensified following placement.
- Student expectations about working on a placement alongside members and students from other professions were positive for almost two thirds of the students, and there was little change in this attitude at Time 2.
- At baseline 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. One exception to this was the proportion tending to agree that there is an atmosphere of competition between professions decreased.
- The stereotyping of other professions was confronted through the scale. The proportion of respondents ascribing high importance to specified qualities for each professional group did change on certain measures. A positive change towards respondents being more likely to recognise leadership, breadth of life experience, being a team-player and decisive-ness as important qualities in other professions following placement.
- The perceived status of other professions was rated at high or very high and this intensified at T2 for all professions except Social Work and Speech and Language Therapists.

These data suggest that experience in the beacon sites sustained or enhanced students' professional identity and positive attitudes towards other professions. This positive response at baseline contrasts with postgraduate/post qualification data also gathered by the CUILU team in another study that will be reported elsewhere. Other work reported with post-graduate participants (Carpenter, 1995, Carpenter and Hewstone 1996; Barnes D Carpenter J Dickinson C, 2000) also demonstrates a more sharply defined positive attitude change in interprofessional education, suggesting a lower baseline from which the change occurs. This raises interesting questions regarding attitude formation and stereotyping development in students. These issues include questions around how negative stereotyping develops in qualified staff and whether such attitudes were apparent in these staff as students.

These data revealed a high baseline of positive attitudes in students commencing experience in the beacon sites. Few changes that were significant in a statistical sense were demonstrated, however the findings suggest that experience in the beacon sites sustained or enhanced students' professional identity and positive attitudes towards other professions. This supports suggestions that interprofessional learning has a role in maintaining positive attitudes during the course of the student's programme of study to qualification.

Interprofessional learning practice placement audit tool

This section discusses the development of an interprofessional learning practice placement audit document as a means of identifying and monitoring the quality of interprofessional learning environments. Interviews were conducted with key personnel in five voluntary organisations to explore the tool's utility in identifying potential placements opportunities in non-traditional settings of which the voluntary sector provides a good example.

The provision of high quality practice placements is seen as a partnership responsibility between the providers of care and the education institutions and The Interprofessional Learning Practice Placement Audit Tool. was developed from initial work to develop a document for the quality audit of nursing placements. This first document was developed collaboratively by colleagues from participating NHS Trusts, South Yorkshire Workforce Development Confederation, the Independent Sector and the nursing schools and departments of the University of Sheffield and Sheffield Hallam University.

The tool builds on guidance for learning environment evaluation (ENB and DoH 2001, QAA 2001, GMC 2003) to capture essential components of the interprofessional learning environment. It has been developed to ensure, enhance and develop the quality of interprofessional practice placement provision. The audit focuses on assessing the access to interprofessional learning opportunities and the support available to develop interprofessional practitioners able to operate within multidisciplinary settings. It is considered that being able to identify practice environments that, although not traditionally being used for uni-professionally focused practice placements, are able to offer opportunities for interprofessional learning experiences carries the potential to expand placement capacity.

(note: the Interprofessional learning practice placement audit tool can be accessed at www.sheffield.ac.uk/cuilu)

The potential of the voluntary sector to contribute to placement expansion.

The NHS Plan (DoH 2001) emphasises the need to break down barriers between the health and social care professionals in order to promote multiprofessional working. Most agencies within the voluntary sector work across health and social care boundaries, if not within their direct service provision certainly in conjunction with other statutory and voluntary agencies, in the interests of the service user. It is a requirement that the learning environment is fit for the purpose, that students should experience work as part of a multi-professional team and should understand the value of a multiprofessional team working for improved patient care. (ENB and DoH 2001).

The issues around the continuing and increasing need for placement provision are well recognised. The report commissioned to inform the development of the Degree in Social Work indicated that placement availability was the factor cited most as assisting the development of opportunities in practice/work based learning (Whittington 2003). Interestingly from amongst the universities who provided information for the study only one had identified the potential to use placements not normally associated with social work. Similar issues are being addressed across all professions. For example in the case of occupational therapy,

Fisher and Savin-Baden (2002) report that although there is an awareness of the increased

numbers of students and graduates entering the profession as yet there appears to be a lack of provision for growth at an organisational level. These findings suggest that placement capacity is not being fully expanded and that barriers to placement provision may be largely organisational in nature.

Different professions are therefore struggling to meet the needs for placement provision to provide the necessary uni-professional training. Casting the net wider to consider the potential for interprofessional as well as uniprofessional placements will increase overall placement capacity and also offer students the opportunity to meet interprofessional learning outcomes that may not be available in uni-professional placements.

Findings of interviews with voluntary sector personnel.

Five voluntary sector (VS) agencies were identified that have provided placements to students. One key staff member from each agency agreed to participate in a loosely structured interview concerning the Interprofessional Learning Practice Placement Audit Tool. This ensured representation of a range of agencies providing varied community-based services for adults or children.

The Interprofessional Learning Practice Placement Audit Tool was used as the focus for discussion regarding how far their organisation could provide support for student learning as indicated within the tool, and its perceived usefulness and usability within the organisation.

Analysis of the interviews revealed five themes within the data: issues specific to the tool; student placements and learning; multidisciplinary working; barriers to access by a wider range of students and nature of the learning experience.

a. Student placements and learning.

This theme identifies the main types of students accessing the experience provided by the service. Interestingly, those formally placed with the service by the university were predominantly social work or social care students.

> ***VS Participant 5:*** *We only take art therapy students that are on the art therapy course.*
>
> ***VS Participant 2:*** *Predominantly social work students. I've had two, three, I've had two first year and one second year social work students.*
>
> ***VS Participant 3:*** *I've been here four years now, just, as director and in that time we've had three placements, student placements, so they're from social work.*

However, four out of the five agencies had hosted students from other professional backgrounds including medicine and nursing. These arrangements were often the result of students proactively choosing to come to an agency for various periods of time and were seeking a different type of experience. The students seemed to manage this experience by acting as volunteer workers or by negotiating student experience with practice based supervisors.

> ***VS Participant 1:*** *A student nurse who was on a placement with a GP practice, and so she opted to come to us because somebody in the practice referred to us and she thought it would be really useful. ..... And that's what's interesting about the self selecting bit, because you know it relies on something that is slightly ad hoc.*
>
> ***VS Participant 1:*** *The only medical students we've that have been medical students who have been volunteers.*
>
> ***VS Participant 4:*** *A medical student who was with us for about six weeks found us herself by devious means.*

There was also an awareness that this experience might in some way meet the professional requirements:

> ***VS Participant 4:*** *I think they have some sort of, a bit of their course that they need to do which is around the community.*

The data indicated that the voluntary sector already provides experience to students across a spectrum of health and social care backgrounds and at different levels. However, particularly in the case of students not following a social work programme, this is not always a product of systematic or organisational planning that could lead to an effective and efficient process that could offer a greater number of students valuable experience, but more as a self-selected student attendance. Part of the reason for this might be found in difficulty of 'labelling' the nature of the experience provided by the voluntary sector for the purpose of planning formal student placements that might satisfy tightly specified curriculum requirements:

> ***VS Participant 1:*** *It brought back that whole thing about actually we're very difficult to pin down as a sector…..it must be very frustrating for health professionals…well we don't do this, we do this.*

b. Barriers to access by a wider range of students

Although in the main the students formally allocated to these placements were social work students, the notion of supporting students from different backgrounds on a more regular and systemised basis was viewed positively. As one agency pointed out, for the most part they had not taken students other than social work students because they hadn't been asked to, or offers hadn't been responded to.

> ***VS Participant 5:*** *We might be interested in taking occupational therapy students, a couple of years ago I was approached about that but I haven't been able to make any further head way with that because I'm not getting any response from OT about it.*

> ***VS Participant 3:*** *But we've never actually been asked for other placements. Well I think (if we were asked) yes we're committed to our resources to be used in that way*

Traditionally, student placements are sought by universities to meet specific, professionally focused purposes within the curriculae the students are following. Maintaining suitability and changeability of the service user group for student learning requirements was a concern for the participants due to changing and responsive nature of the organisations they work for. One agency that had offered a child and family placement realised that such specificity of experience could not be relied upon consistently:

> ***VS Participant 2:*** *All our people we had here at the time (i.e. of being asked to host a student) were eighteen plus.*

The participants felt that educational establishments were keen to ensure an appropriate learning experience, and the organisation would wish to be sure that the student's learning needs were congruent with the service, but such focused specificity could be a difficulty for the service providing the placement.

> ***VS Participant 5:*** *We got quite a bit of pressure in terms of being phoned up to take students and find a way of giving them appropriate experiences. Our difficulty is in the fact that we don't have a kind of a population sitting ready waiting to have services as such.*

Despite some reservations about how the learning experience can be conceptualised, the participants

were keen to point out the benefits of having students learning with them, and also the enriched perspective that students from a range of professions can bring.

> ***VS Participant 1:*** *We've learned stuff for our organisation that's been really valuable and if more experiences followed I have no doubt that we would learn something that would develop the organisation, so I think it would be really worthwhile…. its about learning from people who have had different education ….bringing their own educational and life experiences.*

> ***VS Participant 4:*** *As a staff team we would feel the benefits in terms of all their own professional development and knowledge base.*

However, resources could be seen as a barrier to offering student placements.

> ***VS Participant 3:*** *I think there's a training component needed and that obviously incurs then a time element in terms of staff time*

> ***VS Participant 4:*** *We don't have scope for taking that many … as a staff team we would see the benefits in terms of….professional development and knowledge base…but it is relentless in terms of the input that is to be demanded for each individual.*

The data in this theme illustrate the perceptions of the participants that the more traditional approaches of allocation of student placements according to uni-professional, specific experience can prove to be difficult in the voluntary sector when considering programmes with other than a social work or social care focus. It was also identified that the provision of more regular placements to increased numbers of students from a wider spectrum would have resource implications. However, the purpose of the Interprofessional Learning Practice Placement Audit Tool is to identify interprofessional experience common to the needs of all students, rather than experience with a uni-professional focus. The issue of providing students with experience of multidisciplinary working is addressed in the following theme.

c Interprofessional working.

It was clear when using the audit tool to guide the discussion, that although there was not a large multi-disciplinary team present in any of the agencies, the nature of the work to achieve good outcomes for the service user was of necessity interprofessional.

> ***VS Participant 2:*** *I think we sometimes struggle to function as a member of the multidisciplinary team within the project…a lot of our teams are quite small, but in terms of our stakeholders and people that we have to relate to, then there will be experience of working within multidisciplinary teams.*

> ***VS Participant 1:*** *The range of opportunities that are offered are interprofessional in terms of interacting with different professions, they could be in contact with social workers, O.T.s Physios, people like that really.*

Participant 3, reflecting on his/her own organisation and the voluntary sector in general observed that:

> ***VS Participant 3:*** *A small organisation will be saying 'but we don't have a multidisciplinary team' and they probably do, but they don't realise they do.*

Participant 4 strengthened this message by referring to the necessity for practice of interprofessional working:

> ***VS Participant 4****..... it's fundamental to what we do that we don't work in isolation….we can't do the sort of intervention that social workers do without reference to what's going on in the rest of people's lives and the other*

professionals involved…. when workers feel isolated be it a social worker or a health visitor, that's when their anxiety level goes up and that's when practice goes to pot, pointing to communication, checking out and joint decisions as shared necessities.

It seemed clear that the participants felt that, although not always recognised, the work undertaken across the sector was by necessity multiprofessional in some way and certainly interprofessional in order for the service-users' needs to be met. The following theme more closely explores how this background way of working could provide rich opportunities for interprofessional learning for all students.

d. The interprofessional nature of the learning experience.

The richness of the voluntary sector experience in relation to the learning opportunities offered, particularly around seeing the person as a whole, was apparent. The participants illustrated some of available learning opportunities as caring for people directly and being able to learn about generic issues that impact on the situation of clients.

VS Participant 2: *Care, quite often is about actually providing a hands on service whereas our service is more about supporting, empowerment and stuff that will maybe help people do things for themselves*

VS Participant 1: *One of the big learning opportunities, for instance, is to visit or to sit with some of the people that are our clients*

Participant 3 saw the agency as a suitable place…..

VS Participant 3: *To learn about more generic stuff about how homelessness can impact on health and how we support homeless people to access health services.*

There was a strong suggestion of the value of the potential learning for all professions as well as the particular gains possible for professions unused to this community based service provision. With reference to a medical student who spent time as a voluntary worker, one participant remarked that:

VS Participant 4: *I think she did find it useful, its quite an eye opener the bit about going into people's homes, very different from the medical model tendency to compartmentalise which misses out a huge bit in terms of assessment in fact for all those professions who don't routinely go out and meet service users in their own environment, it's really valuable to contextualise people's health and wellbeing. ..... (it's) not going to be relevant to their continuing as a medical professional in terms of operating on people and things like that, but in terms of how you relate to a variety of different people with a variety of different needs which, again is about bedside manners and things like that.*

The richness of available experience in terms of learning relevant to interprofessional understanding and working seemed obvious.

VS Participant 4 *To see their patients, potential patients actually in the community….seeing them in a very chaotic, lifestyle which is very different from how they present……I think its really valuable to contextualise people's health and wellbeing. The wonderful service you are providing its very much appreciated but sometimes inaccessible to people and its nothing to do with you and them being feckless or whatever, it's just that life gets in the way and I just think that's a useful lesson across the board*

e. Quality enhancement issues specific to the tool

Consideration of the audit tool facilitated a discussion of the voluntary sector's potential for providing interprofessional learning experience for students and for the potential of such a conceptualisation of the available experience making additional placements available for a

wider range of student groups than traditionally accessed the sector for formalised placements. However, looking through the audit tool also brought up issues for the agencies of development in terms of provision of student support. For example participant 1 looked to develop a student information pack in order to give:

> ***VS Participant 1:*** *A specific response to what we do when we have students.*

Other participants also commented on how considering the questions in the tool helped concentrate the mind on what they could offer to students.

> ***VS Participant 3:*** *Toolkits like this (i.e. the audit tool and its guidelines) do work because they help you to find out the barriers, and that it would help to look at what would you expect of a student and whether or not the student, fits certain criteria*

> ***VS Participant 2:*** *It seems to cover all the areas and it would help in the process of exposure to as much as possible of the working environments in which all those people do their professional practice.*

However, participant 5 felt the questions did not allow for demonstrating the complexity of particular areas:

> ***VS Participant 5:*** *I always have difficulty with boxes that just have yes or no, because sometimes the answer is maybe or perhaps…it's an audit which is based on particular ways of working which don't necessarily apply to the way we do things in the voluntary sector.*

Another participant commented on perceived complexities of educational language,

> ***VS Participant 3:*** *This is an educational document about the learning experience, but for example if you say to some voluntary organisations learning opportunities they'll say 'pardon?'.*

Although the same person felt that the provided guidance notes went a long way to addressing this issue:

> ***VS Participant 3:*** *If you want from this tool that you ensure that the provision for the placement is adequate then it would do the trick I think*

Participant 4 recognised the tool's utility in quality enhancement, but seemed to see this as a discipline or profession based issue rather than one that was important for all students:

> ***VS Participant 4:*** *This tool would be useful in professions that have much tighter guidelines in terms of practice than social care that is not quite so tight*

However in terms of communication with the educational departments, one participant felt that:

> ***VS Participant 3:*** *This is a very, very productive culture shift…….a novel way of doing it, I've never been asked ..to do anything like it, there's never any evaluation of our organisation*

Certainly in all the agencies the motivation was there to continuously improve the experience. The audit tool seemed therefore to serve a valuable purpose but the data indicated that questions remained about its suitability for the voluntary sector in terms of language, flexibility and systems not necessarily being in place for monitoring and communication between agencies and education providers. Some of these issues related to how placements were being conceptualised by the participants as being specifically related to social work experience, rather than as interprofessional working experiences.

Key points:

- The Interprofessional Learning Practice Placement Audit Tool could serve a purpose in identifying the Voluntary Sector's potential to offer interprofessional student placements to a range of health and social care professions. The participants from the Voluntary Sector would welcome the use of such a tool and consider they are in position to bring expertise and experience to bear in order to be in a better position to provide such placements.

- Use of the tool could potentially strengthen links between placement providers and Educational Departments by putting in place stronger monitoring arrangements that would benefit communication.

- Voluntary Sector agencies are potentially rich learning environments for students across health and social care. Nursing and medical students who have accessed these agencies on a voluntary or elective basis have fed back positively on the experience.

- Although the tool proved useful in identifying interprofessional learning experience and support, more work would be required in considering the identification and quality monitoring of uni-professional focused placements.

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Section 2

What Students Need to Learn in Order to Develop Interprofessional Capability

This section discusses how two of the major objectives of the 'Hub and Spoke' bid that concerned interprofessional learning outcomes were met.

These objectives are stated as:

- Evaluate the interprofessional learning outcomes
- Research further developments in interprofessional learning outcomes

The identification of appropriate learning outcomes

This part of the work placed emphasis on how students could be assisted to develop the skills and knowledge that enable them to become effective interprofessional workers. Planning the result or the end-point of learning is undertaken through the setting of learning outcomes to make the teaching-learning process transparent for all participants. It gives direction to what students should achieve, focuses teaching sessions and other learning opportunities and can offer a basis for subsequent assessment of the student's learning. To date, interprofessional learning outcomes for undergraduate students have tended to be set largely on an intuitive or 'common' sense basis and often address topic areas such as teamwork, communication and understanding the roles of other professions. The specific outcomes of learning for interprofessional working therefore needed to be articulated and this necessarily involved describing the components of interprofessional working. This immediately generated a problem in that although strategies that may facilitate interprofessional learning have been described quite extensively in the literature, the term 'interprofessional working' itself is poorly understood (Gerrard, 2001) and little work is reported regarding learning the processes of interprofessional practice (McCray, 2003).

It was necessary, therefore, to employ a systematic approach to generating interprofessional learning outcomes that also served a purpose of indicating what interprofessional working involves. Additionally, these outcomes had also to be not only suitable for undergraduate students and relevant to all professions, but practice orientated and achievable in the workplace. This task was approached through understandings of what was required of modernised services: the centrality of the patient/service user: collaboration across professions in the interests of patients and the development of new ways of working.

Developing the interprofessional capability framework

The Interprofessional Capability Framework was developed to reflect the drive for more collaborative practice in service delivery. Practitioners are required to provide an increasingly specialised service but at the same time, in order to provide 'joined up ' services, they need to be able to manage change, be responsive to need and work in close collaboration with those receiving services as well as their colleagues. Effectively practising in the context of health and social care is, therefore, an increasingly complex endeavour, and the conceptualisation of what students need to achieve is correspondingly complex. This

demanded that attention needed to be paid to the nature of any learning outcomes that would be developed.

The nature of the learning outcome statements: competency versus capability

Acknowledging the complexity of interprofessional working and learning, the CUILU Interprofessional Capability Framework draws on the work of the Sainsbury Centre for Mental Health (SCMH, 2001) – The Capable Practitioner. The learning outcomes contained in the Interprofessional Capability Framework are stated in terms of learning achievements leading to 'capability', rather than as competencies. Competency-focused approaches in both health and social care pre-qualifying education and professional development are currently popular. However, questions have been raised regarding the adequacy of concentrating only on 'competence' in preparing practitioners to respond effectively to the complexity of working in contemporary health and social care (Wilson and Holt, 2001) and it has been argued that 'competence' does not take complexity into account but merely considers the performance of task (Heron and Murray, 2004). The concept of capability better recognises the many-layered and multiple processes that professionals are expected to perform (Barr 2002). A capability does not stop at being able to successfully undertake a 'task', but is defined as an integrated application of knowledge where the student or practitioner can adapt to change, develop new behaviours and continue to improve performance (Fraser and Greenhalgh, 2001).

Students' attainment of capability

The work of the CUILU project is based on a premise that students learn to become interprofessional workers in the practice arena.

The complex nature of what students are required to learn is intensified by various factors:

- students access the learning environment at different stages of their courses
- students access a variety of practice environments throughout their career
- students of the various professions have a different focus and levels of theoretical knowledge
- students study these knowledge bases for different purposes related to their particular professional pathway.

These factors are addressed within the Interprofessional Capability Framework through the assumption that as adult learners, students will bring to the workplace previous knowledge and will actively engage with what they need to learn in order to meet their specific learning needs (Knowles, 1990). Students' achievement of the learning outcomes is therefore informed by classroom-based theory, guided by practice experience and through access to the knowledge and expertise of practitioners supporting the students through their practice experience. The practice environment therefore shapes the learning, and students develop capability in Fraser and Greenhalgh (2001) terms, by applying, adapting and synthesizing new knowledge in different service contexts.

The source of the learning outcomes

In order to take a strategic approach to interprofessional learning across all the health and social care professions in both universities, it was considered important that students worked towards 'common' learning outcomes. It was also necessary that the outcomes reflected the complexity of interprofessional learning and could

be shown to be relevant to all professional groups. A decision was made to utilise the Higher Education Quality Assurance Agency (QAA 2000; 2001; 2002a) benchmark statements relating to the undergraduate programmes of medicine, dentistry and the professions allied to medicine including nursing, midwifery and social work. This was considered appropriate as the benchmark statements signify the attributes and capabilities that qualifying health and social care professionals should be able to demonstrate, and provide general guidance for articulating the learning outcomes associated with the programmes (QAA, 2002b).

The CUILU interprofessional capability framework

The methodological approach to developing the framework is discussed in the method section. The domains, capabilities and associated learning levels contained in the Framework can be seen in Table 6 below.

Table 6 CUILU Interprofessional Capability Framework – table of domains, capabilities and learning achievement levels.

Domain: Ethical Practice	
Capability	**Learning Achievement Levels**
The interprofessional team member continually develops, promotes and practises understanding and respect for others' cultures, values and belief systems.	**L1** Recognises the importance of respect and cultural awareness when providing any service and can relate this practice to consider own culture, value and belief systems. **L2** Can discuss differing cultural and value belief systems and begin to engage with these issues in practice team working. **L3** Shares knowledge of other cultures' beliefs and value systems to inform patient/user centred care and promote good practice.
The interprofessional team member interacts within the health and social care practice community to consistently promote and support patient/user participation and autonomy, on the basis of informed decision-making and exercise of choice.	**L1** Recognises examples of patient/user focused care, in which participation and informed decision are central to promoting the well being of the patient/user. **L2** Engages in some strategies to empower patients/users through promoting their participation in interdisciplinary care provision. **L3** Engages with other members of the interprofessional team to use strategies of involvement and empowerment to ensure informed decision-making by the patient/user.
The interprofessional team member consistently ensures an interprofessional approach to the exercise of duty of care within a legal and ethical framework.	**L1** Is aware that members of the interprofessional team may be subject to differing demands of law and regulation in the exercise of duty of care. **L2** Acknowledges that the differing requirements, made in law, of all professions in the exercise of the duty of care affects care/service-planning processes. **L3** Co-operates with others to ensure the legal requirements of differing professions to the exercise of a duty of care are met.
The interprofessional team member critically evaluates policy and practice in the context of: Patient/client-focused care The changing role boundaries that inform the nature of the interprofessional team Making recommendations to influence developments to improve the quality of service/care for patients/clients of the service.	**L1** Is aware that patient/client focused care, changing role boundaries and future service provision is influenced by policy and practice. **L2** Recognises and discusses policy and practice that influence changing role boundaries in the interprofessional team, patient/client focused care and how the interprofessional team can inform the development of services. **L3** Brings knowledge about policy and practice to inform patient/client focused care and changing role boundaries within the interprofessional team. Can apply the experience of interprofessional team working to discussions regarding future policy and practice within the service.

Domain: Knowledge in Practice	
Capability	**Learning Achievement Levels**
The interprofessional team member has an integrated understanding of the legal frameworks and statutory and regulatory requirements of the professions that make up the practice team.	**L1** Is aware that regulations that govern practice may differ between professions. **L2** Identifies the regulations that apply to different professions and can begin to engage with these issuers in practice team working. **L3** Uses knowledge of statutory regulations and requirements of all team members when contributing to care/service delivery.
The interprofessional team member exercises a critical understanding of team structures and effective team functioning through knowledge of group dynamics and professional roles of all team members.	**L1** Is aware of team structures in the practice area. **L2** Identifies that teams and structures can differ in relation to service provision. **L3** Brings knowledge of team structure, dynamics and professional roles to effective personal functioning as a team member.
The interprofessional team member maintains and develops a critical understanding of the requirements and non-judgemental and anti-discriminatory practice in order to effectively participate in care management decisions	**L1** Is aware of decision-making processes in care management and can recognise how they are informed by non-judgemental anti-discriminatory practice. **L2** Can identify and discuss how anti-discriminatory practice and non-judgemental behaviour informs the decision-making processes in the interprofessional team. **L3** Uses knowledge of non-judgemental and anti-discriminatory practice when contributing to decision-making processes in the interprofessional team.

Domain: Interprofessional working	
Capability	**Learning Achievement Levels**
The interprofessional team member is able to lead or participate in interprofessional team and wider inter-agency work, to ensure a responsive and integrated approach to care/service management that is focused on the needs of the patient/client.	**L1** Is aware of the roles and services provided in the interprofessional team and can point to examples of how these are appropriately delivered in patient/client focused approaches to care. **L2** Can begin to interact and co-operate with others in the interprofessional team in providing appropriate patient/client focused care. **L3** Uses knowledge of roles and services within the interprofessional team and wider inter-agency work to participate in and/or where appropriate, utilise supportive mechanisms to take a lead in the management of patient focused care.
The interprofessional team member implements an integrated assessment and plan of care/service in partnership with the patient/client, remaining responsive to the dynamic needs of care/service requirements.	**L1** Has an awareness of the need to have an interprofessional approach, that is patient/client focused, to planning care/service in order to meet the complex needs of people receiving health and social care services. **L2** Participates in some aspects of the mechanisms and processes involved in an integrated assessment and plan of care/service in partnership with patient/client. **L3** Uses appropriate strategies in an integrated assessment to plan care/service, that is patient/client focused.
The interprofessional team member consistently communicates sensitively in a responsive and responsible manner, demonstrating effective interpersonal skills in the context of patient/client focused care.	**L1** Recognises the need for effective interpersonal skills to enhance patient/client focused care and can indicate a development of these skills in own interactions with members of the interprofessional team and the patient/client. **L2** Demonstrates developing skills of interpersonal communication with the interprofessional team and the patient /client. **L3** Uses appropriate interpersonal skills that promote effective communication in the interprofessional team with the aim of enhancing patient/client centred care.
The interprofessional team member shares uni-professional knowledge with the team in ways that contribute to and enhances service provision	**L1** Is aware of the benefits of sharing knowledge base, skills and roles amongst the team and can give examples of constructive ways in which this knowledge can be shared. **L2** Recognises opportunities and begins to participate in knowledge, skill and role exchanges within the team to enhance care/service delivery. **L3** Utilises communication skills in order to participate in sharing knowledge with other professionals, to enhance the provision of care/service delivery.
The interprofessional team member provides a co-mentoring role to peers of own or other professions, in order to enhance service provision and personal and professional development.	**L1** Is able to give examples of where mentoring from members of own or other professions has been helpful in personal or professional development. **L2** Effectively uses mentorship provided to self in order to enhance personal and professional development and begins to participate in informal mentoring amongst peers in a supportive way. **L3** Is able to utilise skills to provide and promote informal co-mentoring amongst peers of own and other professions that will support further personal and professional development.

Domain: Reflection	
Capability	**Learning Achievement Levels**
The interprofessional team member utilises reflective processes in order to work in partnership with patients and colleagues ensuring a patient/client focused, and integrated care/service provision.	**L1** Participates in the processes of reflection to determine own learning needs. **L2** Utilises reflection in relation to the development of own role within the team in promoting patient/client focused integrated care/service provision. **L3** Demonstrates developed reflective processes in order to evaluate personal skill level and plan future development to ensure effective partnership working in meeting the goals of care/service.
The interprofessional team member utilises a reciprocal process of reflection and supervision to support the continual development of the interprofessional team.	**L1** Is aware of formal and informal processes of reflection and supervision in the interprofessional team that enable the team to utilise evidence-based practice **L2** Begins to explore formal and informal processes of reflection and supervision within the interprofessional team in order to develop evidence-based rationale for current and future practice. **L3** Participates in formal and informal processes of reflection and supervision within the team to further evidence-based activity in the interprofessional team.
The interprofessional team member responds to the needs of the service by utilising problem-solving approaches and evidence-based practice to identify and anticipate future changes in interprofessional team role.	**L1** Is aware of problem-solving approaches and evidence-based practice in care delivery/provision. **L2** Begins to utilise problem-solving approaches and evidence-based practice in the interprofessional team in response to the needs of the service. **L3** Participates in problem-solving approaches and utilisation of evidence-based practice within the interprofessional team in response to the needs of the service.
The interprofessional team member addresses professional development and lifelong learning needs in the interests of personal, professional and organisational / service development.	**L1** Is aware of continual professional development and lifelong learning and relates this to own continual learning requirements for practice. **L2** Recognises how continual professional development and lifelong learning can enhance development of self within the interprofessional team. Can select and discuss areas of learning to further understand aspects of the interprofessional team. **L3** Formulates a plan of activities and behaviours that will support continual professional development and indicate how this aids personal, professional and service development.

(note: the Interprofessional Capability Framework can be accessed at: **www.sheffield.ac.uk/cuilu**)

Validation Capability

Strategies to validate the framework were employed in phase 2 of the project. These strategies involved qualitative interviews with students on placement (n = 38) in the beacon sites and the practitioners who support them (n = 22). One purpose of the interviews was to 'test' the conceptual domains within the framework that had been generated through the analysis of the QAA benchmarks. This aspect was addressed through the participants' reflecting on whether and how the capabilities could be achieved in their practice area, thus considering their 'fit' with how interprofessional working was perceived by the interviewees. The views of the participants on whether they considered the capabilities in the Framework were relevant to and appropriate for their own profession were also explored. Due to greater experience, and their roles in supporting students of other professions the practitioners were also asked to comment on whether they felt any of the capabilities were not appropriate to any of the professions. The strategies employed to validate the Interprofessional Capability Framework concerned familiarisation of the Framework and exploration through interviews:

Students were:

- Familiarised to the framework and asked to keep the capabilities and learning levels in mind during their placements
- Students were reminded about the framework at intervals throughout their placement and during any seminar sessions and meetings.
- At the end of their placement, students were asked, through the medium of loosely structured interviews to discuss the Capability Framework and to comment on whether each capability was appropriate to their own professional preparation and to self-assess their learning against the Capability Framework.

Practitioners were:

- Familiarised to the framework and asked to keep the capabilities and learning levels in mind during the students' placements
- Towards the end of the project, through the medium of loosely structured interviews, practitioners were asked to consider whether each capability within the Capability Framework was appropriate to all professions, and if not which professions they were inappropriate to. They were asked to discuss the achievability of the capabilities in their practice context with respect to the level of learning students could be reasonably be expected to achieve.

Various themes emerged through analysis of the interviews:

a. Service organisation can restrict working towards capability

It has been argued earlier in this report that the CUILU beacon sites can be described through reference to Trevillion and Bedford's' (2003) arguments about interprofessional curricula. The beacon sites can be seen as 'utopian' in that holistic approaches to service provision are present and 'pragmatic' in that students can be exposed to real world working practices. However, there were issues raised in the interviews about perceptions that at times the service organisation limited the opportunities for students to learn from practice. When discussing the capabilities in the domain of Interprofessional Working, the interviewee below raised concerns:

> ***(Nurse 1)*** *Within the context of team working, because I know there are meetings and, and, erm, certainly doctor / nurse kind of case note handover, are there opportunities where, because we all have different, erm, kind of,*

erm, professional codes and also different value systems, are there.

***(CUILU)** Are there opportunities when discussing, erm, a case that this comes up that there are differing views on how someone's cared for?*

***(Nurse 1)** Yes, if, if, a lot of the time what happens, if there's a case they want to discuss, they'll sit down together as a multidisciplinary team, depending on how busy the ward is, a nurse might not be able to release, to be released to go into that room, so it may just be a medical. That's a downfall.*

This restriction seemed to be particularly marked if there was a lack of awareness and co-operation across professions (both university and practice based) regarding students' interprofessional working. The interviewee below was discussing how attempts to integrate student learning could be compromised. The interviewee wanted student groups to spend more time together on placement and found that agreement for this could not always be found across the team.

***(Nurse 1)** Now, that, if I'm honest, has not gone down well with (members of some professions)…… and because (certain) students are not my remit, you know, I can't really take that any further, which is a shame, and they've said that, you know, that the University said they can't have a full day and they haven't got the time to spend a full day. However, I think that they should spend a full day. There's a lot of benefits and we could have a lot of aims and objectives of what we should get out of that day, ……. So I think that's a lost opportunity.*

The notion of lost opportunities caused by professional education issues was reflected in a comment from another site

***(Trust Exec1):** I remember a lecturer once saying you can't teach undergraduate medical students all about leadership and resources because they need to learn about pharmacology and physiology. I just thought mmm yes, yes. Because that, well my comment was, if that was the deal, then we would always have the doctor that we've got. Would you put social, actually, is social care part of this model?*

*(**CUILU**) It is, yes, yes.*

***(Trust Exec1)** Right, because I think there's two issues, isn't there? There's the professions inside an organisation and there's the professional relationships that cross the boundaries of the organisation and some of those can be more, almost restrictive than those inside the organisation, you know.*

Another organisational issue appeared to be funding, particularly when considering the need to bring staff and students together for interprofessional learning and also in the context of promoting interprofessional capability in post qualification education:

***(Nurse 2)** But that would be a good one for doctors to come along to, junior doctors.*

***(CUILU)** Why doesn't it happen, then?*

***(Nurse 2)** one of the reasons is, I think, is that it's a different funding. Because the medical staff have a very good teaching module, all right, and they can access that quite readily and they, to ensure that the, erm, the doctors, SHOs stay here, they've got to provide regular teaching. So, it's, you know, there's a funding issue, really.*

***(Nurse 3)** When we, this is the problem with here, we have no overlap from late to earlies, night staff, day staff, so there's no overlap where time can be shared, to look at new teaching and stuff, which if there was then we could do more interprofessional teaching, couldn't we?*

(Nurse 3) *So it's something about the structure, the funding structure, and the way the work's organised.*

(CUILU) *Shift patterns work against you doing stuff that you know would be beneficial?*

(Nurse 3) *Yes.*

However, even though acknowledging that these restrictions could be a barrier to offering interprofessional learning, there was a suggestion that the framework reflected what was seen as important for service development:

(Trust Exec1): *I think the sooner we start teaching professionals about the value of team, so that you embed the team concept first and the professional concept second, if that's possible and then everybody will win, because I still see people who believe they come from teams, but it's actually not team work its group work. There's less common, there's no commonality of purpose.*

This theme is concerned with difficulties around being able to facilitate student learning around the capabilities in the framework. However, another strong theme in the data, despite these restrictions, was nevertheless that the capabilities were important expressions of what all students need to learn.

b. Capability's appropriateness to what students need to learn

Almost all participants considered that the capabilities and learning achievements contained in the framework were appropriate and relevant to their own, and other professions' learning. There was one exception in that a medical student felt that the ethical domain did not apply to medical practice. However, on exploration of this, it became obvious that the student's reservation was more about being able to develop the capabilities during the course, than it not being an essential component of learning. The following quotes are typical of how the participants discussed the framework's appropriateness.

The social worker below considered that the capability framework was an appropriate reflection of what social work students needed to learn:

(CUILU) *I think all that you've said there then, looking at all of the components included here in our Framework would be relevant to social work students.*

(Social Worker 1) *Definitely, I mean, yeah, you could, well, yeah, because it's all is to do with ethics, values, yeah, anti-discriminatory practice, yeah, that, as I said before, it's the core elements of social work, of the job.*

(CUILU) *So having had a quick look through that, what are your thoughts and feelings on using something like that with other students, as well, from other professional backgrounds?*

(Social Worker 1) *I have no problem with that, I think it's relevant, it is relevant …… quite relevant in any profession, I would say, particularly in a caring profession.*

(Social Worker 2) *I would have thought that they [capabilities] are quite reasonable, quite general and pretty reasonable to expect across the board.*

A nursing student agreed, commenting that:

(Student Nurse 15) *I think that all of those levels are achievable.*

(CUILU): *and appropriate?*

(Student Nurse 15): *yeah and appropriate, yeah, yeah, because you're doing all of those skills all the time during your nursing that you probably don't realise at the time.*

Another practitioner also mentioned that the capabilities were similar to the learning outcomes already expected from the uni-professional focus of his discipline

> ***(Occupational Therapist 1)*** *Like I say, you can relate it to any, any discipline.*
>
> ***(CUILU)*** *So, basically, are there any of those capabilities that aren't relevant and that you couldn't assess in this practice area?*
>
> ***(Occupational Therapist 1)*** *Erm, no … it's quite similar to the, actually, occupational therapy assessment booklet that we assess students on, … er, similar things.*

The discussion of the capability framework also provided opportunities for students to reflect on the interprofessional learning experiences encountered whilst on placement, which wasn't always readily apparent to students, as this quote by an occupational therapy student talking about ethical practice demonstrates:

> ***(Occupational Therapy Student 2)*** *It's so many things going on that you don't necessarily realise you're participating in…it's like the ethical practice stuff, I had awareness of it and I've explained what I know about it, but I haven't got to the point of really making decisions about someone…its been done as a group and but I've had my input.*

c. Capability draws attention to learning opportunities that promote interprofessional working

This theme refers to examples in the interviews where, when considering the framework, the interviewee is sensitised to interprofessional issues in the learning opportunities available in the practice context. The focus on the learning achievements and capabilities contained in the Framework, can therefore potentially develop the educational environment of the practice context, thus extending consideration of a learning opportunity from just the topic matter, to a wider view of the topic as an interprofessional and collaborative working issue and consideration of the learning that can be gained from that.

When discussing the Capability around understanding the roles of other professions, the interviewee below started to discuss a tutorial that had been organised for medical and nursing students. Thinking about the framework raised the interviewee's awareness of the interprofessional aspects of practice and teaching the students:

> ***(Practice Educator Nurse 6)****……..the doctors just had loads of light bulbs come on because the nurses were saying 'If this drug isn't prescribed properly in a legible handwriting with the right dose, I cannot give it.' Most of the time, though on that, the prescribing of the drugs and that it still tends to go back to the nurses.*
>
> ***(CUILU)*** *Why?*
>
> ***(Practice Educator Nurse 6)*** *Because it's the nurses, especially the ones that are checking the drugs that, er, if you've got a prescription, yes, the doctor's wrote it but if you know that prescription's wrong and you still give it, then it's still thought the responsibility of the nurse, not the doctor.*
>
> ***(CUILU) Yes.***
>
> ***(Practice Educator Nurse 6)*** *So you've still got to make sure that what they're writing up is legible and that the doses are correct and that they are checked and if you've got any doubts then you don't give it.*
>
> ***(CUILU)*** *Yes, yes.*
>
> ***(Practice Educator Nurse 6)*** *So there's areas here that go on that you have to be aware of each other's roles and then understand that*

the responsibility ultimately remain with them (the nurses administering the drug).The doctors thought it was their responsibility because they prescribed.

This reflection particularly, emphasises how the framework promotes a re-emphasis of the interprofessional possibilities arising from practitioners' existing teaching practice.

d. Capability to advance professional practice

There was some suggestion in the data that when organising learning opportunities across professions for students, often in terms of students from different professions shadowing the other student or spending the day observing the work of a qualified practitioner of another profession, practitioners conscientiously set learning objectives that the 'visiting' student could reasonably achieve. These objectives were necessarily set at a low level because the student could not be expected to have any proficiency in another profession's skills or knowledge. Such objectives, however, do not reflect the complexity of the other profession's role, nor it could be argued, particularly advance the student's own professional understandings.

Interestingly in the quote below there is some concern that the person setting the objectives did not him or herself understand the role of the profession the student would be visiting:

*(**Nurse 8**) Yes, which is why we've moved them into (another department) so they can achieve more of the things (ie set learning outcomes), but what, the things they need to achieve are things that a health care assistant does, not a qualified nurse.*

***(CUILU)** Right.*

***(Nurse 8)** They are basic clinical skills that you'll find that nurses don't perform much any more, which I thought was quite interesting, because obviously (that person) has got an old fashioned view of what nurse, you know, what nursing is.*

This quote draws attention to the challenge of trying to set learning outcomes appropriate for students 'visiting' other professions if a 'uni-professional perspective is taken. The level of learning outcomes that students can achieve when working with other professions, if set inappropriately low, raises issues about the motivational aspects of the students' learning, and whether a realistic understanding of the complexity of the other profession's role can be communicated. The learning achievements and capabilities contained in the Framework, because they are applicable to all professions and centre on interprofessional issues that are best learned through interaction with other disciplines potentially enable advancement of the student's practice in interprofessional issues appropriate to his or her own profession.

***(Student Nurse 10)** Erm,to actually see what other people, other professions do, because when you're at uni and you, you know, you learn all your physio stuff, but you don't necessarily, you know, think 'Gosh' you know 'what do social, what does social work actually involve or, you know, what do the nurses actually do?' So, and you don't learn that in university. You can work in a team of people and you can learn about our policy issues together but actually knowing what they do and what they're actually involved in is with the patients is really good, because you get a better idea that you know, then what things, you know, if you come across a patient out there who needs something else you know, you might think they need something extra but who do I go to to kind of address that issue? You know, you get a better idea of who to look towards then for services, refer to or ask for appropriate kind of advice or management, you know.*

e. Capability draws attention to changing roles

The discussion about the capabilities gave rise to issues about how interprofessional learning sessions and consideration of the capabilities to be achieved could make students and practitioners aware of changing role boundaries. Here the interviewees were discussing the teaching they undertake themselves and also their own learning. The capabilities around interprofessional working were being discussed.

> ***(Nurse 7)*** *Yeah, so it's understanding that your, there's boundary, roles and the boundaries are changing and, perhaps, the rest of the team isn't really up to speed with the way those are changing.*

> ***(Nurse 6)*** *I can see now where, when I've done this course, I could be examining patients better than asking doctors to examine them for certain things.*

The student below was describing how she had observed how the nurse's role had extended with regard to nurse prescribing.

> ***(Student Nurse 7)*** *Erm, when I was in the community I spent a day with the epilepsy nurse and she, erm the doctor had actually prescribed the drug but she had control of how much they took or whatever regime was taken and she can actually change the drug without the doctors permission*

f. Capability brings the patient to the foreground

The NHS Improvement Plan (DoH, 2004) underlines the need for the National Health Service to be 'patient driven'. This theme concerns how a move towards students being facilitated to achieve 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.

> ***(Occupational Therapist 2)*** *Yeah, as I say, we're all, for whatever patient everybody's got their own particular role to play in it and so we have to work very closely with, and, with all the disciplines and it depends very much on what patient it is. There might be a patient with more physical needs that we work with the physios with, but more cognitive and language problems that work with the speech and language therapist with. We're very much working with the nursing staff, because we, we set up programmes and they have to carry them out as well on the wards. So, yeah, it is like that, yeah.*

> ***(Student Nurse 6)*** *In the end it's about providing the best care for the patient isn't it? You know? Having input from everyone is going to provide that. Because you're like, it's the difference between having a flat piece of paper in front of you and having a 3D picture.*

When discussing the Capability Framework, the following participant underlined how seeing students work with patients was necessary if assessing students' achievements within the framework:

> ***(CUILU)*** *But it's that balance between what you're saying in terms of kind of being able to do it in practice, through having contact and knowledge with what the, how the person's behaving towards people and the contrast with that and a kind of a paper exercise.*

> ***(Medical Practitioner3)*** *Yes, seeing is, seeing is believing, Seeing is believing. You have to see it. So, I tell the medical students they must spend time with me in my clinic on a Thursday afternoon and we chat about - if there's time, we talk about everything that comes through,*

you know, not just the ..... what particular chromosomes caused this.

In addition, students were also able to recognise how actually observing the multidisciplinary team at work, when planning care for a patient facilitated greater understanding of the roles of different disciplines and how that impacted upon the care received by the patient, as demonstrated in this quote below, from a student nurse.

*(**Student Nurse 3)** I attended an MDT with a gentleman … and there was an occupational therapists, social worker, nurse and family member of the patient there so I got to see each perspective from each discipline, what they had to do for the patient and for him to go home.*

g. The complexity of the framework and students' ability to achieve capability

Despite a general agreement of the capabilities and learning achievements contained in the Framework being appropriate and reflecting the realities of interprofessional working, some practitioners commented on certain of the statements being complex. When discussing capability 3 in the domain of ethical practice 'The interprofessional team member consistently ensures an interprofessional approach to the exercise of duty of care within a legal and ethical framework' the interviewee below considered this capability at least to be quite challenging.

***(Nurse 4)** That's, that's quite broad. It's really a big area under that one. So you've got to be aware of each person's role and understanding of and everything, what - who's responsible for what.*

The following participant indicated that all the capabilities were relevant, but was hesitant about whether students could achieve the learning within capability 5 of the interprofessional working domain 'The interprofessional team member provides a co-mentoring role to peers of own or other professions, in order to enhance service provision and personal and professional development'. This person's concerns, in keeping with some of the other interviewees', were centred on the level of learning the students could achieve within the length and scope of the practice placement.

***(Nurse 4)** And IW4, very relevant, I like that. (Very long pause) IW5 - I don't know what level we'd be able to do.*

***(CUILU)** It's about levels again?*

***(Nurse 4)** Mmm, ... If you think of the students, then yeah, the capability's important but I don't know what level we'd be able to focus that on ..... I mean it's all wonderful, isn't it, in an ideal world but, if they need to achieve a lot of this while they're actually here on the ward, it's, maybe it depends how long they're here for doesn't it as well. There's some very, very good important things in here that, yeah, but maybe not as lengthy.*

The Capability Framework was developed from the QAA benchmarks indicating that the capabilities are set at the level of practice that students emerging as qualified practitioners are expected to attain. The learning levels within the Framework attempt to provide a graduated development towards the achievement of the capabilities. The following quote raises an issue of perceived tensions about expectations of newly qualified practitioners and the responsibility they can be given in order to learn and be prepared for qualified roles.

***(Nurse 8)** I don't think, unless they were third years, or later on (if) in their medical training, they would take a lead in the management of patient focused care. But I think they can use their knowledge of roles and services, because*

if you've got a third year student who's perhaps discharging somebody into the community and they need to have links with them and, perhaps, the health visitor as well, maybe even the social worker, there's definitely opportunity for them to do that. They would never take a lead on it because they're always going to be supervised. That would just be that last bit that I would say no to. You don't lead on anything until you're qualified because you're not accountable.

Interestingly and when considering the implementation of interprofessional learning, the quote above raises issues about when in students' individual courses they should be expected to achieve learning levels. The practice educator above seems to indicate that it is not a question of where students might be in their differing uni-professional courses in terms of years, but the amount of practice experience they receive in the course. In this way, the practitioner expects medical students not to achieve as quickly as students of other professions due to the medical courses having comparatively less practice experience in the early years.

The perceived complexity and demand of the Capability Framework in some ways was inevitable in that as Barr (2000) has indicated, the concept of capability, better recognises the many-layered and multiple processes that professionals are expected to perform. Contemporary practice demands that practitioners are required to be able to manage change, be responsive to need and work in close collaboration with those receiving services as well as their colleagues. Effectively practising in the context of health and social care is, therefore, an increasingly complex endeavour, and the conceptualisation of what students need to achieve appears to be found by some participants as correspondingly complex.

The following section explores the assessment of student performance against the interprofessional-learning framework and considers self assessment by students and assessment by practitioners and patients/service users.

Student self-assessment of interprofessional capability achievement

The Capability Framework provided a mechanism for students to recognise and assess their learning whilst in practice. By considering the domains of the framework, students were often able to apply and transfer or integrate the theoretical context of interprofessional learning which had been learned within the classroom, to the practice based learning experience. This linking of theory to practice enabled students to progress their learning and achieve higher levels of capability, which is demonstrated in the following examples :

(Occupational Therapy Student 2) *The ethical part of the course … erm I mean we've sort of in the first year learned about duty of care and the rest of it but it was a sort of lecture … its been more through practice … that's the chance I've had to apply it.*

(Physiotherapy Student 3) *level three I'd say on that one. Erm much more placement-wise, kind of, knowledge in practice, I was having to apply it all the time, sort of putting yourself on the legal side of things. Yes I'd say level three from being here, whereas uni wise, I thought more level two. You sort of have that knowledge but you weren't applying it as much because whereas out here you do.*

(Student Nurse 4) *that you learn so much more when you're in practice. In the classroom I do learn, I think, but I think its easier to …you do have it on your mind when you come here you think 'oh yeah, it does work like that' or 'this happens because of whatever' it seems to link together. But when you're in the*

classroom it doesn't tend to click, but when you come to practice you just see it and it does.

Students were able to draw upon and reflect on their placement experiences of interprofessional learning to provide documentary evidence in order to support or demonstrate the achievement of learning outcomes. This provides further evidence to support the appropriateness and relevance of the learning outcomes within the capability framework across student groups.

Also students were able to recognise a course of progression through the capability levels and the student quoted below was able to not only place herself on the framework at what she considered an appropriate level but also recognise at what point a student might be at a higher level.

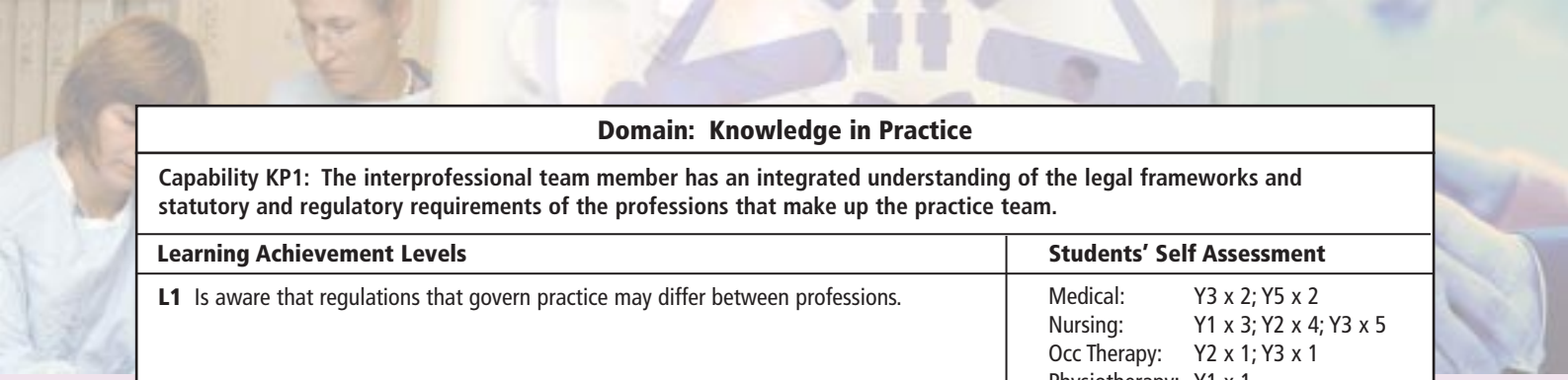
(Student Nurse 14) *Interprofessional working… I can see how it's very important for the inter-professional team to work together. Yeah, level one again really. I don't see how I can be … I don't really think students, unless you're a third level student, I don't really think that you can progress beyond level one unless you have a lot of support and guidance but yeah, I understand that you need an interprofessional approach to planning care*

(Physiotherapy Student 4) *Interprofessional working 2 – I'd say level three for that one. Erm the assessment I'm doing, the assessments of the patients, the forms they are very much sort of , more than just physio orientated …its very integrated in the assessment that you do … so working with other professions to sort of build that knowledge, identifying the right problems and things.*

As well as discussing their perceived achievements in gaining interprofessional capability, the students were asked to plot where they considered themselves to be on the framework. Table 7 below shows the learning levels the students assessed themselves to have achieved. These data are presented only to show that the students felt able to make assessments on their own performance and no attempt at statistical analyses has been made.

Table 7 Student Self Assessment of Capability:

Domain: Ethical Practice	
Capability EP1: The interprofessional team member continually develops, promotes and practises understanding and respect for others' cultures, values and belief systems.	
Learning Achievement Levels	**Students' Self Assessment**
L1 Recognises the importance of respect and cultural awarness when providing any service and can relate this practice to consider own culture, value and belief systems.	Nursing: Y1 x 1; Y2 x 2; Y3 x 2 Physiotherapy: Y3 x 1
L2 Can discuss differing cultural and value belief systems and begin to engage with these issues in practice team working	Medical: Y3 x 2; Y4 x 1; Y5 x 2 Nursing: Y1 x 5; Y2 x 3; Y3 x 3 Occ Therapy: Y2 x 1 Physiotherapy: Y1 x 1; Y2 x 1; Y3 x 1
L3 Shares knowledge of other cultures' beliefs and value systems to inform patient/user centred care and promote good practice	Medical: Y3 x 2 Nursing: Y2 x 1; Y3 x 2 Occ Therapy: Y3 x 1 Social Work: Y3 x 1
Capable	Nursing: Y3 x 2
Capability EP2: The interprofessional team member interacts within the health and social care practice community to consistently promote and support patient/user participation and autonomy, on the basis of informed decision-making and exercise of choice.	
Learning Achievement Levels	**Students' Self Assessment**
L1 Recognises examples of patient/user focused care, in which participation and informed decision are central to promoting the well being of the patient/user.	Medical: Y3 x 2; Y4 x 1; Y5 x 2 Nursing: Y1 x 3; Y2 x 2; Y3 x 1 Occ Therapy: Y2 x 1 Physiotherapy: Y2 x 1
L2 Engages in some strategies to empower patients/users through promoting their participation in interdisciplinary care provision	Medical: Y3 x 1 Nursing: Y1 x 2; Y2 x 3; Y3 x 4; Physiotherapy: Y1 x 1; Y3 x 1 Social Work: Y3 x 1
L3 Engages with other members of the interprofessional team to use strategies of involvement and empowerment to ensure informed decision-making by the patient/user.	Medical: Y3 x 1 Nursing: Y1 x 1; Y2 x 1; Y3 x 4 Occ Therapy: Y3 x 1 Physiotherapy: Y3 x 1
Capability EP3: The interprofessional team member consistently ensures an interprofessional approach to the exercise of duty of care within a legal and ethical framework	
Learning Achievement Levels	**Students' Self Assessment**
L1 Is aware that members of the interprofessional team may be subject to differing demands of law and regulation in the exercise of duty of care	Medical: Y3 x 2 Nursing: Y1 x 3; Y2 x 4; Y3 x 2 Physiotherapy: Y3 x 2
L2 Acknowledges that the differing requirements, made in law, of all professions in the exercise of the duty of care affects care/service-planning processes	Medical: Y3 x 1; Y5 x 1 Nursing: Y1 x 2; Y2 x 1; Y3 x 4 Occ Therapy: Y2 x 1; Y3 x 1 Physiotherapy: Y1 x 1
L3 Co-operates with others to ensure the legal requirements of differing professions to the exercise of a duty of care are met.	Medical: Y3 x 1; Y4 x 1; Y5 x 1 Nursing: Y1 x 1; Y2 x 1; Y3 x 1 Physiotherapy: Y2 x 1 Social Work: Y3 x 1
Capable	Nursing: Y3 x 2
Capability EP4: The interprofessional team member critically evaluates policy and practice in the context of: Patient/client-focused care. The changing role boundaries that inform the nature of the interprofessional team. Making recommendations to influence developments to improve the quality of service/care for patients/clients of the service.	
Learning Achievement Levels	**Students' Self Assessment**
L1 Is aware that patient/client focused care, changing role boundaries and future service provision is influenced by policy and practice	Medical: Y3 x 3; Y5 x 1 Nursing: Y1 x 2; Y2 x 3; Y3 x 4 Physiotherapy: Y3 x 1
L2 Recognises and discusses policy and practice that influence changing role boundaries in the interprofessional team, patient/client focused care and how the interprofessional team can inform the development of services.	Medical: Y3 x 1; Y5 x 1 Nursing: Y1 x 4; Y2 x 3; Y3 x 2 Occ Therapy: Y2 x 1; Y3 x 1 Physiotherapy: Y1 x 1; Y2 x 1; Y3 x 1
L3 Brings knowledge about policy and practice to inform patient/client focused care and changing role boundaries within the interprofessional team. Can apply the experience of interprofessional team working to discussions regarding future policy and practice within the service.	Medical: Y4 x 1 Nursing: Y3 x 3 Social Work: Y3 x 1



Domain: Knowledge in Practice

Capability KP1: The interprofessional team member has an integrated understanding of the legal frameworks and statutory and regulatory requirements of the professions that make up the practice team.

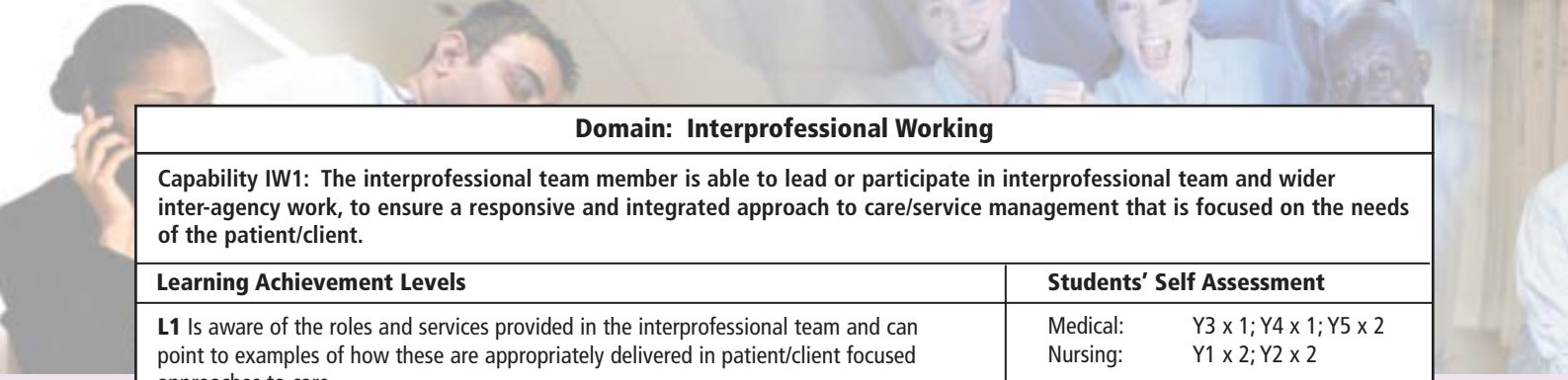
Learning Achievement Levels	Students' Self Assessment
L1 Is aware that regulations that govern practice may differ between professions.	Medical: Y3 x 2; Y5 x 2 Nursing: Y1 x 3; Y2 x 4; Y3 x 5 Occ Therapy: Y2 x 1; Y3 x 1 Physiotherapy: Y1 x 1
L2 Identifies the regulations that apply to different professions and can begin to engage with these issuers in practice team working.	Medical: Y3 x 2; Y4 x 1 Nursing: Y1 x 2; Y2 x 1; Y3 x 2 Physiotherapy: Y3 x 2
L3 Uses knowledge of statutory regulations and requirements of all team members when contributing to care/service delivery.	Nursing: Y1 x 1; Y2 x 1: Y3 x 1 Physiotherapy: Y2 x 1 Social Work: Y3 x 1
Capable	Nursing: Y3 x 1

Capability KP2: The interprofessional team member exercises a critical understanding of team structures and effective team functioning through knowledge of group dynamics and professional roles of all team members.

Learning Achievement Levels	Students' Self Assessment
L1 Is aware of team structures in the practice area.	Nursing: Y2 x 1
L2 Identifies that teams and structures can differ in relation to service provision.	Medical: Y3 x 3; Y5 x 2 Nursing: Y1 x 4; Y2 x 5; Y3 x 7 Occ Therapy: Y2 x 1 Physiotherapy: Y1 x 1 Social Work: Y3 x 1
L3 Brings knowledge of team structure, dynamics and professional roles to effective personal functioning as a team member.	Medical: Y3 x 1; Y4 x 1 Nursing: Y1 x 2; Y3 x 1 Occ Therapy: Y3 x 1 Physiotherapy: Y2 x 1; Y3 x 1
Capable	Nursing: Y3 x 1 Physiotherapy: Y3 x 1

Capability KP3: The interprofessional team member maintains and develops a critical understanding of the requirements and non-judgemental and anti-discriminatory practice in order to effectively participate in care management decisions.

Learning Achievement Levels	Students' Self Assessment
L1 Is aware of decision-making processes in care management and can recognise how they are informed by non-judgemental anti-discriminatory practice.	Medical: Y3 x 1 Nursing: Y1 x 1; Y2 x 1; Y3 x 1 Occ Therapy: Y2 x 1
L2 Can identify and discuss how anti-discriminatory practice and non-judgemental behaviour informs the decision-making processes in the interprofessional team.	Medical: Y3 x 3; Y4 x 1; Y5 x 1 Nursing: Y1 x 3; Y2 x 3; Y3 x 1 Occ Therapy: Y3 x 1 Physiotherapy: Y1 x 1; Y2 x 1; Y3 x 1
L3 Uses knowledge of non-judgemental and anti-discriminatory practice when contributing to decision-making processes in the interprofessional team.	Medical: Y5 x 1 Nursing: Y1 x 2; Y2 x 2; Y3 x 5 Physiotherapy: Y3 x 1 Social Work: Y3 x 1
Capable	Nursing: Y3 x 2



Domain: Interprofessional Working

Capability IW1: The interprofessional team member is able to lead or participate in interprofessional team and wider inter-agency work, to ensure a responsive and integrated approach to care/service management that is focused on the needs of the patient/client.

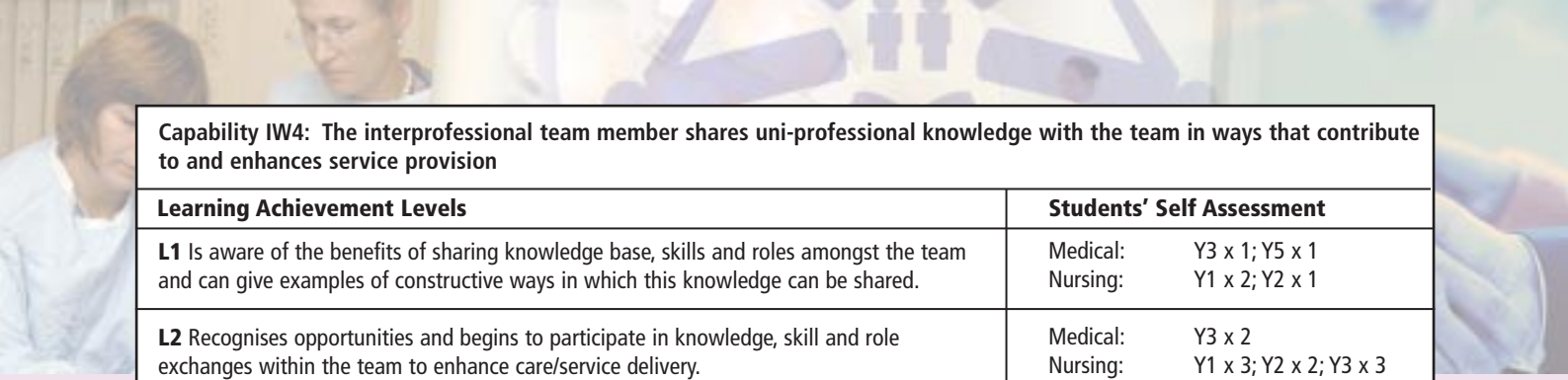
Learning Achievement Levels	Students' Self Assessment
L1 Is aware of the roles and services provided in the interprofessional team and can point to examples of how these are appropriately delivered in patient/client focused approaches to care.	Medical: Y3 x 1; Y4 x 1; Y5 x 2 Nursing: Y1 x 2; Y2 x 2
L2 Can begin to interact and co-operate with others in the interprofessional team in providing appropriate patient/client focused care.	Medical: Y3 x 3 Nursing: Y1 x 4; Y2 x 3; Y3 x 6 Occ Therapy: Y2 x 1 Physiotherapy: Y3 x 2 Social Work: Y3 x 1
L3 Uses knowledge of roles and services within the interprofessional team and wider inter-agency work to participate in and/or where appropriate, utilise supportive mechanisms to take a lead in the management of patient focused care.	Nursing: Y2 x 1; Y3 x 2 Occ Therapy: Y3 x 1 Physiotherapy: Y1 x 1; Y2 x 1
Capable	Nursing: Y3 x 1

Capability IW2: The interprofessional team member implements an integrated assessment and plan of care/service in partnership with the patient/client, remaining responsive to the dynamic needs of care/service requirements.

Learning Achievement Levels	Students' Self Assessment
L1 Has an awareness of the need to have an interprofessional approach, that is patient/client focused, to planning care/service in order to meet the complex needs of people receiving health and social care services.	Medical: Y3 x 2; Y5 x 2 Nursing: Y1 x 1; Y2 x 1 Occ Therapy: Y2 x 1 Physiotherapy: Y1 x 1
L2 Participates in some aspects of the mechanisms and processes involved in an integrated assessment and plan of care/service in partnership with patient/client.	Medical: Y3 x 2; Y4 x 1 Nursin: Y1 x 3; Y2 x 5; Y3 x 2
L3 Uses appropriate strategies in an integrated assessment to plan care/service, that is patient/client focused.	Nursing: Y1 x 2; Y3 x 6 Occ Therapy: Y3 x 1 Physiotherapy: Y2 x 1; Y3 x 1 Social Work: Y3 x 1
Capable	Nursing: Y3 x 1 Physiotherapy: Y3 x 1

Capability IW3: The interprofessional team member consistently communicates sensitively in a responsive and responsible manner, demonstrating effective interpersonal skills in the context of patient/client focused care.

Learning Achievement Levels	Students' Self Assessment
L1 Recognises the need for effective interpersonal skills to enhance patient/client focused care and can indicate a development of these skills in own interactions with members of the interprofessional team and the patient/client.	Medical: Y3 x 1 Nursing: Y1 x 1; Y2 x 1
L2 Demonstrates developing skills of interpersonal communication with the interprofessional team and the patient/client.	Medical: Y3 x 1; Y5 x 1 Nursing: Y1 x 2; Y2 x 3 Occ Therapy: Y2 x 1; Y3 x 1 Physiotherapy: Y1 x 1; Y2 x 1; Y3 x 1
L3 Uses appropriate interpersonal skills that promote effective communication in the interprofessional team with the aim of enhancing patient/client centred care.	Medical: Y3 x 2; Y4 x 1; Y5 x 1 Nursing: Y1 x 3; Y2 x 2; Y3 x 5 Physiotherapy: Y3 x 1 Social Work: Y3 x 1
Capable (note: One medical student and one nursing student did not allocate a level to this capability).	Nursing: Y3 x 4



Capability IW4: The interprofessional team member shares uni-professional knowledge with the team in ways that contribute to and enhances service provision	
Learning Achievement Levels	**Students' Self Assessment**
L1 Is aware of the benefits of sharing knowledge base, skills and roles amongst the team and can give examples of constructive ways in which this knowledge can be shared.	Medical: Y3 x 1; Y5 x 1 Nursing: Y1 x 2; Y2 x 1
L2 Recognises opportunities and begins to participate in knowledge, skill and role exchanges within the team to enhance care/service delivery.	Medical: Y3 x 2 Nursing: Y1 x 3; Y2 x 2; Y3 x 3 Occ Therapy: Y2 x 1; Y3 x 1 Physiotherapy: Y1 x 1
L3 Utilises communication skills in order to participate in sharing knowledge with other professionals, to enhance the provision of care/service delivery.	Medical: Y1 x 1; Y2 x 1; Y3 x 1 Nursing: Y1 x 1; Y2 x 3; Y3 x 4 Physiotherapy: Y2 x 1; Y3 x 1 Social Work: Y3 x 1
Capable	Nursing: Y3 x 2 Physiotherapy: Y3 x 1

Capability IW5: The interprofessional team member provides a co-mentoring role to peers of own or other professions, in order to enhance service provision and personal and professional development.	
Learning Achievement Levels	**Students' Self Assessment**
L1 Is able to give examples of where mentoring from members of own or other professions has been helpful in personal or professional development.	Medical: Y3 x 1 Nursing: Y1 x 1; Y2 x 2; Y3 x 2 Occ Therapy: none Physiotherapy: none Social Work: none
L2 Effectively uses mentorship provided to self in order to enhance personal and professional development and begins to participate in informal mentoring amongst peers in a supportive way.	Medical: Y3 x 2; Y4 x 1; Y5 x 1 Nursing: Y1 x 5; Y2 x 3; Y3 x 2 Occ Therapy: Y2 x 1; Y3 x 1 Physiotherapy: Y1 x 1; Y2 x 1; Y3 x 1 Social Work: Y3 x 1
L3 Is able to utilise skills to provide and promote informal co-mentoring amongst peers of own and other professions that will support further personal and professional development.	Medical: Y3 x 1* Nursing: Y3 x 5* Physiotherapy: Y3 x 1

Domain: Reflection	
Capability R1: The interprofessional team members utilises reflective processes in order to work in partnership with patients and colleagues ensuring a patient/client focused, and integrated care/service provision.	
Learning Achievement Levels	**Students' Self Assessment**
L1 Participates in the processes of reflection to determine own learning needs.	Medical: Y3 x 1; Y4 x 1; Y5 x 2 Nursing: Y1 x 2; Y2 x 2 Occ Therapy: Y2 x 1
L2 Utilises reflection in relation to the development of own role within the team in promoting patient/client focused integrated care/service provision	Medical: Y3 x 3 Nursing: Y1 x 2; Y2 x 2; Y3 x 4 Occ Therapy: Y3 x 1
L3 Demonstrates developed reflective processes in order to evaluate personal skill level and plan future development to ensure effective partnership working in meeting the goals of care/service.	Physiotherapy: Y1 x 1 Social Work: Y3 x 1 Nursing: Y1 x 2; Y2 x 2; Y3 x 5 Physiotherapy: Y2 x 1; Y3 x 1
Capable	Physiotherapy: Y3 x 1
Capability R2: The interprofessional team member utilises a reciprocal process of reflection and supervision to support the continual development of the interprofessional team.	
Learning Achievement Levels	**Students' Self Assessment**
L1 Is aware of formal and informal processes of reflection and supervision in the interprofessional team that enable the team to utilise evidence-based practice.	Medical: Y3 x 2; Y5 x 2 Nursing: Y1 x 3; Y2 x 2; Y3 x 2 Occ Therapy: Y2 x 1 Physiotherapy: Y1 x 1
L2 Begins to explore formal and informal processes of reflection and supervision within the interprofessional team in order to develop evidence-based rationale for current and future practice.	Medical: Y3 x 2; Y4 x 1 Nursing: Y1 x 3; Y2 x 3; Y3 x 3 Physiotherapy: Y2 x 1; Y3 x 1
L3 Participates in formal and informal processes of reflection and supervision within the team to further evidence-based activity in the interprofessional team.	Nursing: Y2 x 1; Y3 x 4 Occ Therapy: Y3 x 1 Physiotherapy: Y3 x 1 Social Work: Y3 x 1
Capability R3: The interprofessional team member responds to the needs of the service by utilising problem-solving approaches and evidence-based practice to identify and anticipate future changes in interprofessional team role.	
Learning Achievement Levels	**Students' Self Assessment**
L1 Is aware of problem-solving approaches and evidence-based practice in care delivery/provision.	Medical: Y3 x 1; Y5 x 2 Nursing: Y1 x 3; Y2 x 1; Y3 x 3 Occ Therapy: Y2 x 1 Physiotherapy: Y2 x 1
L2 Begins to utilise problem-solving approaches and evidence-based practice in the interprofessional team in response to the needs of the service.	Medical: Y3 x 1; Y4 x 1 Nursing: Y1 x 3; Y2 x 4; Y3 x 1 Occ Therapy: Y3 x 1 Physiotherapy: Y1 x 1; Y3 x 1
L3 Participates in problem-solving approaches and utilisation of evidence-based practice within the interprofessional team in response to the needs of the service.	Medical: Y3 x 2 Nursing: Y2 x 1; Y3 x 5 Social Work: Y3 x 1
Capable	Physiotherapy: Y3 x 1

Capability R4: The interprofessional team member addresses professional development and lifelong learning needs in the interests of personal, professional and organisational/service development.	
Learning Achievement Levels	**Students' Self Assessment**
L1 Is aware of continual professional development and lifelong learning and relates this to own continual learning requirements for practice.	Medical: Y3 x 1; Y5 x 1 Nursing: Y1 x 2; Y2 x 2; Y3 x 2 Occ Therapy: Y2 x 1 Physiotherapy: Y1 x 1
L2 Recognises how continual professional development and lifelong learning can enhance development of self within the interprofessional team. Can select and discuss areas of learning to further understand aspects of the interprofessional team.	Medical: Y3 x 3; Y4 x 1; Y5 x 1 Nursing: Y1 x 4; Y2 x 3; Y3 x 3 Occ Therapy: Y3 x 1 Physiotherapy: Y2 x 1
L3 Formulates a plan of activities and behaviours that will support continual professional development and indicate how this aids personal, professional and service development.	Social Work: Y3 x 1 Nursing: Y2 x 1; Y3 x 1 Physiotherapy: Y3 x 1
Capable	Nursing: Y3 x 3 Physiotherapy: Y3 x 1

Assessment of compatibility by practice - based assessors

As well as exploring students' ability to self-assess against the capability framework, an Interprofessional Capability Assessment Tool (ICAT) was devised to consider how accessible the Interprofessional Capability Framework was to assessment by practitioners / interprofessional mentors.

The ICAT assessment tool was piloted in one of the project beacon sites and practitioners were asked to evaluate the usefulness of the ICAT form for assessing students from another profession, when, for example, they had such a student to spend the day with them as part of their placement experience.

Development of the tool

The development of the ICAT tool was informed by The Sheffield Peer Rating Assessment Tool (SPRAT) (Archer & Davies 2003, 2004). This is a peer-rating tool that was derived from the international literature concerning the assessment of performance of medical staff. The tool was mapped explicitly to the General Medical Council (GMC) Good Medical Practice (GMC 2001) and found to be a reliable and valid instrument, (Archer and Davies 2003, 2004).

As the SPRAT had been shown to require little time to complete (Davies, Archer 2003), its format was used as the basis for the development of the ICAT Tool. The sixteen capabilities from the Interprofessional Capability Framework were collapsed into 12 categories to match the layout of the SPRAT tool (see figure1: ICAT Tool below). Participants were informed that the rating system should be viewed on a continuum from 1-6. One being the poorest performance ever encountered, and 6 the best.

Figure 1 ICAT Tool

How do you rate this student in:	Very Poor	Poor	Needs Development	Satisfactory	Good	Very Good	U/C	N/R
	1	2	3	4	5	6		
Capabilities of an interprofessional worker								
1 Ability to promote and practice an understanding and respect for others' cultures, values and beliefs.								
2 Ability to promote and support patient/carer participation, promoting informed decision making and exercise of choice								
3 Demonstrates understanding of role boundaries and legal ethical roles of other professionals in providing services								
4 Demonstrates understanding of team structures, roles of team members in respect of care given and interprofessional working								
5 Ability to maintain and develop non-judgemental and anti-discriminatory practices								
6 Ability to implement an integrated assessment in collaboration with the team including patient/carer								
7 Ability to communicate in a sensitive and responsive manner, demonstrating effective interpersonal skills								
8 Shares uniprofessional knowledge with the team to contribute and enhance the service provided								
9 Ability to co-mentor with peers in the team, to enhance the personal and professional development of others								
10 Utilises reflective practice to work in collaboration with others, supporting the team								
11 Utilises evidence based medicine and problems-solving approaches in developing services								
12 Demonstrates a commitment to personal/professional development and life long learning to improve services								

Six practitioners from 5 different professional groups (dietetics, nursing, occupational therapy (n=2), physiotherapy and social work), based within one of the CUILU beacon sites, agreed to take part in the study. Practitioners were asked to 'reflect' on a student they had recently supervised. Whilst drawing on their 'reflection' of supervising/mentoring the student, the practitioners were asked to complete the form to 'assess' the students' performance with regard to the capabilities. Practitioners indicated the year/level of their 'reflected upon' student and this was noted on the form and they were asked to complete the ICAT form to assess their student

Following completion of the ICAT, the semi – structured interviews were undertaken, which were tape-recorded. Participants were asked:

- Was the tool easy to understand/complete?
- Were there any areas you would like to change?
- Would you feel comfortable assessing a student from another profession using the chart?
- Were any aspects of the capabilities in the chart not relevant to the service context you practise in?
- Any general comments about the tool?

Findings

Eight ICAT forms were completed by 6 respondents, one practitioner completed two forms with two different students in mind, one at an early stage in their training, the other nearing the end.

Three key themes emerged from the data: 'language and terminology'; 'understanding of the roles of other professions' and 'promoting interprofessional capability'.

a. Language and terminology

In response to the questions that specifically focussed on the layout and language of the tool, almost all of the participants commented that it was easy to use and guided them towards how they could support students of other professions.

> ***(Occupational Therapist 1):*** *'For example, if it was, say, a physiotherapy, (different professional to the participant) I'd probably need some, for them to have a supervisor, an overall supervisor in physiotherapy, er, me supervising on a day-to-day basis, but I think you could, using this chart, quite happily do that'*

> ***(Social Worker 3):*** *'Yes. Yeah, very easy and I scan read, erm, and I could focus, I found it fine and I didn't have to keep going back'*

One participant commented that the language and terminology was 'wordy' but acknowledged that the form "needed to be made accessible to all", this participant went on to comment that there was a variety of terminology used within his/her own profession and across the different specialities and that this often created difficulties for practitioners. It was highlighted that this also has an implications for students.

> ***(Nurse 8):*** *'But its hard for students because they get all this and it's, I think they struggle to find, think what it means to them'*

Finding a shared language is noted as a difficulty in interprofessional learning, one example being that the professions use different terms for 'mentor' as commonly used in the nursing context. The fact that the interprofessional capabilities included within the ICAT are common to all professional groups may go some way to address this issue as the language of interprofessional knowledge is common to all professional groups.

Although the participants were able to use the ICAT tool and the Capability Framework readily, the need for education and training in order to

build confidence and prepare practitioners for supporting students of other professions was implicit in their responses. The issue of language and terminology leads to the associated theme of 'understanding of the roles of other professions'.

b. Understanding of the roles of other professions

All participants felt the tool was appropriate for their own profession and believed it was appropriate to use when assessing students from other professions due to the generic nature of the capabilities.

> *(**Physiotherapist):** 'Yes, the things on here are sort of core skill generic, things we should all possess'*

However, the following participant raised the issue of the need to have an understanding of the roles of the different professions within the team in order to feel comfortable to assess students of another profession:

> ***(Dietician 1)** '…I don't do the same (thing) profession (ally), there's perhaps areas that I wouldn't be able to answer comprehensively on or fairly'*

The practitioners seemed concerned that knowing the differences and similarities of each other's roles was a prerequisite to accurately assessing students. This was understood as the mentor/supervisor being required to provide a degree of 'interpretation' of the capabilities in order to facilitate the students' understanding and development of interprofessional knowledge, including the roles of the different professions:

> ***(Social Worker 4):** 'I don't think it would be a problem but I think sometimes they (the student) come from a different viewpoint and then that may be why they've made a decision that they have made, that I might think 'Oh, what's that about?' …Certain things may be in greater aspect, er, there may be a greater aspect of their profession to approaches'*

c. Promoting interprofessional capability

Participants reported that the tool helped to provide a useful and structured framework for assessing students. It was considered an appropriate tool for assessing interprofessional learning, and also ensured equity for students when being assessed.

Students are often involved in shadowing practitioners of different professions to their own and participants thought that the ICAT would encourage and give meaning to such activities, and result in both students and practitioners valuing differences and similarities between professions due to increased awareness, as suggested in this quote below:

> ***(Occupational Therapist 2):** 'Right work with X because you'll pick up so much from working with this other-you'll see it from a different viewpoint'. And then 'What did you do with that? How did you see that? You did the same activity, but you came from a physio viewpoint and you see the difference in what we and what they do'. The activity's the same, to a degree the outcome's the same, the reason behind it is quite different. '*

The experience of being involved in this study and using the ICAT to assess students also appears to have the potential to raise awareness as to the opportunities for interprofessional learning which readily exist within the environment, as suggested in this following comment:

> ***(Nurse 5):** 'I think there's an awful lot of team working opportunities on here that would pretty much cover everything (relating to the tool)'*

This theme closely reflects the data generated through consideration of the Capability Framework itself. The practitioners indicated that consideration of assessing students on the capabilities contained within the framework enabled them to think about interprofessional learning and identify meaningful learning opportunities for students. Assessing against the

capability framework also offered meaning to the practice of students shadowing and learning from members of different professions.

These findings indicate that the ICAT tool was considered easy to use and appropriate to all student groups. However, there were issues raised relating to the current use of different language and terminology across not only different disciplines but also within the same professions. The ICAT tool as a structured approach to assessing the competencies and capabilities contained in the Interprofessional Capability Framework goes some way to address this issue as a common language for interprofessional learning and assessment that is relevant to all professions is provided.

Conclusion

This section describes the work undertaken to identify what students require to learn in order to develop as capable interprofessional workers and to evaluate a framework designed to articulate this through exploring its potential to guide learning and as a means of assessment both of students by practitioners and student self assessment. Its utility as the basis of the assessment of students by service users is described in a later section. The findings of the evaluation processes of the Interprofessional Capability Framework highlighted a number of key 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 the use of the framework as providing 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 sensitises its users to interprofessional aspects of the learning opportunities available in the practice context. This 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 the topic as an interprofessional and collaborative working issue relevant to interprofessional learning.

- **Service organisation can limit interprofessional learning.** Although the beacon sites were recognised as areas where interprofessional working took place, the success in facilitating interprofessional learning for students seemed to be positively related to how integrated the service organisation and student support in the beacon sites was. Where barriers to organising interprofessional learning seem to be in operation, it is not because of lack of learning opportunities, but a function of the students' experience being managed in profession-specific contexts. This results in students learning, in the same setting, in isolation from each other. Non-integrated structures within the organisation, communication difficulties between professions both in practice and in the university context, and educational funding stream issues were also cited as reasons for not integrating student learning fully.

- **The framework's potential to advance interprofessional practice.** When organising learning opportunities across professions for students, learning objectives tend to be set at a level that the 'visiting' student could reasonably achieve, and will be at a lower level than their profession-specific objectives. This is because the student could not be expected to have proficiency in another profession's skills or knowledge. Such objectives, however, do not reflect the complexity of the 'other' profession's role, nor it could be argued, particularly advance the student's own professional understandings. The use of the Framework allows students to access these valuable

opportunities but with a purpose of achieving incrementally more challenging interprofessional learning outcomes, thus raising the student's level of achievement, rather than regressing it.

- **The capability framework brings the patient to the foreground.** The NHS Improvement Plan (2004) underlines the need for the National Health Service to be 'patient driven'. A focus on interprofessional capability through use of the Framework 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. Students' attention being drawn through the Framework to observing the multidisciplinary team at work for the patient. Such attention to the needs of the patient also facilitates greater understanding of the roles and changing roles of different disciplines and how that impacts upon care provision.

- **The complexity of the framework.** Despite a general agreement of the capabilities and learning outcomes contained in the Framework being appropriate and reflecting the realities of interprofessional working, some practitioners commented on certain of the statements being overly complex. The Interprofessional Capability Framework was developed from the QAA benchmarks, thus indicating the level of practice that students emerging as qualified practitioners should attain and the learning levels within the Framework attempt to provide a graduated development. However, this issue highlights the tensions concerning the expectations of newly qualified practitioners in respect to skill level, and the level of responsibility seen as appropriate for them to have been given as students in order to learn and be prepared for qualified roles. In turn this may indicate the need for staff and service development in order for students to be appropriately supported as student practitioners.

Key points arising from students' self assessment of their interprofessional capability are:

- Students were able to recognise and assess their interprofessional learning whilst in practice and grade their level of achievement against the learning outcomes contained in the Framework.

- Students were often able to apply and transfer or integrate the theoretical context of interprofessional learning which had been learned within the classroom, to the practice based learning experience. This linking of theory to practice enabled students to progress their learning and achieve higher levels of capability.

- Students were able to discriminate between the levels of achievement. Interestingly where students placed themselves on the Framework was related not to their seniority in terms of years of study or by profession, but depended to the length of experience they had in practice.

Evaluation of the Capability Framework's utility as an assessment focus revealed:

- Practitioners found the ICAT's structured approach helpful and the tool generally user friendly. They believed it could have a practical application in assessing student interprofessional learning in practice areas although issues around language and terminology could present some barriers and may need to be addressed.

- The ICAT provoked consideration of the perspective of the professional background of the student and practitioners felt that they needed to have confidence in their knowledge and understanding of the roles of the interprofessional team in order to assess students from another profession.

- The practitioners considered that the tool reflected the dimension of interprofessional working and indicated that it validated by their own interprofessional practice.

- The use of a tool that addresses the capabilities of all professions to interprofessional working provides a focus for assessing students from another profession during an interprofessional mentoring encounter.

- The use of an interprofessional assessment tool common to all students, was considered to have the potential to ensure equity for students and would motivate students to fuller engagement when being provided with interprofessional learning opportunities.

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Section 3

Interprofessional Mentorship

The concept of mentoring is well documented within the literature across many disciplines and reflects the development of facilitative relationships between teacher and student. However, different terms are used to describe this process, including supervisor, facilitator, clinical supervisor, practice teacher and placement educator. Within this study the term 'mentor' encompasses all of the terms used to describe the process of teaching, supporting and assessing students in practice environments.

The Department of Health document *Meeting the Challenge: A strategy for the Allied Health Professionals* states "supervising students is a key part of every professional practitioner's role" (DOH, 2000:25) and the literature indicates that the health and social care professions are seeking to understand and develop the mentorship role. The publication Preparation of *Mentors and Teachers* (ENB and DOH, 2001) underlines the importance of nursing and midwifery students receiving high quality mentorship from practitioners. This is echoed in *Exploring Mentoring* (BMA, 2004), which emphasises that mentoring should be available to all medical students for confidential, professional and personal advice and highlights the need for continuing mentorship in terms of development and support. Although produced by specific professional bodies, the issues raised in these documents are pertinent to all health and social care professions and provide multiprofessional guidance to mentors. However, there remains a paucity of literature concerning interprofessional mentorship.

Exploration of the concept of the interprofessional mentor has been central to the work of CUILU as interprofessional mentorship is essential for the support and supervision of students placed within the practice environment.

By reviewing the individual terms *interprofessional working* (Øvretveit 1997), interprofessional education (Barr 1997; UKCC, 2001:33) and *mentorship* (Ryan & Brewer, 1997; ENB & DOH, 2001), CUILU have developed the following definition of interprofessional mentorship:

> Occasions when a health or social care professional facilitates interprofessional learning and supervises and assesses students within the practice setting.
>
> (Marshall & Gordon 2005)

The development of this definition of interprofessional mentorship was the initial step in the exploration of this concept. Further consideration of the concept of interprofessional mentorship and mechanisms involved in undertaking interprofessional mentorship were explored by analysing the qualitative data collected within phase 2 of this study, in order to generate greater understanding and insight of how it might work in practice placements.

Qualitative semi structured interviews were undertaken with practitioners who mentor students whilst on placement within the pilot sites and students who were on placement (see methods section where this is discussed in detail).

Practitioners and students were asked a series of questions relating to their experience of interprofessional learning during the interviews; the questions below were pertinent to interprofessional mentorship.

Practitioners were asked:

- About their involvement in supporting students of their own profession
- How much involvement have you had in supporting students from professional groups other than your own, and what skills do you bring to supporting these students?
- How comfortable would you be in supporting and assessing all student groups on the basis of interprofessional working competence?
- Could you tell me the sorts of learning opportunities you have guided students to that would enable them to meet the competencies?

Students were asked:

- Have you any experience of interprofessional learning and could you describe this experience?
- Have you observed or been involved in interprofessional working in practice?
- What would help you learn about interprofessional working?

Findings

As there is little evidence within the literature to inform interprofessional mentorship, the CUILU definition of interprofessional mentorship was considered an appropriate starting point as this was developed through exploration of the key definitions associated with the terms mentorship, interprofessional education, learning and working.

The CUILU definition of interprofessional mentorship identifies three key components:

- facilitation of interprofessional learning
- supervision of students
- assessment of students.

Further exploration of these three key concepts was undertaken through analysis of the data from the practitioner and student interviews undertaken within phase two of the study.

The results are presented below, with examples of text lifted from the data in order to illustrate the key points being discussed.

Facilitation of interprofessional mentorship

Facilitation in this context is essentially used to describe situations whereby the mentor facilitates interprofessional learning by arranging for the student to spend time in an interprofessional learning encounter.

This could involve a student of the same profession or a student of a different profession but the emphasis is on the encounter and that this is interprofessional.

This theme emerged as the broadest theme, with the following emergent sub-themes:

- Mentors' views on facilitating interprofessional learning
- Recognition of good interprofessional learning encounters
- Culture and environment
- Nature of the Learning Encounter
- Teaching processes

Many examples of interprofessional learning encounters involving both the same profession students and different profession students were evident within the data, indicating that the facilitation element of interprofessional mentorship is already happening and these experiences will be explored now in more detail under each of the sub-themes.

Mentors' views on facilitating interprofessional learning

The actual views of the mentor, with regard to the student experience, seemed to be a key factor in determining whether students would be directed towards interprofessional learning experiences or not. If the mentor was a 'champion' of interprofessional learning and recognised the value and importance of interprofessional working and therefore learning, then the student was more likely to be directed towards good interprofessional encounters or experiences (see below where interprofessional encounters are discussed in more detail).

The example given here clearly indicates that this practitioner is an advocate of interprofessional working and learning:

> ***Nurse 5:*** *Erm, I mean for me it's such a fantastic idea and why didn't we do it before? You know its so simple, but it's erm, I mean its took us, we've only just I'd say, got our head's around what's everybody's role, how does that affect me, do I really understand what they're doing and do I really appreciate that? And it's took us a long time, whereas if you're doing it from the beginning as a student and understanding that and having that awareness, then you're one step ahead aren't you?*

But also acknowledges that the development of interprofessional working requires investment, in terms of effort and a willingness to engage with other professions

> ***Nurse 5:*** *But we've had real problems, it was just by working with each other and really getting to grips with 'oh, right that's what you do.' … … You've got to be able to approach each other and talk about things and listen to each other, which is the main thing, I think.*

Another practitioner described a study day that had been organised for nursing staff but recognised the potential opportunity to include other professional groups and the benefits of this:

> ***CUILU:*** *what would be the benefit to the department?*
>
> ***Nurse 3:*** *oh massive*
>
> ***Nurse 4:*** *everybody would be singing from the same hymn book*
>
> ***Nurse 3:*** *shared ideas, shared roles. We need to appreciate each others roles … the different spokes of the wheel … makes up the whole really …*
>
> ***Nurse 4:*** *yeah, its all round to holistic approach, holistic care so it, it makes more sense.*

In this example below, the practitioner clearly identifies that the views of the mentor are key to the student experience. It is apparent that whilst this person is a champion of interprofessional learning, it is acknowledged that the views of the mentor will impact on the student experience.

> ***Nurse 1:*** *So when we do the induction, I go through all the opportunities and all the people they can see and about talking to families and visiting other areas and if they're quiet there's all things to do, to see. It depends then on who their mentor is and what their level of motivation is to have a student which, obviously, varies dependent …*

It would appear that the 'champion' of interprofessional learning need not necessarily be in direct contact with the student as 'mentor.' Having a champion who is based within the department and is accessible to both mentors and students and able to offer support and guidance may well encourage engagement in interprofessional learning within the learning environment, particularly if there has been hesitancy about doing so, through lack of knowledge or experience or confidence, as this quote below from a clinical educator suggests.

> ***Nurse 7:*** *I used to very much be very closely hands on with them on maybe a day-to-day basis and its gradually changed to, its more me supporting the mentors doing that now. Erm, so although I try and work with each student when they've been, within the first couple of weeks, just to see how they're feeling and how they're settling, that sort of thing and then generally its me discussing with the mentors 'Are you all right? Is your student all right?*

In contrast, when the mentor was not seen to be a champion for interprofessional learning or to work in an interprofessional way, then the student was not always directed towards opportunities for interprofessional learning and as a result often missed out. This sometimes left students with negative feelings about their placement experience. In this example below the student is able to identify the difference between a placement where the team worked interprofessionally by comparing it to a placement experience where her supervisor worked in isolation.

> ***Occupational Therapy Student 1:*** *The fact that I've actually been working with some people other than OT's, because the team is physios and OT's very much combined …they work incredibly closely together … It's a very, very pleasant atmosphere and they work in totally different ways, but they're working together as a team and that is really important and to be part of that I felt really lucky because on my previous placement it was just me and my supervisor, so I had no experience of working with anybody else.*

It was also apparent that some students were proactive in their learning and initiated opportunities for themselves, as is demonstrated by this student below:

> ***Student Nurse 18:*** *Erm, a bit of everything really. I've asked, because it's my third year I wanted to do management, so I've asked like my mentor and she said "You look after your own patients.". So I've been actually talking to the physios and OTs to see where my patients are at to move them further forward, er, and it's been in meetings, MDT meetings that we've had, er, I've been given a chance to voice my opinion on patients and things, which has been good.*

Many experiences were described within the data, which involved practitioners mentoring students of their own profession. In these situations it seemed to be generally apparent to those interviewed what constituted a relevant interprofessional learning encounter.

> ***Occupational Therapist 2:*** *My students will always, I mean we work quite closely with the other disciplines, anyway, so they will do that on a patient basis, but they always spend at least half a day with the other discipline and I always encourage my students to do a nursing shift as well so we do give 'em a good experience of all the roles. I think that it's important that they understand what the roles are.*

> ***Social Worker 2:*** *They're encouraged to use other professionals, work alongside other professions, because otherwise you are not going to get a clear picture of a person's needs. So we have multidisciplinary team meetings where they can discuss it with other professionals. They're encouraged to go and say, see all, you know.*

Dietetics 1: *So, we've got worksheets that they have to do, also visits to other departments to appreciate, sort of other roles and competencies that other health care professionals have, so its sort of shadowing.*

When practitioners were facilitating interprofessional learning for students of other professions, some were equally clear about what this involved, and described how this happened in practice:

Nurse 5: *I think on here, because we make opportunities available because we are able to, because of the teams working on the unit, we do mentor, although a nurse would be mentored by a nurse, they would have two or three days with the therapists*

Nurse 6: *What tends to happen on here is, once they have settled in, whoever's their mentor on the ward will encourage them [students] to come to me and ask to arrange to spend a day with me and learn about my role and how I'm involved and how I fit into the team. I tend to have nursing students and OT's and Physio's*

Whilst it is evident that the practitioners are aware of good interprofessional learning opportunities, the facilitation of these encounters appears to remain with the uni-professional mentor.

Culture and environment

The culture and nature of working within the environment appeared to have an effect on the student experience of interprofessional learning. There was evidence of a strong ethos of team working in certain areas and students were considered being seen as part of the team and to some extent the responsibility of the team, in terms of mentorship and support. Students were appointed a uni-professional mentor, but the team had almost a collective responsibility for facilitating the student's interprofessional learning experience, as illustrated in the following quote:

Physiotherapy Student 2: *I've never worked on a ward where you've got your MD team like you have here, where, sort of everyone is helping everybody out. Er, I'd say the main strength is that they work so much together. Here the physiotherapist and Occupational therapists share the main, you know where they write their notes and everything.*

Additionally, environmental factors appeared to have an impact on the functioning of the team. When teams had the same geographical base or professionals worked within close proximity of each other, then mentors and students were able to readily identify interprofessional working

Occupational Therapy Student 2: *Its good to see the sort of dynamics of the team here because it's a real close knit team and erm everyone is willing to sit down and discuss clients. We have ward rounds where we discuss them and erm, other professions are all happy to do joint sessions.*

Occupational Therapy Student 2: *Erm, talking about the strengths of this placement, I think its an ideal place. Erm, geographical location has put us together. My previous placements where physios are down the corridor and you, you don't really meet, you're in the same building, but it doesn't work.*

Furthermore, environmental constraints or the nature of working was given as a reason for students having little opportunity to spend time with people of professions other than their own.

Nursing Student 12: *I think that the, they do tend to stay in their own professional groups… there wasn't a lot of, there was a little bit of communication, but not a great deal between the doctors and the actual district nurses.*

CUILU: *what sort of meetings did you have with other professionals?*

Nursing Student 12: *erm none because I think I just went to the meeting where all the district nurses met up on a Friday afternoon.*

Physiotherapy Student 1: *Yeah, yeah, erm I mean the only kind of liaison really with a number of professions. I suppose it was quite difficult because we had literally sort of dashed from one GP practice to the next and not really had any contact with anybody other than the patients. I feel as though I've been working with them and no-one else*

Recognition of good interprofessional learning encounters

It is apparent from the data that the key factor necessary for these experiences to be good interprofessional learning experiences was that mentors were able to recognise when a situation or event had the potential to be a good interprofessional learning opportunity. When a mentor is able to recognise opportunities for interprofessional learning either in a fairly formal way, such as prearranged events or on a more 'ad hoc' fashion, the students appear to have developed a greater level of understanding of interprofessional learning and working.

The nature of situations that were deemed as suitable were frequently articulated within the data, by both students and practitioners, such as when a student is to spend a day shadowing someone of a different profession, or when students attend case conferences or multidisciplinary team meetings.

There can sometimes be issues around the knowledge base as students from different professions are at different stages or learning points at different times. It is important to keep this in mind, particularly when the focus of the learning is based around a clinical subject or area. Practitioners identified that this could often be a concern or an issue when teaching a group of students with mixed professional backgrounds.

Medical Practitioner 1: *Nurses tend to be more shy, they need a lot of encouragement and I mean, in that the level of knowledge and experience tends to be less than medical students and whether this hinders teaching or enhances it, but in my experience they needed a lot of encouragement to make them actively participate and talk, and er, and try and really think with us.*

Medical Practitioner 2: *You have to be sensitive to what they feel comfortable with, because if they are too anxious about things they're not going to learn about anything, but to probably ask them about what they want to learn.*

However, when the focus of the learning is interprofessional learning then this is no longer an issue as the focus of this learning is interprofessional knowledge and all students are at a similar or the same stage.

Teaching processes

Several methods or processes were identified within the literature as mechanisms or strategies for delivering interprofessional learning. As well as shadowing other professionals or attending MDT's and case conferences, students and mentors also identified occasions within the practice setting when they had been involved in shadowing and observing other professionals in out-patient clinics, on ward rounds and during staff handovers. Some of examples of such encounters are given below, which demonstrate not only the type of teaching and learning encounter but also provide an indication of the learning that has taken place as an outcome of the students' involvement in the encounter.

Nursing Student 12: *A child abuse case that I went to, obviously there had to be a social worker there, there had to be a health visitor there, there had to be the person who was organising the meeting and the actual person involved in the child abuse, so I did actually see*

one of those meetings and that was good you know. That was done in a very professional way and each person had a time, their time to say something, to speak and give their side of the story.

***Nursing Student 15:** This is the only ward that has like an MDT every Thursday, well that I've been on, and instead of just having handover, it tells you more about why, test results and what's what and what's going to happen next with that patient and is that patient aware of what's going off. It is really informative and I think that you learn a lot.*

In addition, when students identified these experiences as interprofessional they frequently centred around the patient experience, as is illustrated in this example:

***Medical Practitioner 2:** Mmm and I think its been very marked that where we've involved patients in the students' learning that when the students feed back about what they learned from it, very powerful.*

Methods of delivering the learning were also discussed within the data. Students and practitioners suggested that a range of techniques are used, including simulation, seminars, and small group work. Also the teaching of clinical skills was identified, whereby a student is learning to develop their own clinical skills and so observes other practitioners. Within one of the pilot areas, practitioners reflected on a CUILU seminar which they had contributed to within the pilot area, and included members of the CUILU team, practitioners (nursing and social work on the occasion referred to) and nursing, physiotherapy and occupational therapy students:

***Nurse 3:** I think that probably that because they had got, erm, people with more experience, like we have, we could say something and then they could come in on that… There's always one or two leaders and there's a lot who like don't like to say anything, but, I think if people like we, we were able to talk better about things and then they can chip in about it They can come in at different parts with it and have their little experiences or what they think or their thoughts and feelings. Yeah, I did feel a lot of impact in that they were knowledgeable people, so the students didn't feel exposed. Oh, but they're also learning, learning from other, erm, skilled people, picking up things which they wouldn't have been able to pick up on before.*

***Nurse 4:** Yeah, like they might not have had a lot of input from social workers, which I found parts of that very interesting.*

Supervision of students

The supervision element of interprofessional mentorship refers to occasions when a health or social care professional is responsible for the supervision of students who are spending time with them in order to engage in an interprofessional experience.

Again this happens on two levels. On a uni-professional level the mentor is responsible for supervision of the student throughout their placement. In comparison, on an interprofessional level, the supervision will occur during the time that the student and the different practitioners spend together, either formally or on a more informal basis:

***Occupational therapy student 1:** Erm, I've been receiving supervision, erm, obviously it's been weekly. It's a very sort of informal affair. Erm, reflection personally is something that I do all the time. Erm, its not necessarily structured. Erm, I know I have, if I have any questions that everyone is willing to sort of help me out with that. Erm, they help me learn all around, sort of implement work, like problem solving approaches and stuff, so, they're, and I'm aware that all the other members of staff have, erm, supervision both with the senior*

physiotherapist, for example, and with the manager as well.

The student goes on to describe how the experience of supervision varies amongst placements and how the interprofessional working nature of the team has facilitated a more autonomous role for the student, but still within a supported environment.

Occupational therapy student 1: *Yeah, yeah. Erm, it's very subjective, though, as well, and it's different placements like sort of, erm, it's just sometimes the level of, sort of, responsibility and autonomy you're given and where you can take that. Erm, for example, here I've been given free rein and I've taken it on to a high level. In my last placement, I was restrained and so I stayed restrained and I didn't move on as much as I could have, maybe.*

CUILU: *Right and what was, what are the things about this placement that gave you that autonomy, do you think?*

Occupational therapy student 1: *I think it's, erm, such a close team that you don't have to rely on one person, for example, my supervisor. I have two basic grades to draw from as well and, obviously, all the other team members. Also, because it's my final year, I was given a lot more, sort of, rope and, and for me that sort of, I took up the challenge and I took it up better than I would have if I'd been sort of mollycoddled a bit, erm, and I just think it's better when you've got to get on and get doing, because it's really*

It was also evident from the data that it is important that the purpose of the learning encounter is made clear to students in order for them to engage with interprofessional learning in a meaningful way.

In the example given below, the medical students were told that they would be spending morning with the health visitor, without any explanation or discussion as to the purpose of this, and as a result interpreted the purpose as knowing what the health visitor does, rather than understanding about the role of the health visitor and how they might function within the wider multidisciplinary team, to which medicine belongs.

Medical Student 4: *I think that they are all useful for you need to know what health visitors do. Its not particularly useful for me to spend all morning watching them do what they do twenty times when I might not need to know that because I don't want to be a health visitor.*

In contrast, this practitioner clearly states the purpose of the encounters to the students at the beginning of the placement, therefore making the purpose clear.

Nurse 2: *Whether A- they embrace it and B - whether they've got the notion, erm, and if they've not been involved in something like this, erm, whereas when I talk to students on their induction programme, I'm not sure what happens on the medical induction programme, it depends on whether they've been informed about how they would carry out their practice when they are up on the ward.*

From the perspective of the practitioner, a practitioner might be asked to supervise a student from a different profession for a period of time. In these situations, several students described a process of what appeared to be a sort of collective supervision, whereby they had a clearly identified uni-professional mentor but in addition to this, other members of the team also engaged in the supervision of the student, as illustrated in the quotes below:

Nursing Student 13: *The strength of this is that you do get contact with other members of the MDT and that they do help you out in different ways and you do get your management from the team and you do work as a team.*

Occupational Therapy Student 2: *I think its such a close team that you don't have to rely on one person, for example my supervisor. I have two basic grades to draw from as well and obviously, all the other team members.*

Medical Practitioner 3: *I think that it's a fundamental skill, co-mentoring role. I think that everyone should be prepared to both learn and to teach. Er, within my own unit I like to think that to the student everyone is approachable.*

Assessment of students

When considering the assessment of students, in terms of the interprofessional experience, it was evident that there were two primary considerations: whether students were from the same or different background to the practitioner or mentor.

When practitioners were supervising students from their own profession, they sent students along to spend time with other professions and the assessment of these encounters was around the student's uni-professional learning objectives and were therefore confident in assessing students, as demonstrated below.

Dietetics 1: *we do a feedback with them on a six weekly basis where tutors from college come and sit down, so that the college are aware of what we are saying and then we do another at the end of the twelve week placement.*

It is also apparent that when considering assessment on a uni-professional basis, mentors recognise the effect that working within the team has on the students' learning and the quote below from a nurse illustrates this point:

Nurse 6: *The things about assessment of uni-professional knowledge within the team to contribute and enhance the service provided, things that you gain, not necessarily throughout your training, but that you gain through experience.*

However, when students were from a different professional background practitioners expressed that they were uncertain as to the purpose of the students' learning and often felt that they lacked the knowledge to engage in this process, or understood it to be about the student seeing what 'a nurse did' for example, so learning about their role, rather than making the connection that it was actually about the students learning about interprofessional working and therefore developing their own interprofessional knowledge, as the quotes below illustrates:

Social Worker 3: *Assessing students of other professions, yes, my confidence of doing that and whether I'd have the knowledge to do that as well. That's why I would worry, I suppose, even though I said to you that the principles underlying them are simple, you know the same driving force.*

Nurse 7: *You think, I don't know where they're at. I don't understand their curriculum or what they need to know or what we can help them with.*

It was evident that although few practitioners are actually directly involved in the assessment of students from other background, there are many examples that demonstrate that the evaluation of the interprofessional learning experience is taking place. In the example below the social worker reports on the feedback session, which takes place at the end of a student placement:

Social Worker 1: *At the end of the placement, we get together with the placement supervisors, practice teachers and erm students and we talk about how the placement has gone and that and that usually includes the nurses because we do have nurses as practice teachers, so there's that interprofessional dynamic there.*

CUILU: *So, some nurses are qualified to teach on the social work course? To be practice teachers for social work students?*

Social Worker 1: *Yep, you don't have to be , er social worker trained to be involved in practice teaching with the social work students.*

During the interviews, practitioners were asked for their views as to how they would feel about assessing students from other professions, following examination and exploration of the capability framework. It seems that whilst few practitioners have had experience of assessing students from other professions, the overall response seemed to be positive, although some had reservations about certain aspects. The length of time spent with students was identified as an issue, as demonstrated below:

CUILU: *Do you think that you would feel comfortable assessing a student from another profession using the chart?*

Nurse 6: *I think it depends on how often you sort of work with somebody… I think that to be fair about them you need to have worked reasonably closely with them for quite a long time. So, if I've worked with them professionally for a number of weeks, yes probably, but I think there's elements that I may not be able to, because we don't do the same profession, there's perhaps areas that I wouldn't be able to answer comprehensively on, or fairly.*

Another practitioner also alluded to this point but also identified that if the subject area that is being assessed is relevant to all then it is possible, but the need for staff training should also be addressed:

Medical Practitioner 3: *That's a difficult one because that, I think the principle initially is that the people doing the assessments aren't sufficiently aware themselves. Er, just to formalise this, I've been on a couple of away days which are specifically designed to look at minority group interests and so on and issues around gender, race and ethnicity. I think that we've all done that as seniors on the medical side and the nurses have covered that as well and, assuming that we've been trained, I think it starts to make it more possible for you to assess an individual who is spending time with you.*

Furthermore, the nurse practitioner below agreed with the point made about the focus of the subject or topic area, suggesting that the generic nature of the components of the capability framework would apply to all students, but also raised the point that it would perhaps be possible to assess students from professions which naturally engage together in practice.

Nurse 5: *Because there's not too much uni-professional here, but I suppose in some ways it would depend on the profession. I think perhaps I would feel happier, say, with a physiotherapy student where the professions are very similar, than say a dietetic student, who may have different outlooks, but the things on here are sort of core skills, generic things that we should all possess.*

When practitioners were happy to assess students from other professions it was evident that they needed to be clear about the purpose of the learning and assessment and aware of the students' learning outcomes.

CUILU: *How comfortable would you be in supporting and assessing all student groups on the basis of interprofessional working competence?*

Social Worker 1: *Well, I think because I do see [students of other professions] I'd be interested in doing it. I suppose it sometimes helps to know the actual practice issues in order to begin to relate it to the, er, the interprofessional, you know, the requirements. So I think it's easier in your own profession, but I don't think that would rule out working with people from different professions.*

It was also evident that the education and training needs of staff would be an issue, as indicated in the quotes given below, and that this is something

that would need addressing in order for interprofessional mentorship to become a reality.

> ***Medical Practitioner 3:*** *That's a difficult one, because that, I think the principle initially is that the people doing the assessments aren't sufficiently aware themselves of what's going on or they've not been trained to a sufficient level.*

> ***Medical Practitioner 2:*** *I'd say if you were going to ask for one plea it's really that, er, we have more teaching and training on what the different professional, interdisciplinary, professional groups do. I think that we should structure more the input from teaching other professional groups, such as social workers, and they should be able to expand their staffing to do it.*

Conclusion

The three components of the CUILU definition of interprofessional mentorship, namely, facilitation, supervision and assessment, formed the basis for the analysis of data collected within phase two of the study, in order to gain greater insight into the concept of interprofessional mentorship.

The findings of this study indicate that, with regard to students of other professions, practitioners are already engaged in interprofessional mentorship. Both practitioners and students described how mentors or supervisors facilitate interprofessional learning for students of their own professions and other professions, and that several key themes were identified as having an impact on the outcome of this learning experience.

In the first instance the view of the mentor, with regard to interprofessional working, was a key factor in determining the extent to which the student was encouraged to engage in interprofessional experiences. The student was more likely to be involved in interprofessional learning encounters in situations when the mentor could be considered a 'champion' of interprofessional working.

When supporting students with the same professional background, mentors understood what constituted an interprofessional learning experience and directed their students towards these. Practitioners were equally aware, when facilitating interprofessional learning for students from other professional backgrounds, i.e. that the focus was on interprofessional working, or interprofessional knowledge. Additionally, organisational issues and the culture and environment have a clear impact on the facilitation of interprofessional working and learning, such as the geographical environment and the team working ethos within the environment.

The nature of the learning encounter also had an impact on the facilitation of interprofessional learning as students are often at different stages of their training in term of the knowledge base and this has implications when teaching clinically focussed subjects.

It was also apparent that practitioners employ a number of teaching strategies or processes as a mechanism for imparting interprofessional knowledge, and it is important that the purpose of interprofessional learning encounters is made explicit to students.

The second theme explored within this part of the study was that of supervision. Again the findings indicated that this occurs in both a uni-professional context and with students of other professions. In the uni-professional context, the mentor is responsible for supervising the student throughout their placement and retains overall responsibility for this. However, when students and practitioners described supervision in the interprofessional context, it is apparent that a form of collective or collaborative mentorship takes place with the team having some degree of responsibility for student supervision, but with the

uni-professional mentor maintaining overall responsibility.

The third and final theme focussed on assessment. It was evident from the findings that few practitioners were involved in the assessment of students from different backgrounds to their own and were unclear as to the purpose of learning and often lacked knowledge relating to the curriculum of students from other professions.

It was, however also clear that whilst few practitioners are involved in the assessment of students from other professions, many are involved in the evaluation of the interprofessional learning experience, which should ultimately inform inter-professional assessment. Nevertheless, practitioners did convey the view that they would be willing to assess students from other professions but issues were raised, primarily about the length of time spent with a student and the focus of the learning.

Practitioners indicated that the focus of the student learning should be relevant to all students and the participants agreed that the interprofessional capability framework facilitates this and that they would be happy to assess students using it as a basis for assessment (see discussion of ICAT tool in previous section).

The capability framework provides the interprofessional learning outcomes necessary for the student to demonstrate the development of interprofessional knowledge and so as this practitioner says –

Nurse 7: *I think just go for it and see what happens. We've got nowt to lose have we? The only thing will be the added bit of workload for your mentors wouldn't it? Yeah and that is something else that we're looking at. We should be able to sort it, its just going to be some things you've just got to start then, haven't you, and get on with them and see what happens and what you need to change and what the issues are and, I don't know, I get a feeling that maybe you're close to that now. Yeah? Yeah, yeah, its certainly starting to feel that way now, yeah, yeah.*

Key points:

- The facilitation of interprofessional working is already happening but the culture and environment impact on this.
- A range of teaching processes are currently employed within practice to facilitate interprofessional learning
- Interprofessional mentorship is already happening with the uni-professional mentor taking overall responsibility for the student learning whilst on placement
- Interprofessional knowledge is the focus of interprofessional mentorship and this applies to both students of the same profession and students of different professions
- The evaluation of interprofessional encounters / learning is already taking place within practice.
- The capability framework focuses on interprofessional knowledge and is therefore considered an appropriate tool for assessing students
- There are education and training needs that need to be addressed for interprofessional mentorship to become a reality

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Section 4

Interprofessional Teaching and Learning Strategies

This section is concerned with the teaching and learning strategies identified in the project as important to the development of students' interprofessional working capability. Morison et. al. (2003) suggest that interprofessional learning enables students to develop a sense of professional and shared responsibility towards the roles of others in the team. This collaborative work with other health care professionals is seen as pivotal to the improvement of patient care and services. However, the processes of teaching and learning that enable students to participate effectively in integrated services are not immediately obvious and this section aims to describe the work undertaken by the CUILU team.

The purpose of interprofessional education.

The processes of interprofessional education are referred to by a variety of terms including: collaborative learning; common learning; shared learning; shared teaching; multiprofessional education; interdisciplinary education and interprofessional learning. Defining and differentiating between these can be problematic with terms such as shared learning and interprofessional learning sometimes used interchangeably (Barr, 2002).

Some resolution to finding a more robust definition can be found through considering the type of practice that the proposed education seeks to support. Hall and Weaver (2001) distinguish between *multidisciplinary* working where care is underpinned by parallel but independent contributions based on particular expertise; *interdisciplinary working* where, whilst preserving specialised functions, there is close communication and supported contributions allowing holistic management of the patient's health needs and transdisciplinary working where roles and functions overlap, indicating that colleagues must be familiar with the concepts and approaches of each other's professional roles.

Barr's (2002:6) work is also helpful in that he makes the distinction between multiprofessional education as "occasions when two or more professions learn side by side for whatever reason" and interprofessional education as "occasions when two or more professions learn from and about each other to improve collaboration and quality of care". Drawing on Hall and Weaver's work, and on Barr's definitions, the CUILU team propose that interprofessional working is defined by drawing together the descriptions of interdisciplinary and transdisciplinary working. Interprofessional working may be described as:

> A process that places the patient/service user at the centre of the activity, where individual contributions of the care team are

collaborative in *nature and where roles and functions may overlap in order to provide the best possible care for the individual and his or her carers.*

(Gordon and Ward, 2005)

This definition bears some similarity to Rushmer's (2005) views on integrated working which she describes as successful interprofessional working. Rushmer argues that in integrated working overlaps between professions are negotiated and agreed and so are not intrusive or threatening. We would argue that the ability to engage in such negotiation and agreement is supported through interprofessional learning. Below follows a description of some of the strategies employed as part of the CUILU project to assist students to develop interprofessional working capabilities, as set out in The Interprofessional Capability Framework. These strategies were employed within a series of interprofessional seminars.

The interprofessional seminar programmes

The CUILU seminar programmes were delivered in four of the beacon sites. The overall purpose of the seminar programmes 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 patients/clients/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 with respect to becoming interprofessionally capable

Students undergoing practice experience in the practice sites came together to attend the seminars that were conducted in the practice area or simulation venues. Due to the nature of placement and allocation to practice experience across professions and curricula, this resulted in a fairly eclectic attendance with respect to the professional mix of students and their seniority within their own programmes. The range of students attending the seminar programmes was:

Diagnostic radiography students
Dietetic students
Medical students
Nursing students
Occupational therapy students
Physiotherapy students
Social work students
Speech and language students
Therapeutic radiotherapy students

Teaching and learning strategies used in the interprofessional seminar programmes

Previous literature has suggested that interprofessional learning is most successful when it is practice based, active and patient centred (Baxter, 2004). Similarly, interprofessional, practice based learning was seen as beneficial when students were learning common clinical skills. Morison *et. al*. (2003) indicate that practice based learning offers greater opportunity for experiential learning, which they compare favourably with the theoretical knowledge of team-working gained through classroom-based teaching.

When planning the interprofessional seminar programme, the CUILU team considered Hall and Weaver's (2001) and Cooke *et. Al.s'* (2003) suggestions that delivery should centre on problem based learning and that structured

activity be built around a case presentation. Although the CUILU seminar programme adopted a case presentation approach, problem based learning was considered more appropriate to classroom based education (Morison *et. al.,* 2003) and, in keeping with Mandy et. al.'s (2004) and Baxter's (2004) suggestions, interactive and experiential approaches were utilised in which the student activity centred on undertaking collaborative learning tasks rather than on learning activities based on professional specialisms. These methods were enhanced by the use of role-play and reflective practice, in order to facilitate attitudes conducive to interprofessional team-work (Hall and Weaver, 2001).

Each programme comprised four sessions with each session constructed around one of the following learning tasks.

- the identification of interprofessional care goals for the 'patient' or 'service user'
- the writing of interprofessional philosophies and mission statements for the practice sites
- the formulation of stem questions through which patients/clients may be enabled to evaluate interprofessional aspects of their care
- in a simulated practice scenario the students are enabled to practise, through role play, working together with 'patients', or 'service users' and their carers.

The seminar programmes for each of these sites were based on a patient 'story' or case study that was produced in partnership with practitioners, and in one site lay participants also contributed. Each story involved a series of scenarios concerning a 'patient' or 'service user' whose characteristics and problems were typical for the client group being cared for in each of the sites. Although the story offered an integrated approach to the programme, the individual seminars could stand-alone. This ensured that each seminar was meaningful for students able to attend the whole programme, and for those who attended only one or two sessions. The seminars were facilitated collaboratively with members of the CUILU team and practitioners from the sites, and in one site, lay participants.

Example of seminars from two beacon sites

Practitioners and/or lay participants associated with each of the beacon sites participating in the seminar programmes had collaborated with the CUILU team to construct a patient 'story'. This resulted in stories and scenarios, that although fictional, were drawn from composite incidents from practitioners' and lay participants' actual experience, were grounded in practice and so recognisable as feasible representations of the beacon sites' context of care. To give a flavour of the seminar programmes, the description of seminars from two of the beacon sites is offered below. Example 1 describes all four seminars in the programme and Example 2 describes a simulation exercise that formed an individual seminar in a second site.

Example 1: Doug's 'Story'

The following represents the beginning of a story about the care and treatment a patient received following admission to the Accident and Emergency Department. The story is fictional, although based on events that can really happen, and Doug and his dad are not real people.

Social history:

Doug is a 20-year-old young man studying at university. He lives with his Dad and two younger siblings in a town a few miles from his college . He travels to college from home, although will often stay with friends if a night out is planned. It is believed that his quality of life prior to hospital admission was good. He works in a local pub to earn extra money.

Doug's father is currently unemployed. Doug has two younger sisters, Lisa aged 12 who has mild learning difficulties and attends a special school, and Jane aged 8. Doug's mother recently died after long illness and unsuccessful treatment for breast cancer.

Previous medical history:
No previous medical history to note.

Doug

"I feel really tired. Last night I should have gone out with friends, at the weekend we went on a big bender. See, I recently broke up with my girlfriend and was feeling fairly low, just needed cheering up. But last night I just felt really out of it, achy and restless, I couldn't get comfy at all."

"I woke up at about 7:00a.m. and felt really ill. I can't really walk, which is so strange… I feel I have got lead in my shoes. I decided I felt too ill to go in. I called up a mate from university and went back to bed. My Dad called up to me at about 10:00a.m. He thought I was skiving."

" I never realised what people meant when they say they feel really ill, I mean seriously ill. I feel shocking, I feel like something really bad is going to happen. Its like someone has whispered in your ear, 'you're going to die today'.

Dad

"He's a lazy so and so. Always needs a kick up the backside. Since Lucy, his mother died last year; we have all had to muck in. He has two sisters both at school, both of them need lots of help. The youngest as well, her mum dying really hit her bad."

"Anyway this morning I shouted up to him early, no reply. I was going to leave him, but we are forking out for this course, so I went up to lever him out of his pit. When I got up there, he looked shocking. Seeing Lucy my wife really ill for a long time, well I knew something was up. He wasn't really making sense (I know he often doesn't). I had got the girls off to school this morning and then got back, he was still in bed, so like I said I went upstairs to see what was going on. I am glad I did, I told him to get some clothes on as he needed to go to the Doctors. When he couldn't do that I decided to ring for an ambulance.

"Now that we're here they have said they can see a rash on his skin and suspect meningitis. I am very frightened".

The learning outputs – the first sessions

Issues identified by participants in first three sessions of the programme:

- Nursing assessment will include issues to assist with a diagnosis: vital signs, history, plus psychological/communication issues, social circumstances to ensure holistic approach
- Social work assessment will include needing to understand medical aspects as these influence immediate and continuing care, communication issues, home situation, general family issues.
- Physiotherapy assessment: would generally not be involved at this stage unless respiratory problems, but in time would need to know medical status, assess social circumstances, home situation (for mobility issues) exercise tolerance, lifestyle, psychological status.
- Occupational therapy assessment would generally not be involved at this stage but would need to know medical status and prognosis, in time would need to include verifying Doug's normal range of activities and lifestyle and emotional and psychological status in order to consider rehabilitative programme.

Insights drawn from students' reflections:

- The whole team needs to know much the same information but for different purposes
- The whole teams need to know much the same information to inform decision making and ensure integrated approach to meeting needs
- Danger of repeated assessment – MDT notes are useful and each discipline refers to them – importance of trusting each other's findings is raised.

Immediate goals identified by participants:

- Doug's condition will be rapidly and accurately diagnosed and treatment instigated
- Care for Doug will be instigated in a family-centred way that is sensitive to potential grief issues
- Care for Doug will be maximised by family support being offered as appropriate and according to dad's wishes (may be immediate care and safety issues for the children)

Students' identification of professionals who make up the team that need to be involved at this stage:

FAMILY – Doug's dad
Nurses
Doctors
Laboratory scientists and technicians
ECG technician
Radiographers
Social workers
A and E clerk
Paramedics
Porters
Cleaners
Doris (voluntary worker)

The interprofessional philosophy produced by the students

The interprofessional team works together from a value base of sharing appropriate information within the team to provide co-ordinated care that acknowledges all aspects of the individual, including previous life experiences, family network, spiritual, cultural and emotional needs. Sensitivity and honesty are valued components of communication with the patient and family as well as using understandable language that avoids technical terms and professional jargon.

The mission statement

Our multidisciplinary team aims to function in an interprofessional manner, thus supporting each individual to best perform both in own role and as a team member to deliver integrated patient-centred care.

The fourth session: simulation of Doug's resuscitation

The simulation took place in a purpose build environment on university premises and included the use of a 'Sim-Man' model. The student group comprised nursing students only on this occasion, but the interprofessional aspect was ensured through the facilitator team including social work practitioners and 'acting' medical and nursing staff.

The cast

Doug – acted by Sim Man

Doug's dad – acted by CUILU team member (social worker)

Duty social worker – acted by social work practitioner

Medical Officer – acted by A and E practitioner

Care assistant – acted by A and E practitioner
Team leader and 'followers' – acted by the students

Learning facilitators – A and E clinical educators, social worker, nurse consultant in intensive care and CUILU team

The Process

Prior to the scenario, the students were guided through aims and processes of the simulation and details of all participants' roles were given. The students were facilitated to reflect on their previous learning and experience with respect to the needs of patients such as Doug, and a verification of what they would require to do as team members caring for Doug.

The session involved two short simulations, firstly Doug's initial assessment in the Accident and Emergency Department and then later the procedure for Doug's transfer to the Intensive Care Unit – this included a respiratory arrest on the way to the lift. On both occasions Sim-Man was programmed to simulate Doug's verbal and physiological responses to the interventions of the team caring for him. At the same time Doug's dad was expressing his concerns and the team were required to respond to him and meet his needs – and those of the wider family.

Student evaluation of what they learned from the simulation

Student quotes:

> *Understanding ACS. A.B.C.D.E. Team work. Communication. More about nursing role.*
>
> *Learning about communication in a stressful situation. A.B.C.D.E. using systems and reflecting on the system*
>
> *Teamwork – leader/follower. Communication. A.B.C.D.E.*
>
> *Learning about communication in a stressful situation. A.B.C.D.E. Using systems, and reflecting on the system*

Generally students found the simulation process challenging but rewarding. It was clear that they had learned aspects of the nursing role in situations such as portrayed in the simulation but also about interprofessional issues such as teamwork across the professions and communication with each other, the team and the patient and his family.

Example 2 'Lisa's Story'

This second example concerns one individual seminar from the programme of four that was in the form of a role play that took place in a teaching room in the practice area. The students attending the session were from nursing, social work and occupational therapy. The facilitators were from nursing, social work and drug services – the drug service worker also acted the part of Lisa. The students were asked to participate in a role-play in which Lisa had left the ward for a period of time and was to be asked where she had been and what she had been doing.

> *Lisa aged 22yrs, lives with her mother and younger brother on a council housing estate in a part of the city where substance misuse is particularly problematic. Lisa's family are aware of her drug habit.*
>
> *She has used drugs since the age of 14yrs (she injects street heroin and uses other drugs she can buy on the street). Lisa has had several hospital admissions mostly for drug related issues – deep vein thrombosis, bacterial endocarditis and infected leg ulcers, she also is known to have hepatitis C infection. Lisa's present admission is, again, for treatment of infected leg ulcers and a generally debilitated state due to malnutrition and other factors.*
>
> *Lisa has been prescribed Methadone whilst an inpatient. Lisa is aware that if it is suspected that she has been using illicit substances whilst an inpatient that her Methadone cannot be given (there are issues of overdose). This has happened on 2 previous occasions. On both occasions Lisa became distressed and abusive towards nurses and doctors involved even though the team felt the rationale had been explained in a reasonable manner. Lisa has, for a third time, left the ward without explanation and was away for an hour. The team is concerned that Lisa may have been meeting a dealer, and that she would be requesting her prescribed methadone in half an hour when it was due.*

The process of the session

Prior to the role-play, the students were guided through aims and processes of the session and details of all participants' roles were given. The students were facilitated to reflect on their previous learning and experience with respect to the needs of patients such as Lisa and a verification of what they would require to do as team members caring for her. It is important to note that only Lisa was in role. This was considered to be less threatening for the students in that they had only to act as student practitioners and not take on roles that they didn't fully understand or be expected to know or do more than was appropriate for the stage of their respective courses.

The session involved the students raising with Lisa where she had been when she left the ward and her request for her methadone medication. The students were able to practise their approaches to Lisa and gain immediate supportive feedback from the facilitators. This included 'Lisa' stepping out of role and giving expert advice from the perspective of a professional with extensive knowledge and experience of helping service users such as Lisa. The students were enabled to retry their approaches until they felt more confident.

Following the role play, the students reflected on the session with respect to their differing responses to the problems Lisa and her family might have; to consider how their different professional roles may fit together to help someone such as Lisa; to consider ethical and legal issues as well as how their interpersonal skills might develop and to consider how they could be mutually supportive through knowing more about each other's role. A pivotal component of the reflection was for students and facilitators, including any lay facilitators (in this case the drug service worker advocating for patients such as Lisa), to consider the students' achievements of specified interprofessional capabilities.

Student evaluation of what they learned from the role play

Students were asked to evaluate the session by responding to two questions: What was most difficult about this task? What was the most useful/positive thing you learned today?

What was most difficult about this task?

Not knowing enough about drugs and drug use

Thinking of open questions

Dealing with an unknown setting and expecting myself to deal with it professionally

Trying to fully consider and understand other professions' values etc.

Not knowing how to ask Lisa difficult questions

Knowing what to ask and how to build trust with the patient

What was the most useful/positive thing you learned today?

Some perspectives from a drug user and drug worker point of view

We all had Lisa's interests at heart and not to stereotype her

A larger insight into how drug users feel in the hospital setting and everyone else caring for them

To work with other disciplines to look after Lisa

Consideration of the total seminar programme

Barr (2002) states that interprofessional education has its roots in adult education theory, where learners are critical thinkers, flexible and adaptable in team situation, effective communicators, reflective practitioners and supporters of life-long learning (Knowles, 1990; Merrill, 2001). Adult learners are seen as motivated and active in the learning process, which is conducive to interprofessional practice, where positive

interaction, communication and team-work are valued. The CUILU seminar programmes aspired to embrace an adult learning ethos and approach but recognised that adult learning processes can be complex and unpredictable (Miflin, 2004). A major challenge that this approach to learning can raise for educators concerns when to introduce programmes of interprofessional learning into the undergraduate curriculum.

Barr (1996) summarises this dilemma when he indicates that early introduction of interprofessional learning programmes can be demanding for tutor and learner in the sense that learners new to their education and training programmes are less likely to have a strong knowledge base, which is required as a foundation for sharing experience and working flexibly within an interprofessional team and learning environment. Given the difficulties faced in providing students with an adequate foundation to begin learning interprofessionally, it could be tempting to delay interprofessional education until post-qualification period when curricula are less constrained by professional requirements, yet newly qualified practitioners must engage in collaborative practice immediately and may not have the opportunity to return to studies, which suggests that early intervention would be beneficial for working practice and patient care.

A wide range of professional groups were involved in the seminar programmes across the sites, both as students and as facilitators. This, from the perspective of the CUILU team and drawn from the quotes of the student evaluations and the data from the qualitative interviews with practitioners is seen as a solution to some of the difficulties described above of students' still emerging knowledge bases.

(Nurse 7) I think it needs to happen right from the beginning of training. If the focus is there at the very beginning… they've not…learned bad habits and, you know, 'Let's get into our corners...'

As reported above, the students attending the seminars were from different professional groups and at different stages in their programmes – unlike the traditional approach of students following the same programme at the same time seen in most formalised learning encounters. It is considered that this factor, rather than diminishing learning, strengthened it in that students were enabled to learn from and to support each other. Importantly, the interprofessional facilitation team provided support for students from a uni-professional perspective but also of note, as seen in the student evaluation comments below, a wide knowledge resource for the students to draw on. This was particularly notable in the students' comments about the value of learning from social worker students and practitioners even in settings where social work input may not usually be available, for example in acute resuscitation situations.

Student evaluation of the seminar programmes

Below are examples of student comments following their participation in the interprofessional seminars:

What the students said about the difficulties:

Intimidating to begin with, but made to feel comfortable by team members.

The fact that I could only attend one session. It would have been nice to follow the whole thing through to then see how we worked as a team and what would've been the outcome.

Although I felt fairly knowledgeable about roles of MDT, A & E environment is something I have never experienced. I was very unsure of exactly what information they required at the early stage.

Having the confidence to participate and demonstrating personal knowledge and having to delegate to fellow students. Everybody watching, so to give feedback.

What the students said about the usefulness of the process:

"Understanding the role of MDT members and how communication between the MDT affects the care of patients.

Appreciation of roles / thoughts / attitudes of other students. Use of jargon within physio communication sheets – what is understood by myself, I cannot presume others (ie students and other MDT members) will understand it.

Different roles of the MDT. Being able to ring Social Services for information you're unsure about. Social work role.

Interesting and useful getting together with different professionals to see their view on practice and some of the things that they look out for when seeing a patient.

How good communication amongst professionals and disciplines is ESSENTIAL for 'best practice' and to ensure a realistic, factual assessment of patient's needs.

I gained more knowledge about social workers' roles and it was good to learn a little more about what other information members of the MDT require.

What the students said they learned about other professions:

More info on the social worker.

Role of occupational therapist regarding needing to know psychological status – pre and post – of patient.

Social worker – how they plan for home, home circumstances.

Yes, how communication / language is passed on and that it can be interpreted differently by the same profession.

Social work roles generally and specifically about their role in acute situations.

The work undertaken by social workers. The wide variety of professionals involved in the care of a patient

Conclusion

The success of the CUILU seminar programmes depended on a collaborative approach to educational planning that mirrors the requirements of interprofessional working. Below are teaching/facilitation strategies that support interprofessional learning.

- **The centrality of the patient/service user:** An important aim of interprofessional education is to improve care (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 (see previous CUILU articles in this journal) 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 interprofessional learning 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 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.

An important question about interprofessional learning is whether it can improve patient care. CUILU considers that evidence is building on this question but more work needs to be done. However, the final word about the seminar described in this article comes from a field note made by a member of the CUILU team.

> *'Sally' one of the students, told me that after the session we did with the 'acting' drug user, she had to work with a patient with similar problems the next day, she said she felt confident about admitting this patient and working with him, and the session had directly helped her care well for him.*

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Section 5

The Involvement of Patients and Service Users in Student Learning and Assessment

The involvement of service users and patients is regarded as a key vehicle for the promotion of interprofessional learning and reflects the current move toward patient and public participation in all facets of health and social care delivery (see the NHS Plan (DOH 2000a); the Bristol Enquiry Final Report (Kennedy, 2001); Victoria Climbié Report (Laming, 2003) and the Expert Patient (DOH, 2002b).

This section describes work with patients/service users, students and educators in planning patient/service user participation in interprofessional student learning, which was a central theme of CUILU's work. This work focused on exploring the experience of lay participation in student learning from the perspective of students, lecturers and lay participants; exploring approaches to involving patient and service users including issues around sharing stories and experiences, patients as assessors, issues 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 CULU beacon sites. 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.

Background to the public/patient partnership movement

The drive towards user involvement generally in health and social services has emerged in recognition of the need to empower the public, in the interests of improving health and social services (Patients Charter, DoH 1991; 1995; 1997; Waldegrave, 1996; NHS Plan (DoH, 2000a). There is a natural extension of this movement within the education of the health and social care professions, with an emphasis on students learning about people's human rights, anti oppressive practice and the promotion of equality and a recognition that those who use health and social services are themselves well placed to illustrate these concepts to students.

The contribution of service users and patients to education is not new; a great number of people have participated in health or social care teaching sessions or demonstrations for many years. However, what is new is the recognition of the impact that service users and patients can have on services and the focussed emphasis on patient partnership in all aspects of service delivery and education. Such exposure to the service user/patient perspective is something with which many practitioners can identify when reflecting on their own formative experiences.

Students are continually learning from patients or service users during their work experience, however, the opportunities to critically reflect, discuss and link to practice development are not always clearly available. Discussions with students indicate that there appears to be something substantially different about learning with patients, rather than about them. The opportunity to recognise

the reality of the service user/patient experience, and to discuss and reflect may be the essence of this difference.

Barr (2000) found that work-based interprofessional learning was more likely to improve the quality of service and bring direct benefits to patients than college-based teaching. Indeed, as described in the previous section, the CUILU project identified that within practice-based pilot sites, there are many learning situations in which patients and service users are centrally placed, and these provide rich opportunities for interprofessional learning. Teaching approaches that link to practice, and promote service users' involvement utilising their 'real' life experiences, can show students the importance of working interprofessionally with other disciplines and agencies to provide care that is truly focused on people and their families.

Promoting service user /carer and patient involvement in interprofessional learning: The CUILU public & patient advisory group

A lay advisory group of 26 members was formed to inform and guide the processes of the project. Membership was drawn from established patient and service users groups across South Yorkshire, including, for example, the Sheffield Cancer Services Advisory Group; the Patient Council; Sheffield Programmes for Education in Cancer Care; Service User Carer Involvement in Social Work Education; and the Expert Patient Programme. Most group members identified as having experience of training or teaching generally. The title of the group, Public and Patient Advisory Group, (PPAG) was negotiated with the members, as were the agreed areas of the group's activity:

- To develop ground rules (guided by the National User Network: 'Shaping Our Lives', 2004)
- To participate in the exploration of some of the issues around patient/service user involvement
- To help plan different ways of involving lay people in education
- To contribute to a regular newsletter to disseminate information about the project and its processes
- To participate in the development of guidelines for good practice in supporting lay involvement in interprofessional education.

Building on ways of working in partnership with patient and service user educators

Early work conducted by the CUILU team explored the student perspective on learning from patients. Qualitative interviews with students from various health and social care professions and patients or service users, who had been involved in student learning, highlighted some of the issues arising from patient/service user and student experience:

- Achieve greater understanding of the patient journey
- Learning gained is practical and relevant
- Gives the opportunity to talk and listen to service users and patients and learn about their perspective
- Enables reflection on own role and relationships with other professions
- Explains where own profession fits in the patient journey.

Students reported being involved in various learning opportunities that involved patients, including planned classroom or practice based learning exercises where patients recounted stories of their care or explained about their illnesses or disabilities from their own perspective, as well as encounters with patients whilst gaining practice experience. These experiences were viewed positively by the students in that they valued the 'real life' nature of the encounter.

Students also reported gaining an insight into the patient's journey and where their own profession fitted in this journey, as well as their profession's relationship with the other disciplines involved in the patient's care. These experiences led to a deeper understanding of how collaborative and integrated working can be effective.

The exploration of the patient/service user perspective revealed an insight into why people agree to participate in student learning initiatives, which included:

- Provides an opportunity to give something back
- Campaigning - wanting to improve services
- Raises communication issues - underlining the importance of communicating well
- Some have teaching backgrounds – enables continuance of skills despite life changes
- Promotes feelings of being valued
- Enabled to 'make a difference'

The lay participants felt that sharing their experiences and insider knowledge was a way of reciprocating the services that they themselves had received as patients. Some participants felt that being involved in the student learning experience enabled them to campaign for better services and improved communication between themselves and the professional. A number of the participants had backgrounds in education and felt that they could utilise this skill despite having lifestyle changes as a result of becoming a 'patient'. The participants enjoyed feeling their contributions were valued and appreciated by the students and educators and felt rewarded by being able to make a difference to services.

CUILU's work with the Public and Patient Advisory Group reflected the findings of others (Wood and Wilson-Barnett 1999; DOH 2003) concerning the benefits of user focussed education; however questions are also raised around how people can best be involved in student learning in a positive, non-exploitative way. Both the students and lay participants indicated the need for a considered approach to patient / service user involvement, and identified the following areas for consideration:

- The patient not always feeling well enough to be involved
- Reliving the story can be traumatic
- Feeling vulnerable in sharing the story or being perceived as complaining
- Students worried about overburdening the patient
- The knowledgeable patient can feel threatening to students

Participation often depends upon the current health state or current treatment and so at times people are unable to commit. For some people, sharing their experience is not always positive, particularly if it was traumatic. Also, patients can sometimes feel vulnerable when sharing experiences, particularly if they may need to access services in the future.

Students sometimes felt uncomfortable when they felt that the patient or service user was being overburdened, for example, where people became upset or when there were large numbers of students. Also, some students reported that the patients' expert knowledge in comparison to their own relative lack of knowledge felt threatening to them and undermined their confidence as learner practitioners. Other implications for patient/service user involvement in education were also highlighted including: accessibility; payment; inclusivity; resources; health and safety; insurance and training and preparation.

From these findings it became evident to the CUILU team that whilst the involvement of public and patient participants in student learning is

recognised as a powerful learning experience, it is important to ensure that this is undertaken in a positive way. Therefore, further work was planned with a view to developing good practice guidelines to support patient and service user participation in student learning.

Addressing the Issues

Discussion with the advisory group around the findings indicated that supporting service user/patient involvement in education requires not only organisational and budgetary commitment but also commitment to a participative ethos that recognises the reciprocal benefits of service user/patient involvement. It was recognised that whilst good practices were evident around service user and patient involvement in health and social care education there was the potential for negative experiences. Feedback from service user and patients suggested inconsistencies in practice. It was therefore proposed that a set of 'Good Practice Guidelines' might facilitate processes between educators, patients/service users and practitioners.

Development of good practice guidelines

A series of workshops were organised to explore in depth how involvement should be managed. Three workshops were conducted with the Public and Patient Advisory Group, students and educators. The student workshop included three students (medical student, radiography student and nursing student) who had experience of user involvement in interprofessional learning. The workshop conducted with the Public and Patient Advisory Group included 14 members, some of whom were also active in other user groups and had education backgrounds. The educators' workshop included 10 educators from various professions, including: midwifery, medicine and dentistry. Two members from the advisory groups also participated in this workshop
.

Three trigger questions were posed to each workshop:

- What should educators consider when involving service users and patients?
- What should students consider when service users and patients are involved in their education?
- What should service users and patients consider when becoming involved in health and social care education?

The key themes generated from the workshop activity were distributed to participants and incorporated into a draft 'Guidelines for Good Practice'. A working party with representation from each of the three groups was established to identify areas of agreement or difference.

The process of workshop and consultation facilitated the identification of key principles to good practice essential for the development of positive collaborative partnerships (see below); this resulted in the formulation of a practical checklist for educators to consider when involving patients/service users in teaching. To further validate the Good Practice Guidelines the team piloted the guidelines as a case study in one of the CUILU beacon sites. This experience indicated a further dimension, that of collaboration, which was pivotal in building trust and relationships with patients/service users, and students. This will be discussed in the account of the case study to follow.

Key aspects of good practice:

a. Collaboration
b. Preparation
c. Communication
d. Support
e. Debrief

a. Collaboration

The project team worked with a stroke support group associated with one of the beacon sites over a period of six months in order to develop a strong and supportive working relationship. Whilst collaboration was not identified as a key principle in the workshops described above, it would seem that it is undertaken almost instinctively by skilled facilitators and is often overlooked when articulating processes. Collaboration was the groundwork to supporting involvement and the facilitators from the project team drew on their experiences and skills in facilitation, teaching and group work. Building relationships and trust took time and commitment from all involved. This was a very rewarding aspect of the project but the time and resources to support collaboration should not be underestimated. The importance of collaboration is revealed in the focus group discussion in the following section.

b. Preparation

The group considered preparation to be essential for all parties involved. Practical and supportive aspects need to be addressed, such as: supporting training needs, briefing students, confidentiality and opt out clauses; accessibility issues including the use of appropriate language, health and safety, payment arrangements, joint planning and preparation of session, meeting, greeting and hospitality, planning of debrief (see below) and evaluation.

c. Communication

Effective communication was a very strong theme that included the requirement for all involved to be fully aware of the processes of the learning session. Students need to be informed as to why patients/service users are participating and why this is different to other learning opportunities. Educators should offer guidance to students about appropriate communication and what is acceptable to enquire about. Care should be taken to ensure that the patient/service user is able to interact effectively with the learners and this may involve the use of communication aids or in some cases interpreters. These types of learning experiences are valuable in helping students develop interpersonal skill, but must be managed carefully in order to ensure a positive experience.

d. Support

In order to participate in learning sessions, it is essential that patients/service users are supported. Support should include information about institution, details of the course and the aims and objectives of the session, along with any materials required. Additionally, training may be required in the use of equipment and information technology or presentation skills. Advice and guidance may be required about how to present their story and the development of strategies of how to share aspects of their story that are potentially negative in a positive way or conceal elements that might cause discomfort. The rehearsal of question and answer scenarios might also be useful.

e. Debrief

A further dimension of debrief was identified through discussions with patients/services users and students – that of closure. The need for individuals to reflect on their involvement had been highlighted within the workshops and the need to consider strategies for supporting disengagement in a positive way when individuals no longer wished to participate was considered important. Managing closure was therefore considered an important element of good practice

Good practice guidelines

Attention to each of the five areas described above highlights the commitment required to engage students and patients/service users in learning initiatives that are mindful of the needs of all those involved – students and patients/service users. The aim of the Good Practice Guidelines is therefore to encourage reflective practice around patient/service user involvement

in education and to recognise the reciprocal benefits that non-exploitative, positive participation can offer for educators, students and patients/service users alike. Being 'mindful' necessitates that very practical issues are addressed in enabling safe and positive learning environments for all stakeholders including students and patients. This work has enabled the formulation of a series of questions that are recommended as an aid to planning the involvement of patients/service users in educative processes. These questions do not represent a definitive or prescriptive guide to service user and patient involvement, and it is likely that the development of good practice will evolve as lay involvement in education becomes mainstream.

The good practice guidelines – a check list

Good practice can be promoted through considering certain questions around the arrangements for lay involvement in student learning.

- Has a risk assessment been conducted to guide advance planning regarding how to best support individuals' participation? This is best done in partnership with the person who will be involved in the teaching and should include ensuring that the premises meet the various legislative requirements relating to Anti-Disability discrimination and public access, health and safety legislation, and fire regulations.

- Does the risk assessment include issues surrounding any specific needs the person may have, for example related to their condition or problem?

- Have arrangements been made for travel, meeting, greeting and hospitality, including refreshments?

- Has everyone involved including students, and the service user/patient been properly briefed about what is expected for this session, in terms of learning outcomes? Have the students and patients/service users been advised about how they can best relate to the session (information around numbers, working in groups, and so forth)?

- Has there been negotiation with participants around needs and support in terms of training, discussion of what is required for the session and of boundaries around what they are able or willing to discuss with students? Have they been involved in the planning of the session?

- Have plans been made to debrief the patient/service user and the students, and have you planned feedback and evaluation processes?

- Have you taken into account the time and resource that is required to ensure that patients/service users are able to participate effectively and that it is a positive and satisfactory experience for both them and the students?

- Have you made arrangements for reimbursement or advance payment of expenses, including those of support strategies such as a key worker or carer?

- Have you negotiated issues around payment for the individual's participation? This can be a difficult issue to resolve and people have very different views about being paid for participation. Some prefer to offer their services on a voluntary basis, some expect to be paid as visiting lecturers, others prefer a voluntary or other agency to receive a donation or any variation upon this theme. If the person is receiving benefits there may be other issues to consider. Good sources of guidance around these issues can be found elsewhere (see Scott 2003, Steel 2003, Levin 2004).

*(note: the Good Practice Guidelines can be accessed at **www.sheffield.ac.uk/cuilu**)*

Putting the good practice guidelines to the test: a case study

The following describes the involvement of patients and service users in the seminar programme of one of the CUILU beacon sites, utilising the Good Practice Guidelines. This beacon site had good interprofessional systems in place that facilitated both hospital and community based care. A Disability and Stroke Support User Group had been established and a Stroke Liaison Specialist Nurse worked closely with this group to facilitate its involvement in the beacon site. The Liaison Specialist Nurse agreed to facilitate two project team members to introduce the project at a regular meeting and explain the ethical and governance approvals that were in place. A standard pack outlining the project aims and objectives were provided and a presentation given. The Support Group members were extremely receptive to being involved in the project, either by participating in teaching sessions or acting in an advisory capacity, and a list of names interested in supporting the project was volunteered. Participants also agreed to participate in focus group to later reflect upon their experience of being involved.

Utilisation of the guidelines and the outcomes.

Collaboration

The testing of the guidelines emphasised the good practice of collaboration, this being fundamental to providing the groundwork for service user and patient involvement. The project team's attendance at further Support Group meetings ensured that the members had the opportunity to ask questions and to become familiar with the CUILU team. Whilst the involvement of the Support Group was a positive and rewarding aspect of this specific beacon site's seminar programme, the time and resources to support collaboration should not be underestimated.

The project team liaised with the Support Group over a period of six months in order to develop a supportive working relationship. Learning materials were developed in collaboration with both practitioners working in the stroke unit, and members of the Support Group to ensure that the seminar programme reflected actual practice. It was important that the learning materials reflected the experiences of patients and carers. Two members of the project team facilitated a Support Group meeting in which the aims of the project were overviewed. The object of the meeting was clarified– to develop a resource for student learning that reflected personal experience of the members regarding aspects of their care whilst patients in the stroke unit. Group discussion was guided by broad questions around the members' previous experience:

- What explanations of your condition and diagnosis were given?
- What was important to you when being looked after?
- Who did you have to tell your story to?
- Did you have choices?
- Were you made to feel important?

This discussion produced a template of key issues around the patient and carer journey in stroke rehabilitation unit. Volunteers were then asked to form two groups. One group would meet with the PPAG in order to work through any issues of being involved in an educational context and to consult around an educational case study which would then be developed with practitioners in order to further develop the scenario by capturing the clinical aspects of caring for a stroke patient and family.

A second group consisted of volunteers willing to participate in teaching sessions. Many were quite nervous and it was made clear that participants would not have to tell 'their' story but that the

sessions would focus on a case study, and that their contribution would be to support the students in understanding the case study and in providing feedback to students. It was felt that this approach instilled confidence and the group decided to have at least two participants volunteering for each of the sessions and this seemed to reassure participants. It was also felt important that participants should recognise whether they were distanced enough from their experiences in order for them to participate without distress and this was left for participants to decide in accordance with the Project Ground Rules devised with the project Public and Patient Advisory Group (PPAG).

Further meetings were convened in order to discuss the content of the three teaching sessions, and who would participate in which session, their potential role in the session and any additional support such as travel arrangements, pay arrangements and so forth. The group were also asked if they would attend a focus group at the end of teaching programme to talk about their experiences. Whilst collaboration was undertaken almost instinctively the importance is revealed in the following comment derived from the subsequent focus group:

> ***Support Group Member:*** *I think the main thing is you have made it very accessible and pitched it at the right level. And prepared people very carefully. I think that's perhaps the essential thing.*

Preparation

Preparation overlaps with collaboration but emphasises more practical elements to supporting involvement. Team members from the project worked closely to support those patients and service users volunteering to participate in the planned seminars with students. This entailed outlining the content of sessions, the introduction of the student assessment form to be used by lay participants and working with the group to decide who would like to participate in which seminar. The support group decided to have two service users or carers for each session to provide peer support but also different perspectives. Three sessions aimed to engage students in working interprofessionally around the patient/service user needs. The presence of a patient/service user perspective enabled students to hear the experiences of patients and service users and provided opportunities to explore experiences in face-to-face interaction. The following briefly describes the tasks for each session.

- ***Seminar 1:*** students are asked to think about how to set short, medium and long term goals with the patient using a case study
- ***Seminar 2:*** students are asked to develop a philosophy about collaborative working
- ***Seminar 3:*** students are asked to write an evaluation form for patients and carers to use for evaluating the care they have received in hospital.

An issue in preparation was that the group felt that travel and parking to the main hospital were very stressful and that they would feel more confident if the sessions were undertaken away from the acute setting. It was decided that students would also feel more relaxed if sessions were conducted away from the busy clinical area. Seminars were therefore undertaken at nearby teaching premises which were close to the stroke unit but off site with easier parking and access.

Practical preparations included provision of transport if required, and a comprehensive health and safety risk assessment of the premises. This included checking and explaining fire safety drills, accessibility, and health and safety issues. Participants were asked to provide information around specific needs and details of who to contact, should someone become unwell. Such plans may seem routine, but feedback following

the seminars indicated how important such checks are in reassuring those involved,

> ***Service User:*** *The first thing I do,(when asked to teach students generally) is check the fire regulations and then the toilets. So I know I can get out*

Communication

Clear communication underpinned practice throughout, so that all involved – patients and service users and students - were clear about the learning plan for each session. Lay participants were fully briefed as to what support was available and given contact details for the team, to enable them to get in touch if there were any problems prior to, or following the sessions. Information packs were available and the project teams provided contact details should any issues need further discussion. The development of good supportive relationships encouraged good communication. Volunteers were aware that the team recognised that participation might be difficult on the day and that if people did not wish to continue, then that would be supported. Contact details for the team members were given to participants so that they were able to speak to someone about any aspects of the seminars which might have been concerning them and one person was able to contact the project team, to cancel due to health problems.

Support

As well as being available to support volunteers in terms of discussing the proposed session, their role and any training support needed, the project team also considered that pay was an important means of supporting and valuing service user and patient expertise. Pay and reimbursement were key issues for discussion in the preliminary interviews of the project. Discussions with the PPAG demonstrated a diversity of views, some people indicating that they would expect, like any other visiting lecturer, payment for their contribution, others were keen to simply volunteer or to receive a token of appreciation, in the form of donations to their organisation, as an alternative. As identified in the Good Practice Guidelines, it seems important on this issue that informed choice is promoted for participants and respected, and guidance to appropritate authorities be provided.

Debrief

The emphasis on preparation enabled good supportive relationships to develop between the project team and patients and service users involved in the seminars. Time was given to each volunteer following sessions to allow time to discuss any issues arising. For example, during one seminar a participant spoke quite candidly about certain experiences. Following the session, time was spent with the volunteer reflecting on the session, particularly as there had been disclosure around negative experiences of being a patient. However, the response was very positive, as this person had had time to reflect on the seminar and expressed how much they had enjoyed working with the students and having the opportunity to talk about those experiences.

Good practice with students

As with service users and patients involved in the study, students were also identified as requiring support and preparation in order to learn with patients. A standardised information pack which outlined the project aims and learning programme was provided. This included a section on patient and service user involvement in learning, highlighting some of the benefits that previous students had cited. The good practice workshops had indicated that students could find face-to-face interaction around emotional or challenging issues difficult to deal with. Students involved in the sessions were therefore advised that a patient /service user would be present and that this learning experience provided the opportunity to hear a patient's experience and to ask questions about that experience and that CUILU team members would be available post seminar should students wish to talk through issues.

Patients as assessors - developing an interprofessional patient assessment tool

One of the features of the beacon site seminar programme discussed in this section was the involvement of patients/service users not only in teaching but in student assessment.
The development of the Interprofessional Patient Assessment Tool (IPAT) provided the framework for the patients/service users involved to engage as assessors of student performance and learning.

The assessment tool (IPAT) was devised from an established validated questionnaire 'SHEFFPAT' (Sheffield Patient Assessment Tool) (Davies and Archer, 2003). The SHEFFPAT questionnaire is currently used within the paediatric setting to allow parent-patient assessment of a doctor's communication skills. This questionnaire was adapted to capture the domains of interprofessional working defined within the CUILU Interprofessional Capability Framework.

Whilst peer review permits reflection and assessment around interprofessional learning, the service user and patient perspective enables patient focused reflection. The IPAT was therefore adapted for service user and patient assessment of student engagement with interprofessional issues within the seminars discussed in this section.

The development of the IPAT tool involved a process of consultation with the PPAG. The tool identified 11 items on a likert scale, one example being "Did students work in collaboration with the patient?" This was presented to the PPAG for discussion. The group felt that the tool was clear and suitable for patient/service users to use to assess students.

The patient/service users involved in the seminar programme were asked to use the tool to assess the students who had been involved in their seminar following the session. Following the seminar programme, a focus group interview was held with the patients and service users involved that aimed to capture their views on the experience. Feedback from this interview suggested that service users and patients found the assessment tool provided a framework for engagement, which helped to overcome anxieties of 'stepping on professional toes', and of 'not providing what was needed'. Participants felt comfortable with assessing students, although they were worried about student anxiety. However, they felt that collaboration and preparation had helped to overcome anxieties as this provided the opportunity to introduce the tool and its use. In this way, participants were empowered to contribute to the learning process rather than being the 'object' of learning. This initial work focussed on the usability of the tool and student feedback relating to this form of assessment was not gathered. However, it seems that the tool may offer the potential for employing patient and service user expertise in a way that does not objectify service users and offers a clear structure and format for inclusive involvement.

Issues around hard-to-reach user involvement and inclusivity

Hard to reach

The exploratory qualitative interviews at the commencement of the project identified communication as the key for good service provision by both students and service users and patients, with students citing that learning to talk and listen with patients was an important aspect of developing their professional role. The NHS Plan (DoH: 2001) recognises that the NHS workforce does not always reflect the community it serves and recruitment to encourage diversity is central in providing an inclusive service. However, it is currently likely that many health and social care students will care for people who are 'not like them'. Involving hard-to-reach individuals

and groups in education therefore provides the opportunity to develop workers who are able to provide care which meets multicultural needs in its widest sense. In other words, diversity offers a powerful interprofessional learning opportunity to ensure that specific needs are met by the interprofessional team. It is therefore essential to involve people whose experiences and needs are often overlooked, misunderstood or 'hard-to-reach'.

Tackling social exclusion and inequalities are key targets of current government policy with the aim of developing inclusive services which meet the needs of non-mainstream populations. Terms to describe those who are non-mainstream include 'hidden' or 'hard-to-reach,' signifying that some populations are hard-to-locate (such as the homeless, refugees), or hard-to-reach in terms of language, or because of accessibility issues (Atkinson and Flint: 2000, and DoH :2002). Jones and Newborn (2001) however, argue that the term 'hard to reach' is problematic as it can be misleading, difficult to define and potentially stigmatising. Nevertheless 'hard-to-reach' does attempt to indicate that some groups are under represented, or hard-to-engage.

Involvement in health and social care within an educational context requires that service users and patients feel empowered to work within both an educational institution (most programmes are university based) and the health service; for many service users both areas can be unfamiliar or difficult domains. Strategies for involvement include awareness of the barriers to involvement, such as language and accessibility and thinking through ways of overcoming barriers, such as networking and out reach work to support particular communities. For example, the project team engaged with the local interpreting service and response was positive, with volunteers keen that experiences around ethnicity and diversity were included in interprofessional learning. Discussions with an educator in social work, who works closely with an ethnic women's group also emphasized the importance of outreach work in meeting and working with community groups. It is essential that there is awareness to the barriers to involvement and recognition of the need to be prepared to creatively explore strategies for inclusivity.

Hard-to-join-in

Current policy around inclusiveness utilises the term 'hard-to-reach' but as well as consideration of how to encourage multicultural diversity there is also an issue around supporting 'hard-to-join-in' people. The CUILU project involved a number of patients and service users who found it difficult to engage with the project not simply because of different cultural backgrounds but also because of specific needs, or disabilities. People were willing to be engaged, but experienced difficulties around illness or access and consequently had anxieties around not being able to meet commitments. One disabled PPAG member, for example, describes the difficulties of physically getting to a venue, whilst one man described feeling self conscious and intimidated in formal forums, given the risk of sudden deterioration in his condition. For many involved it is not that they are hard to reach but that the agenda and platform for involvement makes it hard to join in.

One of the key themes highlighted by service users was that being involved in sharing one's experiences was a highly emotional process and there were real anxieties around being involved in an educational context. There were instances in which service users had recounted their experiences to students with negative consequences both for the students and for the service user. One student cited the example of a service user with HIV who talked to students about their experiences but became very distressed. The students found the experience disturbing with consequent negative impacts on learning outcomes. For service users and patients who are not part of the mainstream, i.e. with potentially stigmatising experiences, or for whom there could be very high anxieties around engagement, then there should be recognition and full consideration of the emotional support required.

This is not to exclude 'hard to reach' groups, but to recognise that there are real issues around vulnerability and power differentials which must be recognised (Wilson, 2001).

Consideration of power differentials and vulnerability indicate an ethical dimension to supporting service user and patient involvement. For example, the project worked within a paediatric beacon site and wanted to focus on the interprofessional learning issues around a child with diabetes. Whilst this beacon site provides in-house training and involves young people in delivering learning, the team felt that there were ethical issues around consent and potential for distress in asking children and families to relive their experiences. Simulation was chosen as a more appropriate way of bringing in the child/parent perspective. This is not to deny that young people should be involved interactively in health and social care education, however the time and resources to support involvement safely and ethically should not be underestimated.
A final issue to consider is that of student competence to learn from interactive 'live' sessions. Whilst learning in an interactive way with service users and patients might be extremely beneficial both to the service users and the students, there should be consideration of the students' current position in terms of competence and learning outcomes. If students are at an early stage of learning, then their ability to learn interactively with a service user/patient with potentially distressing or stigmatising experiences, may not be sufficiently developed to ensure that interaction is supportive or that learning outcomes can be achieved.

Supporting inclusivity

Supporting inclusivity requires consideration of the resources available to enable positive engagement. Resources include both time, personnel and finance. Some of the service users and patients who supported the project had specific needs, including dietary, emotional and accessibility issues. The project budget therefore included a service user and patient component to ensure that involvement could be supported. The commitment and support of those patients and service users involved in the project was extremely rewarding for the team, and hopefully fulfilling for the participants, however the resources required for supporting involvement, in terms of time, emotion and finances are substantial.
The key issue is how to bring service users and patients into the learning environment, in a way which is positive for all involved. The project team felt that given ethical, feasibility or resource implications, some hard-to-reach or hard-to-join-in experiences might be difficult to support and consequently might not be the best way of achieving positive outcomes, either for service users or students. This is not to exclude particular groups or individuals but to instead explore different strategies for bringing that perspective to the learning environment.

Practical solutions for inclusive engagement

Creative and innovative approaches to involving those for whom there may be difficulties in engaging in face-to-face interactions, might include strategies which are based on service user or patient experiences, such as simulation, use of video or actors and role play. In certain circumstances there may be greater benefits from using simulation or role play, particularly in creating learning situations which can be stopped and 'replayed' and practised. The CUILU team utilised the strategies of simulation, role play and patient stories, in order to safely bring the patient or service user 'into the room' (see section 4 where this is discussed in detail).

Reflections on the process: patients/service users, students and the CUILU team

Interview data and more general reflections on the processes of being involved in the lay participation aspects of the CUILU project are offered in the remainder of this section. Areas discussed are: service user and patient perceptions of being involved in the CUILU project generally; more specific service user and patient perspectives

of participating in the seminar programme and the impact of use of the Good Practice Guidelines on their experience; student perspectives on the role of lay participation in their learning and CUILU team reflections on the process.

Service user and patient perceptions of involvement in the CUILU Project:

Gott (2004) notes that evaluations involving patients and service users in research have focused on the experiences of the investigators, rather than the perspectives of service users. In order to capture the experiences of being involved in the CUILU project, members of the PPAG and the Stroke Support Group were invited to participate in a focus group interview to discuss their expectations and perceptions of being involved in the project, including what aspects of involvement were positive and what might have been done differently. The focus group discussion was tape recorded and fully transcribed. Nine participants were present (Stroke Support Group: n=2; PPAG: n=7). Analysis captured key emergent themes around Barriers and Tensions, Motives and Empowerment, and Closure.

Barriers and tensions

Key aspects of the discussion indicated that for some there was lack of clarity around purpose of the project or that various agendas were enacted within the meetings. For example, some service users and patients interacted as though the project provided a support group, understandably as this would be drawn from previous experience of participating in groups that focused on their experience of requiring health or social care services. Others had specific issues which they wanted to address in health and social care. Some had anticipated more involvement in teaching and were frustrated at lack of more direct involvement, for example:

> ***PPAG member:*** *I would have liked to have been more involved in teaching cos I would have liked to get in front of doctors and students as I have a rare condition and I have spent the last 11 years trying to get this across.*

Other participants discussed wishing to provide input into the teaching by using their previous experiences. Whilst this provides an interesting interprofessional learning opportunity for students, their experience had occurred some time previously. This can present an issue, that was reflected in the student discussions, but could be reframed by the CUILU facilitators.

> ***CUILU:*** *But some of your experiences are from years ago, and so they (students) were very interested in how well services have changed and do work across…*

Interestingly many did not understand the scope of professional roles themselves and as involvement was based on sharing their story, this could have implications for the ways that patients and service users deliver positive and relevant input into the interprofessional curriculum.

> ***Support Group Member:*** *I didn't realise there was half the people available to help you in hospital.*

A key practical barrier to participation was illness and anxiety about letting people and student down due to illness and many found this inhibiting;

> ***PPAG Member:*** *You feel you are excluding yourself from these things and you would like to have more input, but it's your health what stops you. And I think there would be a lot more people who would get involved if they thought that because you see you feel you are letting others down if you are not able to come. You know that's why a lot of people don't join in..*

This had implications for continuity and the opportunity to become fully involved in the teaching as one woman indicated,

> ***Support Group Member:*** *Its only fair we all have a go, but if you're not sure of what's gone on before, or only half way through…*

Whilst there are concerns that service users may not have adequate training or teaching skills, it should be acknowledged that many of the service users and patients involved were often experienced trainers with a background in teaching and therefore had many skills to offer,

> ***PPAG Member:*** *I do a lot of training in hospitals.*

> ***Support Group Member:*** *Well I'm not a tutor or anything like that but I have worked in schools for 20 years.*

There was a notion that participants wanted to be more deeply involved in the agenda and delivery of service user and patient involvement and many had excellent ideas around this. For example some were keen that future initiatives encourage patients and service users themselves to deliver training and support, as they would have the empathetic understanding of how best to engage people in an educational context, and this idea was positively received.

> ***PPAG Member:*** *If you had wanted training would it have been nice to have been taught by someone like yourself who had already done it, so be trained by another service user.*

The suggestion of patient/service user training may also indicate that patient/service user participation could be supported by a process of peer mentoring. Such processes may offer the potential to empower patients/service users engaging in educational programmes.

Group dynamics

Being involved in the project required that de facto, one became a group member, either of the advisory group or the group involved in teaching within the beacon site. It was also clear that individuals may be members of a number of groups operating around the arena of patient and public involvement. This meant that individuals operated at various levels with different levels of experience. This could be intimidating, as illustrated in the following quotes:

> ***PPAG Member:*** *You can feel that everybody knows more than you…. and I did wonder why I was coming.*

> ***PPAG Member:*** *It was a bit like a party .. … and if you didn't know anyone it was impossible to do that , And the first one I went to, I just scuttled with some sandwiches and went to sit down.*

> ***PPAG Member:*** *You know I must be as thick as two planks because I can't understand what they are saying, and if you have missed a bit, and everybody had been to other things. If you are not used to it you feel like an outsider anyway.*

There was also an issue around groups within groups, which was off putting to other members,

> ***PPAG Member:*** *We had a xx group dynamic and they seemed to be a lot more… and they always talked amongst themselves and that was off putting.*

Providing venues which were accessible and at the right time, and suitable for meetings and teaching sessions was carefully planned; the group commented on how important venues were in shaping group dynamics and making people feel comfortable. Facilitation and use of everyday language rather than jargon was also important in creating an inclusive environment,

> ***PPAG Member:*** *Overall its been very good and there has certainly been times when a little bit too much jargon has been used but we pointed that out to you and you seemed to settle down.*

The emergent themes indicate that becoming part of a group offered benefits in terms of belonging, sharing and support. However, it is also evident that tensions can exist, emphasising the importance of investing time and resources into building positive relationships, which recognise group dynamics, offer good facilitation skills and provide clear agendas regarding what is offered and what can be done.

Empowerment and motivation

Involvement required commitment from volunteers and despite tensions at times, offered positive outcomes. The primary motivation for involvement was the desire to 'make a difference' in terms of impacting on service provision for the benefit of others, particularly relating to issues such as communication. As a by product, many found that involvement also 'made a difference' to themselves in that volunteers found learning was reciprocal; they, as well as the students, developed understanding and confidence. The following examples provide a flavour of motivations and outcomes:

> ***PPAG Member:*** *Even if you can only do little bits now and then. Because when you are ill you do feel like a number and if you do say anything, you are making trouble.*

> ***PPAG Member:*** *Well. I think I am doing good, and by the feedback I get, they tell me I am, so I've got to take that back with me.*

> ***PPAG Member:*** *I thoroughly enjoyed it (speaking at conference), I was a bit apprehensive when you first suggested it, but if you keep off the professional bit, like medical terms and so on, then I found it very educational for myself and I thoroughly enjoyed it. Especially at the end they gave me big ideas of going on stage!*

Closure

Involvement gave many a sense of purpose and belonging and so whilst people understood why when the project was drawing to a close, there was some sadness,

> ***PPAG Member:*** *And don't undersell yourself, and its amazing when you try and when you talk to other people, like we do its amazing what you can do and with the help of people like the CUILU team, it's amazing and you feel like you belong again..*

> ***PPAG Member:*** *Yes, important belonging, it is important*

> ***PPAG Member:*** *And I would have liked to see this group carry on for a lot longer, but there are various other reasons, financial and all sorts.*

Such responses flag up issues around closure and whether it is possible to provide ongoing involvement for those who supported the project so enthusiastically. Efforts were made for group members to link into other learning initiatives which the project had collaborated with. On an individual level therefore, closure was identified as an important aspect of good practice; it was felt important to consider strategies for positively supporting disengagement when individuals no longer wish to, or are unable to participate, or where particular participation no longer meets learning needs, (for example in curriculum change). However, we would suggest that where initiatives are project based, then Good Practice should also consider strategies for closure at the completion of a project/initiative.

The service user and patient perspective on participation in the seminar programme

The service users and carers involved in the beacon site seminar programme were invited with members of the PPAG to participate in a focus group to discuss their views and experiences of being involved in the project. Four people were able to attend, including three involved in the seminar programme and one from the PPAG. The session was tape recorded, transcribed and data analysed using qualitative approaches as described in the method section.

The feedback resonated very strongly with both the workshop findings, and the preliminary interviews discussed above. The key emergent themes were:

a. Involvement as an emotional process,

b. Potential for empowerment (reciprocal learning, service user and patients in supporting role, having an impact),

c. Need for mindfulness in collaboration, preparation, communication support and debrief

What appears to be the central issue is an implicit recognition that engagement as a patient/service user has the potential to be disempowering or negative, but that successful engagement can empower and provide a powerful interprofessional learning experience for students. Successful engagement however requires reflection around good practice.

a. Emotional process

All participants felt the need to tell their story and recognised that this was often an unpredictably emotional process and that despite preparation, there was the potential for participants to become upset and preparation and especially debrief were recognised as key strategies.

> ***Focus group participant::*** *And you can do all the preparation to go in and tell your story or whatever, but on that day sometime you might end up emotionally. And that's when you need the structure built in to the structure of the training. That there is someone there you can talk to at the end of the end or later the next day even*

There was recognition that students may also find high emotions difficult in the context of a seminar and may need support and debrief:

> ***Focus group participant::*** *Or the students you might find the students actually get concerned about the person being, uncomfortable*

As well as the emotional process of reliving one's story, emotional processes included anxiety around issues of 'letting the side down' by not being able to attend or of not delivering 'is this what you want?'. There were concerns about 'stepping on toes' for example, in being careful how you assessed professional students. There was also a discussion around not being labelled, with one participant commenting:

> ***Focus group participant::*** *you've got to be careful how you deal with these problems because you don't want to be victimised. You know someone could if you were complaining.*

However, despite anxieties, the group members expressed feeling well prepared and were very appreciative of the preparation and support given by the team.

b. Potential for empowerment:

Supporting service users and patients in an educative role using good practice guidelines can empower patients and this included a process of 'patients supporting students.' The service users recognised that they could support students and were cognisant of student anxieties, as this following comment suggests:

> ***Focus group participant:*** *cos the ladies, the nurses, they were new to the ward aren't they, and er they were keen to learn themselves*

Such comments indicate that patients recognised that students may require support and preparation to participate positively in learning encounters with patients and service users.

The potential of having an impact on services was revealed as an aspect of empowerment. Many of the service users and patients involved in public participation could be identified as campaigners in that they wished to give something back or improve service provision. Those involved in the seminars discussed here were no exception, and the opportunity to do this in a way which was supported and valued appeared to be very empowering. Participating in the teaching was about getting involved and making things better

for patients by educating health care students, not through negative input but simply by giving their experiences, as demonstrated in this quote below:

> ***Focus Group member:*** *you just hope they are going to carry it forward don't you*
> *It was also about challenging professional perspectives to refocus on the patient or service user:*
>
> ***Focus Group member:*** *because at one time you couldn't touch doctors, but now they are seeing sense that they could be more educated from the patients*

c. Mindfulness

Feelings of empowerment were underpinned by notions of feeling valued and supported. This was encapsulated by the theme of mindfulness - a considered and inclusive approach to facilitating participation in a learning role. In terms of preparation, participants felt secure and supported in taking on a new role:

> ***Focus Group member:*** *I think the main thing is you have made it very accessible and pitched it at the right level. And prepared people very carefully. I think that's perhaps the essential thing.*

Helping people to feel comfortable and supported required attention to issues such as: preparation, ease of parking, venue, and the timeliness of the sessions, for example, considering when is best for someone to participate, such as early morning or later in the day. Attention to detail encourages a sense of being valued and whilst health and safety issues such as fire procedures, access to a toilet and refreshments may all seem part of housekeeping, they are essential, in terms of duty of care and in providing a secure and safe experience. The above themes resonate and indicate the importance of thinking through good practice around the key issues of collaboration, preparation, communication, support and debrief.

Student perspectives on lay participation in their learning

The use of the Good Practice Guidelines provided a positive framework on which to base engagement and develop positive learning opportunities. Engaging with patients and service users collaboratively however, requires time and commitment; this is a key consideration in supporting service user and patient involvement. Given the resources required to support involvement, it is important that service user and patient involvement does impact positively on learning outcomes. Student evaluations of the seminar programme discussed in this section indicated that patient involvement was powerful in understanding the patient perspective but also in developing interprofessional learning.

Students appeared to be highly receptive to the involvement of service users and patients in the sessions and identified this as the most beneficial aspect of the seminars as the following comments demonstrate:

> ***Student social worker:*** *The patient who spoke in the session about her fears and barriers to what they can or can't do was the most useful thing*

Patient involvement also reiterated and supported interprofessional learning as indicated in the comments below by the student participants:

> *We now have a wider appreciation of roles and input after listening to a patient and recognise how dedicated the other professions are working with the well being of the stroke patient.*
>
> *Patient rights and their care should be focused around them – the patient being in control*
>
> *Carol's (service user) in put was excellent. She raised many points I had not considered, like how vulnerable a patient can feel, and how happy it made her when different staff complimented her on the smallest things.*

I really understood the role of social workers. Listening to the patient experience and seeing a new perspective.

It was really interesting to think about and listen to the emotional in put by the nurses and how important this is.

However, data from students in the other beacon sites also revealed the impact of patient/service user involvement from the perspective of students. These comments pertain to other, more general experiences of learning with patients, rather than the planned opportunity provided in one specific beacon site. Nevertheless the key emergent themes reiterate the role of the service user and patient perspective in interprofessional learning.

Different modes of learning from service users and patients were identified including, classroom and placement, via conferences, videos and through service planning initiatives. The key benefit of learning with service users and patients was the opportunity for interactive communication, which enabled a real and meaningful engagement with the user perspective. One student for example cited an example of someone with schizophrenia talking to students in placement.

Occupational Therapy Student 1: *It was really, really good, because learning it from books, you could not get the gist of what on earth was going on and they when you can sit there and openly ask him … your knowledge and insight of the world is so much greater than sitting reading it in books.*

There was also recognition of patient expertise, which enabled a subjective understanding with which to complement clinical understanding;

Physiotherapy Student 3: *They've got to pass on, a lot of valuable knowledge and yeah, living with something things like OA – osteoarthritis. I mean they are far better qualified to tell me how they cope with it than I possibly could.*

Gaining interprofessional understandings around contributions to care from the multidisciplinary team emerged as a theme for some students:

Student Nurse 8: *Because it's like the difference between having a flat piece of paper in front of you and having a 3D picture.*

Occupational Therapy Student 1: *We had stroke awareness day in October and a patient's wife gave a talk and everybody on the day thought that was the best part of the day, the most informative because she gave an overview of everybody's input into the situation and it made you wake up to what the reality is.*

Understanding the patient perspective appeared to complement student learning and increase confidence and competence. It was also recognised that knowledge acquired in this way could be shared with other patients.

Physiotherapy Student 3: *I don't actually know a lot myself and I don't know from patient experiences what to tell you because I haven't got that experience. But you can relate to them a lot more and you can 'well, this is typically what other people find works and offer advice that way.*

These understandings resulted in the individual being viewed as a person rather than the patient and an awareness of how important this is in planning care.

Occupational Therapy Student 2: *It's a case of using like narrative reasoning really just to sort of plan your interventions round that and be aware that they're a person and not a patient.*

However, despite recognising the positive benefits of service user/patient involvement in education, students did cite tensions. Tensions included recognising professional resistance in learning from patients,

Medical Student 5: *They don't like thinking that 'Oh right this person might have a bit more knowledge about something than them'. It's a pride issue and I think it's a bit of a shame really, when that happens, because you can use a patient as a really good source of knowledge and I think the patients who understand can sort of co-operate and perhaps have a better outcome to their treatment.*

Other comments demonstrated that some patients/service users might not yet be ready, or well enough prepared to help students meet learning outcomes.

Social Work Student 2: *… wheels this client out, brought him in and he gave us his spiel and, from what I gather, it's been the same spiel for years. So that's not been updated…*

Social Work Student 2: *And so there's a lot of they're not at that stage where they're the expert yet.*

Social Work Student 3: *Someone who's HIV positive has to come in and give this tearful, you know…*

Such reflections indicate involvement in education must be supported by good practice, particularly in terms of preparation support and debrief. Student evaluation clearly supports the importance of mindfulness in considering best practice for supporting patients/service users in education. Whilst it is important to recognise that there are tensions in involving patients and service users in interprofessional learning and health and social care generally, the benefits cited by students indicate the enormous potential for high impact interprofessional learning. By being aware of possible tensions there is the potential to transform involvement into a positive process.

Testing the guidelines: CUILU team reflection

The Good Practice Guidelines focus on preparation and communication but the actual process of engaging with service users and patients in a learning programme emphasised the importance of collaborative working relationships. The importance of collaboration is cited in the literature; for example, Jones (2003) argues that service user involvement should include consultation, surveying the views of service users about what should be taught, production of learning materials and facilitating the role of service users as teachers and assessors. In many ways this echoes the *Requirement for Social Work Training* (2002), which advocates that involvement is not simply in the delivery of a teaching session but also around the planning, devising and assessment of a programme. The case study indicates that collaboration is often intuitively undertaken, but should be highlighted as an essential step to underpinning successful partnerships.

Collaboration requires time and resources and this should be an important consideration when embarking on service user and patient partnership in education. For example, one learning session involving two participants cost around one hundred and sixty pounds to support (costs covered travel expenses, payment, and refreshments). The team also met with and collaborated with volunteers over a period of six months in order to support involvement and develop sessions. Service users and patients involved in the project were very committed and made great efforts to support the team. Whilst this was one of the most rewarding aspects of the project, the time, emotional and financial implications of being involved in, and in supporting involvement, should not be underestimated and planning must take account of all requirements.

The experience of working with service users in the beacon site and with the advisory group

highlighted that there can be tensions to manage as well as drawing the significant benefits of working in a participative way with volunteers. It is likely that as user involvement becomes more embedded in health and social care education that further tensions and benefits will emerge and we would advocate that working with service users and patients requires a considered and reflective approach which encourages mindful good practice to ensure positive involvement and outcomes for all concerned: educators, students and the lay participants.

Vignette: Changing Practice

One educator involved in the project worked with a service user in many regular teaching sessions and took the opportunity to use the good practice guidelines to reflect on her practice. Whilst the service user had always managed to deliver the session alone and had never voiced any problems in doing this, the educator decided to meet and find out if she could provide any further support. The guest speaker found that spending time discussing the background to the session and activities undertaken by the group in previous weeks, made it easier to plan and structure the session content, by building on prior learning. Also preparing the students prior to the session, in terms of setting boundaries for questions and providing opportunities for debrief following the session, seemed to result in a more detailed discussion, with students feeling confident about asking questions and engaging in discussion. Both the service user and educator now meet regularly to prepare for and to debrief following sessions. Reflection indicated that using the guidelines helped to frame the session in a much more constructive way.

Conclusion

This section has presented a wide ranging discussion of the involvement of patients and sevice users in student learning and assessment and has included the presentation of the perceptions of lay participants in the CUILU project generally and more specifically in teaching and assessing in the seminar programme of one of the CUILU beacon sites. The generation and testing of Good Practice Guidelines to support service user and patient participation in student learning has been described and student perspectives of lay involvement in their learning have been explored. Summary points of the content of this section are provided below: Findings arising from use of the Good Practice Guidelines highlighted the following key points:

- Testing the Good Practice Guidelines revealed that collaboration provided the groundwork to building good working relationships. This element was undertaken through purposeful planning and engagement by the CUILU team and service user and patient feedback indicated that collaboration underpinned the key tenets of Good Practice.

- Closure was identified as an important aspect of good practice, not only to support opportunities for continued involvement following the completion of initiatives, but also to consider strategies for positively supporting disengagement where individuals no longer wish to, or are unable to participate, or where particular participation no longer meets learning needs, (for example in curriculum change).

- The time and resource implications of supporting good practice should not be underestimated.

- Service User and Patient evaluation indicated that the Good Practice Guidelines of Collaboration, Preparation, Communication, Support, and Debrief (see table 8 overleaf) enabled a positive and empowering experience of involvement.

Table 8 checklist derived from themes generated by interview data

Themes	Checklist
Collaboration – developing partnerships	Time and resources for developing collaborative relationships Build up trust to enable participants to feel safe to contribute Joint consideration of aims and processes of teaching
Preparation – consideration of practical and supportive aspects of involvement.	Information pack – clear about agenda i.e. what is offered and what is required. Risk Assessment, Health and Safety and Anti-discriminatory policies Accessibility and hospitality Training and preparation for service users and patients Pay expenses and reimbursement
Communication – requirement for all involved to be fully informed about the processes of the learning initiative.	Students should be informed about service user participation Clear learning outcomes Evaluation (including reflection on process and outcome)
Support – ongoing support and training to participate in the learning sessions.	Being mindful of Service User perspective and needs throughout the process Consideration of closure-how to support individual disengagement as well as end of initiative closure
Debrief –gaining feedback from participants following teaching/learning activities.	Debrief for students and patients/service users-provide support as required and respond to issues raised by evaluation and teaching/learning processes

Key points arising from
service user/patient perspectives
on involvement in CUILU processes are:

- Learning that occurred was reciprocal in that both patients/service users and students learnt from the process, however there is the possibility that patients/service users did not always understand the interprofessional learning interface and experiences may not always be contemporary. This has implications for the way in which involvement is linked to interprofessional learning and how learning situations are facilitated.

- Being involved in a project was empowering, particularly where actual patient experience had been negative. Time was important in developing positive and supportive group dynamics.

- Successful facilitation involves a recognition and awareness of issues relating to novice and expert patients and the impact that the group dynamic can have on the effectiveness of participation and engagement.

- The issue of closure is an important element of supporting lay involvement in projects.

- Service user and patient reflections highlighted barriers to involvement in health and social care education. These included: physical barriers to joining in, issues around accessibility and training and support. Mechanisms of peer support and peer training might be useful in empowering service users and patients to work in the educational environment.

The final point above leads to the discussion of **inclusive patient or service user involvement** in student learning. The following key points are emphasised:

- Hard-to-reach groups must be encouraged and supported to contribute to health and social care education in order to ensure equity and diversity in practice.

- There should be recognition that as well as hard to reach groups there are individuals for whom engagement can be difficult due to physical and emotional barriers. This requires a willingness to explore strategies which encourage inclusivity and involvement.

- Exploration of creative and innovative ways of 'bringing the patient in' such as use of technology, role play, patient assessment, and sharing of stories have potential to expand the involvement and role of the service user and patient perspective in interprofessional learning.

- Simulation and role play heavily grounded in patient and service user experience provide safe and meaningful experiential learning opportunities and can provide powerful learning in which the patient/service user perspective is central. Such learning, based on meeting the needs of patients in 'real' situations, promotes understanding and collaboration and hard-to-engage groups can be brought into the learning context for the benefit of students, and in turn benefit those requiring care.

The student perspective on the role of lay involvement in their learning gave rise to the following key points:

- Student feedback indicated that the involvement of service users and patients provided high impact and interprofessionally focused learning.

- Learning from service users and patients can take place in a variety of settings, modes and

contexts. Reflection on this learning experience can highlight the potential and importance of learning with and from service users and patients.

- Patient/service user involvement can provide an interactive interprofessional learning experience that is fully grounded in 'real life' practice.
- Patients and service users provide the key to subjective understanding or 'narrative reasoning' in understanding the service user and patient perspective.
- Understanding the patient and service user perspective provides a clear opportunity to emphasise interprofessional learning and the impact this can have on practice.
- The importance being mindful when planning interactions between students and lay participants is essential as there can be tensions involved in learning with patients/service users.

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Section 6

The promotion of positive Interprofessional Learning Environments

Introduction

Section 1 of this report discusses the nature of those practice-based learning environments that carry the potential to promote the acquisition of interprofessional capability in students. This section describes a series of workshops that aimed to disseminate information about how positive interprofessional learning environments may be promoted across university departments and in turn into the experience of academics, students and provider institutions.

The CUILU team brought together representatives from departments across Health and Social Care in both the University of Sheffield and Sheffield Hallam University to participate in a workshop. A primary purpose of this programme was to disseminate to colleagues findings from the CUILU project. A second purpose was to facilitate and support the participants of the programme to work together to develop seminar programmes of their own in order to cascade findings and generate new insights about interprofessional learning. A detailed report of the initiatives conducted by the CUILU facilitated workshops and those facilitated by the participants is presented in this section.

The workshop programme to promote a positive culture in interprofessional learning

The workshop programme aimed to mirror the experience identified as effective for interprofessional education for students: the use of adult learning theory, small group experience, interactive facilitation; multi-professional participants and the provision of a comfortable safe environment (Parcell *et al* 1998).

The workshop programme was based on the belief that in order to support a positive culture in which effective interprofessional learning can take place, particular attention should be given to the following: multidisciplinary participation in preparation for interprofessional teaching; that the aims of both the preparation for educators and for what students need to learn be explicit; that preparation for teachers communicates the positive outcomes of interprofessional learning and how these may be achieved, and that the impact of positive role modelling be emphasised.

The overall aims of the workshop programme were, therefore:

- To promote wide understanding of the requirements and advantages of interprofessional learning across education and practice contexts
- To ensure an interdisciplinary and collaborative approach to the planning and delivery of workshops
- To promote positive interprofessional learning environments through interdisciplinary professional exchange, ownership of planned change and development and collaborative working across professions

The structure of the total workshop programme

The overall structure of the programme is represented in diagram 1 below.

Diagram 1 Structure of total workshop programme

Workshop	Content	Facilitators	Participants
CUILU Half Day workshop 1	Introduction to work of CUILU: IPL learning environments IPL capability IPL opportunities IPL mentorship Public Patient Participation	CUILU Team	Nominated individuals from university departments (approx. 20 persons)
CUILU Half Day workshop 2	Background and sharing regarding culture of IPL in individual departments and disciplines	CUILU Team	Nominated individuals from university departments (approx. 20 persons)
CUILU Full Day workshop 3	Planning of content and processes	CUILU Team	Nominated individuals from university departments
Participant Facilitated Workshops One Day x 20 (each nominated individual to deliver 2 workshops)	Delivery of Workshops	Nominated individuals in partnerships (ie to own department with colleague(s) from other department	Members of departments and practitioners from associated disciplines (approx. 25 persons)
CUILU Full Day workshop 4	Evaluation of programme and action plans	CUILU Team	Nominated individuals from university departments

The process

- Heads of Departments were invited to nominate one representative to attend the workshop programme; in return they would receive allocated funding to facilitate the release of this individual for 5 days participation.
- The nominated representatives from departments/disciplines of both universities were to come together to devise the detailed content and processes of the workshops and to plan a programme of shared interprofessional delivery.
- The workshop programme was facilitated by CUILU as a resource within both universities and the South Yorkshire NHS Trusts, PCTs and other relevant organisations
- The total programme comprised two half day workshops facilitated by the CUILU team to prepare participants to plan their own interprofessional learning workshops; a day workshop to facilitate the actual planning of

the participants' workshops; participants delivered collaborative workshops (one per participant who was assisted by his/her collaborator[s]) and one day feedback and evaluation workshop facilitated by the CUILU team.

- Ownership of the initiatives was promoted through a collaborative approach to the planning and delivery of workshops involving the key departments/disciplines of both universities and associated practice colleagues.

- Delivery of the workshops was to university teachers from both universities and practice-based educators with representation from a range of professional groups. Each workshop was for up to 25 participants. The objectives and outcomes of the workshops were devised collaboratively, and the broad aims were:

1. To communicate the requirements and advantages of interprofessional learning

2. To consider the aims and outcomes of learning to promote interprofessional working

3. To explore how interprofessional learning might be taken forward in the context of specific professional preparations

4. To consider partnership approaches to the implementation of interprofessional learning

5. To consider how tenets of interprofessional teaching practice can be addressed in the workshops

- The content of the workshops were centred around: the 'case' for interprofessional learning; how it may be facilitated; what interprofessional learning outcomes are; the learning opportunities that promote interprofessional learning.

- The workshops mirrored the experience identified as effective for interprofessional education for students: adult learning theory; small groups; interactive facilitation; multi-professional; comfortable safe environment.

- The planned workshops and evaluation were a resource for further cascade activities

The workshops

CUILU half day workshop 1

The aim of this workshop was to promote interprofessional collaboration. This was commenced by ensuring seating positions prevented uni-professional groupings to ensure a participative, collaborative approach.

The outline of this workshop was:

1. Introduction to the work of CUILU including:

- the nature of interprofessional learning environments
- interprofessional capability
- interprofessional learning opportunities
- interprofessional mentorship
- Public Patient Participation in interprofessional learning

2. Generation of interprofessional ground rules for the workshops.

3. Exercise: What participants want and don't want from the workshop programme.

Results of the exercise:

Participants identified the following as things that they wanted from the workshops:

- better understanding

- real opportunities for developing and creating interprofessional learning at operational level
- better awareness of benefits and problems
- how can my department contribute to others?

The following were identified as things that the participants did not want from the workshops:

- assumptions
- narrow perspectives
- tokenism
- forced involvement
- professional isolation.

In preparation for the second workshop, participants were asked to prepare a short presentation, which focussed on the following three areas:

a. What is successfully occurring around inter professional learning in your department?

b. What are the barriers and difficulties?

c. What strategies do you think would assist in the development of interprofessional learning?

CUILU half day workshop 2

Workshop outline:

1. Personal meanings exercise:

a. What does interprofessional learning mean to you now that you have been able to give some thought to it after the first workshop?

b. Consider your own experience of interprofessional learning and working. Reflect on the positive and negative aspects of your experience.

2. Presentations of 'homework' exercise

- What is successfully occurring around interprofessional learning in your department?
- What are the barriers and difficulties?
- What strategies do you think would assist in the development of interprofessional learning?

3. Planning for workshop 3

Results of the personal meanings exercise

The personal meanings exercise asked people to reflect on their own positive and negative experiences. Individuals recalled a variety of different experiences both positive and negative. For example one person recalled the waste of time as a practitioner waiting for someone from another profession to do a task they were perfectly capable of carrying out. Another commented favourably on a time of supervising a staff member carrying out shared learning across two professions.

Presentations:

The following barriers and difficulties were identified: logistical issues, such as timetables, venues, group size and placement patterns. Suggested strategies that would assist in the development of interprofessional learning included taking a whole university approach and a need to listen to peoples' fears.

CUILU one day workshop 3

Workshop outline:

1. The context and drivers of interprofessional learning and working at both a local and national level

2. Outline for participants departmental interprofessional workshops

3. Exercise:

a. Key features: What would you consider to be the three main characteristics of your profession?

b. Finding collaborators: Which of the other disciplines are most like your own and which is most different?

4. Workshop content
5. Feedback
6. Looking forward

Results of the exercise:

Participants were asked to identify three key features of their profession. These are presented in table 9 below.

Table 9 Key features of each of the professional groups represented within the workshop participants

Professional Group	Key Features
Radiotherapy and Oncology	• Effective communication and empathy • Good technical skills • Knowledge of cancer
Physiotherapy	• Communication skills (appropriate to assessment and management) • Personality and approach (empathetic and motivating) • Competency and capability within the scope of practice
Health & Human Sciences (children's services)	• Critical thinking • Making partnerships work (clients and professionals) • Understanding the 'life course'
Social Work (children's services)	• Partnership • Identification of needs and services (clients and professionals) • Child focus • Values and respect: anti-oppressive practice
Community Rehabilitation and Ageing Nursing	• Empowerment and promoting independence • Communication and clinical skills competency • Cross sector working
Diagnostic Radiography	• Knowledge and use of appropriate tests • Knowledge of # and pathology • Evaluation in relation to legal principles – children and adults Acute and Critical Care Nursing
Acute and Critical Care Nursing	• Communication • Technical skills • Patient perspectives – beliefs and values
Dental Health	• Dental Health • Health promotion • Professional development / team work • Communication

The second part of the exercise involved participants finding suitable collaborators with whom they would be working to develop and deliver their own workshops within each of their departments. This resulted in the formation of four groups: a triad of participants involved in children's services: children's nursing, social work and health and human sciences; a partnership between an acute nursing lecturer and a dental health lecture; a partnership between Community Rehabilitation and Ageing nursing lecturer and Diagnostic Radiography lecturer and partnership between a Radiotherapy and Oncology lecturer and a Physiotherapy lecturer.

In order to commence the planning of the collaborative workshops, the following prompts were provided to aid discussion between the collaborators:

- Consider your personal hope for the workshop
- Consider together what the main challenge and main advantage of working together might be
- Formulate the overarching aim for your workshop to feed back to the group.

This exercise enabled the participants to start planning their workshops, descriptions of which follow.

Participant workshops

Group 1: The development of interprofessional mentorship through clinical learning

Summary of Workshop

Aims:

- To explore Interprofessional Working
- To develop an ethos of interprofessional mentorship
- To develop an action plan
- To agree a statement of Interprofessional Care

Facilitators: Physiotherapy, Radiotherapy and Oncology,

Areas of Discussion:

- Barriers and opportunities for Inter Professional Working,
- Resources available and resources necessary to support IPW,
- Factors that will either help or hinder inter professional mentorship
- Statements of the philosophy of Inter Professional Care.

Action Plan:

- Develop inter-professional respect
- Education for all- students, mentors and staff, pre and post graduate staff
- Embed education and culture into the organisation/Trust
- Clarify definitions, roles and boundaries of inter-professional mentorship
- Develop core groups of inter-professional mentors
- Share good practice guidelines adapted in each profession
- Re-education via "rolling programme" to maintain core knowledge and competencies
- Develop evaluation tool to assess student/patient/mentor/ experience and effectiveness of IPW and IPM

Group 2: Interprofessional learning and practice

Workshop Outlines

Three workshops were held, which were a small scale, "pre-induction" initiative. The emphasis

was on inviting and sharing views and experiences, rather than on promoting a particular interprofessional learning model or process. The output for the Trust, for CUILU and for participants would be a better understanding of current policy implementation issues and staff concerns/ideas re interprofessional learning.

1. A day workshop with practitioners (20-30) facilitated by Group 2 members and with input from a senior manager. We brought together practitioners from social services, education (inc early years), health and the voluntary sector. Participants gained information about current policy and practice developments, as well as networking opportunities; via group work, they were able to air questions, views and concerns and these were later be fed back to managers (see 3)

2. A day workshop with students and educators. Again, this started with some scene-setting and then involved group work to get down to detailed discussion of experiences/views/issues.

3. A feedback event involving managers and (some) educators. The key points from workshops 1 and 2 were fed back, for managers to work on and respond to.

Facilitators: Sociological Studies, (University of Sheffield), SCHARR (Medical Care Research) and Nursing (Department of Midwifery and Children's Nursing).

Aims:

- To help inform the future educational and recruitment needs of the new Children's Trust and its workforce
- To explore the benefits and problems of interprofessional learning in promoting best practice in the new organisation.

Objectives:

- To provide opportunity for initial exploration of the vision as set out in proposals for organisational and structural change
- To provide a safe and inclusive environment for mixed professional groups to meet, discuss and promote dialogue around issues of common concern
- To share experience of current arrangements and professional roles and how these impact on interprofessional practice
- To provide opportunities for participants to consider the meaning and value of good interprofessional practice
- To consider the expectations of participants for effective team working
- To provide an early opportunity for feedback to be provided to relevant managers and educators.

Report on Five Workshops held January – February 2005

Age 0 – 19 + Partnership Specialist Services Workshops

A series of five multi-agency Workshop events were held for staff to explore how multi-agency working could be strengthened in the future through new models of services delivery and co-location. A number of important points arose with many suggestions for how service delivery could be improved, many questions and some anxieties around the issue of multi-disciplinary working arose which will need to be addressed to enable the service to move forward.

Attendance:

The range of attendees across all agencies was broad, and overall numbers attending was 107 over 5 workshops.

The attendance across all 5 workshops was high, with an overall attendance rate of 76.4%. Attendance for all quadrant workshops was at 86%, with no significant variation between them. The City-wide workshop had a lower attendance rate, at 61.4%, although this workshop had an expected attendance of between 2 and 3 times the sector workshops.

Of those who were expected to attend, absences were evenly split between the three broad groupings of Health, Education and Social Care staff.

These figures, when linked to the individual feedback responses, suggest that interest was high, and that attendees were keen to be provided with information and to participate in discussion about developments at an early point in the process.

Attendees were given the opportunity to come together to consider the developments in the 0-19 partnership, and to consider the implications for themselves and for the delivery of services to children and their families. Discussion within small groups and in plenary sessions was combined with individual feedback to provide an overview of the initial thoughts from participants. These are grouped into four broad themes:

- Communication and Information
- Location and Service Structure
- Service Structure and Process
- Staff Development

Identified across these four themes were current issues and barriers regarding interprofessional working as well as ways forward. Examples of issues raised in each of those areas include:

- A degree of ignorance re the roles of other professionals and consequently regarding appropriate joint working arrangements does exist, but most cohorts agreed on the importance of having the needs of the child at the heart of an effective communication strategy.
- Familiar boundary issues and which agencies required to be co-located, also featured despite broad agreement that co-location was a good idea.
- Regarding service structure, current arrangements appeared to suggest "passing on" rather than a widening of the resource and intervention net to best serve the interests of the child and family.
- Need for joint training and clarity regarding the role of the lead professional

There was a high degree of commitment expressed in favour of the proposed changes. However whilst the intellectual case seemed to have persuaded most participants, awareness remained that many were still emotionally wedded to current professional structures and allegiances. This was an opportunity valued by most participants who felt that there was much still to understand about each other, the nature and range of professional services and the contributions that each could make. Most thought it would be worth building into the change process.

Two very tangible outcomes from the workshops were:

1. Improved networking in place for age 0-19 services.
2. A working group in place to look at inter professional learning materials.

Group 3: Promoting a positive environment for interprofessional learning: opposites attract

Facilitators: School of Nursing (CARER, University of Sheffield), Radiography (Sheffield Hallam University)

As part of the Combined Universities Inter-professional Learning Unit's workshops, a shadowing exercise was organised between

Pre-Registration Diagnostic Radiographers and Student Nurses.

The aims of this activity were for students to:

- Gain an appreciation of another profession's role
- Gain an appreciation of how collaboration can improve the patient's journey
- Gain an appreciation of key skills across both professions

In order to achieve these aims the students attended an initial introductory session. During the course of the activity the students received an introductory taught session in order to contextualise the activity. This addressed a range of theories relating to inter-professional learning and working. It also helped the students to appreciate the rationale behind the activity.

Students completed a professional identity scale with a view to establishing a baseline assessment of their pre-conceived ideas. This was further developed by group discussion and feedback that clearly identified stereotypical images that the students held regarding each others' roles in the delivery of health care. Guidance on arranging the shadowing experience was then given, however the mechanisms for pairing and arranging the actual visits was viewed as a student led activity with the facilitators providing information letters for mentors and contact details only. The actual shadowing experience involved one day per speciality, which was self negotiated and organised by students with their placement areas.

Feedback was delivered during the course of a formal session where students repeated the professional identity scale for a second time to ascertain how their views had changed following the experience. Each pairing of students presented a power point presentation that included:

- An overview of their experience
- Key skills which were profession dependent and those which were transferable
- Action plans for future learning/ implementation of learning to date.

The presentations provided an excellent medium for the students to jointly present their findings from the experience. They clearly identified the key skills that were both transferable and profession dependent. There was also evidence of proactive planning for example the need to establish a way of identifying clients 'who are not for resuscitation' when attending radiography. Students from both professions generally expressed a greater appreciation for why patients may be delayed at ward or department level and also the importance of effective sharing of information between different professions in order to provide seamless care for the client.
Formal evaluation of the experience was achieved by administering a simple 13 item questionnaire utilising a 5 point Likert scale (see table 11).

Whilst this was a small scale project it was a highly successful exercise in inter-professional learning and working however it was not without difficulties during the implementation. Difficulties are often cited when devising such activities and included

Table10 Demographic Details of Participants

Radiography students					Student Nurses				
Gender		Age range			Gender		Age range		
M	F	18-25	26-35	36-45	M	F	18-25	26-35	36-45
3	3	2	4	0	1	5	3	2	1

Table 11 Results of the evaluation

	% Strongly agreeing/ agreeing	% with no opinion	% no response
My understanding of my colleague's role has improved	100 (n=12)		
The experience enable me to better appreciate my colleague's role	91.66 (n=11)	8.34 (n=1)	
The introductory session was informative	75 (n=9)	16.66 (n =2)	8.34 (n=1)
The introductory session highlighted my preconceived ideas about my colleague's role	83.33 (n=10)	8.34 (n=1)	8.34 (n=1)
I was surprised by the nature of the work undertaken by my colleague	91.66 (n=11)	8.34 (n=1)	
My understanding of how collaboration can improve patient care has increased	100 (n=12)		
I better understand the commonalities across the 2 professions	100 (n=12)		
I better understand the differences between the 2 professions	100 (n=12)		
The experience has led to a greater understanding of my role in patient care	100 (n=12)		
I enjoyed the shadowing experience	91.66 (n=11)		8.34 (n=1)
The shadowing experience was a positive learning experience	91.66 (n=11)		8.34 (n=1)
I enjoyed collaborating on the presentation	91.66 (n=11)		8.34 (n=1)
The feedback presentations were a positive learning experience	100 (n=12)		

difficulties in synchronising placements on plans of training, obtaining volunteers, matching students and attrition with only 12 students completing the exercise from the original 20. Clinical staff's attitudes to the project were also interesting with a range of responses from very positive and welcoming to highly negative and obstructive. Despite these obstacles the group evidenced a significant move towards collaborative learning and appear to have established friendships with students being reluctant to leave the second session and arranging to meet in the future. It was also encouraging to note that several of the students said they may try to shadow other professionals when they returned to practice which offered evidence of independent proactive learning. Finally one of the local radiography departments was so impressed with the exercise that they offered to repeat it with future intakes of students that clearly identified the importance of establishing such small group activities in acting as a catalyst for future developments in inter-professional learning.

Group 4: Interprofessional learning: sharing the experience

Facilitators: Adult Dental Care (University of Sheffield), Nursing (Acute and Critical Care, University of Sheffield), Medical Education (University of Sheffield)

This workshop did not take place due to a lack of response to the invitation to take part.

CUILU one day workshop 4

Aim: To evaluate the promoting positive interprofessional learning environment workshops both with CUILU and within the departments.

In CUILU workshop 4 participants were given the opportunity to review their experiences of organising and delivering their own workshops. Their reflections fell into the following categories or themes:

Reflecting back on the total programme.

Positive comments included the observation that an individual's department had been supportive. Other comments likened the process to "switching on the light" and a means of "keeping up awareness-raising". One person felt that they perhaps did not have the right experience but was "volunteered" anyway. The vision of interprofessional learning was seen as "sensitised" by one participant and another felt that interprofessional learning was present in university but less so in practice, although this was changing. Also that interprofessional learning can sometimes be seen as an intrusion into the professional area.

What did participants learn?

It was noted that it was disappointing that a number of departments across both universities declined to take up the opportunity to participate in the programme. It was felt that a possible reason for this was that some people might see interprofessional learning as an "add on" and therefore not considered to be high priority in terms of attendance. This reason was also suggested for the lack of take-up for the second participant-facilitated workshop.

There were also a variety of positive outcomes for participants, including:

- Affirmed own professional identity and learnt about the roles of other professions
- It planted the seeds of desire to do more
- One participant reported on usefulness and it being worthwhile and this being a change from previous perception
- Brought back concrete issues regarding evidence of learning that would feed into presentations and evaluations
- Realisation of interprofessional agenda emerged later in the course

In addition, further questions and issues were raised, such as:

- Difficult to measure long-term impact
- Embedded attitudes as a barrier
- How do we find models of learning to explore interdisciplinarity?
- Is achieving complementary learning across groups bound by specific subjects and context?

Success

Success was reflected by "planting seeds to provoke thought", "identifying possibilities", "a marked change of attitude" and "seeing how learning can address what's there".

Difficulties

Difficulties included definitions of interprofessional learning, previous negative experiences of interprofessional learning, amount of work required and simply people "not knowing how to"

Personal Learning

There were a number of positive comments on the experience of working collaboratively:

- Benefits of staff and students working together
- Process of speaking with each other impacted personally
- How easily we worked together
- The potential for harmony
- We have the same agenda
- Putting the patient/client at the centre
- Process of discovery

There were also comments about other less positive learning:

- Learning that people don't understand/want to engage.
- The complexity of it
- How difficult/rewarding it is

Challenges

Identified challenges were around practical and logistical difficulties such as getting people there, selling it to students, language and the weather; as well as general uncertainty around organisational issues, attitudes and structures. Other more varied questions emerged:

- Where are the medics?
- Are we working with the converted?
- Is this sustainable?
- Is voluntary participation realistic?

Gains

The gains seemed to indicate that meeting the challenges was worth it with some reservations. "Overcoming challenges pays off-amazed at how successful it was". Staff gained insights through working with the students into service structures that promote or inhibit interprofessional learning. However since outcomes can be "nebulous" in long term the situation regarding investment is uncertain. One key to the success was seen as "client-centredness".

Departments

A reflection around all the different departments produced some practical and deep rooted issues, including: the need to change resistance, taking on something in addition to current workload, saboteurs, sustaining effort, demonstrating benefits from the costs, multiple and competing demands. On a positive note it was felt that there was a lot of interest and "departments would come round eventually if we keep chipping away".

Looking to the future

"It will happen- policy is driving it forward so let's be in control and manage it/make it work for us." As ever there is a downside in that there is no "grand plan" and there are doubts as to whether we all see it "having the same level of importance"

The feedback reflected very well the wider context of the interprofessional agenda, capturing some of the enthusiasm driving interprofessional learning forward as well as the major difficulties and barriers. A good mixture of positive comments about the experience of the participants and students together with some scepticism and concerns about how this can be capitalised upon to drive forward the process of embedding interprofessional learning.

A final question was posed asking if the participants would do it again?

Answer: Yes(ish)

Evaluation of the CUILU workshops

Participants were asked to evaluate the CUILU Workshop Programme and the following comments were expressed:

I gained a lot by collaborating with colleagues from different disciplines and different universities….Positive Interprofessional learning environments were created and it was great to be a part of it. The professional exchange between the students was useful, fun and they gained a lot from the exercise, as did I.

The programme of workshops has given me a wider understanding of IPL….including exploring areas of IPL that were not necessarily familiar to me

Felt we had good opportunity for interdisciplinary and collaborative working and planning Workshop programme facilitated further development (understanding of IPL) in particular across the 2 universities

Some really useful opportunities have opened up [regarding collaboration]

Provided a good opportunity to share benefits and challenges, helping to extend understanding

I think change cannot be presumed-either at an organisational departmental or individual basis.

Chance to meet and discuss issues which rarely get a proper airing in a multi-professional group

Thought provoking exercises

Additional Comments included:

Realisation of the potential and importance of this (IPL) and taking initiatives and value of including educationalists skills in all aspects of Interdisciplinary working practice

Very effective perspective from other professions was well explored in the initial sessions then reinforced/developed in subsequent meetings

Re promoting change - On a personal level this was effectively achieved however how sustainable this is when faced with logistics of operationalising ideas is difficult to judge at present

Found the workshops very useful in terms of understanding the difficulties in developing/embedding IPL throughout the two universities

Working cross-university is interesting as experiences are very different

I enjoyed exploring areas of IPL that were not necessarily familiar to me

Conclusion

The evaluations of both the CUILU facilitated workshops and those that the participants facilitated collaboratively reflect understandings of interprofessional learning generally. Participants encountered barriers regarding entrenched attitudes towards interprofessional learning and working and faced difficulties of resistance to engage in the processes. However where engagement could be promoted, rich results occurred and very positive evaluation resulted. The logistical issues of organising interprofessional encounters were reflected in the participants' experience and it seemed that the barriers and difficulties balanced the very positive results achieved in some instances. Key points emerging from the workshop programme are:

- Champions for interprofessional learning emerged from this process. These individuals, in interdisciplinary partnership, were able to achieve a high level of success through their initiatives. However issues were raised about sustainability of actions following withdrawal of the champions' input and support.

- Giving opportunities for collaboration across institutions and disciplines enabled colleagues to create positive interprofessional learning environments. Both students and educators reported gaining a great deal from the process, and found it enjoyable.

- Participating in the programme gave participants a greater understanding of interprofessional learning and built positive relationships across the institutions and disciplines.

- New insights and innovative approaches to learning can be generated by disciplines that do not normally encounter each other working together.

- Change can be achieved when it receives focussed support in terms of financial input and access to expertise as in this workshop programme, but sustainability may be difficult as support is withdrawn.

Section 7

Conclusions and Recommendations

It has been clear throughout the conduct of the CUILU project that the promotion of interprofessional learning initiatives is not a simple endeavour, but is fraught with complexity with many barriers set against successful implementation and sustainability. This is by no means a unique perspective as identified in the introduction of this report. Davidson (2005) has summarised recognised barriers, all of which to some extent were encountered within the CUILU project. These include stereotypical and counter-productive views of other professions often stemming from lack of knowledge of the roles, skills, values and philosophies espoused by other professions. This in some way links to issues of professional status and power relationships. Davidson comments on documented evidence that suggests that students from professions perceived as 'less powerful' may be reticent about expressing their views when in the presence of more powerful, higher status professions. This view can be found in the data of the CUILU project.

> ***Medical Practitioner 1:*** *Nurses tend to be more shy, they need a lot of encouragement and I mean, in that the level of knowledge and experience tends to be less than medical students and whether this hinders teaching or enhances it, but in my experience they needed a lot of encouragement to make them actively participate and talk, and er, and try and really think with us.*

However, this did not seem to be an issue for students who attended the beacon site seminar programmes who seemed more concerned about the relative amounts of actual experience they had with patients or service users rather than any power differentials in their respective professions.

> ***Student nurse 5:*** *I was really lucky to have this experience, I got on well with the social work student and we had some really good chats about our different courses, and how they are different but that we are trying to do the same thing.*

Nevertheless, it can be noted in the interviews with managers and practitioners that profession biased issues can get in the way of implementing interprofessional learning.

> ***(Trust Exec1):*** *I remember a lecturer once saying you can't teach undergraduate medical students all about leadership and resources because they need to learn about pharmacology and physiology. I just thought mmm yes, yes. Because that, well my comment was, if that was the deal, then we would always have the doctor that we've got. Would you put social, actually, is social care part of this (CUILU) model?*
>
> ***(Nurse 2)*** *one of the reasons is, I think (ie of difficulties in bringing groups together for learning), is that it's a different funding. Because the medical staff have a very good teaching module, all right, and they can access that quite readily and they, to ensure that the, erm, the doctors, SHOs stay here, they've got to provide regular teaching. So, it's, you know, there's a funding issue, really.*

The comment immediately above relates more to postgraduate learning but certainly on isolated occasions some resistance was encountered with respect to the release of students from their profession-focused learning to participate in CUILU interprofessional learning encounters. This mainly occurred in situations where uni-professional

learning held primacy in decisions made by students or their supervisors about which learning opportunities students should attend. These difficulties are acknowledged in the quote below, emphasising the need for interprofessional learning to be embedded strategically into the planning of student learning and to be seen as a subject in its own right and integral to all professions.

> ***Medical practitioner 3*** *I have a feeling that if you didn't do this (explicitly focus on IPL), if you didn't try to guide it, it wouldn't happen. It would be easy for people to just sit within their own professional enclaves and, you know not to, pay even lip service to joined up thinking. The only way you will get joined up thinking is for people to actually be directed towards it in a friendly, expert, talented, you know, way. You know what I'm trying to say.*

As the guiding principle of interprofessional learning is to encourage inter-professional working around the needs of the patient, then it follows that such learning must be informed by the patient's voice. This introduces further logistical and ethical barriers (related to patient consent and other issues as reported elsewhere in this report) to achieving effective patient-centred interprofessional learning for large numbers of students without intimidating the patient (Davidson, 2005). This issue is echoed in the data of this project and was seen as a pivotal interest in CUILU's work. The enrichment to student learning through lay participation has been acknowledged, but also identified has been the need for careful management and allocation of adequate resource to ensure a positive experience for all involved.

Davidson outlines the difficulties in assuring comprehensive professional representation in interprofessional learning encounters in that no single Higher Education Institution in the UK offers programmes for every health and social care profession. This means that there are inevitably institutionally biased gaps in professional representation and perspectives that can undermine the validity and relevance of interprofessional learning. Despite this issue, interprofessional learning, particularly where university based, still gives rise to problems with capacity and logistics due to the number of students involved. There is often insufficient teaching space with appropriately sized and configured breakout rooms to accommodate large numbers of students from different professional courses. Meanwhile, all health and social care courses require students to spend a significant part of their learning time in practice settings. Thus opportunities for inter-professional 'classes' are severely constrained and impacted by timetabling restrictions.

The difficulties of representation and the logistics of managing large numbers of disparate students were to some extent ameliorated by the collaboration across institutions as a structural feature of the CUILU project and the practice-based focus meaning that smaller numbers were involved and classroom timetables were not an issue. However the practice-based nature of the project meant that the seminar programmes and students learning together more informally were dependent on the student placement patterns in operation, and the diversity of student group could be narrow depending on the individual beacon site and, as mentioned above, the students' availability or being positively facilitated to attend.

This raises the issue of the appropriate mix of students in interprofessional learning groups. When disseminating work at national or international forums or facilitating discussions more locally, the CUILU team frequently encountered expressed views that interprofessional learning would be more fruitful if the students were grouped to reflect naturally occurring multidisciplinary teams. This certainly makes sense when considering how to develop learning materials that are relevant to all students in mixed groups and to manage logistics. This being said, however, data from this project do suggest that positive outcomes can be achieved by

bringing together students or postgraduate learners who would normally never encounter each other in practice. This can be seen in the description of workshop described in the previous section: *Group 3: Promoting a Positive Environment for Interprofessional Learning:* Opposites Attract and was a feature of several of the seminars in the beacon sites as seen in student evaluations.

> ***Evaluation question:*** *Have you learned anything about another profession you didn't know?*
>
> ***Dietetics student:*** *How dedicated the other professions are working with the well being of the stroke patient*

and strikingly in the following quote,

> ***Trust Exec2.*** *When we became involved in the CUILU project, interprofessional teams began to visit the facility for the first time. Social workers were among the group and I was worried that they might find it too clinical and disengage. It was a tremendous success, and it was a pleasure to watch how the acute staff engaged with the social care staff, I really believe it was a rich learning experience for all. We now offer places to all staff, both health and social care. No longer do we question social care involvement, we encourage it!*

A further issue in practice-based interprofessional learning is how students can experience differing levels of exposure to inter-professional collaboration during practice placements. Some placements expose students to frequent interactions with other professionals and good practice in inter-professional working, many placements do not. The CUILU beacon sites were selected on basis that they presented good opportunities for students but even in sites that were recognised as providing high quality interprofessional learning environments, the relative levels of 'success' in terms of meeting project aims and subsequent sustainability is determined by champions in the site to promote project based initiatives such as CUILU and also to continue and take forward work after the project closes.

The theoretical perspective of the 'contact hypothesis' underpinned the CUILU project's ethos and processes. This perspective proposes that properly managed contact between groups can change attitudes and foster more positive stereotypes, so enhancing collaborative team working. The main work of this project took place in the practice environment of identified 'beacon sites' in which interprofessional learning and working was taking place. The findings have been generated though the active involvement of lay people, students, practitioners and educators who worked as collaborators in the project and were contributors to its outcomes. The CUILU team work with our collaborators in these integrated environments enabled a description of practice-based interprofessional learning environments and how they might be promoted and developed; a formulation of what students need to learn in order to become collaborative workers; offered insights into processes of teaching and assessment of students' interprofessional learning including the role of interprofessional mentors and, most importantly, emphasises the centrality and involvement of those we care for in these processes. The CUILU team consider more work needs to be done, but below are recommendations drawn from the processes and findings of the CUILU project:

1. The Beacon Sites involved in the CUILU project enabled a description of the learning environments that promote the acquisition of interprofessional capability. It seems that the more integrated a service is in terms of organisational structure and management of student experience, the more conducive the environment is to effective interprofessional learning. Pivotal to the successful organisation of interprofessional learning is the presence of co-ordinating 'champions'.

Recommendation: As services modernise and become more integrated, student placement learning arrangements should be considered as 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 interprofessional learning required by all students.

2. Non-traditional placement areas, which may or may not be appropriate to provide profession-specific experience for students, may nevertheless offer rich opportunities for students to meet the learning outcomes contained in the Interprofessional Capability Framework, thus raising the potential for expansion of placement capacity. The use of the Interprofessional Learning Practice Placement Audit Tool was seen as an appropriate method for identifying such placements and monitoring and enhancing their quality; and as a vehicle for enhancing communication between service organisations and Higher Education Institutions.

Recommendation: Attention should be given to the potential of non-traditional placements to offer very rich and valuable learning experience for students of all professions. This process should be mediated through formal quality monitoring and enhancement procedures such as those offered by the Interprofessional Placement Audit Tool.

3. The Interprofessional Capability Framework contains interprofessional capabilities and incremental learning outcomes that are 'common' to all professions and rather than being an 'optional extra' are required aspects of the professional preparation of all students of health and social care. The Framework defines the domains of interprofessional working and guides students and educators to what students need to learn in order to become interprofessionally capable. The Framework was seen as relevant and appropriate to the students and practitioners referring to it, and the learning outcomes were seen as being able to be assessed by students, practitioners and lay participants in the project.

Recommendation. Clear learning outcomes that are accessible to assessment and common to all students should be utilised In order to take a strategic approach to managing interprofessional learning across all professions. The Interprofessional Learning Capability Framework offers one methodology for this, acknowledging that others may be available and appropriate.

4. Although there has been to date a lack of conceptualisation of interprofessional mentorship, CUILU have identified that aspects of interprofessional mentorship already take place in the beacon sites. CUILU contends that the purpose of interprofessional mentorship is to develop students' development as interprofessional workers though facilitation, supervision and assessment of students' interprofessional learning. This process is conducted with students from the mentor's own profession as well as students of other professions. The interprofessional mentor does not replace the uni-professional mentor, but nevertheless develops important skills and knowledge common to all professions. The interprofessional mentor assists students to understand: professional demarcations and the roles of various professions; where individual contributions of the care team are collaborative in nature and where roles and functions may overlap in order to provide the best possible care for the individual and his or her carers.

R**ecommendation:** Preparation for the interprofessional aspects of the role of individuals who support students both in university and in practice should be undertaken either as part of uni-professional preparation of individuals in these roles, but preferably as an interdisciplinary endeavour.

5. Patient and service user involvement in student learning is seen as pivotal to interprofessional learning and students perceive such contact with patients, service users and their carers as a rich and enhancing source of learning. The perspective of lay participants as part of the learning and assessment process emphasises the centrality of the patient and provokes consideration of service arrangements. However, such participation is not without its problems and difficulties for all stakeholders in the process and the resource demand to ensure effective participation can be overlooked.

   Recommendation Participation in student learning by lay participants must be carefully planned, managed and adequately resourced. The CUILU Good Practice Guidelines can assist educators to consider the issues.

6. The active promotion of positive interprofessional learning environments is a fruitful way of commencing a culture change process and embedding interprofessional learning into the educational ethos of both practice and university contexts. However, implementing such culture change and logistical organisation is extremely challenging. Pivotal to success this process is the presence of enthusiastic individuals to take forward the process and acting as champions for interprofessional learning. This raises issues of resource and where projects are funded and champions are in place progress can take place, this is true also in placement areas where champions take forward interprofessional learning, but if funding or support is withdrawn the initiatives subside. The workshop programme facilitated by CUILU demonstrated that where resource was made available for individuals to take part, extremely interesting and important results were achieved.

   Recommendation. In order to sustain change in the educational culture with respect to interprofessional learning, commitment of adequate resource must be made available.

   Recommendation. Strategic embedding of interprofessional learning cannot rely on the activity of champions alone, however vital they will remain to be. Attention needs to be given to structures and processes in the management of education to facilitate interprofessional teaching, learning and assessing both in the context of the Higher Education Institution (HEI) and the service providers that provide student experience in partnership with the HEIs. Performance indicators both in educational commissioning and quality enhancement procedures also have a potential role in supporting the development of interprofessional learning.

Interprofessional learning to promote interprofessional working is driven by high profile inquiries and media reports (see the Bristol Enquiry Final Report (Kennedy, 2001); Victoria Climbié Report (Laming, 2003) and successive policy emphasis on the need to provide a more coherent, integrated and patient-centred approach towards educating future health professionals (DoH 1999, 2001, 2004a,b,c; Wanless 2004). The work of CUILU, along with other funded initiatives across the country, is adding to the evidence base regarding interprofessional learning and a high level of interest has been expressed by a wide range of institutions from across the country. This may indicate that the proposals put forward through the work of CUILU could contribute to the development of a truly interprofessional workforce, delivering care within the integrated modernised services for the future, in which the patient/service user is placed at the centre of care.

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