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Interprofessional Education in Wales: case studies in health and social care

July 2010

Cyflwyniad i Astudiaethau Achos Addysg Rhyngbroffesiynol

Gorffennaf 2010

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Foreword

The Higher Education Academy Subject Centres play a key role across the UK in enhancing the quality of the student learning experience at the disciplinary level. This publication reflects the active commitment of the Higher Education Academy's Health Science and Practice (HSaP) Subject Centre to work both regionally and nationally. The case studies build on a conference in April 2008 hosted by Cardiff University and supported by the three HEA Subject Centres: Health Science and Practice (HSaP), Medicine, Dental and Veterinary Science (MEDEV), and Social Work and Policy (SWAP).

The Welsh Assembly Government is committed to cross-institutional and cross-professional boundary working, as articulated in its agenda for both Higher Education and Health in Wales. These case studies are a significant contribution to the exploration of interprofessional learning in Higher Education in Wales, and provide a foundation from which further developments can grow.

I hope that the case studies will spark interest and debate within and outside Wales, and I look forward to future additions to the current on-line collection.

Gabriel Jezierski

Head of Policy and Partnerships (Wales and Northern Ireland)
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Uwch Ymgynghorydd
Yr Academi Addysg Uwch

Rhagair

Mae gan Ganolfannau Pwnc yr Academi Addysg Uwch rôl allweddol ledled y DU o ran gwella ansawdd profiad dysgu myfyrwyr ar lefel y ddisgyblaeth. Mae'r cyhoeddiad hwn yn adlewyrchu ymrwymiad parhaus Canolfan Pwnc Iechyd Gwyddoniaeth ac Arferion (HSaP) yr Academi Addysg Uwch i weithio'n rhanbarthol ac yn genedlaethol fel ei gilydd. Mae'r astudiaethau achos yn adeiladu ar gynhadledd a gynhaliodd Prifysgol Caerdydd ym mis Ebrill 2008 gyda chymorth tair Chanolfan Pwnc yr Academi Addysg Uwch: Iechyd Gwyddoniaeth ac Arferion (HSaP), Gwyddoniaeth Meddygol, Deintyddol a Milfeddygol (MEDEV), a Gwaith a Pholisi Cymdeithasol (SWAP).

Mae Llywodraeth Cynulliad Cymru wedi ymrwymo i weithio ar draws ffiniau sefydliadol a phroffesiynol, fel sydd wedi'i nodi yn ei hagenda ar gyfer Addysg Uwch ac Iechyd yng Nghymru. Mae'r astudiaethau achos hyn yn gyfraniad pwysig tuag at archwilio dysgu rhyngbroffesiynol mewn Addysg Uwch yng Nghymru ac yn rhoi sylfaen lle gall datblygiadau pellach fynd o nerth i nerth.

Rwy'n gobeithio bydd yr astudiaethau achos yn ennyn diddordeb ac yn ysgogi trafodaeth yng Nghymru a thu hwnt ac edrychaf ymlaen at weld rhagor yn cael eu hychwanegu at y casgliad ar-lein cyfredol yn y dyfodol.

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Introduction to IPE Case Studies from Wales

By editors Clare Kell and Marion Helme, Higher Education Academy Subject Centre for Health Sciences and Practice

In 2008 Cardiff University hosted a conference to support and showcase interprofessional education in health and social care in Wales. The conference was funded and organised by the UK Higher Education Academy Subject Centres and Academy York and EIPEN, the European Interprofessional Education Network. The conference included a preconference seminar with representatives from the Welsh Assembly Government (WAG) and the Welsh Health Care Students' Forum, a key note speech from Professor Hugh Barr, presentations and posters, and discussion focussing on the 'interprofessional learning environment' (Event Report www.health.heacademy.ac.uk/ipe/ipeinuk/ilereport). At the conclusion of the conference participants were asked for their views about how best to promote good practice in interprofessional education in Wales. There was strong support for a publication following the conference.

An open invitation to submit case studies of interprofessional education was issued to HEIs in Wales in 2008-2010. Those submitted were read by a panel including people knowledgeable about IPE, Higher Education in Wales and the use of the Welsh language in Higher Education, and perspectives of learners, teachers and service users and carers. Following review, authors have had opportunity to update and develop the original submission, a process which we hope will continue as courses evolve.

The case studies are some examples of interprofessional education developments in Wales in the last 5 years. Readers familiar with IPE will recognise many of the challenges for the teams introducing interprofessional learning. The intention in this collection is not to provide models of best practice or 'how to do' interprofessional education, but contextualised examples with critical reflection on the planning and implementation to enhance transferability and future development.

The Welsh context is important in terms of history, politics, geography, and language. The Care Council for Wales emphasised the importance of citizen-centred policies and models of service delivery which create "… new opportunities to respond more flexibly and creatively to the diversity of Wales's communities: the particular mix of rurality, industrial valleys and urban areas, as well as its unique language and culture" (WAG 2006 7.8). Since devolution in 1999, Welsh Assembly Government policies have recognised the importance of multidisciplinary practice in health and social care, for example NHS Wales Designed for Life (WAG 2005) states that in primary care, "all [GPs] will work increasingly with other health professionals undertaking extended roles" and "in each locality there will be a team of professionals working together". Multidisciplinary interaction is also embedded in the six NHS Wales National Service Frameworks[1]. The Welsh Assembly Government's document *Raising Standards: the Qualification Framework for the Degree in Social Work in Wales*, produced in collaboration with the Social Services Inspectorate for Wales and the Care Council for Wales, details the regulatory requirements of the social work degree in Wales. It stipulates that "the institution must ensure....that students are provided with the theoretical knowledge and the practical experience necessary for effective interprofessional and inter-agency social work" (WAG 2005:81).

[1] See http://www.wales.nhs.uk/sites3/home.cfm?OrgID=334

While the political landscape provides opportunities and challenges for multidisciplinary working, Wales also experiences the implications of a geography that challenges easy day-to-day cross- country collaboration, and a perceived remoteness (made more acute post devolution) from the regulatory and professional bodies of all healthcare professions except social work and social care.

Collection published in 2010

Our intention, and hope, is that this collection will be added to and updated in its electronic form to capture ongoing developments. The forty years development of IPE in the UK has gained considerable momentum in the last ten years after a slow start, especially in pre-registration education. New roles, the need for new knowledge and skills, recognition of collaborative practice and team work as essential to practice, and '*learning together to work* together' in many different contexts has widened the range of interprofessional learning. These trends are represented in this collection. The one omission, which we hope will be covered in future, is interprofessional learning in work places outside education settings.

This collection of 13 submissions includes case studies from 6 Higher Education Institutions in Wales, and covers students and staff from health and social care disciplines, with one case also including magistrates and early years practitioners. Six of the case studies include students and staff from social work and two include students and staff from medicine; this may reflect the distribution of professional education in Wales. We start with three 'extra-curricular' case studies which demonstrate how continuing professional development, involvement in networks and groups, and less formal settings can promote interprofessional learning. These are also included because of the importance of increasing awareness of difference and developing skills in collaborative working in many different contexts and not just in providing health and social care services. These case studies also show incidences of legitimate peripheral participation (Wenger, 1999) in learning to work collaboratively.

The five postgraduate case studies reflect changing practices and new or extended practice roles. One of the case studies describes the development of a transnational interprofessional programme, and two are pilots with the first intake of students in 2010.

The remaining five case studies explore IPE opportunities at undergraduate, pre-registration levels. The challenges of establishing interprofessional learning at this level are particularly identified. While the most marked shift in the recent development of interprofessional education globally has occurred at the pre-registration level, the authors here share their very real challenges of both starting pilot initiatives (involving fewer than 20 students) and particularly turning pilots into embedded practice. Challenges are not insurmountable however, with one team offering embedded interprofessional learning experiences for 30-40 students and another for 90-100 students.

We hope that you will enjoy reading this collection and feel able to contribute some of your own initiatives and embedded practices when this first edition is updated.

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Welsh Assembly Government (2005) Designed for Life – Creating World Class Health and Social Care for Wales in the 21st Century (NHS Wales)
http://www.wales.nhs.uk/documents/designed-for-life-e.pdf

Wenger, E (1999) *Communities of practice: learning, meaning and identity*, Cambridge, Cambridge University Press

Cyflwyniad i Astudiaethau Achos Addysg Rhyngbroffesiynol o Gymru

Yn 2008, cynhaliodd Prifysgol Caerdydd gynhadledd i gynorthwyo ac arddangos addysg rhyngbroffesiynol ym meysydd iechyd a gofal cymdeithasol yng Nghymru. Cafodd y gynhadledd ei hariannu a'i threfnu gan Ganolfannau Pwnc Academi Addysg Uwch y DU ac Academi Efrog ac EIPEN, sef Rhwydwaith Addysg Rhyngbroffesiynol Ewrop. Cafwyd seminar cyn y gynhadledd gyda chynrychiolwyr o Lywodraeth Cynulliad Cymru (LlCC) a Fforwm Myfyrwyr Gofal Iechyd Cymru. Yr Athro Hugh Barr a gyflwynodd y brif araith ac roedd hefyd yn cynnwys cyflwyniadau, posteri a thrafodaethau oedd yn canolbwyntio ar yr 'amgylchedd dysgu rhyngbroffesiynol' (Adroddiad am y digwyddiad - www.health.heacademy.ac.uk/ipe/ipeinuk/ilereport). Ar ddiwedd y gynhadledd, gofynnwyd i'r rhai a gymerodd ran ynglŷn â beth yw'r ffordd orau o hyrwyddo arferion da mewn addysg ryngbroffesiynol yng Nghymru yn eu barn nhw. Roedd nifer sylweddol o blaid cael cyhoeddiad ar ôl y gynhadledd.

Cyflwynwyd gwahoddiad agored i sefydliadau addysg uwch yng Nghymru i gyflwyno astudiaethau achos o addysg rhyngbroffesiynol yn 2008-2010. Cafodd y rhai a gyflwynwyd eu darllen gan banel oedd yn cynnwys pobl sy'n arbenigo ym meysydd addysg rhyngbroffesiynol, addysg uwch yng Nghymru a sut y defnyddir y Gymraeg mewn addysg uwch, yn ogystal â safbwyntiau dysgwyr, athrawon, gofalwyr a defnyddwyr y gwasanaeth. Ar ôl cyfnod adolygu, mae'r awdurdon wedi cael cyfle i ddiweddaru a datblygu'r cyflwyniad gwreiddiol. Gyda lwc, bydd y broses hon yn parhau wrth i'r cyrsiau ddatblygu.

Mae'r astudiaethau achos yn rhai enghreifftiau o ddatblygiadau addysg ryngbroffesiynol yng Nghymru yn ystod y 5 mlynedd ddiwethaf. Os ydych yn gyfarwydd ag addysg ryngbroffesiynol yn ymwybodol o'r anawsterau sydd gan dimau sy'n cyflwyno addysg ryngbroffesiynol. Nid rhoi engheifftiau o arferion gorau na nodi'n benodol 'sut' i gyflawni addysg rynbroffesiynol yw bwriad y cyhoeddiad hwn. Yn hytrach, mae'n rhoi enghreifftiau cyd-destunol ac yn ystyried yn feirniadol sut cawsant eu cynllunio a'u gweithredu er mwyn gwella trosgladwyedd a datblygu yn y dyfodol.

Mae'r cyd-destun Cymreig yn bwysig o ran hanes, gwleidyddiaeth, daearyddiaeth ac iaith. Pwylsieisiodd Cyngor Gofal Cymru bwysigrwydd polisïau sy'n rhoi'r dinesydd yn gyntaf ac enghreifftiau o gyflwyno gwasanaeth sy'n creu "… cyfleoedd newydd i ymateb yn fwy hyblyg a chreadigol i amrywiaeth cymunedau Cymru: yn benodol, y cymysgedd o gefn gwlad, y cymoedd diwydiannol a'r ardaloedd trefol yn ogystal â'i hiaith a'i diwylliant unigryw" (LICC 2006 7.8). Ers datganoli ym 1999, mae polisïau Llywodraeth Cynulliad Cymru wedi cydnabod pwysigrwydd arferion amlddisgyblaethol ym meysydd iechyd a gofal cymdeithasol. Er enghraifft, mae Cynllun Oes (LICC 2005) GIG Cymru yn nodi "bydd pob un [meddyg teulu] yn gweithio'n gynyddol gyda gweithwyr iechyd proffesiynol eraill wrth ymgymryd â swyddogaethau estynedig" ar lefel gofal sylfaenol ac y bydd "tîm o bobl broffesiynol yn cydweithio â'i gilydd ym mhob lleoliad". Mae cydweithio amlddisgyblaethol wedi'i ymgorffori yn chwe Fframwaith Gwasanaeth Cenedlaethol GIG Cymru[2]. Mae dogfen *Codi Safonau: y Fframwaith Cymhwyster ar gyfer y Radd mewn Gwasanaethau Cymdeithasol yng Nghymru* gan Lywodraeth Cynulliad Cymru, a luniwyd gydag Arolygiaeth Gwasanaethau Cymdeithasol Cymru a Chyngor Gofal Cymru, yn nodi gofynion rheoliadol y radd mewn gwaith cymdeithasol yng Nghymru. Mae'n nodi bod "rhaid i'r sefydliad sicrhau....bod myfyrwyr yn derbyn y wybodaeth ddamcaniaethol a'r

[2] Gweler http://www.wales.nhs.uk/sites3/home.cfm?OrgID=334

profiad ymarferol sy'n angenhreidiol ar gyfer gwaith rhyngbroffesiynol a rhyngasiantaethol effeithiol" (LICC 2005:81).

Tra bod y dirwedd wleidyddol yn cynnig cyfleoedd a heriau o ran gweithio ar draws asiantaethau, mae Cymru hefyd yn wynebu goblygiadau o ran ei daearyddiaeth sy'n herio cydweithio beunyddiol a thraws gwlad rhwydd ac mae cyrff rheolaethol a phroffesiynol pob maes gofal iechyd ar wahân i waith cymdeithasol a gofal cymdeithasol yn teimlo'n anghysbell (yn enwedig ers datganoli).

Casgliad i'w gyhoeddi yn 2010

Ein bwriad a'n gobaith yw i'r casgliad electronig hwn dyfu a chael ei ddiweddaru er mwyn cynnwys datblygiadau parhaus. Mae datblygiad addysg rynbroffesiynol yn y DU dros ddeugain mlynedd wedi mynd o nerth i nerth yn ystod y degawd diwethaf ar ôl dechrau'n araf, yn enwedig mewn addysg cyn-cofrestru. Mae swyddogaethau newydd, yr angen am wybodaeth a sgiliau newydd, cydnabod arferion cydweithio a gweithio mewn tîm yn elfennau hanfodol ac mae *'dysgu gyda'n gilydd i weithio gyda'n gilydd'* mewn sawl cyd-destun wedi ehangu amrywiaeth dysgu rhyngbroffesiynol. Mae'r casgliad hwn yn adlewyrchu'r tueddiadau hyn. Nid yw'n cynnwys dysgu rhyngbroffesiynol y tu allan i ganolfannau addysg, ond rydym yn gobeithio y caiff hyn ei gynnwys yn y dyfodol.

Mae'r 13 cyflwyniad yn y casgliad hwn yn cynnwys astudiaethau achos gan 6 sefydliad addysg uwch yng Nghymru. Maent yn ymwneud â myfyrwyr a staff y disgyblaethau iechyd a gofal cymdeithasol ac mae un achos hefyd yn cynnwys ynadon ac ymarferwyr blynyddoedd cynnar. Mae chwech o'r astudiaethau achos yn cynnwys myfyrwyr a staff ym maes meddyginiaeth; hwyrach bod hyn yn adlewyrchu sut mae addysg broffesiynol wedi'i dosbarthu yng Nghymru. Rydym yn dechrau gyda thair astudiaeth achos 'allgyrsiol' sy'n dangos sut gall datblygiad proffesiynol parhaus, cymryd rhan mewn rhwydweithiau a grwpiau, a lleoliadau llai ffurfiol hyrwyddo dysgu rhyngbroffesiynol. Mae'r rhain hefyd wedi cael eu cynnwys oherwydd pwysigrwydd cynyddu ymwybyddiaeth o wahaniaethau a datblygu sgiliau mewn sawl cyd-destun ac nid er mwyn darparu gwasanaethau iechyd a gofal cymdeithasol yn unig. Mae'r astudiaethau hyn hefyd yn dangos enghreifftiau o gymryd rhan ymylol cyfreithlon (Wenger, 1999) wrth ddysgu sut i gydweithio.

Mae'r pump astudiaeth achos ôl-raddedig yn adlewyrchu arferion sy'n newid a'r swyddogaethau ymarfer newydd neu estynedig. Mae un o'r astudiaethau achos yn disgrifio datblygiad rhaglen ryngbroffesiynol drawsgenedlaethol, ac mae dau ohonynt yn gynlluniau peilot fydd yn derbyn myfyrwyr am y tro cyntaf yn 2010.

Mae'r pum astudiaeth achos arall yn bwrw golwg ar gyfleoedd am addysg ryngbroffesiynol ar lefelau israddedig a chyn-cofrestru. Mae'r heriau sydd ynghlwm â sefydlu dysgu rhyngbroffesiynol ar y lefel hon yn cael eu nodi'n benodol. Er mai ar lefel cyn-cofrestru y mae addysg rynbroffesiynol ledled y byd wedi datblygu fwyaf yn ddiweddar, mae awduron yr astudiaethau hyn yn trin a thrafod yr anawsterau ymarferol amlycaf y daethant ar eu traws wrth ddechrau'r mentrau peilot (oedd yn cynnwys llai nag 20 o fyfyrwyr) ac wrth ymgorffori'r cynlluniau peilot yn benodol mewn i ymarfer. Fodd bynnag, mae modd datrys yr anawsterau hyn ac roedd un tîm yn cynnig profiadau dysgu rhyngbroffesiynol wedi'u hymgorffori ar gyfer 30-40 o fyfyrwyr ac un arall ar gyfer 90-100 o fyfyrwyr.

Gobeithio y byddwch yn mwynhau darllen y casgliad hwn ac yn teimlo y gallwch gyfrannu rhai o'ch mentrau eich hun a'r arferion rydych wedi'u hymgorffori pan fydd y fersiwn cyntaf hwn yn cael ei ddiweddaru.

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Audit of Children and Families Teaching and Learning in the Social Work Degree Programmes in Wales Adroddiad Terfynol Mai 26 2009 Yr Athro Imogen Taylor a Margaret Boushel, Prifysgol Sussex, Adran Gwaith Cymdeithasol a Gofal Cymdeithasol www.ccwales.org.uk/edrmsdocredirect.aspx?db=2&doc=70868

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Mae Fframweithiau Gwasanaeth Cenedlaethol Llywodraeth Cynulliad Cymru ar gael yn http://www.wales.nhs.uk/sites3/home.cfm?OrgID=334

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Case Study 1: Wales Chapter for Healthcare Improvement: Student-led IPE

Andrew Carson-Stevens[3], Chair of Wales Chapter for Health Care Improvement, Wales Centre for Health and Institute for Healthcare Improvement Open School; former Chair, Wales Health Student Forum, Welsh Assembly Government; and former Medical student, Cardiff University.

Date of writing: April 2009

Key words: quality improvement, healthcare improvement, patient safety.

Course specifics:

Title: Wales Chapter for Healthcare Improvement

Aims: The Wales Chapter for Healthcare Improvement is a multiprofessional student-led group focussed on health improvement education and initiatives. Our target is to engage healthcare students in Wales in the healthcare quality improvement agenda and contribute to creating a world-class healthcare service in Wales by 2015. We aim to gain representation from across the healthcare professions, and create meaningful working relationships and networks throughout the country.

Objectives: To empower students to work in multiprofessional teams to:
1. Learn the quality improvement skills to be safe, effective and innovative team members in the workplace;
2. Learn from and share clinical experiences; and
3. Undertake local quality improvement in healthcare projects.

Professions involved: Medicine (10), Midwifery (5), Nursing (5), Nutrition Dietetics (1), Occupational Therapy (1), Physiotherapy (3), Clinical Psychology (2)

Organisations involved: Wales Centre for Health, UK; Institute for Healthcare Improvement, Cambridge, USA; Wales Healthcare Student Forum, Welsh Assembly Government.

Teaching methods: classroom teaching, e-learning, problem-based learning, case study.

Supporting resources: Online resources provided by the Institute of Healthcare Improvement Open School e.g.

- Online quality improvement courses: http://www.ihi.org/IHI/Programs/IHIOpenSchool
- Learning materials: http://www.ihi.org/IHI/Results/WhitePapers

Number of students per course: 25-50

Background and purpose

The Wales Chapter for Healthcare Improvement is a multiprofessional **student-led** group focussed on health improvement education and initiatives. Our target is to

[3] With input from Miss Rebecca Firks, Healthcare Improvement Lead Officer, Wales Centre for Health; Professor Jonathon Gray, co-Director of 1000 Lives Campaign; and student colleagues from the Wales Chapter for Healthcare Improvement steering group and Wales Healthcare Student Forum (2008-2009).

engage healthcare students in Wales in the healthcare quality improvement agenda and contribute to creating a world-class healthcare service in Wales by 2015. We aim to gain representation from across the healthcare professions, and create meaningful working relationships and networks throughout the country.

The Chapter itself, is a branch of the Institute for Healthcare Improvement's Open School for Health Professions. This is an internet-based resource affording healthcare students free access to patient safety and quality improvement courses given by world-renowned experts. There are currently over 100 Chapters spanning 10 countries, and the IHI Open School enables worldwide collaboration and communication between like-minded groups with the aim of improving their healthcare systems.

Our initiatives aim to develop **real-life awareness of patient safety** and healthcare improvement.

Rationale

As healthcare students living and studying in Wales, we have become increasingly aware of the need and desire to improve patient safety in Wales, the UK and across the world. At the same time, we have also become aware of our lack of knowledge and understanding of these issues, which has led us to question why patient safety is not a more prominent feature of the medical curriculum. We tend not to be educated in healthcare quality and patient safety improvement, neither are we encouraged to think about how systems can be improved to ensure our patients receive the safest care possible. In fact it is quite possible that, as young professionals entering the workplace, we could actually do more harm than good, despite the very best of intentions.

We are therefore taking action to address these issues and have brought together a group of healthcare students, studying in Wales, to form the Wales Chapter for Healthcare Improvement. The Chapter is part of a global movement to advance healthcare quality improvement and patient safety competencies in the next generation of health professionals worldwide. The goal to achieve a world class healthcare syste by 2015 is set out in national health policy 'Healthcare Improvement Quality Improvement Plan: Designed to Deliver', produced by the Welsh Assembly Government in 2006.

The Wales Chapter was launched in April 2009 and from that point onwards we will be engaging healthcare students from across Wales to play their part in our quality improvement vision. The Wales Chapter is just one of a number of similar Chapters which are being established worldwide. The Chapters are part of the Open School for Healthcare Professions which has been set up by the Institute of Healthcare Improvement (IHI) in the USA. IHI is an internationally renowned not-for-profit organisation leading improvement of healthcare throughout the world. The purpose of IHI's Open School is to reach out to healthcare profession students globally, and give them the opportunity to learn much of what they will need to know to improve the healthcare systems in which they will work as graduates.

Currently, we are a small group of dedicated students from a range of healthcare professions including medicine, nursing, dietetics, occupational therapy, physiotherapy and clinical psychology. Together we form a Steering Group and have tasked ourselves with the establishment of the Wales Chapter. Students are invited to join an interprofessional group of students passionate about improving quality in

healthcare. To improve patient safety and patient care by raising awareness of healthcare quality among all current healthcare students in Wales through involvement in healthcare improvement educational and awareness raising initiatives, via direct collaboration with the 1000 Lives Campaign.

Student chapter learning opportunities

Being a member provides students with access to the innovative IHI Open School. The Open School is an internet-based resource enabling healthcare students from all over the world, to have free access to certified, patient safety and quality improvement courses and regular interactive lectures, which students are invited to participate in.

The Open School provides a plethora of other resources designed to educate healthcare students in the skills of healthcare quality improvement, including access to must-read books and articles, case studies and video interviews with some of the best minds in healthcare. As part of an international community, we also have the opportunity to share and learn from our peers. This is possible through participation in real-time lectures from renowned experts in healthcare improvement. In addition, links between the various Chapters are encouraged – the Wales Chapter has already made meaningful links with the Chapter of the University of South Florida and The University of North Carolina Chapel Hill, U.S.A.

Skill Building through Health Improvement Initiatives

The Wales Chapter has so far outlined four healthcare improvements initiatives aimed at developing healthcare quality improvement and patient safety competencies.

Quality Improvement Academy

We are presently organising a Quality Improvement Academy, a 3-day short skills course, for healthcare students in Wales.

Student stories

Students are in a unique position to see the healthcare system with fresh eyes as they begin their training. To harness this power, the Wales Chapter will support students, in collaboration with the 1000 Lives Campaign, to **gather students' stories** of their experiences of working in healthcare settings. This initiative will engage students in healthcare quality and provide a forum for sharing experiences and ideas. Fundamentally it will support students to apply their critical thinking skills and use their experiences to inform and improve healthcare quality and patient safety. The Wales Chapter for Healthcare Improvement aims to record those first impressions as Student Stories in collaboration with the 1000 Lives Campaign. In this way, we hope to provide students with a forum to share their thoughts and ideas as well as use their experiences to inform healthcare improvement policy in the future.

Patient Stories

Patient Stories enable patients to talk about their healthcare experiences and are an essential component of making care patient-centred. **Patient stories** are not the same thing as taking a clinical history; a patient's story is about how they feel about their care and what they believe could be better. The Wales Chapter for Healthcare Improvement in collaboration with the 1000 Lives Campaign team aims to train students how to take patient stories effectively, centrally record this information and use it to inform healthcare improvement policy. This activity also combines well with the focus on developing communication practices which currently represents an integral part of medical curriculum in universities across the UK.

Quality Improvement Projects

Students who have participated in the IHI Open School, student or patient stories projects may then be able to pinpoint areas in NHS healthcare provision that they can have a positive impact on. The range of possibilities is vast and the key feature of initiatives that we run wil be entirely student-led. Students will participate in, and learn, all aspects of project development, from feasibility studies and budgeting to fundraising and project evaluation.

Audits and projects that we anticipate engaging students with include:

1. Ensuring bed angles are at 45^0 to prevent aspiration pneumonia;
2. Establishing and monitoring hand washing protocols on wards to prevent infection;
3. Monitoring the implementation of the WHO Surgical Safety Checklist before the start of each procedure to minimise surgical harm and complications;
4. Evaluating approaches to nutritional care during hospital stays to optimise healing and recovery.

Steering group members that oversee the development of the Chapter have specific roles and these include:

1. Liaise with peers and faculty at respective healthcare schools to optimise support for the Open School;
2. Coordinate activities between other healthcare disciplines and meet with representatives from other professions on a regular basis to ensure this;
3. Work to bring together an interested group of students who would like to get involved with the Open School's educational and awareness activities (numbers to be confirmed);
4. Manage the day-to-day projects as determined by the Chapter;
5. Complete the IHI open school's modules on healthcare improvement, patient safety and leadership.

What do the student representatives get in return?

1. The opportunity to work with leaders in the field of healthcare improvement from across the globe;
2. Firsthand exposure to the current issues in healthcare in Wales today;
3. The possibility to forge lasting working relationships with colleagues across a broad range of healthcare disciplines;
4. Knowledge that they are actively working towards a better NHS for their patients, family and friends.

Preliminary evaluation and reflection

Students have shown tremendous will and enthusiasm to work interprofessionally by planning and executing a series of student-led projects that promote the sharing and learning from eachother beyond professional silos.

Dedicated support and committment from the Healthcare Improvement Team at the Wales Centre for Health, the 1000 Lives Campaign and its partners, and the Institute for Healthcare Improvement has proven valuable in establishing the Chapter.

Plans for the future

We are currently working with the Deans and Heads of Schools across the professions to formally integrate quality improvement and patient safety into the curriculae. In addition, the student Chapter has developed a series of student-led quality improvement projects for healthcare students across Wales to participate in and acquire new skills with accreditation from the Institute of Healthcare Improvement, U.S.A.

Further plans include:

- Recruit students to a quality improvement academy for 40 undergraduate healthcare students to learn quality improvement skills from across Wales in June 2009.

- Increase Chapter membership beyond the core steering group from April 2009 - each steering group member to act as the conduit to student cohorts across Wales.

- Evaluation of Academy and consideration of further trials of course resources in undergraduate healthcare curriculums e.g. Medicine.

Longer term aims of the Chapter are to formally integrate the quality improvement agenda into healthcare curricular in keeping with the Healthcare Improvement Quality Plan: Designed to Deliver.

For further information:

Please visit the website of the Wales Chapter for Healthcare Improvement at:

http://www.wales.nhs.uk/sites3/home.cfm?orgid=841

Case Study 2: Learning and teaching about mental health: the Wales network

Marjorie Lloyd, School of Health Social Care Sport and Exercise Science, Glyndwr Univeristy, Wrexham

Key words: participation, mental health, e-learning, networking

Course Specifics:

Title: Learning and teaching about mental health in wales network

Professions involved:

a) Attending: Higher Education staff from Medicine, Nursing, Social Work, Physiotherapy, Occupational Therapy, Psychotherapy Pharmacy and Counselling, Service Users and Carers;
b) Facilitating: Nursing, Psychology, Social Work, others by experience. Total = 7.

Organisations involved: Glyndwr University Lancaster University, Cardiff University, University of Glamorgan, Trinity College Carmarthen, Independent Carer and Service Users;

Length: The network meets 1 day twice a year. Interim networking supported online through jiscmail, and website;

Assessed? No;

Supporting resources? Website, discussion list administrator, meeting venues with appropriate equipment, Service user involvement costs e.g. travel and accommodation; *http://www.mhhe.heacademy.ac.uk/countries--regions/wales/learning--teaching-about-mental-health-in-wales-network*

Number of times this course has run: 3

Objectives:

1. To enhance student and practitioner experience of learning about mental health through the development of networks of stakeholders, across disciplines and settings.
2. To support the development and dissemination of good practices in learning and teaching about mental wellbeing and ill-health; providing a testing ground for new ideas and promoting pedagogic research.
3. To increase understanding of how mental health is taught across the disciplines, with a view to combating stereotypes and enhancing opportunities for interprofessional education and other collaborative initiatives.
4. To develop educators' awareness of workforce developments, as well as their capacity to influence policy initiatives and debates.
5. To embed service user and carer involvement within mental health teaching programmes and facilitate the exchange of good practice in this area.
6. To provide support, stimulate enthusiasm and facilitate the mutual exchange of resources and ideas.

Relevance to student learning:
Pre and post qualifying students, lecturers and practitioners are encouraged to share practice and knowledge and to network with other professionals and service users in developing their skills and knowledge in mental health practice. This network is specifically related to Wales and the different policy and practice guidance that applies to all professionals and service users.

Supporting resources:

1. ‘Stronger in Partnership 2 Involving Service Users and Carers in the design planning delivery and evaluation of mental health serivces in Wales’, Welsh Assembly Government 2008
2. ‘Raising the Standard Revised National Service Frameworks for Adult Mental Health in Wales’, Welsh Assembly Government 2005
3. ‘Designed for life: creating first class health and social care for Wales in the 21st Century’, Welsh Assembly Government 2005
4. the mental health in higher education (mhhe) website. - http://www.mhhe.heacademy.ac.uk

In practice:

Mental Health in Higher Education (mhhe) is a website that has been in existence for a few years and provides information to professionals and service users and carers in the mental health field (Anderson & Burgess 2007). The website is a Higher Education Academy supported project that encourages interprofessional working in mental health.

However much of the information is focused upon English policy development and not relevant to Wales’ developing health and social care system. The senior project development officer, Jill Anderson, was therefore looking for someone in Wales to manage a section of the website specifically for Wales and to develop a network. Together with my colleague, Richard Mottershead, we met in June of 2008 and planned a network event and website development. We were unable to obtain funding for the network and so were working on a tight budget that mainly consisted of our own time. Some funding was secured via the Higher Education Academy in Wales to pay service users’ out-of-pocket expenses.

As lecturers and students ourselves, we recognised the need for a central information point for practitioners and service users which would bring together all the up-to-date work around mental health in Wales and encourage team working amongst professionals that would improve outcomes for professionals, students, service users and carers (Dickinson 2008, Lloyd 2007). In addition, many of the practitioners, students and service users that we work with in the private and voluntary sector are unable to access library or NHS resources and so this would be a resource that would enhance interdisciplinary teaching and practice development. We also recognised that it is important to acknowledge individual, team and policy needs when developing interprofessional practice (Barr et al 2005).

Three network meetings have now taken place and a trend has developed in the shared experiences of all participants. The opportunity to talk with other people at the meetings and sometimes on the discussion list has lead to a deeper understanding of mental health initiatives within Wales. The mix of professionals is fairly wide including student counsellors, lecturers, charity organisations, nursing and social work practitioners and lecturers, service users and carers and student support service staff have all attended and shown an interest in developing mental health awareness across Wales. We also managed to interest the secretary of a local politician along to the last meeting. Inter professional education in mental health is particularly important because it develops communication between people who are often in isolated or marginalised posts in education and practice (Anderson & Burgess 2007). There is also some evidence emerging that IPE in mental health has been found to contribute to better out comes for service users and increased multidisciplinary communication between professionals (Priest et al 2008).

Things that worked well:

Planning took place via email and telephone calls and we agreed on an extra page being added to the website which I would update with some help from Jill. We also agreed on a networking event to launch the project and to encourage people to take part. Jill was able to obtain some money for the event so that it could be free to participants and we decided to send a flyer out asking people if they would like to share their activities at the event. We wanted to make sure that people did actually network at the event and did not want people to think that we owned the event. This was again achieved via email saving posting and printing costs.

We had offers from all over Wales to talk about practice and education and found speakers on service user involvement, children's mental health services, student mental health, management of aggression, problem based learning, service user education and interdisciplinary practice. With so many speakers lined up, we had to decline a few but this was much better than we expected. The first event was planned to be held in November 2008 in mid Wales to allow fair access to all who were travelling from the north and the south. The event was eventually attended by 27 people from a variety of backgrounds and experiences including counselling, radiography, physiotherapy, occupational therapy, service user groups, nursing and social work. The event was held in a room in The Media Resource Centre in Llandrindod Wells with all the equipment we needed with full access to the internet which was a great for accessing the website and giving a small demonstration of what was available.

What the participants thought:

This was evaluated very positively. Some of the feedback from the event included

> *A chance to discover useful links from academics / service users / carer / whole sector / multi-agency perspectives*
>
> *Very good event to network and find out about what is going on websites links etc*
>
> *Hearing from everybody else – I feel inspired!*
>
> *Some people did not know about the mhhe website and were eager to use it in their teaching / practice. Other people were surprised to find people from their own organisation at the event and made stronger links with them for the future.*
>
> *Networking with people from Wales will save me hours*

A voluntary organisation Hafal, surprised many people by presenting the amount of training that they were providing around mental health issues to service users and other professionals in South Wales, by service users who had been trained themselves.

Subsequent events have focused upon the student experiences of services and opportunities to develop learning about mental health in higher education. The last meeting, in November 2009 at Glyndwr University, led to the recognised need for mental health awareness in every curriculum. The network will focus on this in the

future as a method of developing awareness while at the same time promoting student mental wellbeing.

Things that did not work so well:

At the first meeting, there were problems with parking especially **disabled access** for a service user. Although the room was on ground floor, the participant had to park some way away to get to the venue. It was also noticed that we did not have a hearing loop system and that handouts were in small print. This information was provided by the service users and carers who attended the event and were quite vocal throughout the event. Two people presenting were service users and carers, so were representative of their group.

Time was difficult to manage, and we gave too much to the speakers (10 minutes each which they inevitably ran over). This left less time for networking, which was the main purpose of the event.

We did carry out a valuable evaluation exercise before everybody left, which gave us goals to work towards for the website and for any future networking events. A discussion list, hosted by JISC, was also launched so that people could keep in touch in between meetings and share any new information quickly. However it is difficult to **keep people motivated** even if they had the best intentions and the list has not been as active as we would like. Many people also agreed to add their areas of interest to the website

Upon reflection, **funding** for the network meetings continues to be a problem and a recent application to the All Wales Mental Health Network was unsuccessful. We will continue to try and find funding to support the network meetings and develop research projects, but this will require considerable demands for time and effort on the network facilitators. Participants have agreed to host meetings in their own organizations, reducing costs again, and it was suggested that we could charge a small fee for lunch.

Plans for the future:

The Network needs to **promote its activities** and demonstrate how bringing together a mix of professionals and service users and carers can enrich the student and professional experience in higher education (Priest et al 2008). As a support network for mental health practitioners it provides a valuable resource to people who are often the main link person for their whole university or organisation, and may receive little mentorship as a consequence. Safe and supportive practice is therefore a high priority for the network.

Translation into Welsh is a problem that continues with the network information, as we do not have any funding to carry out this process. This will be a priority for us in the future.

The meetings held in June 2009 at Glamorgan University, South Wales and November 2009 at Glyndwr University in North East Wales, were organised so that networking opportunities were given plenty of time. Group activities led to:

1. the development of a proposal for a Wales-wide student mental wellbeing policy which should be embedded in the curriculum of all HE courses. This will provide us with something to work on over the next 12 months;
2. the setting up of a *ning* so that people could network more.

The next meeting (June 2010, Trinity College, Carmarthen) will explore how we can encourage course teams to **adjust curricula** to draw on the shared experiences of practitioners and service users in Wales to focus on mental wellbeing rather than mental illness. The main purpose of the network has been achieved and now needs to demonstrate its impact on mental health education and practice in Wales (Dickinson 2008).

In Wales, which is a very rural country with a small population, it is easy to become isolated and cut off from current events in Wales and in the UK as a whole. Given little time and funding, it will be difficult to maintain a focus for the network, but we must continue to develop a product from the network meetings either in research or strategy papers to demonstrate the effectiveness of IPE. However the LTMH Wales has achieved its main aim, in providing an opportunity for those people living and working around mental wellbeing in Wales, to seek advice and offer peer support and mentoring to other people in a similar situation to themselves. We will continue to link people together who need support in particular areas and this is where providing their details on the website will be useful.

For further information:
http://www.mhhe.heacademy.ac.uk/countries--regions/wales/learning--teaching-about-mental-health-in-wales-network

or contact:
Marjorie Lloyd: m.lloyd@glyndwr.ac.uk

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Case Study 3: Learning together: Working together (a staff perspective)

Clare Kell[4], Human Resources Directorate, Cardiff University

Key words: staff perspective, challenge, safety, identity, novelty

Preface

We offer this case study to colleagues as a reflection of the powerful interprofessional learning experiences we received when we, as staff, became students together. Being thrown together as students in a foreign discipline has been a powerful trigger for reflection on profession-induced life views and personal philosophies of learning. Through group learning we, who claim to have worked in Multi-Disciplinary Teams for many years, have begun to understand our own, and others' disciplinary perspectives and consequent impact on practice. The experience has challenged our previous assumptions about Interprofessional Education (IPE) and helped us to see that IPE, as it is currently conceived in our local academic context, is unlikely to succeed. We suggest that IPE begins with staff joint learning. Through this reflection, we illustrate a student-perspective on IPE that has had a profound impact on the way we will set up IPE experiences for our future students.

The context

The School of Healthcare Studies (SOHCS) is part of a large, research-intensive University and provides a range of programmes in Operating Department Practice, Physiotherapy, Occupational Therapy and Radiography (Diagnostic and Therapeutic). The School has a long history of trying to support Interprofessional Education (IPE) within its undergraduate and postgraduate curricula through the passionate commitment of a nucleus of staff. Despite these efforts, and acknowledging recent notable successes for first year undergraduate students and some postgraduate modules, IPE has continued as a peripheral, appendaged activity.

Concurrently, 3 staff members from different professions have been learning together as students on a social-science-based Professional Doctorate in Education programme. As long-standing academic staff, each enrolled on the Professional Doctorate programme explicitly for the personal development opportunities it offered to achieve a Doctoral Level qualification. The opportunity to explore the Social Science life view (completely new to two of the authors) during the taught element of the programme, and the ability to progress to professionally relevant research, were attractive and challenging to us all.

As academic staff we were each secure in our own professional community implicitly and explicitly acting simultaneously as educators, practitioners, role models and gate keepers to our respective professions. We took these roles unquestioningly and

[4] with reflections from Caroline Adams, Cardiff University and Sally Scott-Roberts, University of Wales, Newport

considered our preparation of our professions' students to be robust and unproblematic.

Course specifics

Title: Professional Doctorate (Education)

It should be noted at this point, that this abstract is being written by staff who were students on this programme. We have NOT developed the programme ourselves but, through reflection, have realised its interprofessional learning power. What we present is our interpretation of the programme.

Aim and intended laerning outcomes:
Overall the PD programmes are intended to help participants acquire research skills and theoretical capacities and have experience of deploying them in a manner appropriate to their particular professional context (Course Handbook, 2007). Specific learning outcomes are framed about three key areas: Research, Theory and Transferable Skills.

Interprofessional learning is highlighted as a key aim ('This unique interprofessional learning enables students to reflect on both what is shared across professional boundaries and what is distinctive to their own occupational traditions.'), though not a learning outcome, of the programme.

Teaching methods: This is a programme of study for practising professionals. The taught elements of the course are run over intensive weekends. Specifally the taught weekends use classroom teaching, inquiry-based learning and case study.

Professions involved: Physiotherapists (1), Occupational Therapists (2), Radiographers (2), Nurses (5), Social Workers (2), Dentists (1), Police (1), Government Workers (2), Voluntary Sector Workers (1).

Organisations involved: The EdD is a programme of study provided by the School of Social Sciences, Cardiff Univeristy

Length: The taught phase of the programme (to which this case refers) takes 2 years

Assessed? Yes, summatively, an essay per module.

Supporting resources? None - but the removal of all 'home' comforts

Number of times this course has run: ongoing for 10+ years

Staff becoming students

The first intensive Doctoral weekend was threatening for us all! Embarking on a novel, complex task, we each felt 'out of our comfort zone' and assumed that, because we were staff and students within the same Institution, we had more 'to lose' than our student peers. While this latter was undoubtedly true, the immediate consequence of being in a non-health learning environment was a powerful leveling experience. For our lecturers it mattered not which health discipline we hailed from: to them we were students from mixed social science aware disciplines who had to be nurtured into full Social Science-based Doctoral students within the coming 5-7 years. There was no potential for cross-disciplinary power struggles in an environment focused upon a completely different perspective.

The learning environment we experienced

In addition to the impartial lecturers, we feel that the physical environment played a crucial role in our IPE experience. Taken away from our 'health' building and campus, we were isolated from our familiar support networks and thrown together to learn, lunch and socialise as a student group. Often behind locked doors in evenings and weekends, our student group had to find strength and resourcefulness to complete class experiences / make sense of our new learning etc. within ourselves. As students in a foreign land, we spent many hours helping each other unravel the unfamiliarity of our new learning. Through stories, analogies, narratives etc the fresh perspective of an interpretation offered by someone from a different professional background was often the trigger to help others learn.

What we learnt about ourselves as students

Through dialogue with others we each recognized that the view of the world we hold is implicitly shaped by our professional lenses. Not through arrogance, but through well-intended assumptions that we 'knew' what underpinned the practice of other professions, we had each spent years working in multi-discipline teams with completely the wrong value-set for our colleagues. Working together now as students in a mutually-alien area, helped us to explore the different perspectives through which we came to our new learning. With nobody 'right' or 'wrong', we saw beyond our professional labels and uniforms and began to unpack the values and perspectives that implicitly and explicitly underpinned our professions. But this is not a comfortable experience.

Looking at your profession through a different lense

As a consequence of having our eyes opened to the perspectives and underpinning value-systems of other professional groups, each of us has been profoundly challenged to question the values and systems upon which our own professions and professional identity is based. Now **nothing is 'true' or 'secure'**. Through learning about and with each other we have each been challenged to look again at ourselves and the way we think, practice and educate the future generations of our profession.

Relevance to our own teaching

Attempting to unpack our learning experience and make recommendations for the creation of IPE experiences for our students, we offer the following as key elements that triggered our change. We recognise that the following may not be transferable / applicable to all learning contexts, but they offer ideas that challenge the assumption that IPE will happen automatically when you put people from different professions into the same room focussed upon a common task.

The **learners** should be:

- Comfortable in their role and identity but…
- Uncomfortable / having some sense of insecurity in the task to be accomplished.

The **environment** should be:

- A place where NO group has ownership or familiarity;

- A place that breaks individuals from their familiar support networks (i.e. no ability to ‘go back’ and check emails / chat to colleagues);
- An environment where supporting staff have overtly considered and catered for the balance between threat and comfort applicable for the developmental stage of the learner.

The **task** should:

- Have a learning focus that is novel to all and requires many different perspectives to be aired and discussed;
- Challenge assumptions about self and others;
- Have an output that comprises a personal element in addition to anything group-generated.

The **facilitators** should:

- Be comfortable in their own identity;
- Not be drawn, if possible, from the professional divisions within the learning groups;
- Be task and outcome focussed.

Putting thoughts into practice

Changing academic roles have withdrawn us from the day-to-day teaching of our undergraduate programmes. Opportunities to develop postgraduate modules however, have enabled us to explore the **challenges of transferring learning into practice**. Working with others, we have helped to develop a multi-disciplinary module in workplace learning into one that we feel is truly interprofessional. Drawing on our list of learning points above, we have created a safe place for participants and facilitators to share their developing understanding of themselves as learners and as healthcare professionals. Starting a module with a deep, peer-assisted reflection of personal learning styles and preferences, enables participants to recognise and value diversity within the classroom. As sessions progress to explore 'profession', participants are supported to question their own and then each other's underpinning practice rationale, to start to notice things about what they may do in their professional practice that they have neither noticed nor questioned before.

Through formative presentations facilitators and participants make visible their professional similarities and diversity - a process developing collective cultural competence. With the module specifically focussing upon workplace learning, participants use their shared learning experiences to plan an educational change appropriate for their local context. While **academically and emotionally challenging** for all participants and facilitators, this module is a profound learning experience for everyone and, we feel, a truly IPE experience.

Summary and conclusions

While recognising the rhetoric of the education programme on which we each enrolled, we were unprepared for the powerful IPE experience we encountered. From the perspective of students we have been challenged to revisit our assumptions about ‘how to organise IPE’ for our own students. We acknowledge that not all staff can have the opportunities for development opened to us, and hope that this reflection will be useful to colleagues charged with developing IPE experiences for their student groups.

The application of our learning to the development of a postgraduate module has strengthened our view that IPE cannot be achieved where staff are not **culturally competent** themselves. We acknowledge that the translation of our experiences into an undergraduate curriculum is altogether a different challenge - but we hope that others will try.

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Case Study 4: Interprofessional Education for Disaster Healthcare

Jeff Evans, Faculty of Health, Sport and Science, University of Glamorgan

Key words: disaster, healthcare, simulation

Course specifics

Title: MSc Disaster Healthcare

Aims: The aim of the programme is to prepare health care practitioners from a range of disciplines to lead competently and confidently in multi-disciplinary and multi-cultural teams involved in disaster response and field management across the world. The MSc is an integrated stand alone three year course resulting in the award of Masters in Science in Disaster Healthcare.

Learning outcomes / objectives:
The overarching aim of the programme is to develop the next generation of healthcare professionals who can take up leadership roles within the fields of disaster response and humanitarian relief.

Teaching methods: Delivered through a Virtual Learning Environment (VLE) and a series of three summer schools, each of two weeks duration. These summer schools include a large element of simulated field work.

Assessed? Yes, summative assignments are attached to every module of the programme. They are variable style and length but include; individual presentation, traditional written assignments, case study analysis, reflective writing and assessment of clinical practice.

Professions involved: Nurses (general, child, public health, mental health), midwives, surgeons, anaesthetists, military mental healthcare workers, environmental health officers, paramedics, plus nursing and medical staff from around the world (Finland, Sweden, Norway, USA, Greece, Italy, Nigeria, Zimbabwe, Tanzania).

Organisations involved: University of Glamorgan, Hammenammattikorkeakoulu, Hammenlinna, Finland

Length: Three years part-time distance learning and summer schools

Supporting resources: Large element of simulated fieldwork, VLE, summer school resources.

Number of times this course has run: 5+

Number of participants per course: 10-25

Background

This distinctive Masters (HEFCW Level 7) award is aimed at experienced healthcare professionals working in the humanitarian field, or those who aspire to do so. Participants study the key areas of theory and practice that are relevant to healthcare in complex humanitarian disasters, from resilience and response to mitigation and recovery. A key element of this course is its strong international and trans-cultural focus, which is needed to develop and maintain relationship between colleagues in

the institutions and countries that underpin the programme. Participants study on a part-time, distance learning basis, with an annual two-week residential summer school. National healthcare providers, non-governmental organisations (NGOs) and inter-government organisations usually employ healthcare professionals undertaking this award. Graduates of this award have taken up key posts with the International Federation of Red Cross (IFRC) and Red Crescent Societies, the UK Foreign and Commonwealth Office, the Department of Health, the armed forces and with NGOs in Sudan, Iraq, Angola and Afghanistan.

Rationale

The programme began life over ten years ago as a collaboration of higher education institutes interested in disaster nursing that was funded through the Erasmus scheme. This resulted in the development of a Level 7 programme in disaster relief nursing that was an award shared by three partner institutions, University of Glamorgan, University of Ulster and HAMK in Finland. The original award was validated in 1999 and subject to quinquenial review in 2004.

Following critical appraisal of the award as it stood, it was obvious that there was great interest in the programme from non-nurse health care professionals. At that time there was no provision for awards specifically in disaster health care services. At the first quinquennial review it was decided to change the name of the award to Master in Disaster Healthcare. Nursing was de-emphasized and a more generic approach to health care taken. This has resulted in the recruitment of an increasingly diverse student body. In addition, the scope of the teaching team has expanded to support this increased diversity.

The need for interprofessional working is evident to all who deliver the programme. Interprofessional working is often viewed as a named profession set against another named profession, however this analysis can be criticised for being overly simplistic. Most of the teaching team have field experience in disaster settings. These settings are prime examples of the centrality of interprofessional working and role flexibility. The programme faculty (11 staff from at least 4 disciplines) bring this experience to the course and use it to promote collegiate working that underpins effective disaster response.

The students on our programme come from a range of countries around the world, each bringing their own perspective of what professional practice means, likewise we have students and staff from what may appear to be opposite ends of the humanitarian spectrum, namely military and non-government organisations such as the Red Cross. By brining these groups together we create mutual respect and understanding of each others value systems and operational modalities.

In practice

<u>Key elements of underpinning philosophy</u>

- There are no experts in disaster healthcare, only expertise. The aim of the programme is develop the individual expertise of the student. The role of the academic faculty is to act as a resource and a scaffold as the student constructs their own expertise. It is also recognised that knowledge is constructed, deconstructed and reconstructed socially through dialogue with peers and those with particular insights and experiences.

- Effective disaster preparation, response and mitigation only occurs when there is collaboration between communites and healthcare services, the course emphasises the virtues of humility and compassion.
- Inter-cultural working is larger than multi-national, multi-ethnic working, it encompasses working with the differing world-views held by different professional groups and different organisations that act within the field of disaster response and preparation. Lack of interagency and interprofessional cooperation has been consistently highlighted as a weakness in international disaster and humanitarian response efforts.

Each year of the course begins with a two week summer school that alternates location between University of Glamorgan/Sth Wales and HAMK in southern Finland. The first week of the summer school involves introducing each year (first year, second year etc.) to the aims and general content of the upcoming modules. In addition first year students are given intensive instruction on the use of the VLE. There is a field experts day, when recently deployed health care professionals share their personal experiences of differing disaster situations. This is followed by a themed conference where speakers from around the world present their work that illustrates differing dimmensions of the chosen theme. This class room based week is followed by a week of simulated field experience. Each year group has a different field experience that builds up from personal skills in year one, through operational management in year two to strategic leadership in year three.

First year students undertake survival training including dealing with armed non-government forces, hostage situations, dealing with officials, shelter building, water and sanitation in the field, navigation, landmine clearance, emergency care in pre-hospital settings etc. The second and third year groups work collaboratively to run either a field hospital or a refugee centre. The second year students work as operational staff whilst the third year students provide strategic leadership. Live actors are used to play the part of victims of disaster, thus enhancing the authenticity of these simulations. Simulations also give opportunities for students to adopt different roles, the surgeon can be given the role of security coordinator, the environmentla health oficer can be given responsibility for victim registration and tracing, whilst the nurse can be put in place as the medical officer. This shifitng of role in controlled learning experience affords healthcare professionals some insight into the demands and expectations placed on their colleagues.

Throughout the simulation exercises, debriefing is carried out either as a group event or on a one-to-one basis. This “in-field” reflection is developed through reflective writing that students undertake as the first element of assessment in years one and two. Third reflection is anchored on the field placement that all students undertake.

The value of the simulation and subsequent reflection is that it gives space to unpack and analyse the taken-for-granted assumptions that govern a lot of professional behaviour and outlook. The student body consists largely of health care professionals with a background in emergency and critical care. As a professional group, these people are trained not to think and analyse, but to act quickly and decisively, to follow established protocol and not to waste time to the detriment of the patient. Reflection allows space for questions to be asked about the how and why of actions. In addition, by being associated with a University rather than a non-governemnt organisation, inter-government agency or military force, **a place of safety is created** where fundamental questions can be asked about the efficacy and morality of such organisations.

Following the summer school, students return to their homes and commence studies through the VLE. A range of teaching materials are available for the students to access including PowerPoint presentations, text, electronic copies of articles and other publications and web-links. Continued interaction between the whole year and the academic faculty is maintained through asynchronous discussion boards. In such a board, students compose their thoughts and responses to questions off-line and post them on-line when they are happy with their contribution. This removes some of the pressure to respond in real time that students whose first language is not English can feel.

In keeping with the underpinning philosophy of the **social construction of knowledge**, small group work is also set. Here a group will be given a task and a deadline to post their group thoughts. This activity encourages the social interaction between students that can be missing in on-line learning environments. For an example of on-line exercises, see Appendix 1.

What is working well

The most successful elements of the programme to date, have been the field simulation exercises held during the summer schools. Through **careful situational engineering**, students can swap roles with other members of the student body, or can adopt other novel professional roles. Thus we have seen front-line emergency room nurses taking operational command of a field hospital, paramedics acting as security advisors and mental health workers acting as first responders to bioterrorism. Of equal, if not greater value, is the debriefing and reflection that occurs during the simulation and post-event. This reflection is an opportunity for students to challenge their belief systems and ways of working in light of their interprofessional working.

What could have been better

The move from MSc Disaster Relief Nursing to MSc Disaster Healthcare involved a total re-write of all the on-line teaching materials. This rewrite was needed to move nursing away from the central focus and to replace it with a more general approach to health care. This has not been easy, both due to the volume of work required and also the difficulty of teachers trying to put their own personal history to one side in order to create a more balanced approach. I think it is fair to say that course material authors often do not recognise the subtle biases in their materials, for example reading lists, journals cited, and clinical examples presented. We rely upon our non-nursing health care professionals from both the student body and the teaching staff to identify and challenge these drifts in emphasis. However, the development of the course is ongoing and iterative with constant refinements being made that address the concerns of students and to tailor the programme to a general health care audience.

Thoughts for future development

With the benefit of hindsight, I think the greatest limitation was a lack of confidence in our vision of what disaster relief was about. From the outset we could have developed a course that was firmly entrenched in the ethos of interprofessional working rather than limiting ourselves to nursing. We took this latter course because

it was what the planning team knew well, and it built on exisiting programmes at our partner university in Finland. As it stands now, interprofessional working is a key theme of the programme and has certainly developed in scope and grown as the course has. Yet at the same time there is an occasional lapse into a feeling that the award is a nursing house and other professionals are our valued guests. Just like any growing relationship, it will take some time for the programme to adopt a unified and seamless whole where all professional groups feel not only that they are treated equally, but that the course has been written specifically with them in mind. A tough ask but one that is achievable with thought and dedication.

The course is currently undergoing a further quinquenial review. The recent improvements we have made to the programme are designed to increase the degree of collaborative working across a broad spectrum of professionals involved in disaster preparedness, resilience, mitigation and recovery. We have reconfigured modules so that they can for a generic core for a suite of Master's programmes in disaster relief. We already have ongoing course developments with colleagues in the department of geography. They are interested in a shared core covering the central themes of working in disaster settings plus developing specialised modules that address issues specific to their discipline, for example mapping and information systems, environmental risk assessment, human-environment interactions. The possibility of a shared core is particularly exciting as this would expand the scope of interprofessional working even further, thus creating greater challenges and greater learning.

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Appendix 1

Activity 1 - collaborative problem based exercises.

To do this you will find two Case Studies outlined below. Group A will work on Case Study 1; Group B will work on Case Study 2.

Group A –	**Group B –**
Jane Clare Franco Mikka	Kelly Tiina Mark Jimmy

Case Study A

You are the field manager for an international non-government organisation working with HIV/AIDS positive children and orphans in sub-Sahara Africa. One of the principles of your NGO is not to degrade the local infrastructure by placing a resource burden on the local population. To this end you have been supplied with all your food stuffs via regular shipments from head office. Due to local difficulties with banditry and corruption of local government officials, your head office is having increasing difficulty in supplying the mission with food and the last resupply was a week late in getting to you.
You need to identify several possible positive resolutions to the current difficulties. You then need to select **one** of your solutions and formulate a plan to achieve it.

Case Study B

You are head of a field operation providing in-patient rehabilitation services for civilian victims of land mines. You have just returned late to the facility after attending a meeting in the local municipal centre. As you arrive you find that none of the local guards you employ to provide 24 hour security are on duty. The security office is locked and the sentry post is empty. Upon questioning, your driver admits that the guards are probably sleeping in the out-patient clinic. Identify two or three possible outcomes for this situation. Decide on **one** of these outcomes and draw up an action plan to achieve it.

In your work group you can collaborate via e-mail, BlackBoard discussion board, telephone or the on-line chat facility.

By Sept 16th I would like each group to be ready to present their ideas to the whole group via a posting on the Discussion Board.

The learning objectives for this activity are

- To familiarise you with on-line collaborative working
- To develop your analytical skills in framing problems in different ways
- To develop management plans to resolve complex situations

Case Study 5: Independent (Non Medical) Prescribing

David O'Neil, School of Nursing and Midwifery Studies, Cardiff University

Key words: independent prescribing, nursing, pharmacy, non-medical, interprofessional

Course specifics

Title: Independent (Non Medical) Prescribing (PgC, 60 Level 7 credits)

Outline: The course is currently provided to both nurses and pharmacists as a stand-alone course. It has recently been added to the Advanced Nursing Practice Level 7 pathway, and been accredited by Allied Health Professions body for provision to physiotherapists, podiatrists and radiotherapists again, as a stand-alone course.

Learning outcomes:

1. After an appropriate patient assessment to be safe Non Medical (Independent) Prescribers in a collaborative team arena;
2. To appreciate their role within a team ethos and environment;
3. To know their limitations and when to refer to other more appropriate team members.

Teaching methods: Practice placement, work-based learning, classroom teaching, simulation, clinical skills.

Professions involved: Nuses and Pharmacists

Organisations involved: Cardiff University, Welsh Assembly Government

Length: The programme will run over 7 months (October 2008- April 2009) and will include:

1. 20 study days (taught contact) at Cardiff University, SONMS (Cardiff & Caerleon);
2. the equivalent of 12 days (as a minimum) learning in practice under the supervision of designated.

Assessed? Yes summative. Written assignment, portfolio, element of practice or clinical assessment, written exam, oral exam, computer aided assessment. Assessment of competence by Supervising Medical Professionals at Specialist Registrar or Consultant level.

Supporting resources: Clinical Assessment skills delivery. Medical staff preparation for the role of supervising the students. Liaison between different clinical schools (Nursing and Pharmacy.

- Multi media clinical skills videos. Access via the University VLE (Blackboard);
- Queens University Befast, Clinical Skills Website http://www.qub.ac.uk/cskills/index.htm
- Bickley, LS (2008) *Bates Guide to Physical Examination and History Taking*, Philadelphia Lippincott Williams & Wilkins

Number of times this course has run: 1 but ongoing

Number of students: 25 – 50

Background and purpose

Healthcare is in a constant state of flux, there is always change on the horizon. Many pressures exist in healthcare which result in these changes, but as a result of the multiple professional parties legislatory requirements and professional bodies, change takes time to effect. Non-Medical Prescribing is a perfect example of this type of change. Nurse prescribing was first proposed by Baroness Cumberlege in 1986 (DHSS 1986).

The development of a nurse and pharmacist prescribing course has taken place in the NHS at a time when there is a shortage of doctors for varying reasons from the implementation of the European Working Time Directive to reduce junior doctors hours to a mandatory 48 hours per week, (DoH New Deal 2004) and Modernising Medical Careers (DoH 2004). Despite this implementation time, the rate of change since its inception, has been quite dramatic. Extended formulary prescribing was implemented for community nurses in 2002 and evaluated in 2005 by the Department of Health (DoH 2005). Supplementary Prescribing for nurses and pharmacist was approved by WAG and the first course ran in 2004. Since 2004 there have been 2 "pump primed" supplementary prescribing courses run in Wales and evaluation has led to full Independent (Non-Medical) Prescribing by pharmacists and nurses starting in 2007 with conversion courses for Supplementary prescribers in 2008 and 2009 This evaluation is based on my experience as an associate lecturer and the impact of the lived experience of the journey from supplementary prescriber to full independent prescribing and the appointment as an Associate Lecturer on the current Non Medical Prescribing course in Cardiff University. My reflection is based on Gibbs' Model of Reflection (1988).

Student becoming teacher and course developer

I am an Advanced Nurse Practitioner in medicine in one of the largest district general hospitals in South Wales. As a result of my clinical practice I am able to assess, examine and diagnose patients problems, request chest X rays and even perform investigations such as venepuncture, cannulation and taking arterial blood gases similarly to junior medical staff. However, I was unable to implement a plan of care because of the inability to prescribe any treatments such as antibiotics, intravenous fluids, analgesia and even oxygen if required. My role came about in 2002 as a result of the shortage of junior medical staff following on from the implementation of the New Deal for Junior Doctors (1991) and European Working Time Directive on junior doctors hours (NHSME 1991).

In 2007 I applied to undertake the Supplementary Prescribing (SP) course for Nurses and Pharmacists to enable me to manage chronic disease within my sphere of practice (respiratory medicine). My use of SP was infrequent due to the need for a tripartate consultant/patient/SP clinical management plan which was logistically difficult to operationalise in an acute hospital. Due to the speed of change in the NHS, and a rapid evaluation of SP by the Welsh Assembly Government, Nurse Independent Prescribing was announced by Dr Brian Gibbons the Health Secretary for WAG (WAG, 2007). I applied and was successful on the course. Following completion, I obtained a two-year secondment to the Prescribing Team as an Associate Lecturer with a remit to redesign the Clinical Patient Assessment component of the course following evaluation by the first cohort of Independent (Non Medical) Prescribers (IP). Their evaluation concluded that there was not enough

time to become competent in the Clinical Assessment of the patient prior to reaching a diagnosis and treating the patient.

With a background in Clinical Patient Assessment (CPA) and having experienced the courses first hand, I had discussions with the course team I had several ideas to (hopefully) improve the experience. On reflection from my experience of the course, I realised that both professions (nurses and phramacists) appeared to gravitate to their own social group (this being a social norm anyway). Despite the course team attempts to mix the professions for group work, the tendency was to the social norm after group work was completed. Having no background in educational theory, I felt that there was a missed opportunity for both professions to gain more from each other. I thought this could be achieved by being actively encouraged to mix in groups with similar areas of practice. They would then (hopefully) gain something from each others areas of expertise.

Moving from a multi-professional to an interprofessional approach

The first method used by the team appeared to just foster multiprofessional education where the two groups were learning similar things for the purpose of the course but not learn about and from each other. This idea was as a result of a relationship developed between myself and a pharmacist when we were looking to become prescribers for the same client group but in different clinical areas, both COPD, but I was in acute care and the phamacist was in Primary care. We shared learning experiences and information and both gained something more than just the information exchange. I felt there was a symbiotic learning experience for both of us, i.e. something greater than just the sum of its parts. I have since found out this is similar to the model of Interprofessional Education proposed by the Centre for Interprofessinal Education (CAIPE). It is the implementation of my ideas for the CPA component of the course that I would like to discuss further.

Planning for change

With an almost free reign to design the CPA days for the course, I discussed how much time was allocated to the task at hand. The course had been increased from 18 full contact days over 7 months to 20 days. This gave me 4 days to plan and implement change that would hopefully make the students experience more useful. The first thing I did was “front load” the course with two days on the theory and practice of patient history-taking by moving them from the original timetabled session in November to the second and third study day in October where there was a gap in the timetable following on from the introductory day. This gap was because of a lack of room space in the normal location, but as the CPA days were located on a different part of the campus space was not a problem.

From planning to practice

I discussed the feasibility of mixing the professional groups to achieve this **symbiotic learning effect** I had experienced. To this end we went through the application forms and allocated the cohort to groups with similar practice areas. These groups were then implemented from the introductory day with the groups made to sit with each other and perform an Ice breaker by introducing themselves to each other, thus

personalising the groups from the outset. Personalisation and commonality are an essential component of making IPE work, (Barr, 2005). These groups were modified slightly after day one because there was often a tenuous link between some of the group members that they were ancouraged to find a stronger one. This was due to the shortage of information provided within the application.

When I undertook the course there was little preparation for the Observed Structured Clinical Evaluation (OSCE) prior to undertaking these in practice with the Designated Supervising Medical Practitioner (DSMP). We had to undertake a minimum of two formative and a summative OSCE. However, I felt that I needed more and actually undertook 6 formative OSCEs. On the basis of this I felt that the students would need preparation before going into practice.

Recognition of prior experience of the cohort, led me to believe that the pharmacists would be very good at obtaining a drug history, and the nurses would be good at patient assessment and social history taking. So the idea of interprofessional learning, although unkown to me at the time, appeared to lend itself perfectly to the task at hand.

After the theory of history taking session on day one of the CPA the already established groups were split into three large groups of 12 and subdivided into triads of both professions. There were three separate workstations based loosely on cardiovascular problems, respiratory problems and gastrointestinal problems. The triad was then given a task of a tripartate role play. One was to be the patient, one to be the person taking the history and the third was to be a peer assessor. This was facilitated by two lecturers who were overseeing four groups at a time. After the "interviewer" reached potential differrential diagnoses, the triad was given another scenario and swapped roles. When they had all undertaken the three roles of patient, interviewer and assessor they moved to the next workstation in another room. The patient histories were adapted from the InContext website (http://incontext.intrica.net/), an internet-based learning resource of real patient medical histories including drugs, medical notes, investigations etc. This was evaluated very well.

A similar plan was then implemented for the patient assessment component of the second two days. Theory of patient assessment was integrated with a demonstration of a systematic approach to patient examination using a neo-medical model of patient examination based on the work of Jarvis (2007) and Bates (2008). Although the groups were larger (between 8 and 12), the students took it in turn to practise the examination skills necessary with their peers, giving positive feedback and providing prompts when the student carrying out the examination forgot what was required. The students were also directed to the Queen's University Belfast Clinical Skills website for videos of patient assessment following agreement with the copyright owner.
(http://www.qub.ac.uk/cskills/video%20resource/video%20page(examination).htm.

Impact of change on learning

Using the students as peer learners in this way, enabled several things.

1. the number of facilitators was reduced to only those who were essential to provide the sessions;
2. the fear of performing in front of peers wa redcued as the students had repeated 'exposure' to each other, firstly in groups of three, then in larger groups;

3. the change enabled the facilitators to provide feedback in small and larger groups, about the nature of the performance, and also provide further information from their area of expertise to enhance the teaching and learning experience;
4. Finally, the repeated exposure allowed plenty of time for each individual to practise, and the fact that they all had to do it, gave them added confidence to undertake the OSCEs in practice with their DSMP. This then reduced the amount of time needed by the student with their DSMP to teach these skills, only enhancing the ones they already possessed, even in rudimentay fashion.

What worked well?

I feel actively setting up mixed groups on day one promoted greater understanding of the ability of each profession by the cohort. This then fed through into the history-taking and OSCE sessions for the CPA. Everyone was willing to 'have a go' as it was all conducted in a **non-threatening environment** where relationships had already been established.

The triads for the history-taking worked really well and evaluated well by the students, and these are the mainstay for the existing cohort. This was because of the repeated exposure to the format for history-taking at least 9 times throughout afternoon. The larger group feedback for the patient examination also worked well, but having two sessions in one room (CVS and Respiratory) may be better separated despite the fact they are usually conducted together in practice. I am not sure how many students accessed the Queens University website at this point but the cooperation shown by the copyright owner was very much appreciated by the team, so much so that we are planning a formal joint school evaluation of the resource.

The *Incontext* resource was also extremely valuable and will be used again.

What did not go so well

As the main faciltator for the days, it was not possible for me to quality assess the other sessions. I had to rely on the other facilitators to report back as to what was working well and what was not.

There was a problem with start time on day one, but this was due to a communication breakdown on the directions to the alternative campus location which has been addressed for the current cohort.

Time is always an issue, and I felt that there was a lot of information to impart over the four days to a group of people with disparate learning needs and abilities. This led to the CPA being increased to 5 days for the current cohort. It was also difficult to complete an assessment of pharmacists competence for various aspects such as blood pressure measurement, ophthalmoscopy, otoscopy, deep tendon reflex assessment and a CNS examination as was deemed necessary for course accreditation by the Royal Pharmaceutical Society of Great Britain (RPSGB). However, whilst these sessions were happening, the nurses were undergoing a formative Drug taking OSCE facilitated by pharmacists. However, as we now have five days, the last one is an assessment day where the students will be assessed by the lecturers on their clinical examination skills.

However, due to the constraints of cost, lecturers and time it was much harder to facilitate the examination skills in groups smaller than 8. This led to there not being adequate time for each student to practice. It was also obvious that there was a lot of information to cover in a short space of time and because of the changing from one body system to another at each workstation that there was probably insufficient time for consolidation of the first system before moving on to the next one.

Evaluation by the students of these sessions was very good, with an average score of 3.4 for a 4 point Likert scale for the teaching method over the 4 days. There were also many positive comments about the group work. However it was recognised by both staff and students, that it is a lot of information for just four days. Therefore it has been delivered in a different way this time. Both myself and the management team felt it ran well, complemented the existing timetable and have made minor adjustments for the existing cohort.

Since the CPA component of the course ran, it has been accredited by the Allied Health Professions Council to include Physiotherapists, Radiotherapists and Podiatrists and this cohort is currently running. We have also agreed to provide access for Surgical Care Practitioners (who are not currently able to act as prescribers) to the CPA component of the course, as they cannot get this elsewhere within the University.

Ongoing developments

Evaluation has led to the following changes:

1. The CPA is now 25% of the entire course (5 full days);
2. Each day has a body system approach to history taking and clincal skills required to perform the appropriate examination;
3. Looped videos play in each facility for the students to refer to when necessary;
4. The triads continue to work well for history taking but there is no need to jump from system to system.

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Case Study 6: MSc Chronic Conditions Management

Tessa Watts, Department of Interprofessional Health Studies, School of Human and Health Science, Swansea University

Key words: chronic conditions management; interprofessional education, flexible learning

Course specifics:

Title: MSc Chronic Conditions Management

Aims:
The course aims to engage a wide variety of professions so that a) they learn the characteristics of Chronic Conditions Management, b) they all learn what the other professions have to contribute to care, so that c) each can adapt their action to best fit in with the roles of the others and hence 4) provide a better service to the patient.

Intended learning outcomes: By the end of the course participants will be able to demonstrate:

1. a systematic knowledge and understanding of interpersonal, interprofessional and organisational issues in health care provision for chronic condition management;
2. an ability to use an understanding of some underpinning theories of collaborative working to justify actions in practice;
3. competency in, and understanding of, interprofessional, multi-professional and multi-agency working.

Teaching methods: Classroom teaching, Simulation, E-learning, Problem-based learning, Inquiry-base learning, case study.

Current professions involved: Nursing (n=14), Medicine (1), Physiotherapy (4), Chiropractic (1).

Organisations involved: Swansea University; NHS parnters; Volunary Sector e.g. M. S. Society, Parkinson's Disease Society; Service users.

Length: 13 months full-time; 36 months part-time

Assessed? Yes summatively
Individual presentation, group presentation, written assignment, portfolio, element of practice of clinical assessment, written exam, oral exam.

Supporting resources: Additional staff from clinical practice, specialist equipment, textbooks:
Braun, C A, Anderson, C M (2007) Pathophysiology: Functional alterations in human health. USA: Lippincott, Williams and Wilkins;
Carrier, J (2009) Managing long-term conditions and chronic illness in primary care. London, Routledge;
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Number of times this course has run: Commenced September 2007. Cohort 1 not yet completed.

Other opportunities for student learning: Some Part 1 modules are shared with students from the following multiprofessional MSc programmes: Advanced Clinical Practice, Public Health and Partnerships in Care, Ageing and Public Health, Health Promotion.

Background and purpose:

A chronic condition may be described as a:

> *'disease or disorder that contintues over an extended period of time and causes continous or episodic periods of incapacity'*
>
> (Welsh Assembly Government, 2006 p: 1).

World-wide the prevalence of chronic conditions is high and is forecast to increase. Indeed it has been predicted that over the next decade the global incidence of chronic illness will grow by 17%. By 2020, chronic conditions will be the leading cause of disability and the most expensive problem for healthcare systems throughout the world (World Health Organisation, 2003). In the United Kingdom approximately 17.5 million people live with a chronic condition (Department of Health, 2005a). Wales has the highest prevelance of chronic conditions in the UK. Moreover the prevelance is increasing.

Advancing science and technology has resulted in significantly increased numbers of people living with one or more chronic conditions. Moreover for some the management of an individual's chronic condition may be quite complex. The impact of supporting people with a chronic condition on health and social care services is considerable. Furthermore two thirds of all chronic conditions admissions are emergencies, resulting from an exacerbation of a chronic condition. Nevertheless evidence suggests that improvements in patient care can be obtained through high quality chronic condition management (Welsh Assembly Government, 2006). Thus across the United Kingdom chronic conditions management, essentially a system of systematic, coordinated care and communication across health and social care communities, has become a political priority and a driver of health care policy and strategic development.

In England the Department of Health (2005a) has embraced the idea that multi-professional teams are the key to the the aforementioned system. Furthermore the Welsh Assembly Government supports the need for integrated, multidisciplinary chronic disease management programmes that reflect the impact living with a chronic condition has upon people. Whilst the use of the term multidisciplinary implies a level of independent working (MacIntosh and McCormack, 2001) it is conceivable that to maximise chronic conditions patients' health and well being and enhance the quality of the care experience, interdependence, interaction, collaboration and thus interprofessional team working is required. Indeed across the world it is widely accepted that interprofessional teamwork is a significant contributor to high quality care and positive health outcomes (Wenger, 2000; McNair *et al,.* 2005). Nevertheless, evidence suggests that there is scope to enhance collaborative working between health and social care professionals (Reeves *et al.,* 2009; Xyrichis and Lowton, 2008).

In light of the emerging trends in chronic conditions, the complexities of patients' health and social care needs and the changing landscape of health care it is imperative that changes are made in the ways in which health and social care professionals are educated (Jensen *et al.,* 2009). Indeed the effective care of people with chronic conditions is dependent on excellent interprofessional working across health and social care professional boundaries. Arguably, whist recognising the limited evidence base, interprofessional education potentially offers a means by which interprofessional collaboration and thus patient care may be enhanced (Barr, 2002). Moreover the competencies within the Department of Health's educational framework for professionals working with those with chronic conditions (Department of Health, 2006) privilege the promotion of interprofessional education.

Interprofessional education has been defined as education which “occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care” (Centre for Advancement of Interprofessional Education, 2002). The words *from and about* distinguish interprofessional from multiprofessional education and also indicate that dynamic interaction is a defining feature of the process of interprofessional education. Indeed in discussing the meaning of prefixes in primary care literature, MacIntosh and McCormack (2001) proposed that the term *inter* signifies cross boundary collaboration which is focused on a shared objective.

The MSc in Chronic Conditions Management at Swansea University was thus conceived as a means by which international, national and local agendas and initiatives in chronic disease management might be adressed and complimented. Given that effective care demands excellent multisectoral collaboration an interprofessional approach to the education process was selected. Indeed following the work of Barr (1995) it was envisaged that through a process of interprofessional education, students might obtain a richer and deeper insight into each other’s roles, responsibilties and contribution to chronic conditions management.

Oandasan and Reeves (2005) highlighted the significance of curriculum planning as a determinant of success. Accordingly in order to plan and design the curriculum representation from a range of educators from different Schools, health professionals involved in chronic condition managaement, service users, government agencies and the voluntary sector was sought and obtained. Subsequently a curriculum development team was established and charged with the responsibilty for designing a mutiprofessional interprofessional programme which, in terms of its philosopy, pedagogical approach and content, was reflective of need.

Many people with one or more chronic conditions experience multifaceted health and social care problems (Department of Health, 2004). By ensuring stakeholder representation from higher education, the health service and the voluntary sector, key aspects relating to the management of chronic conditions could be reflected in the curriculum planning process. Furthermore external suport was crucial to the success of the initiative. However the focus on health professionals meant that the opportunity to include representation from the social care sector was seemingly overlooked. Yet social care professionals may also contribute to the care of people with chronic conditions and their families. Moreover policy documents relating to chronic conditions advocate greater partnership working and integrated approaches to promote, even ensure ‘joined up’ care (Department of Health 2005b; Department of Health 2010). Furthermore enquiries into cases in health and social care, for example the Kennedy Report (2001) and the Victoria Climbie Inquiry Report (Laming, 2003) highlighted the need to strengthen collaborative cross sector working and communication. Professionals in social care draw on a complementary model of understanding health and social care. Arguably inclusion of social care professionals in the planning process could offer novel and important insights into the rich tapestry of care for this group of patients. Furthermore inclusion would open up the potential to enhance collaborative interprofessional working.

In practice

The planning team identified the need for a ‘flexible’ programme which would be attractive to a range of health professionals. Moreover to enable students to advance their discipline specific knowledge the programme structure should be comprised of core modules focused on science, research and clinical practice and a range of optional modules. In designing the curriculum optional modules, for

example, health promotion and education, exercise therapy, diabetes and cardiac rehabilitation were accordingly developed. Moreover students were afforded the opportunity to select relevant optional modules from other Master's programmes within the School, for example those related to health care management and non-medical prescribing. Thus students have the opportunity to design a personal, 'bespoke' programme of relevance to their practice in chronic conditions management. As students have the potential to enable the student to 'drill down' within their specialist areas this structural aspect certainly renders the programme attractive

Whilst the opportunity to design a 'bespoke' programme is appealing to many, operationally this does present a number of logistical challenges. Furthermore professional specialization may act as a barrier to interprofessional education (Gilbert, 2005) and it has certainly emerged that certain optional modules appear more attractive to specific professions. For example, to date Exercise Therapy generated interest from physiotherapists whilst despite its centrality to chronic conditions management theory and policy (Welsh Assembly Government, 2005; 2007) some perceived Health Promotion was irrelevant to their field of practice. As a consequence the number of students enrolled on optional modules can be small. Nevertheless, in terms of underpinning educational theory small group learning is a distinctive feature and a key strategy for facilitating interprofessional education. However small numbers from single professions raises the issue of the impact of professional socialization and culture on interprofessional education (Oandasan and Reeves, 2005) and challenges the whole concept of interprofessional learning, its possibilities and its potential benefits in terms of collaboration and enhanced team working. Furthermore in terms of human and financial resources small numbers can generate concern among senior managers regarding viability and sustainability for senior managers.

The Programme's learning and teaching methods draw on both received and interactive approaches (Barr, 1996) within the classroom. Whilst learning and teaching is the domain of individual module leaders, a significant proportion of the Programme utilises the latter through what might be described as 'action based learning.' This approach is underpinned by the principles of adult learning (Knowles 1980), experiential learning (Kolb, 1984) and reflection (Schon, 1987). With effective facilitation these learning methods draw on students' experiences to cultivate and sustain interest and to draw comparisons between professional groups. To date national and international students who work with people with chronic illness and from a range of professional backgrounds have come together with the aim of learning '*with, from and about'* each other. However whilst the interprofessional education literature recommends striving for a balance, the majority of students are drawn fom nursing. In many ways this is hardly surprising as nurses form the largest professional group withing the United Kingdom health care sector. Moreover, nurses have a significant role at all levels of chronic conditions management. Nevertheless informal evaluation and feedback from students suggests that they clearly value and enjoy the opportunity and share their experience and expertise and thus learn from each other. Indeed as students progress through the course their synergy enables them to share tacit, personal and propositional knowledge (Schon, 1984). It is though this **synergistic process** that the generation of new knowledge for practice becomes evident.

On reflection

There is a sense that in planning, designing and developing what is essentialy a complex Programme a sense of pragmatism bounded by time prevailed. Indeed whilst the Programme's development was driven by a strong determination to respond proactively to policy drivers and diverse needs, the time span in which development occcured was relatively short. Nevertheless, **planning and developing interprofessional education is a painstaking, complex and lengthy process which is fraught with logistical challenges**.

On reflection a number of aspects, notably those relating to Programme planning and development, might be addressed differently, and in an evolutionary manner in the future, as follows:

- Staff development focusing on the concept, context, practice and facilitation of interprofessional education. This would offere educators in particular greater insight into interprofessional education in relation to multiprofessional education and faciliate an opportunityt to translate this insight into curriculum design;
- Senior educational leadership to coordinate programme planning and development, identify and address actual and potential logistical issues.
- Build in logitudinal evaluation of interprofessional education to the Programme from the outset.
- Examine the possiblility for facilitating and assessing interprofessional learning in practice.

How are things going? Where next?

Since the Programme's inception, modular and informal evaluations have taken place. A recent change in Programme Management has resulted in a review of aspects of the curriculum. This has resulted in structural and logistical amendments. Nevertheless there is a pressing need and therefore a plan to rigorously evaluate the whole curriculum once the first cohort of students complete at the end of 2010. In terms of the organization there is a need to sustain interprofessional education. Thus future plans include the development of facilitators to work with students. Indeed as Barr (1996) has argued, the facilitator is the key to interprofessional learning. Furthermore work is planned to break down [mis] conceptions of interprofessional learning *vis a vis* multiprofessional learning and to also develop confidence in curriculum design: specifically methods of learning, teaching and assessment *for* and *of* multiprofessional learning. Nevertheless the future of the Programme depends on sustainability which in turn depends on students. Plans are afoot to enhance marketing of the programme on national and international levels. Furthermore the programme is now subject to constant monitoring and dialogue with post graduate programme leaders has been established to identify areas for shared learning with other interprofessional curricula, for example in relation to research and health promotion. Yet recruitment is, and will continue to be, a significant issue in a time of global economic downturn and will be the major challenge to meet in the near future.

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Case Study 7: Issues in collaboration between undergraduate professional qualifying programmes of youth work and social work

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Key words: Youth Work, Social Work, Interprofessional Practice, Inter Professional Teaching and Learning.

Abstract

The aim of this paper is to explore the development of an interprofessional master's programme and its subsequent impact on the undergraduate programmes of social work and youth work in the School of Health & Social Sciences at Newport University, Wales. Arguments for closer professional collaboration in teaching and learning are developed and the wisdom of uni-professional training questioned.

Course specifics

Title: MA Interprofessional Practice (European)

Aim: The MA Inter Professional Practice is an innovative and boundary crossing development that addresses the current need for improving practitioner skills and understanding of effective multi agency collaboration and places the programme at the forefront of Wales and European workforce development strategies. The programme provides an opportunity for graduates of applied professional programmes and our colleagues in Europe, to address the growing recognition that major public services, working in partnership, provides a more effective and cost efficient model of support and care for service users.

Learning outcomes: By the end of the course participants will be able to:-

1. Critically evaluate and debate the key challenges experienced by social care, health, education and social welfare professionals in relation to their roles as leaders and team workers in the context of effective interprofessional partnerships;
2. Create a collaborative and inclusive model of interdisciplinary learning designed to produce effective, interprofessional frameworks for the delivery of a range of 'public social services';
3. Critically examine the European model of providing "mixed economies of social care" and the role of the Social Educational Care Worker within this approach.

Teaching methods: work-based learning, classroom teaching, simulation, e-learning, problem-based learning, inquiry-based learning, case study.

Professions involved: Social Work, Youth Work, Youth Justice, Social Pedagogues / Social Education Care Workers. Teachers, Criminal and Community Justice Workers, Police.

Organisations involved: University of Wales, Newport; University of Stavanger, Norway; University of Vilnius, Lithuania.

Length: 18 months full-time, 2-3 years part time

Assessed? Yes, formative and summative: individual presentation, group presentation, written assignment, portfolio, element of practice or clinical assessment, computer-aided assessment.

Supporting resources: Key texts, Distance learning material, Web-based interactive learning through Moodle, Case studies from IPE pilot projects.

Key texts:
Carpenter, J., Dickinson, H.(2008) Interprofessional Education and Training. Bristol: The Policy Press
Fitzgerald, D., Kay, J (2008) Working Together in Children's Services. Oxon: Routledge
Iasby, J., Dickinson, H (2008) Partnership Working in Health and Social Care. Bristol: The Polict Press

Number of times this course has run: Due to commence 13th October 2010

Relevance to student learning: Will prepare students for employment in multi – context and inter-disciplinary teams.

Background and purpose

This paper explores the development of an interprofessional master's programme (HEFCW Level 7) and its subsequent impact on two existing undergraduate professional programmes in the School of Health & Social Sciences at University of Wales, Newport. The process began in 2006 when I attended a UK EU Presidency Conference entitled 'Working with Young People, Workforce Fit for the 21st century, at the Millennium Centre Cardiff. Professor Walter Lorenz in his keynote speech, *Professional Formation in Youth Work / Social Pedagogy across Europe - challenges and achievements,* spoke of the risk of making youth work too academic and suggested that universities may be ill-equipped to develop the professional element of youth work practice; they may not know how to deal with the realities of contemporary youth work practice. Professor Lorenz also referred to the development of Masters Programmes and the tendency for these to focus on 'the development of management skills and knowledge' rather than embedding and developing the learning gained through studying undergraduate programmes: 'Masters degree level in Europe feels like a flight from identity of undergraduate level' (Lorenz, 2005 UK EU Presidency Conference). It was this notion of a movement away from the realities of practice that struck a chord and influenced my thinking when submitting a concept proposal to develop a master level programme offering a progression for youth workers, social workers and in the longer-term, social pedagogues from partner institutions in Europe. The initial proposal for a master's programme was founded on the principles of developing interprofessional practice skills and knowledge in a range of related disciplines but primarily the professional areas of youth work, and social work. Two partner institutions, Stavanger University, Norway and Vilnius University, Lithuania, were involved in the early discussions and development of the subject content. It was agreed option modules would be developed at the postgraduate diploma stage of the programme to encourage student and staff mobility between the partner institutions

Policy drivers

In Wales, the UK and Europe, there is recognition that major public services, working in partnership, provides a more effective and cost efficient model of support and care for service users. The following statements from the Laming Report (2003) encapsulate these views:

> It is clear that the safeguarding of children will continue to depend upon services such as health, education, housing, police and social services working together. (17.112)

> The skills involved in working successfully across organisational boundaries must be given proper recognition in both the basic training and in the continuing training of staff. It cannot be left only to those individuals who have the motivation to do it. Working across boundaries should be an expectation placed on all staff, and it must be reflected in training programmes. (17.113)

The 2006 Beecham Report's review of local service delivery was commissioned by the Welsh Assembly Government as part of its action plan for implementing its *Making the Connection* strategy for improving public service delivery in Wales. The vision of this strategy was of 'small country governance for Wales' and the delivery of flexible, citizen-centred local services (in Royal Pharmaceutical Society of Great Britain, 2007). The key recommendations of Beecham include a reference to 'joint working across organisations, sectors and services' and there was some discussion of placing '*a duty of collaboration'* on Welsh public bodies to underpin this. There is already a legislative precedent for this in the form of the 2004 *Civil Contingencies Act*, which requires partners to work together on resilience issues (in Welsh Local Government Association, 2006: 3). However, the WLGA (2006: 5) called for 'a sense of reality' in terms of cross-functional collaboration: 'Organisational boundaries can be resilient and protective. They are also largely organised in vertical structures, concentrated on functional delivery not collaboration across boundaries. We will need a change of culture in some areas because there is evidence of resistance to effective partnering.'

The most recent consultation on a Children and Young People's Workforce Strategy in Wales, aims to develop the skilled, motivated, energetic workforce…"envisaged by Beecham and crucial to making services in Wales amongst the best in the world" (WAG 2008). The consultative document seeks to provide some clarity around a Children and Young People's Workforce and requires an increased emphasis on integrated service provision and greater recognition of the contributions made by the different professional sectors.

> The experience of those working with children and young people is often similar. While dialogue and understanding between people working in different sectors of the workforce is often excellent, it is also ad hoc, relying on personal relationships rather than organisational structure. Although professional boundaries often exist for good reason, they can often translate into insularity. (WAG 2008 4.5)

The document highlights the challenges associated with interprofessional practice but suggests that one strategy would be to 'create a sense of identity that resonates across professional and sector boundaries' (4.7). This notion of a unifying model of practice is discussed further in the section on 'social pedagogical frameworks'. The document also recognises the need for a coherent qualification framework that facilitates lateral movement from one strand of work to another within the Children and Young People's Workforce. It advocates 'opportunities for practitioners to work and train with colleagues from other sectors', which will result in greater trust and understanding between them. This encouragement to 'train' together is focused on CPD opportunities and yet there is no firm recommendation to Universities to pursue integration of professionally qualifying programmes. In England the Children's Plan: Building Brighter Futures (DFES 2008) places an expectation on Local Authorities that by 2010 they will have high quality arrangements for integrated working in place.

> The Children's Plan sets out a powerful vision of children's services, with schools and early years settings at their heart, working together and in

> effective partnership with children, their parents and young people, to give every child and young person the support they need, when they need it, to fulfil their potential across the five ECM outcomes. Integrated working lies at the heart of this, providing the glue that binds together services and practitioners across agencies and professional groups, from leaders and managers, through middle managers, line managers and supervisors to practitioners, with families themselves. (DFES 2008 4.1)

From development into practice

For students of different professional disciplines to learn effectively – and at depth – they need to feel themselves to be in a safe environment where they are respected as human beings and their professional perspectives are recognised. Without this, they are unlikely to learn much beyond surface level. We see it as being essential that students should feel themselves as being valued and as belonging to the interprofessional group. It is only when this has been achieved that they are likely to be able to engage with the business of learning.

> However, interprofessional education is not an easy option. Professionals are trained and educated in their own disciplines, learning their own unique and specialist knowledge for their chosen profession (Howkins & Bray 2008 p4)

We echo Maslow's "Hierarchy of Needs" concept in his 1943 paper "A Theory of Human Motivation" and his subsequent book, Motivation and Personality. (www.psychology.about.com), from which we understand that human beings are confronted by a series of unmet needs each of which must be satisfied in a roughly sequential nature before subsequent needs become apparent. Once basic physiological safety needs have been met the need for "Belongingness" becomes apparent, followed by that for "Esteem." Maslow suggests that it is only when these needs have been met that the individual is likely to strive for what he has described as "self actualisation" - the need to fulfil potentials, to "be all that you can be" – and there are clear parallels here with the process and outcomes of interprofessional learning.

The proposed block delivery of the master's programme will therefore be experience-led, problem-orientated and learner-centred to enable students to experience a collaborative approach to learning. The learning and teaching strategy for the MA Interprofessional Practice programme is cognisant of the variety of learning and teaching styles and experience students from a range of professional disciplines will bring to their studies. It offers a blended learning approach that builds on the work of Knowles (1975, 1990), and is based on the following assumptions:

- Adult learners need to know the relevance of what they need to learn before undertaking to learn it.
- Adults prefer responsibility for their decisions and desire to be viewed as capable of self-direction.
- Adults accumulate a great volume of experience, which represents a rich resource for learning and necessitates individualisation of learning strategies.
- Adults become ready to learn things when they need to know them in order to cope effectively with real-life situations.
- Adults have a task-centred orientation to learning and like to feel free to focus on the task or problem

- Students can work collaboratively and in dialogue with others with mutual trust and respect, both peers and lecturers, to shape, elaborate and deepen understanding.

Proposed practical examples include:

Problem Based Learning: students working in small interprofessional groups examining service user-centred scenarios or case studies. The idea is that students work cooperatively as an interprofessional team in order to achieve both subject based learning outcomes and transferable teamwork skills. This emphasises self-directed learning supported by study guides where understanding is reinforced through its application in problem-oriented, task-based and work-related experience.

Simulation-based learning: Role-play with other students, practitioners from public services or volunteer service users, is common practice within professional education. Simulation provides a relatively safe context in which students can practice skills and receive feedback in a way that would not be possible with real service users. More elaborate role-play exercises can also be used where students take on their professional roles engaging in a simulated case conference or a court session (for example).

Exchange-based learning: this approach emphasises the students exchanging their views and experiences and learning from each other in doing so. If the programme does not attract a range of disciplines in its early cohorts arrangements will be in place to invite practitioners, service managers and service users to hear about their experiences.

Observation-based learning: during the programme, students will be encouraged to shadow members from another profession to see what they do and how they do it. Mutual learning will be enhanced through discussion of experiences and the opportunities to question each other's perceptions of their respective professional roles.

Reflective learning: Schön (1987) argues that the traditional modes of delivering formal theory do not sufficiently prepare professionals for real life as it tends to be much more 'messy' in practice. Reflective practitioner theory emphasises relations between knowledge and experience and suggests that individuals reflect in an attempt to link up theory and action in practice. Encouraging students and teams to reflect on their activities and processes of working together, with a focus on service user care, can develop an understanding of one's own role and values and those of other professions.

The classroom situation will also provide a supportive environment where students will be expected to receive feedback and learn from the experiences and knowledge of other students and tutors. Such experiences will be particularly valuable, given the anticipated cross-sector and cultural experiences of the student group (Carpenter & Dickinson 2008, pp 74-76).

Arguments for closer collaboration at undergraduate level

The increasing pressure for youth work, social work, health, education, and those working in criminal and youth justice to collaborate in an ever increasing variety of professional contexts, arises from the multiple and diverse needs of specific groups of service users. Exchanges of professional information and coordination of service

responses is seen as providing a more **holistic approach** to meeting service user needs. However, poor functional links between and within service agencies can and has resulted in a failure of service and an increased risk to the service user. A past example of dysfunctional teamwork in the UK is the case of Victoria Climbie in 2001.

> The failure of individual professions to work effectively with others that relate to their area of activity has been well documented. On occasions, such failures have exploded spectacularly into the public consciousness; failures of inter-professional working, which contributed significantly to her death, were a critical finding of the Victoria Climbie enquiry (DFES 2003b) (Wilson et al 2008 p388)

There is, therefore, a need to bring professional workers from allied disciplines together, in a collaborative learning environment, to develop greater understanding of what each can and will bring to any multidisciplinary team.

The importance of multi-professional (now seen as inter-professional) learning and education for health professionals was emphasised in 1988 by the World Health Organisation (WHO) *Learning Together to work together for Health*, and this drive has been repeated by other legislative and policy requirements in several different countries. Examples of this include: *Learning Together to Work Together* (Department of Health, 2000) in the UK and the *Inter-professional Education for Collaborative Patient-Centred Practice* initiative, supported by Health Canada (Herbert 2005). In the UK, a report from the Department of Health: 'requires health and social care services to provide effective interprofessional education (IPE) both in the workplace and in undergraduate programmes in higher education institutes (DoH, 2003).

The master's programme therefore, provides **a much needed critical space** in which to explore the opportunities and challenges of interprofessional working. According to the Co-ordinator, for the Gloucestershire Neighbourhood Projects Network (Gale, 2007)

> Working together collectively has given us much greater strategic insight and understanding of others' roles and challenges. By listening and learning from others we can share practical experiences, success and failures, and all quickly implement successful activity. Even if coming from a wide background you find many common issues, which you can then respond to far more effectively as a group.

However, attracting interested practitioners and managers from a range of public service backgrounds to a master's programme is in reality a later stage of the process. The challenge of creating an effective and informed multi-disciplinary team or group is to break down the professional barriers that we know to exist between complementary but often competing services, for example youth work and social work. This would be a vital and first stage of a planned process but in accepting this one has to question why this acknowledgement and understanding of 'other public services' in the fields of social care, and education, is not addressed at undergraduate levels of training? At present, the undergraduate programmes of youth work and social work at Newport University are delivered separately. There are professional requirements, particularly in the case of the undergraduate qualification in social work that necessitate this artificial separation. The Care Council for Wales, the statutory body responsible for the regulation of the social care workforce and social work education and training in Wales, has been clear in the past that social

work should be treated as a separate qualifying pathway and their students not be taught common or shared modules.

UK Professionals are trained and educated in their own disciplines, learning their own unique and specialist knowledge for their chosen profession. Therefore, although each profession is well equipped for its singular contribution, they find their 'educational preparation a total mismatch for the complex, interactive world into which they graduate and practice' (Sullivan, 1998: 428). Sullivan's view reinforces the WLGA's concerns, that professional boundaries demarcate social professions (and others) from each other and that resistance to collaboration and co-operation on any meaningful level has been compounded by the historical development of the uni-professional training model. We need therefore to **agree a uniting philosophy** and conceptual framework that facilitates a dialogue between these professional disciplines and gives reasons for these discrete services to work together in providing effective inter-professional solutions to shared social problems.

Interprofessional Teaching and Learning

Despite the anticipated concerns of professional bodies and some academics, in my view the case for interprofessional teaching and learning at undergraduate level, as a way of developing effective interprofessional practice, is compelling. Much work needs to be done, however, in breaking down harmful perceptions in professional relations. According to Howkins (2008: 10):

> During the process of professional socialisation damaging stereotypes of other professions are learnt and then become part of everyday professional behaviour. An essential stage therefore, of interprofessional education is to help the participants to explore these damaging stereotypes, understand each other's professional view and thus avoid further perpetuation of these in the workplace.

A first step in bringing the youth work and social work undergraduate programmes of training closer together could, as a starting point, be facilitated by mapping and identifying the respective professional standards and identifying common or shared values and principles. If this were done with the central imperative of working with and meeting service user needs, it would provide opportunities in which the two professions could share experience and understanding of each other's professional contexts. I am not suggesting a 'bulldozer' approach to this development but a staged process that openly acknowledges professional sensitivities and seeks to move beyond restrictive practices to a more responsive interprofessional delivery of services.

At Newport School of Health & Social Sciences, both professional programmes of social work and youth work are due for re-validation. This presents an ideal opportunity to map individual modules from each undergraduate programme and identify shared areas of professional development and generic skill competences. Module titles can be changed to accommodate both disciplines and module content adjusted to facilitate the education and training of both cohorts of students while maintaining and to some extent protecting professional interests and integrity. This bringing together of students from what has been two very separate qualifying programmes can only enrich the learning process by encouraging students to engage with and experience different professional perspectives. By introducing the notion of "interprofessional" teaching and learning at undergraduate level we immediately begin to challenge and breakdown the historical "silo" mentality and

approach to professional education.

In the early stages, it would be interesting to seek opportunities for joint discussions between youth work and social work students of journal articles or research papers concerning, for example, the evolving integrated services for children, young people and families in the UK. This could provide a non-threatening yet important forum to share understanding of contemporary developments in workforce development. Developing effective communication skills in a professional context and reflective practice are also areas where joint teaching and learning should not present any perceived threats to professional identity or integrity.

Conclusions

I began this paper by describing a journey that resulted in my thought processes moving forwards and backwards almost simultaneously. As the possibilities and opportunities of a master's programme in interprofessional practice began to unfold so did the rather obvious and necessary need to re examine the undergraduate student experience of professionally qualifying programmes in youth work and social work. It seems rather strange, that academics and professional bodies have little fear of developing master's programmes where different disciplines come together to discuss multi agency approaches to delivering services, yet do little to openly promote such essential and in some policy contexts expected professional collaboration at undergraduate level. Is it just because of stereotyping that we resist joint training or is it the dilution of professional role and identity?

I acknowledge that the ideas expressed here raise questions about the possible dilution of professional role and loss of professional identity. However, I would argue that many of the students we train as discrete youth work and social work practitioners struggle with the realities of integrated services and the government's clear expectations of multi-agency approaches to service delivery. I therefore contend that we are derelict in our duties if we do not accept the realities of the practice context and begin to take opportunities to forge greater understanding and appreciation of what different services can contribute to meeting individual service user needs.

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Case Study 8: An interprofessional approach to understanding domestic and sexual abuse within society

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Key words: Interprofessional, Domestic Abuse, Multi agency, Workforce development, Sexual Abuse

Course specifications

Title: Two modules at higher education levels 4/5 and 6/7 called 'An interprofessional approach to understanding domestic and sexual abuse within society'

Aim: Promoting knowledge and understanding of other professions working in the field of domestic and sexual abuse.

Intended learning outcomes:
a) Theory focussed. By the end of the modules the student should be able to:

1. Develop knowledge and understanding of domestic and sexual abuse;
2. Demonstrate a knowledge and understanding of appropriate theory, law and policy in relation to practice within and interprofessional frame;
3. Demonstrate knowledge and understanding of relevant organizational policies and procedures specific to their practice and to interprofessional practice.

b) Practice focussed: By the end of the modules the student should be able to:

1. Identify the ways in which domestic and sexual abuse may present;
2. Identify and implement the appropriate actions to be taken within an interprofessional context by professionals when domestic and sexual abuse is suspected;
3. Demonstrate understanding of the respective roles and responsibilities of different professionals in relation to domestic and sexual abuse and contribute to effective working relationships.

Professions involved: It is expected that the students will come from a wide range of public and voluntary sector professions which include the following:
Women's Aid, Bawso; NSPCC; New Pathways; Housing; Social Services; Community and Acute Health, particularly Accident and Emergency Department staff, Paramedics and Ambulance staff; Health Visitors; School Health Nurses; Practice Nurses; Mental Health Practitioners; Family Therapy; CAMHS; Midwives; Police; Probation; Crown Prosecution Service; Magistrates; Education; Early Years Practitioners.

Organisations involved: A wide rnage opf organisations – please see Appendix 1

Outline: The modules recognise the complexity of the workforce development needs in respect of professional roles, both generic and specilaist, in the field of domestic and sexual abuse. The stakeholders have identified that undergraduate and postgraduate development opportunities are needed that use an interprofessional approach to learning.

Length: The course will comprise 42 hours of delivery time per 20 credits delivered over 14 days, once a week.

Assessed? Yes summatively
The following methods of assessment are being considered. The final choice of summative assessment will be guided by the level and credit value of the modules.

1. Poster presentation to peers and 2000 word reflective piece discussing learning in relation to producing the poster and linking theory to practice;
2. Cognitive map presentation to peers and reflective piece discussing their learning in relation to the cognitive map and linking theory to practice;

3. An Objective Structured Clinical Examination (OSCE), using group simulation of a scenario devised by service users, to examine interprofessional working skills such as communication and application of theory to practice;
4. Interprofessional interactive CD Rom;
5. Case study comprising 3000 words demonstrating knowledge and understanding of the policy context and application of theory to practice.

Supporting resources: Simulation, on-line and classroom learning environments. The simulation and on-line facilities were demonstrated to the stakeholders during the initial interprofessional workshop.

Number of times this course has run: None – developmental phase

Intended Teaching methods: Workbased learning; classroom teaching; simulation; e-learning; problem-based learning; inquiry based learning; case study.

1. Simulation, including possible use of Hydra, to explore interprofessional roles, interprofessional team working, and scenario based problem solving;
2. Professional mentoring to support the synthesis of theory to practice, provide clinical supervision, and to ensure the student receives personal support;
3. Cross agency practice visits to support interprofessional education;
4. Blackboard to facilitate online group inquiry based learning and student discussion;
5. Face-to-face teaching and learning including group work, inquiry-based learning and student lead seminar;
6. Academic supervision and University based pastoral support;
7. Study skills support.

Future plans: While the modules can be attended as stand alone continuous professional development acredited courses, they will become components of appropriate awards which are to be decided.

Background and purpose

The course is being set up in response to a range of factors and insights. Particularly influential, was a personal realisation that graduates, working in the voluntary sector as specilaists in the field of domestic and sexual abuse, were turning to HEFCW Level 3 courses for their professional development due to a lack of specialist, locally available, higher education development opportunites at HEFCW Levels 4, 5 ,6 and 7. In addition, there were anecdotal comments from specialist workers, that other professionals stereotyped them within a femininist frame and did not understand the nature of their work. Action towards addressing both issues indicated a need to set up a specific domestic and sexual abuse higher education programme of education that was interprofessional in its delivery approach.

This endeavour fits with the continuing high level of support by government, both Westminster and the Welsh Assembly Government, for addressing domestic abuse. In addition, they place emphasis on the need to educate and train a wide range of professionals in a way that facilitates knowledge and understanding of each others roles and responsibilities, subsequently leading to the development of attitudes and skills that result in effective joined-up working. '*Working Together to Safeguard Children*' (Department of Health, 2006, p91) asserts that, "training delivered on an inter-agency basis is a highly effective way of promoting a common and shared understanding of the respective roles and responsibilities of different professionals, and contributes to effective working relationships".

Because domestic and sexual abuse occur across society regardless of age, gender, race, sexuality, wealth, and geography, all professionals and agencies

working with communities, individuals, families, children and young people require an understanding of its nature, knowledge of how to recognise individual cases, and skills to support and manage cases. It is also crucial that professionals have the skills to work effectively within an interprofessional context due to the complexity of individual cases which require the expertise and resources of a number of agencies and rarely sit within the brief of a single profession. For example, individual cases may involve psychological, physical, sexual, emotional or financial abuse, honour-based violence, female genital mutilation, and forced marriage. In response to the gravity of risk to individuals, including children and young people, and the complexity of domestic and sexual abuse requiring multiple agency involvement, Multi Agency Risk Assessment Conferences (MARACs) have been established across England and Wales that aim to share information on individual cases to enable the provision of coordinated multi-agency support and protection of victims.

The primary scoping of stakeholder views on aspects of the curriculum content and its delivery, were conducted through the identification of key professionals representing local agencies that deliver support in relation to domestic and sexual abuse. These agencies included Welsh Women's Aid, Midwifery, Police, Local Authority and the NSPCC. One-to-one meetings were arranged and were structured by an initial consultation grid that focused ensuing discussions on exploring specific facets relevant to curriculum development. They included: possible audience; timing of module delivery; teaching and learning methods; module levels and credit; aims and objectives; desired learning outcomes; possible assessment; agency specific knowledge and skills; timing of delivery; and relevant practitioner manager, and policy maker contacts. Once stakeholder contacts had been identified, spanning a comprehensive cross section of the main public and voluntary sector local agencies, they were invited to attend a one day interprofessional stakeholder workshop held at the University of Glamorgan. Prior to formal emailed invitations, each stakeholder contact was approached by telephone.

The overall interprofessional stakeholder workshop aim was to obtain a melting pot of curriculum ideas, and to identify the core knowledge and skills required for professionals working in domestic and sexual abuse across agencies. In order to keep the stakeholders focused on practice, participants were asked to map their identified curriculum requirements to the aspects of practice they applied. Participants were asked to appoint themselves to one of seven theme groups located in different areas of the workshop venue. The seven groups included: identification of and understanding the dynamics and impact of domestic and sexual abuse; advocacy, dignity, supporting and holistic care planning including consideration of survivors; safe guarding and working with children and young people; safe guarding and working with diversity, including older people and vulnerable adults; housing and homelessness, safety and security; perpetrators, victims, safety, criminal law and justice; and promoting public awareness and prevention. The stakeholder group work was divided into two parts. During part one, participants were asked to mind map the comprehensive curriculum knowledge and skills required for their theme, where necessary braking them down into sub topics. Part two of the themed group work required the stakeholders to prioritise their comprehensive mind maps in order to identify the core ‘nuts and bolts’ knowledge and skills that they would include in a 20 or 40 credit interprofessional module that set out to provide fundamental key knowledge and skill education.

The University also showcased the simulation possibilities it could offer in relation to domestic and sexual abuse and demonstrated its on-line teaching and learning environment. The workshop aimed to encourage stakeholders to start thinking about the best use of a range of teaching and learning methods in relation to the

curriculum. Participants were asked to consider the design of an ideal interprofessional simulation environment for interprofessional training in domestic and sexual abuse. A core group comprising volunteer professionals was formed to take the work of the theme groups forward to inform the development of a 'nuts and bolts' domestic and sexual abuse module. The core group's discursive focus was structured by the requirements of the University's module development requirements. Areas that were discussed, refined and agreed included the module aims and rationale; the curriculum synopsis and key skills; the levels and credits; the learning & teaching environment; the learning outcomes; assessment possibilities; ethical considerations; and the investigation of service user involvement. This concludes the current development status of the two modules at HEFCW Levels 4/5 and 6/7 called, "*An interprofessional approach to understanding domestic and sexual abuse within society*".

Translation into practice: where we are now

The modules recognise the complexity of the workforce development needs in respect of professional roles, both generic and specilaist, in the field of domestic and sexual abuse. The stakeholders have identified that undergraduate and postgraduate development opportunities are needed that use an interprofessional approach to learning.

The final published description of the modules has not been agreed with stakeholders or service user contributors, but at this early stage in their development the aims of the modules are to:

1. Enable early identification of, and intervention with, victims and perpetrators of domestic and sexual abuse through the understanding of evidence-based knowledge and its application to an interprofessional practice environment;
2. Develop critical analytical and reflective skills through the exploration of relevant psycho-social theories, as well as the historical and contemporary justice and service context within the UK and a devolved Wales;
3. Increase understanding of the range of professional and agency roles and enhance interprofessional working skills through an interprofessional education approach.

The synopsis of each of the modules will be delivered under four broad headings:

1. Identification and understanding of the dynamics and impact of domestic and sexual abuse, including promoting public awareness with a view to its prevention;
2. Examining issues concerning perpetrators, victims, criminal law and justice, including housing and homelessness, safety and security;
3. Safe guarding and working with children, young people, and diversity including older people and vulnerable adults;
4. Advocacy, dignity, and holistic support delivery planning including consideration of survivors.

Each of the four module components will be underpinned by a requirement for the students to make constant links to: their specific area of practice and role; the interprofessional working context; the theoretical frameworks that inform and direct their practice and professional perspectives as well as those of other professions; and the policy and evidence-base supporting practice. In addtion, during their participation in the different module learning environments the students will develop

transferable skills that include: managing and developing self; working and relating to others; communicating; managing tasks and solving problems; applying technology; and applying design and creativity.
Lessons learnt and to be shared

The **intial scoping approach**, using key professionals, one-to-one interviews and a structuctured grid to guide discussion, worked well for a number of reasons. Each of the professionals were passionate, highly knowledgeable, had excellent interprofessional networks, and were fully supportive of the development of higher education opportunities that used an interprofessional education appraoch and focused on domestic and sexual abluse . The grid was easy to use, it was effective in maintaining the focus of discussion, and ensured the main module development areas were covered. Both the interprofessional workshop and core group meeting were successful in fulfilling their curriculum planning aims.

Emailing out drafts for comment was not successful. The reasons for this have not been discussed with the participants, but are assumed to be mainly due to workloads. The task of adding to or editing written material is more arduous than contributing and debating verbally face-to-face.

The long-term vision for interprofessional education on domestic and sexual abuse embraces an aspiration to **work in partnership** with Welsh Women's Aid towards achieving seamless interprofessional workforce development pathways through Further Education at Levels 1, 2 and 3 to Higher Education from Levels 4 to 7.

The domestic and sexual abuse modules will be validated later in 2010 and marketed to commence in February 2011. Simultaneously, working in partnership with local stakeholders, there are plans to continue to explore the interprofessional development needs of the workforce in the area of domestic and sexual abuse.

For more information please contact:
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Appendix 1: Module Development Team

A wide range of organisations are engaged in ongoing work with the University to set up the two modules:

Margaret Abraham Cwm Cynon Women's Aid Trustee
Diana Barran CAADA Director
Steve Bartley Welsh Assembly Government
Ann Batley Field Services Manager
Dr Mwenya Chimba BAWSO
Yvonne Connolly Fairbridge De Cymru
Cheryl Emery Housing Advice Centre
Ann Evans RCT Domestic Abuse Co-ordinator
Denise Evans Children's Services Manager RCT
Lucy Faithful Cwm Cynon Women's Aid Management Committee
Deborah Gardner Pontiypridd Domestic Abuse Unit
Billy Hardy Family Institute University of Glamorgan
Paula Hardy Chief Executive Welsh Women's Aid
Bridie Jones Senior Lecturer Care Sciences Simulation Suite
Helena Jones NSPCC
Libby Jones Chief Executive New Pathways
Sally Jones Lead Nurse for Domestic Abuse UHW
Professor Joyce Kenkre University of Glamorgan
Claudia Kinrade Bridgend Police Honour Based violence
Marc Lamerton Detective Inspector
Lyn Lynch Consultant Midwife Cwm Taf
Linda Mages Senior Lecturer Public health
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Shaheen Munsif BAWSO Trainer
Michelle Naughton Training & Development Worker Pontypridd WA
SusanParker Rhondda Women's Aid
Pam Parson Price Charles hospital A & E
Rachel Phillips Information Librarian
Jan Pickle Welsh Assembly Government
Wayne Preece Principal Lecturer E-Learning
Julie Richards Royal Glamorgan Hospital A & E
Deborah Rogers Crown Prosecution Service
Ann Scourfield Merthyr Tydfill Health Board
Mary Smith Senior Lecturer Public Health
Dwynwen Spargo Associate Lecturer School Health Practice Teacher
Jackie Stamp New Pathways
Anita Thomas Cwm Cynon WA Trustee
Patrick Tucker Senior Lecturer Policing and Police Services
Stewart Twigg Senior Lecturer Policing
Pat White Divisional Head Department of Care Sciences
Terry Williams Trainer for New Pathways
Collette Winters Trainer and Assessor CAADA
Leanne Wood Cwm Cynon Women's Aid Director
Cwm Cynon Women's Aid
Rhondda Women's Aid
Pontypridd Women's Aid

Case Study 9: Inter-professional teaching of communication skills at undergraduate level

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Sandra Fender, School of Nursing and Midwifery Studies, Cardiff University

Key words: communication skills, healthcare, undergraduate teaching

Course specifics

Title: Introduction to Communication Skills 1 and 2 (CS1 and CS2)

Aim:
To pilot the development of inter-professional communication-skills and professional-awareness across schools in a university environment. Initially this started as an informal collaboration between two schools (Optometry and Physiotherapy), the success of which has led to a formal ongoing collaboration. Expansion of this philosophy led to the delivery of a further pilot study involving Optometry and Nursing students, as a precursor to applying for internal funding for an expanded programme. Since this pilot, funding has been obtained and this aspect of the project has now completed its inaugural delivery to a full cohort of 1st year Optometry and Nursing students.

Objectives: By the end of the activity participants will be able
1) To develop an introductory communication skills "mini-module", involving groups of 1st year students. This would enhance awareness of the need for good communication skills and also introduce the idea of how different skills may be needed in different situations and / or professions. (CS1)
2) To enhance the application of communication skills via the clinical scenario, whereby the students act as practitioner (2nd year students) and / or patient (currently 1st year students) and to critically review this experience via tutor-led group discussion. (CS2)
3) To develop group-working skills and enhancement of the awareness of differing communication requirements, via the group discussions. Also, to begin to improve awareness of the roles of other healthcare professions. (CS1 and 2)
4) For some students (Nursing and Physiotherapy) these episodes will form part of their ongoing portfolio development. (CS1 and 2)

Teaching methods:
Lead lectures, group-based workshops and patient episodes.

Professions involved:
Optometry, Physiotherapy and Nursing.

Organisations involved:
School of Optometry and Vision Science, Cardiff University.
School of Nursing and Midwifery Studies, Cardiff University.
Department of Physiotherapy, School of Healthcare Studies, Cardiff University.

Length:
CS1: one 1-hour lead lecture, two 3-hour mixed-cohort workshops at the beginning of the first semester, first year.
CS2: one 2-hour mixed-cohort patient episode / workshop followed up by varying amounts of workshops embedded within the individual cohort's curricula.

Assessed?
For both components, formative assessment occurs for some participating students via

portfolio completion.

Supporting resources:
CS1: Powerpoint presentations for the lead lecture and the two workshop structures were developed. The lead lecture was delivered to each cohort independently by a member of staff from their school. Each workshop was delivered twice, in parallel (to keep the student numbers manageable at 90 students) to the mixed cohort: each workshop was supervised by one member of staff from each school, hence 4 members of staff were involved in total.

CS2: one member of staff from each school helped deliver the patient episode and group discussion workshop, which lasted a total of 2 hours and was run 4 times to keep the numbers manageable at 48 students maximum. Evaluation sheets were provided for the "patients" to formalise their evaluation of the "practitioners" communication skills and professionalism.

Number of times this course has run:
CS1 had one pilot run (one workshop, 10 students from each of two schools) in the previous academic year, and has now completed one full run this academic year. CS2 has now run for three consecutive years, and has remained virtually unchanged.
Number of participants:
CS1: 90 Optometry students and 90 Nursing students.
CS2: 90 Optometry students and 90 Physiotherapy students.

Background and purpose

Virtually all students that are engaged upon undergraduate courses that lead to careers that are governed by professional bodies have specific, frequently compulsory, core-competencies that include patient management and communication skills. This is ceratainly true of the three professions involved in this project, hence all their undergraduate programmes incorporate communication skills and professionalism into their respective syllabi. It is obvious that individual professions will have their own specific requirements with regards to the development of communication skills, as multiple factors may influence the patient / practitioner interaction e.g. familiarity via frequency of interaction, patient choice in practitioner, severity of the presenting condition etc. But equally, with a little consideration, it becomes obvious that there are significant areas of overlap: the same patients, particularly in an aging population, will attend multiple healthcare professionals and hence patient-specific communication issues will be common to all professions. Also, most patient interactions will involve some combination of questioning, followed by the carrying out of specific investigations with varying levels of invasiveness, and informing the patient of a range of outcomes, which may vary hugely in terms of both complexity and severity. For the patient / practitioner communication to be effective, these skills have to be learnt by the practitioner. Our inter-disciplinary approach to teaching these skills hinges on our belief that these skills are common to all professions and that the appreciation and learning of these skills by the student will be **enhanced by the contrasts of their own experience and profession with other healthcare related professions**.

In practice

This course has evolved from an initial collaboration between Optometry and Physiotherapy, a collaboration that began with a chance meeting of staff from both schools at a teaching conference. This initial collabotration consisted of first year physiotherapy students sitting as patients for a routine eye examination for second

year optometry students. For the optometry students, this patient episode was the first where they were not testing members of their own profession peer group, i.e they were dealing with a naive patient, and occurred directly before they began to engage with members of the public who are recruited as dummy patients. As such, it was perfectly placed for these students to address the aquired habit of communicating in a jargonistic way to overly-familiar patients. The optometry students were aware that the physiotherapy students were specifically assessing the communication aspects of their experience, to which end they had a proforma list of questions to consider. Immediately after completion of the eye examination, the two groups evaluated the experience in a group-based workshop session (see Appendix 1). This session focussed particularly on considering how the communication issues that arose would impact upon the working environment for both professions, and also discussion as to how differences between the professions might alter the importance of various elements, via the use of profession specific examples provided by the students (and staff, where appropriate).

Testing equipment dictated that this course be run in the optometry clinics, which can cater for up to 24 students testing (and hence 24 patients) and was further facilitated by the fact that the school computer room can easily accommodate this total of 48 students for the group discussion component. In total, the session took two hours, one hour for the patient episode and one for the group discussion. To accommodate all students in the cohort, the workshop was run four times in total in the first week of semester two. Staffing involved one member of staff from each school. Logistically, this course could comfortably be managed by just one member of staff, but representation from each profession was considered essential for the enhancement of inter-disciplinary learning in the discussion component, by providing profession-specific context for the issues arising.

This mixed-cohort session subsequently seeded further consideration of communication and professionalism within the individual course curriculi. This session, and particularly the group discussion element, was viewed very favourably by both staff and students (which was confirmed by student evaluation form both schools), and hence continues to run on a yearly basis. This workshop now forms the CS2 component of the course as currently delivered.

The success of what became CS2 led to our exploring other links that could be formed within the University that could enhance the student learning experience by further examples of interdisciplinary teaching.

The first steps in doing so included running a pilot workshop (2 hours duration) with students from the schools of optometry and nursing. This consisted of 10 students from each discipline (1st year nursing and 2nd year optometry) with one staff member per discipline. Delivery was based upon a workshop that was currently part of the communication skills module for the nursing students, but was tailored slightly to enhance those aspects that were most amenable for inter-disciplinary opportunities. Again, the students responded favourably and hence plans were made for this pilot to be expanded. Internal funding (via the University's Teaching and Learning Committee) was gained, allowing for freeing up of staff time in order to develop and deliver a more comprehensive "mini-module" of communication skills teaching, i.e. what became CS1. This course consisted of a lead lecture that was adapted from that which was given to previous cohorts of nursing students (see Appendix 2), followed up by two 3.5-hour workshops. The lead lecture was delivered to each cohort (90 students each) independently by internal staff. Each workshop was run as two parallel, mixed-cohort, sessions of 90 students each, and involved one member of staff from each school. This course was delivered to 1st year

students in the first weeks of semester 1. The intention was to highlight, from the very beginning, the crucial role of good communication in delivering quality healthcare. The lecture introduced the basic concepts of communication skills and the workshops (which were a combination of tutor led discussion, group discussion and group activities) backed this up by the application of some of these skills. Specifically, questioning and listening skills were practiced via small, mixed-group sessions based upon the role of each profession. As these students were at the beginning of their studies, the focus was largely on information gathering, rather than decision making and delivery (components of communication that will be taught in later modules). This was considered pertinent timing for both groups of students, as the nursing students would soon be going to their first work placement, and the optometry students were beginning their practical module on basic clinical techniques.

Things that went well, and not so well

For CS2, planning has been relatively painless, not least because staff from both schools clearly recognized the benefits of such a collaboration and the positive student feedback spurred the desire to continue with it. For one school (optometry), incorporation was straight forward, as the module leader has some flexibility in course content, design and delivery. For physiotherapy, this was a little trickier as the staff members involved did have this authority. However, by keeping the committment small and embedding it within current structures, bureaucracy was successfully navigated. Student feedback has been extremely positive from both sides: the optometry students clearly identified the issues of ”jargonistic” patient instructions and had the opportunity to have their first “external” patient in a relatively unthreatening environment, the physiotherapy students had the opportunity to critique the same issues, and then both sets had the opportunity to compare and contrast the issues form their differeing vantage points. This low-maintenance session has now run successfully, with minimal alteration, for three years. I think this is a perfect example of how engaged staff members can improve the teaching environment in small but significant ways, allowing them to concentrate their energies on the quality of teaching without significantly encountering the structures and procedures required of larger scale changes.

For CS1, this was the first year of delivery and as yet we have no formal feedback from the students (a feedback survey has been developed and will be launched imminantly). The feedback from last years pilot session was positive, but note that this was run later in the year: it will be interesting to see what the students think of the timing of delivery. Anecdotally, however, staff supervising the recent optometry clinical exams (this author included) commented upon a much higher level of communication skills and professionalism for students at this stage of the course. Something seems to have rubbed off! From a planning point of view, the larger amount of content has require more development time, and also more administrative time. The fact that this was funded inevitably means more encounters with internal bureaucratic structures. Whilst ultimately the teaching seemed to come off well, (again due to dedicated staff), control over and ownership of the project became more of an issue: the “cosiness” of the CS2 component was less evident. Timetabling was also difficult: finding available slots was less easy and required more cooperation from other members of staff who were not involved in the project. Thankfully, this did not become a major stumbling block, but it easily could have. Also problematic was the isue of space: in particular the availability of suitable venues for dealing with large numbers of students. The workshops were delivered in lecture theatres. These are not ideal as tutor mobility, and hence interaction, were limited by the physical layout, leading to less interactivity from the students and hence a

tendency for the teaching to drift towards the feel of an actual lecture. However, staff opinion on the teaching was positive and hence we intend to repeat this teaching next year (student feedback permitting).

Recommendations to others following our path

We would strongly recommend pursual of interdisciplinary teaching where appropriate. The students benefit from it, and both staff and students can clearly see these benefits. Starting small may be best, for a number of reasons. With regard to running pilot studies, these can be easily administered, reviewed, developed and expanded without a huge commitment of staff or student time. Aim to **get under the bureaucratic radar** initially, then if feedback is positive, consider grant proposals that will allow for the funding required to generate the time to be devoted to further development. But even without expansion, staff involved have found these teaching episodes rewarding in themselves. Indeed, staff satisfaction seems to be better with the smaller, self-contained components, although rewards may remain purely altruistic. Either way, these projects add variety to the semester, and allow for the comparison and sharing of teaching methods and tools

Plans for the future development of this course

Staff and students from the three schools involved in these projects all feel positive about these inter-disciplinary learning sessions and hence we aim to continue with the current set up. We are also looking at ways to expand it: communication is a recurring theme in all these disciplines and hence we are considering ways to continue these collaborations across all years of course delivery. In particular, delivering information to the patient is an area that would be ideally suited to mixed-cohort groupwork. Furthermore, there may be the opportunity to involve other healthcare professions that will have similar needs. However, we will proceed with caution as we are wary of the increasing administrative demands associated with more ambitious projects, along with the issues of loss of ownership.

As yet, there are no firm plans in place to consider the issue of communication with English-as-second-language patients, however as this is a significant issue in Wales, we are currently investigating the possibility of doing this in an interdisciplinary environment.

For more information please contact
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Appendix 1: Sample Eye examination feedback sheet

School of Optometry & Vision Science
Physiotherapy Department

Eye examination feedback sheet

The statements in this feedback sheet relate to the General Optical Council's (2005) Code of Conduct for individual registrants. Although these statements have been taken from the Code which governs the practice of optometrists' in the UK, the same statements are found in the Health Professions' Council's (2008) Code of Conduct, Performance & Ethics which regulates the practice of physiotherapy in the UK. It could be argued therefore, that these attitudes & behaviours form a key element of contemporary professional practice.

A registered optometrist or dispensing optician must:

- Make the care of the patient his or her first & continuing concern
- Treat every patient politely & considerately
- Respect patients' dignity & privacy
- Listen to patients & respect their views
- Give patients information in a way they can understand & make them aware of the options available
- Respect the rights of patients to be fully involved in decisions about their care
- Respect & trust confidential information
- Make sure that personal beliefs do not prejudice patient care

GOC (2005)

Once your eye-test is finished, reflect on your experience & write some feedback for your practitioner. Try not to give just one-word responses, but use the space to tell the practitioner why you felt that something was 'good' or 'bad' etc. There's also some space for you to highlights the strengths of your practitioner, as well as giving them some ideas of how things that could improve their performance.

Name of practitioner: Name of patient:

1. Was this your first experience of having an eye-test? YES/NO
[delete as appropriate]

If **yes**, was the experience what you expected?

If **no**, how did this experience compare with your previous experience(s)?

2. Did the practitioner dress in a professional manner?

3. Did the practitioner treat you with courtesy?

4. How did the practitioner manage issues of privacy, confidentiality & personal space?

5. Did the practitioner explain the reasons for the tests involved?

6. How did they obtain your consent to proceed with the tests?

7. Were the instructions given clear & understandable?

8. Did you feel able to ask your practitioner questions as appropriate?

9. Did the practitioner explain all findings adequately?

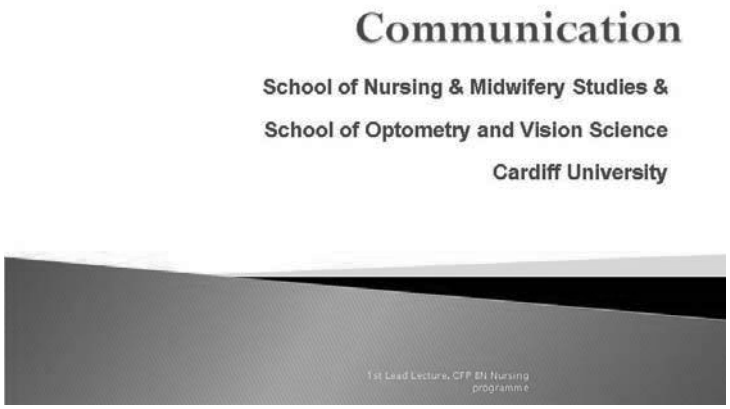
10. Did the practitioner give you clear management/advice?

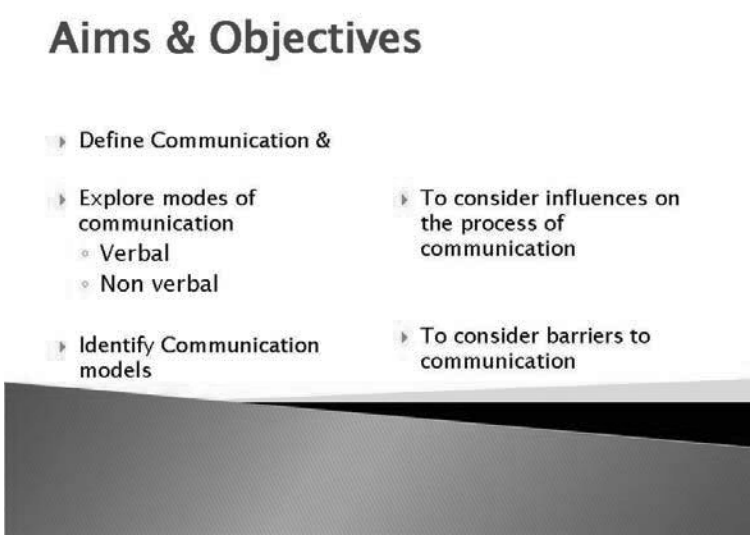
11. List three things that your practitioner did well
a.
b.
c.

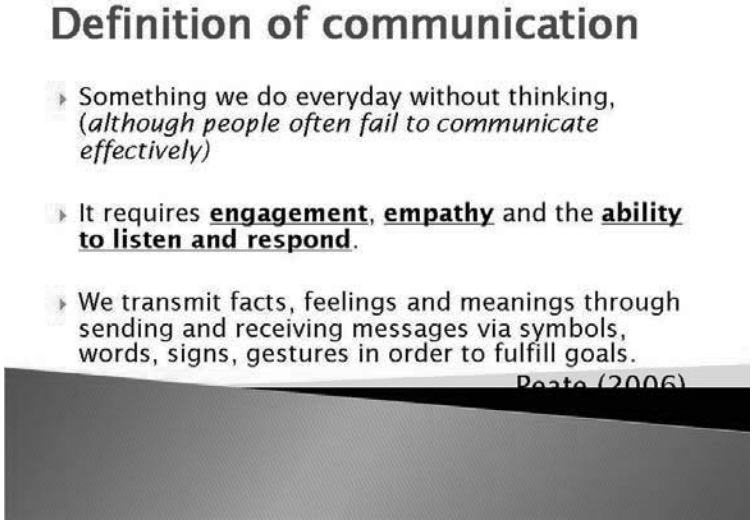
12. List three things that would help your practitioner improve their practice:
a.
b.
c.

Thank you.

Appendix 2


Communication
School of Nursing & Midwifery Studies &
School of Optometry and Vision Science
Cardiff University
1st Lead Lecture, CFP BN Nursing programme


Aims & Objectives
Define Communication &
Explore modes of communication
Verbal
Non verbal
Identify Communication models
To consider influences on the process of communication
To consider barriers to communication


Definition of communication
Something we do everyday without thinking, (although people often fail to communicate effectively)
It requires engagement, empathy and the ability to listen and respond.
We transmit facts, feelings and meanings through sending and receiving messages via symbols, words, signs, gestures in order to fulfill goals.

One cannot not communicate

-the crucial nature of non verbal communication

- Message impact – *7% Verbal communication*
  - *38% Vocal (tone, inflection)*
  - *55% non-verbal signs/cues*

Modes of Communication

- Verbal
- Non verbal
- Written word
- Electronic Via web, text messages
- Signs and Symbols

(Bailie 2005)

Verbal:– Choice of words /Jargon

Paralanguage - Features of a spoken message that are not contained in the words alone:

Tone
Pitch
Volume
Speed
Accent
Silence

Non verbal behaviours

- **Artefacts**

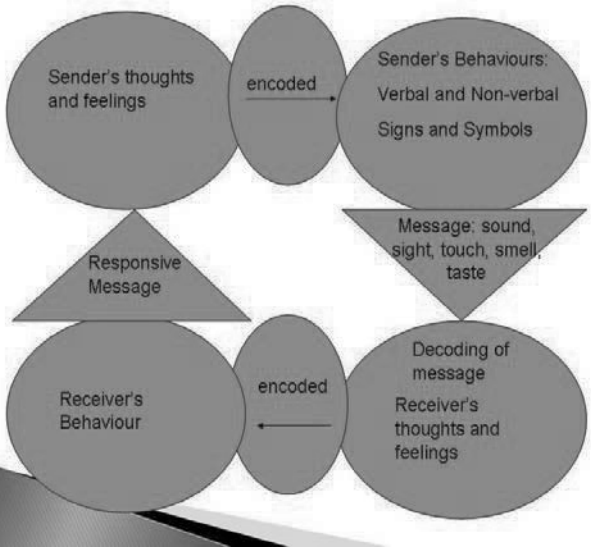
(Dress / Physical appearance)

- **Kinesis**
- **Facial Expression**
- **Eye Contact**
- **Proxemics**
- **Touch**

INFLUENCES on the process of communication

- How we behave, think & feel, influences others.
- The responses/behaviours of others may influence how we behave, think and feel.
- Important to be aware of and to consider verbal and non-verbal communication from other areas:-

Context
Culture
Congruence
Perception



Barriers to Communication (1)

Sender

- First impressions: cultural/prejudice/values/beliefs
- Approachability, insecurity
- Communication: language
- Attitude and power
- Eye contact: over use/lack of

Barriers to Communication (2)

Message:

- Body language-tone of voice
- Confidence and competence
- Judgemental
- Language and accents
- No reassurance
- No touch
- Unclear
- Indecisive
- Lack of sympathy

Barriers to Communication (3)

Receiver

- Approachability
- Eye contact
- Body language
- Vulnerability
- Confidence
- Confusion
- Insecure
- Scared
- Pain
- Poor concentration

SUMMARY

- Communication is vital in the delivery of effective patient centered care.
- It is important to recognise and understand the barriers to communication as it influences the development of a therapeutic relationship, and may result in ineffective care management and care delivery.
- Communication between the care team is essential to secure inter-professional care management (WAG 2003)

Workshops

- **Workshop 1 – Listening and questioning skills**
- **Workshop 2 – The health care professional and a therapeutic relationship**

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Case Study 10: Making interprofessional learning compulsory for all students

Fiona Hill, Occupational Therapy Education, Bangor University

Key words: peer learning, Occupational Therapy, Nursing, Interprofessional

Course specfics

Title: Compulsory IPE event

Outline: This is a compulsory session for students studying on the PG Dip OT (pre-reg) and both the BN Mental Health and BN Learning Disability Nursing courses.

Objectives:

1. To develop collaborative working skills - to produce a client centred care plan
2. To identify similarities and differences within each other's roles
3. To address stereotyping and challenge preconceived ideas of each other's roles

Professions involved: OT (n=12), Mental Health Nurses (n=20), Learning Disability Nurses (n = 10/12)

Organisations involved: Bangor University

Length: 1 full day

Teaching methods: Classroom teaching, problem-based learning, case study; peer learning.

Assessed? No

Supporting resources: A collection of bilingual case study scenarios. See Appendix 1 and 2 for examples

Number of times this course has run: 4

Background and purpose

This session was initially instigated in 2006 following a request by a colleague to run a session for mental health nursing students on the role of the OT in mental health. I felt it would be more beneficial to include both sets of students and to let the students learn from each other and so I wrote the plan for the day and my colleague agreed to co-facilitate. This was then extrapolated to include a similar session with the learning disability nursing students the following year and is now **an integral part** of all curricula.

I designed a workshop that would enable the students to work collaboratively through the use of case studies. This approach is line with the student-centred teaching and learning philosophy of all curricula that encourage students to learn about each other's roles and to teach each other about some of the philosophy and theory behind their respective professions.

In practice

OT students are advised about the workshop via their core curriculum timetable. The session is carried out first with the Mental Health Nursing students (around April) and then again a similar session is carried out with the Learning Disability Nursing students later in the year (September) and both these sessions are identified on the timetable. Interprofessional education is identified as a requirement of the curriculum and there are **interprofessional learning outcomes** associated with various modules.

Students are split into small mixed profession groups. They teach and learn from each other about their individual professional roles in respect of a given case scenario, write a plan for the client and then discuss the similarities and differences. Bilingual (Welsh/English) written case studies (Appendix 1) are given to students as well as verbal and written instructions (Appendix 2).

Group participants negotiate timings of when they feed back to each other in their mixed-profession groups, and facilitate their own discussion. After initial information is given to the students, they organise their own learning around the case scenarios. Students have access to computers and library services during the session. The Lecturer role is to informally facilitate and offer support to the small groups.

Large group discussion and feedback takes place towards the end of the day when the students have developed their joint care plan. The Lecturer role then, is to facilitate reflection and discussion on the learning.

Evaluation

Students are asked to verbally feedback at the end of the session what they have learned and how useful they found the day. The session is also evaluated as part of a module of study.

To date the course team have received very positive responses. Students have identified that they valued the opportunity to teach and learn from each other, and to work collaboratively. They have identified that they would like to work in this way earlier in the curriculum and have stated that it has been useful to get to know students from other courses who are sharing the same education building. Some students have also reported meeting up in placement settings, which has aided their settling in to the placement.

What went well

The use of the case studies as a focus for discussion worked very well.

Planning took into consideration the academic levels of the students and their experience on practice placement. Due to difference in numbers for the first session, it helped to pre-select the OT students to groups that focused on cases they would know about. This was not necessary for the session with the learning disability nursing students, as the numbers were fairly equal. It is recognised that this will change from year to year depending on cohort size.

Students have engaged well in the process of learning from each other and seem to appreciate the opportunity to consolidate and share their knowledge about their chosen profession as well as learning about each other's roles.

The workshops have also provoked some **healthy debate** amongst the students about whose role it was to carry out specific assessments. Such discussions required students to negotiate and recognise the need for compromise for the good of the patient/service user. Having introduced each other to 'this is the way OTs do this' or 'this is the nursing theory', debate the similarities and differences in their underpinning philosophy and execution of practice. I believe it **broke down 'professional ego'** issues and enabled students to consider the realities and challenges of maintaining a client centred approach to their practice.

What might have gone better

From our refelctions we offer the follwoing points so that others, adopting our apporaach, can be mdade awre of the potential chalgnes and perepare for tehm from the outset

1. The main challenge was finding time on both timetables that worked for both sets of students;
2. In the very first session we did, there were some individuals who challenged other students quite aggressively. This required careful facilitation but has not happened since;
3. The session includes a short PowerPoint presentation on interprofessional working and why we do it. This is pretty dry, and does not seem to fit with the student-led, peer teaching ethos of the rest of the session;
4. The length of the session is quite ambitious and relies on enthusiastic engagement from both sets of students and staff;
5. Group number imbalances needed to be considered and explicitly planned for.

Plans for the future

The future plans are to slightly alter the format so that the OT students are not repeating exactly the same type of session with two different sets of nursing students within a few months of each other.

I would also like to more formally assess students' views of each others' professions with a questionnaire before and after the session to see if there has been a change in their beliefs as a result of the session.

Since the first session, this workshop has been incorporated into the curricula of the OT course, the MH nursing course and the LD nursing course. I would like to consider the feasibility of including it also with some of the other pre-reg nursing students.

For more information please contact
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Appendix 1: Sample Bilingual case study

MEL

Mel is 32 and is due to move from her family to live on her own in her own flat in two weeks' time.

Mel has a mild learning disability.

She has a part-time job in a local supermarket. She is a sociable person and has a good range of friends.

Mel's mother has tended to do things for her. This has meant that she has had little opportunity to practice the kind of skills she will need to run her own home. Mel has said that she wishes to do as much as possible for herself in her new home.

The move will mean that she lives two miles from her parents and two miles from work. Currently she walks the half mile to work. She wishes to get to work independently and maintain contact with her circle of friends.

You will have the opportunity to work with this lady for the next four months.

MEL

Mae Mel yn 32 ac mae i fod i symud oddi wrth ei theulu ymhen pythefnos i fyw ar ei phen ei hun yn ei fflat ei hun.

Mae gan Mel anabledd dysgu ysgafn.

Mae ganddi swydd ran-amser mewn archfarchnad leol. Mae'n hoff o gymdeithasu ac mae ganddi amrywiaeth da o ffrindiau.

Mae mam Mel wedi tueddu i wneud pethau drosti. Oherwydd hynny nid yw wedi cael fawr o gyfle i ymarfer y math o sgiliau y bydd eu hangen i redeg ei chartref ei hun. Mae Mel wedi dweud ei bod eisiau gwneud cymaint â phosibl o bethau ei hun yn ei chartref newydd.

Mae'r symud yn golygu y bydd yn byw ddwy filltir oddi wrth ei rhieni a dwy filltir o'r gwaith. Ar hyn o bryd mae'n cerdded yr hanner milltir i'r gwaith. Mae'n dymuno mynd i'r gwaith yn annibynnol a chadw cysylltiad â'i chylch o ffrindiau.

Byddwch yn cael cyfle i weithio gyda'r ddynes ifanc hon am y pedwar mis nesaf.

Case Scenario 5 – Older Adult

Setting: Community Mental Health Team

Dora is a 78 year old lady who has been referred to the team by the Consultant Psycho-geriatrician who has seen her in clinic recently, when she scored 18/30 on the Mini Mental State Examination. She has been given a diagnosis of Alzheimer's Disease and has been started on Aricept 5 mg daily.

Dora lives with her husband, Jim, who is 79 and has glaucoma, angina and hypertension. Dora reports she has always been extremely healthy and prides herself on her good physical health. She has a little arthritis in her fingers and shoulders, but otherwise reports no physical problems.

Up until recently, Dora has been extremely independent and has been the primary carer for Jim. She does all the cooking and housework. Dora drives and they go shopping together on a Thursday afternoon to the local supermarket. They enjoy gardening and trips to the garden centre as well as visiting stately homes and gardens. They are usually able to take a holiday abroad each year and are planning to go to the Cotswolds this summer.

However, about six months ago, Jim began to notice that his wife was beginning to forget names and dates and had muddled up times of appointments on more than one occasion. She had been putting the milk into the oven instead of the fridge and on several occasions had left the gas hob on after cooking. On one particular occasion last month she had become distressed in the supermarket as she was unable to find the meat counter and Jim had had to take her outside to calm down.

Dora has also been accusing people of stealing her purse and had accused her husband of having an affair with the lady from next door. Her mood swings and emotional outbursts are 'out of character' according to her husband and are very distressing to him. Dora states that she feels sure that he is cheating on her and treats him quite hostilely during the interview when he denies this.

She says she is very upset about the diagnosis and about the fact she has to take tablets and feels sure she probably doesn't need them. She says she knows her memory has been getting worse recently but says she has always been forgetful and doesn't think it's as bad as Jim is claiming. Her main concern during the interview is that she cannot find her purse. (It is on the sofa next to her).

Jim says he is devastated by the diagnosis and is really worried about how they will cope in the future if Dora continues to lose her memory at such a rate. He is also worried about how they will maintain their independence as the doctor has told them that Dora must give up driving.

Sefyllfa Achos 5 – Oedolyn Hŷn

Lleoliad: Tîm Iechyd Meddwl Cymunedol

Gwraig 78 mlwydd oed ydy Dora Jar sydd wedi cael ei chyfeirio at y tîm gan Seicogeriatregydd Ymgynghorol sydd wedi ei gweld yn y clinig yn ddiweddar, pan sgoriodd hi 18/30 yn yr Archwiliad Cyflwr Meddyliol byr. Mae hi wedi cael diagnosis o Glefyd Alzheimer's ac mae hi wedi cychwyn cymryd Aricept 5 mg bob dydd.

Mae Dora'n byw efo'i gŵr, Jim, sy'n 79 a chyda glawcoma, angina a gorbwysedd. Dywed Dora ei bod wedi bod yn iach iawn erioed ac mae hi'n ymfalchïo yn ei hiechyd corfforol da. Mae ganddi ychydig o gryd cymalau yn ei bysedd a'i hysgwyddau, ond fel arall dydy hi ddim yn sôn am unrhyw broblemau corfforol.

Tan yn ddiweddar, bu Dora'n annibynnol tu hwnt a hi fu prif ofalwr Jim. Hi sy'n gwneud y coginio a'r gwaith tŷ i gyd. Mae Dora'n gyrru ac maent yn mynd allan i siopa efo'i gilydd ar brynhawn dydd Iau i'r archfarchnad leol. Maent yn mwynhau garddio ac ymweliadau â'r ganolfan arddio yn ogystal â mynd i weld plastai a gerddi. Maent yn gallu cael gwyliau tramor fel arfer bob blwyddyn ac maent yn cynllunio i fynd i ardal y Cotswolds yr haf yma.

Fodd bynnag, oddeutu chwe mis yn ôl, dechreuodd Jim sylwi bod ei wraig yn dechrau anghofio enwau a dyddiadau a'i bod wedi cymysgu amseroedd apwyntiadau ar fwy nag un achlysur. Roedd hi wedi bod yn rhoi'r llefrith yn y popty yn lle yn yr oergell ac wedi gadael yr hob nwy ymlaen nifer o weithiau ar ôl bod yn coginio. Ar un achlysur arbennig y mis diwethaf roedd hi wedi cynhyrfu yn yr archfarchnad am ei bod yn methu â dod o hyd i'r cownter cig ac roedd Jim wedi gorfod mynd â hi allan o'r siop i'w thawelu.

Mae Dora hefyd wedi bod yn cyhuddo pobl o ddwyn ei phwrs ac wedi cyhuddo'i gŵr o garu ar y slei efo'r ddynes drws nesaf. Dydy'r amrywiad yn ei hwyliau a'i hyrddiau emosiynol ddim yn nodweddiadol ohoni yn ôl ei gŵr ac maent yn ei dristau yn fawr. Dywed Dora ei bod hi'n teimlo'n sicr ei fod yn ei thwyllo hi ac mae hi'n ei drin yn eithaf gelyniaethus yn ystod y cyfweliad pan mae ef yn gwadu hyn.

Mae hi'n dweud ei bod hi'n brudd iawn ynghylch y diagnosis ac am y ffaith fod yn rhaid iddi gymryd tabledi ac mae hi'n teimlo'n siwr nad oes arni eu hangen fwy na thebyg. Mae hi'n dweud ei bod hi'n gwybod bod ei chof wedi dirywio'n ddiweddar ond dywed ei bod hi wedi bod yn anghofus erioed a dydy hi ddim yn meddwl ei fod cynddrwg a beth mae Jim yn ei honni. Ei phrif bryder yn ystod y cyfweliad yw ei bod yn methu â dod o hyd i'w phwrs. (Mae hwnnw ar y soffa wrth ei hymyl).

Mae Jim yn dweud ei fod wedi ei ysgwyd gan y diagnosis ac mae'n wirioneddol boenus sut y byddant yn gallu ymdopi yn y dyfodol os bydd Dora yn dal i golli ei chof mor gyflym. Mae o hefyd yn poeni sut y byddant yn gallu dal i fyw'n annibynnol gan fod y meddyg wedi dweud wrthynt y bydd yn rhaid i Dora roi'r gorau i yrru car.

Appendix 2: Sample written instructions

Instructions for IPE case scenario presentations

PART ONE (during morning session)

Aim: To prepare a 10 minute presentation to illustrate your professional perspective (as a nurse or an OT) when assessing and planning intervention using an allocated case scenario.

Nursing and OT students will work separately within small groups for this first section of the workshop in order to produce a presentation. These presentations will then be delivered to, and discussed with, the other students within each mixed professional small group to begin developing inter-professional understanding.

Students will have 90 minutes preparation time. Each presentation should include information about the underpinning philosophy of the profession being illustrated, and an explanation of models / approaches used when assessing and planning intervention for each allocated scenario. Students need to be prepared to expand on sections of their presentation during discussion, and be able to back up professional view points with referenced literature.

PART TWO (during afternoon session)

Aim: Mixed professional groups to jointly agree and write a collaborative care plan for the first 4 weeks of intervention for their case scenario

The care plan should be realistic and client centred. It can involve the input of other MDT members as necessary and should strive to illustrate good interdisciplinary practice. It needs to be clearly written on flipchart paper.

There will be 45 minutes to devise the care plan and these will be displayed for other groups to view and give feedback on.

Cyfarwyddiadau ar gyfer cyflwyniadau achosion senario IPE

RHAN UN (yn ystod sesiwn y bore)

Amcan: Paratoi cyflwyniad 10 munud i ddangos eich safbwynt proffesiynol (fel nyrs neu OT) wrth asesu a chynllunio ymyrryd gan ddefnyddio senario achos penodol.

Bydd myfyrwyr Nyrsio ac OT yn gweithio ar wahân mewn grwpiau bychain ar gyfer y rhan gyntaf hon o'r gweithdy er mwyn cynhyrchu cyflwyniad. Yna caiff y cyflwyniadau hyn eu cyflwyno i'r myfyrwyr eraill ym mhob grŵp bychan proffesiynol cymysg, a'u trafod â hwy, er mwyn dechrau datblygu dealltwriaeth ryngbroffesiynol.

Bydd myfyrwyr yn cael 90 munud o amser paratoi. Dylai pob cyflwyniad gynnwys gwybodaeth am yr athroniaeth sy'n sail i'r proffesiwn a ddisgrifir, a dylid egluro modelau / dulliau gweithredu i'w defnyddio wrth asesu a chynllunio ymyrryd ar gyfer pob senario penodol. Yn ystod y drafodaeth mae angen i fyfyrwyr fod yn barod i ymhelaethu ar rannau o'u cyflwyniad a gallu ategu safbwyntiau proffesiynol â chyfeiriadau o lenyddiaeth.

RHAN DAU (yn ystod sesiwn y prynhawn)

Amcan: Grwpiau proffesiynol cymysg i gytuno gyda'i gilydd ac ysgrifennu cynllun gofal ar y cyd ar gyfer 4 wythnos gyntaf ymyriad ar gyfer eu senario achos.

Dylai'r cynllun gofal fod yn realistig a chanolbwyntio ar y client. Gall gynnwys cyfraniad gan aelodau MDT eraill fel bo'r angen a dylai ddangos ymarfer rhyngddisgyblaethol da. Mae angen ei ysgrifennu'n glir ar bapur fflip siart.

Ceir 45 munud i ddyfeisio'r cynllun gofal a chaiff y rhain eu harddangos i grwpiau eraill eu gweld a rhoi sylwadau arnynt.

Case Study 11: Interprofessional simulated learning, a pilot study

Pam Stead, Department of Occupational Therapy, Cardiff University[5]

Key words: simulated learning, reflective practice, problem-based learning, interprofessional learning, e-learning

Course specifics

Title: **Undergraduate, interprofessional simulated learning, a pilot study**

Aim: To create an interprofessional simulation and e-learning experience for Child-Branch Nursing and Occupational Therapy students

Objectives: By the end of the course, it is hoped that participants will be able to:

1. research knowledge and share professional understanding of the paediatric case study, using a PBL approach;
2. use the similarities and differences in role between the two professions creatively to carry out a simulated assessment and formulate a client-centred intervention plan;
3. utilise the digital recording of the role-play scenario to aid reflection and evaluation of the experience.

Teaching methods: simulation, e-learning, problem-based learning, case study.

Professions involved: child branch nursing, occupational therapy

Organisations involved: School of Nursing and Midwifery Studies, Child Branch and School of Healthcare Studies, both Cardiff University

Length: 5 sessions totalling 15 hours

Assessed? No

Supporting resources? Simulated learning environment (the flat), specifically prepared case scenario.

Number of times this course has run: once as a pilot project

Number of participants: Nursing (n= 17), OT (n=8)

Background and purpose

There has been a significant improvement in the long-term survival of chronically ill children, which has led to increasingly complex health and social care scenarios. Apart from the legal and professional expectations of staff to work interprofessionally, parents expect, quite rightly, that there should be seamless service provision in the best interests of children. Cardiff University is fortunate in having not only a School of Nursing, but a School of Healthcare Studies, and this pilot project took advantage of the opportunity to share knowledge and skills between the undergraduate students

[5] With Jane Davies and David Clarks, School of Nursing and Midwifery (Child Branch), Cardiff University

and staff of these Schools. The intention was to help students meet the complex care needs of families.

Child branch nursing at Cardiff has extensive experience of simulated learning with undergraduate nursing students and excellent facilities for this, albeit on a different site in Caerleon, sixteen miles from Cardiff. The Department of Occupational Therapy grounds its curricula in problem-based learning. When nursing eductors at Caerleon wanted to learn more about using PBL to prepare students for these simulations, they contacted the Department of Occupational Therapy, seeing it as an opportunity for interprofessional education.

Both Heads of Schools were supportive of the initiative in interprofessional learning, and staff were enthusiastic to work collaboratively on this as a pilot project. In both nursing and occupational therapy undergraduate curricula, it became apparent that the second year was the most appropriate place for this course, both pragmatically in terms of timetabling but also, importantly, in terms of the theoretical content of the curriculum.

The most suitable environment for this pilot study was the simulated flat that belonged to the School of Nursing. Non-contact time learning was supported through a project-specific e-learning resource on the in-house VLE, Blackboard.

In practice

An important factor at the beginning was our commitment, as a staff group, to overcome potential problems. We worked well together, pooling our knowledge and experience of the different learning and teaching techniques, and we were enthusiastic, which was important for the success of the project, as it helped enthuse the students. It is important to note that, as experienced staff, we had considerable **autonomy** to make decisions about the form and content of this pilot project to ensure it met the needs of both groups of students. This combination of **enthusiasm** and autonomy is a crucial factor in the success of the project and should not be overlooked, but we were still working within the narrow confines of each of our curricula.

The students were not involved in the planning, but the occupational therapy students did give a presentation about PBL to the nursing students, as this was a new way of working for the nurses.

We put the students into three groups, each group consisting of three occupational therapy students and five nursing students. They met in an ice-breaker session initially, and then had three sessions together to research the case study and plan a joint discharge assessment in the child's home, liaising with the family. The subject of the case study concerned a child with severe head injury and complex needs.The case study was designed both to engage the specific knowledge base of each profession, and more generic knowledge and skills such as communication and team-working. It was expected that the students would share and negotiate these areas before deciding on their assessment plan and carrying out their simulation, which was session four.

The simulation experience of all three groups achieved excellent responses from the students. Each student had a chosen role in the simulation, playing the parts of the family and the professionals in the realistic environment of the flat, complete with blaring television set. One student in each group recorded the scenario and the staff

left the students to enact their own, unfolding home visit. The students were animated and inter-active, clearly enjoying the experience and openly stating that they felt **empowered** by realising they knew more than they thought, when carrying out the simulation. Their comments were that they now understood the role of the other profession, which was very satisfying to hear. The DVD was later downloaded onto Blackboard for the groups to be able to view their work.
The DVD review and reflection session was session five, and this proved to be a very rewarding learning opportunity as evidenced by the students' evaluations:

> *"useful for me to review and evaluate my performance"*
>
> *"it was so helpful to watch the scenario back - a very good learning experience"*

From this session, students were able to write a joint assessment plan in their groups and share the plan with other groups and the wider OT cohort.

Evaluation

The outcome of the project was very positive, but that is not to say there were not problems and issues along the way. The majority of these came at the beginning of the pilot, which we had expected, as the **use of PBL** was always going to be a big challenge for the nursing students, who were more used to a didactic approach to teaching. The other difficulties at the beginning had pragmatic foundations, due to the different timing of placements and college blocks. The occupational therapy students volunteered for the project and were told about it early at the start of term, a couple of weeks before the project started. This was in contrast to the nursing students, who had been out on placement and had received a letter telling them about the project and that it would start on their first week back.

The whole nursing cohort was used, not affording them the chance to volunteer their participation. This led to some early discontent amongst some of the nurses, who were tired after placement, and had not expected to return to be faced with small group work and PBL. Also, the nurses were not given a formal opportunity to talk about their accustomed learning style to the occupational therapy students, who had talked about PBL, a pedagogy they had adjusted to since the onset of their course. Some of the nursing students initially found it difficult to extend their usual hospital role, **bridging into the community** on a home visit, though the necessity for nursing advice in the home situation had been designed into the case study.

The smaller number of occupational therapy students in each group found these issues challenging, but it is to the credit of both groups of students that they negotiated between themselves to come to a working solution that did indeed seem, in retrospect, to favour the occupational therapy students. All the students agreed, on their evaluations, that the shared experience had been worthwhile and that they had learnt a great deal from each other. They all enjoyed the project as an innovative teaching experience and felt it should be repeated. In fact, the pilot was so successful, the rest of the OT cohort was sorry not to be extended the same opportunity to have the simulated learning experience.

Recommendations to others following our path

In summary, the challenges to be addressed by anyone contemplating a similar initiative are:

1. Carving out enough time in the curriculum of each profession to allow for an adequate number of joint sessions;
2. Reasonable parity across the participating cohorts in terms of similar levels of study reached. Ours were both second year students, but it turned out the nursing students had a year of general nursing and had only just started in child branch nursing, which is how the programme is structured in Cardiff;
3. The sizes of the cohorts should preferably be evenly matched, so no-one is excluded from the joint sessions and one profession doesn't feel swamped by the other;
4. Educationally, the IPE sessions need to link to relevant learning in the rest of the curriculum. Are the IPE sessions actually congruent with the level of the students learning?
5. It is better if both groups have some preparation uniprofessionally for the sessions, so they then anticipate them positively, rather than not knowing what is going on. In terms of nursing, the lecturers are going to give their students some preparation on community nursing;
6. Prepare your technical support services well so that the DVD tapes from the scenarios can be quickly and smoothly transferred to whatever interactive system you are using, such as Blackboard. (We are investigating the use of YouTube as an alternative method of sharing the information.);
7. The scenarios can be written to suit any situation/ number of professions as long as they are realistic (to ensure meaningful learning). A sample of our vignette is attached as Appendix 1;
8. Allow plenty of time for the students to review the DVDs to allow for depth of evaluation and reflection as well as time to jointly plan their intervention for the client;
9. Finally, we have to say that a high level of autonomy is needed to make the necessary curricular changes, so the agreement and support of high level staff is essential. But enthusiasm carries you a long way and we did not have scrupulous regard for all of the above and the sessions worked well, so there is a lesson to be learnt there in not being too cautious to get things perfect before trying - things will never be perfect!

Plans for the future development of this course

We need to address the perceived imbalance between the nursing and OT students at the outset of the course. Face-to-face meeting in IPL is always preferable to establish good relations, so this needs to be built into each profession's current timetable to enable the students to introduce themselves and their profession earlier to each other. PBL could also be introduced in this session, giving the nurses time to adjust to the concept.

We are also considering asking the students to each research the other's profession before meeting and present on it as they perceive it. Is this a suitable challenge or a terrifying prospect? In retrospect, the expectations of what the students were anticipated to achieve, was very high - some review of expectations and a more streamlined approach to outcomes might help clarify these expectations to students.

The other issue that needs consideration next time is the inclusion of the whole OT cohort. The main difficulty is the imbalance of numbers between child branch nursing (17) and occupational therapy (45). The obvious solution is for the groups to each have two nurses and six occupational therapists. But care is needed to ensure that the nurses do not feel totally overwhelmed. Ways to address this would be to have better preparation for the nursing students in terms of introducing the project and more opportunities for both groups of students to meet informally. We are considering a social meet-and-greet session away from the University, in the summer term, before the project starts properly, possibly a group treasure hunt in the grounds of our (free) open air museum in Cardiff.

One issue for us is that we may be faced with the loss of the flat. Other options we have considered are the use of some willing person's own property (might raise lots of issues?) or the simulation of a flat as best we can in a classroom. Not ideal, but still an innovative learning opportunity - it is the way things are presented that makes a difference to the students' experience.

We intend to run this course in 2010/2011, come what may, and hope to reduce the problems by improved timetabling and better preparation of the students but we feel we have a good base now from which to repeat the experience. We have offered the opportunity to work with us to other relevant health professionals, so we hope the project keeps evolving.

As for the staff, this quote from the students' evaluations makes it all worthwhile:

> *'I've learnt that IPL is effective, in terms of communication and understanding different roles.'*

And surely that is what we were trying to achieve?

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Appendix 1: Group scenario

Tom Williams

Tom is a seven year old boy who sustained a head injury as a result of an RTA which knocked him off his bike. He was admitted to hospital with a major diffuse head injury with cerebral oedema and spent three weeks in intensive care before being transferred to an acute children's ward. He has now been on the ward for several weeks, visited regularly by his family.

At the MDT meeting

Karen Evans (Tom's designated nurse)

"Dr. Brown apologises for not being here today, but, as most of you are aware, he considers Tom no longer needs acute hospital care and asks the team to consider arrangements for discharge. He needs the bed for a new patient. As you know, Tom came to us in a pretty bad way, with his condition stabilised but with some major concerns. He had been difficult to wean from the ventilator but he has made good progress with his respiration and is breathing normally. But his difficulty in swallowing means he still needs PEG feeding and we've got him on a ripple mattress. I think he could return home now as long as there is good community support to the family. His mother is on her own, and she has another child, older than Tom. But his mother gets good support from the grandmother and they are all keen to have him home."

Sue Walker (Tom's physio)

"Tom is making progress with the walking frame plus two helpers, but he'll still need an attendant controlled wheelchair for discharge. He's a really determined little character - even though he can't talk well, you soon know what he likes and what he doesn't!"

Dawn Jenkins (Tom's OT)

"Yes, Tom does get frustrated sometimes, though that is understandable. Cognitively, he is recovering well, and he has started to be able to play simple computer games, which he loved before his accident. As far as discharge goes, his mother told me that when Tom's father left, the family moved to be close to Tom's grandmother, who lives in the same street, but they could only get a flat from the council, not a house. I will certainly need to do a home visit to assess the property."
Karen
"I'd like to come with you on the visit, so we can make appropriate recommendations to the community nursing team."
Dawn
"I'll arrange it with Tom's mother and let you know. Which date suits you best?"
Sue
"Let me know the date and I'll do my best to come too, though my list is very heavy at the moment."

The meeting moves on to the next patient.

Case Study 12: Inter-professional learning and teaching with occupational therapy, physiotherapy and dental undergraduates

Dinah Sweet[6], John Sweet[7] and Christine Locke[8], Cardiff University

Key words: Interprofessional, briefing and debriefing, collaboration, peer learning, clinical work-based situated learning, scholarship

Course specifics

Title: Inter-professional learning and teaching with occupational therapy, physiotherapy and dental undergraduates

Professions involved: Physiotherpay, Occupational Therapy, Dentistry

Organisations involved: Cardiff University

Length: 6 months for 10-25 students on an optional basis

Assessed? Formatively as an element of practice / clinical assessment

Special resources needed? Dental clinic, support staff, academic staff, video, audio, still digital camera

Number of times this course has run: Once as a funded pilot project

Number of students involved: physiotherapy: 5 (yr 2/3), OT 3 (yr 2/3), Dental 2 (yr 2)

Objectives: By the end of the period of study, participants should
1. be able to give and receive professional advice from colleagues
2. have increases awareness of workbased learning in an interprofessional environment
3. have experienced patient centredness through role play in the workplace.

Teaching methods: Practice placement, workbased learning, classroom teaching, simulation, clinical skills

Relevance to student learning:
The objective was to improve the dental students' awareness of their working posture by getting feedback from the 2 other groups of students. It was hoped that the benefits to the OT and Physiotherapy students would be to enhance their communication skills and elicit 'good' practice with an awareness of the importance of patient empowerment.

Supporting resources:
1. RIBA ergonomic scale
2. Evidence based medicine article
3. Patient centredness article

[6] Physiotherapy Department,
[7] Formally School of Dentistry,
[8] Department of Occupational Therapy

Background and purpose

Occupational therapy, physiotherapy and dental students were given the opportunity to work together and learn from each other in a dental workplace setting. Initially there appeared to be deficiencies in the dental undergraduate curriculae such as lack of prevention strategies for back and neck problems. It was thought that, through posture awareness and training, this could be rectified using an interprofessional approach. Dental students were already aware themselves that they could benefit from ergonomic information and good practice. Occupational Therapy and Physiotherpay students value early work-based experience.
This innovative approach to inter-professional collaboration in learning and teaching, used a 'safe' clinical environment to share and exchange learning. The content included working posture and ergonomic advice whilst engaging in a 'person centred' approach. The approach to ergonomics was articulated by using a full body index scoring system devised by Hignett and McAtamney (2000).

This work was underpinned by three educational theories:

1. Learning communities (Shapiro and Levine, 1999) where students from different disciplines and backgrounds are given opportunities to learn from each other;
2. Situated learning (Lave and Wenger, 1991) where students have the opportunity to exchange information and share advice in a real workplace;
3. Learning with integrity (Shulman, 2007) where students are encouraged to reflect on the quality of their actions and others' actions, so that they can ensure that their practise is 'just right'.

How it worked

The course initiative was funded by the Cardiff University Learning and Teaching Committee. Permission was gained from the Heads of Schools involved and the proposal was passed by the School of Healthcare Studies Research and Ethics committee.

A pre-course questionnaire was given to the student body to assess the different students' interests and experiences of adverse conditions causing back and neck problems. The questionnaire also surveyed their attitudes to patient centredness. Following this, a number of students approached one of the staff showing an interest in participating while others who willingly engaged with the subject were selected using purposive sampling. There were pre-course meetings with the interprofessional tutors where fruitful dialogue promoted further ideas.

The interactions were set in different environments. The initial briefing in the seminar room, set the focus for each session. The move then to the dental work station, simulated the practitioner/patient practice, and was followed by small group discussion with peer feedback. Another environment was the dental phantom head laboratory where lively discussion followed observation of the inflexible working positions. Each session ended in the seminar room with debriefing, dicussions and focus groups taking place.

What worked well

A particular benefit was the enthusiam with which students worked and enjoyed learning together by respecting the skills and knowledge that their peers were developing and sharing. The use of briefing and debriefing sessions were particurly useful in the small group working as they provided opportunity for detailed appreciative and critical dialogue. The opporntitiy for all students to role-play a dental patient, clearly alerted all participants to the vulnerable situation patients can feel they are in, and how modification of the workplace environment can greatly ameliorate this. Participants reported the value of **peer teaching** and expressed a preference for peer- rather than staff- led learning.

The paritciapting staff also gained much from the prolific and profound cross-fertilisation of ideas and practices experienced during the course. This was not an "ordinary" interprofessional mix, and a few years ago many teachers would have thought the mix too extreme to ever try out. The learning for staff should be to take the "risks" of moving outside professional dogmas because the diverse working together of students cannot but produce learning - seeing things anew (Marton, 2003).

The sessions worked well for all students, although it could be argued the dental students benefited most from the encounters. With the sessions taking place on their home territory, dental students benefited from other students bringing knowledge and expertise, on an important topic in which, for historical reasons, they had no formal training. Lasting life benefits of working in a correct posture were valued greatly by the dental students, and other students who had not participated often commented to the dental staff member on how they were disappointed to not have the benefit of this. The Dental students also mentioned that the sessions set them ahead of their peers favourably in a clincal medical history test exercise they were given on their course. The Physiotherapy and Occupational Therapy students benefited from some increasing awareness of oral hygiene, and had the experience of workbased learning which they would not have received at that point in the course, but all these benefits did not correspond to a specific course deficiency.

What did not work so well

The main limitations of the study were problems of timetabling, and gathering disparate groups of students together who were based in different areas of the University. Also there was noise pollution due to repairs taking place at the School of Dentistry, which impacted on the video recording and disturbed the discussion groups. At first all the students were low in confidence, but the initial briefing sessions and explanations of the role-play gave, them all the opportunity of experiential learning in a non-threatening environment.

What we will do differently next time

Next time this course is run we would determine more clearly the **level of knowledge** and training of the students involved, to enable better framing and organisation of initial interactions. But the nature of a pilot study is that it must fit into, and where possible augment, the current courses that the students are experiencing. There is no doubt that the ideal situation would be where the different professional groups were working in a **University-wide interprofessional umbrella**, where

interactions between multiple professional groups of students would be the expectation. Then, at a programme level, course objectives could be compared and contrasted for common learning pathways, but as in this case, innovative integrations of comparable and complementing learning outcomes could be timetabled.

Plans for the future

Plans for the future are to publish aspects of our evaluation of the course and its implications. This is an important stage to help gain acceptability for an interprofessional (IP) approach. The learning, that could be transferred to other IP courses, is to value unusual interactions of student groups for the powerful educational Learning Community tools that they are. Relatively short periods of IP learning and interaction can have a profound and lasting impression on staff and students. The educational dialogue necessary to set up a collaboration is valuable professional development. The application of complementary strengths of staff from very different professions, provided a beneficial team teaching environment.

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This work has been pulsihed elsewhere as:

Sweet D, Sweet J, et al. "Undergraduate healthcare students' perceptions of back pain, working posture and patient empowerment"; 6th Interdisciplinary World Congress on Low Back and Pelvic Pain: Diagnosis and Treatment; The balance between research and clinic; World Congress for Interdisciplinary Physiotherapy; Barcelona; November 2007.

Sweet D, Sweet J, et al. Health Sciences and Practice Network “Inter-professional learning and teaching in the dental workplace setting with physiotherapy, occupational therapy and dental undergraduates exchanging posture, ergonomic and oral health advice.” Cardiff April 2008

AMEE Conference 2008 “Inter-professional learning and teaching in the dental workplace with physiotherapy, occupational therapy and dental undergraduates exchanging posture, ergonomic and oral health advice.” Prague August – September 2008, Funded by an award from the HEA Subject Centre for Medicine, Dentistry and Veterinary Medicine.

Sweet D ‘Inter-professional clinical exercise to exchange posture/ergonomic and oral health advice between physiotherapy, occupational therapy (OT) and dental undergraduates’. 2nd European Conference on Physiotherapy Education, Life long learning: Developing the profession. Sept 25-26 2008 Stockholm.

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Case Study 13: BSc Health and Social Care: working together

Carolyn Wallace, Health, Sport & Science (HESAS), University of Glamorgan

Key words: Health and social care, nursing, social work, Nutrition and exercise, undergraduate, interprofessional

Course specifics

Title: BSc Health and Social Care Year 1 – 120 credits HEFCW Level 4

Aims: The first year programme aims to introduce participants to the range of health and social care professions in order to facilitate their career decisions and their plans for programme years 2 and 3.

Objectives:

1. To promote common understanding of health and social care organisations, including structures, systems and relevant theories which enable individual flexibility in practice, boundary spanning and 'silo' avoidance;
2. To introduce the student to health and social policy, the law and the legal system of England and Wales in context;
3. To explore boundaries and approaches to promoting health and wellbeing within society.

Teaching methods: A blended learning approach comprising: practice placement, classroom teaching, simulation, problem-based learning, clinical skills, case study.

Professions involved: Generic support workers, Social work, Nursing, exercise, sport and community health workers, interdisciplinary teams such as intermediate care and reablement (occupational therapy, physiotherapy, dietetics etc), management e.g. project managers in health or social care health promotion.

Organisations involved: University of Glamorgan, Aneirin Bevan Health Board, MIND, , Coleg Sir Gar, Territorial Army, SCOPE, Rhondda Cynon Taf Local Authority, Blaenau Gwent Local Authority, GP practices, Vision 21, private industry etc

Length: 8 months

Assessed? Yes, summative. Group presentation, written assignment, exploration of a care plan

Supporting resources: Key texts include:

1. Adams, R (2007) *Foundations in Health and Social Care*, Palgrave Macmillan, Basingstoke.
2. Wallace, C & Davies, M (2009) Sharing assessment in health and social care. A practical handbook for interprofessional working. Sage, London.
3. Malone, C., Forbat, L., Robb, M., Seden, J., (2004) *Relating experiences: stories from health and social care*, Routledge, London.
4. Jelph, K and Dickinson, H (2008) *Working in Teams*, The Policy Press, Bristol.

Number of times this course has run: Twice

Number of participants on each course: 32-45

Background and purpose

Policy within Wales and the UK supports the development of the support/generic worker to enable the professionally registered members of the multidisciplinary teanm to focus on delivering their core/specialised skills. Policies and reports such as the Primary and Community Services Strategic delivery programme (Jones, 2009) Community Services Framework (WAG, 2007a), Improving Health and the Management of Long Term Conditions in Wales (WAG, 2007b), Lewis (2007), Beecham Report (WAG, 2006a), Making the Connections (WAG, 2006b), Fulfilled Lives; Supported Communities (WAG, 2006c), National Service Framework for older People (WAG, 2006d), Designed for Life (WAG, 2005) and the Wanless Report (WAG, 2003) are driving Local Authorities and Health Boards to design 'associate practitioner' and support roles to ensure that they can deliver their new community service models.

In practice

The Health and Social Care students are studying for the award in order to either introduce themselves to the differing professional groups in health and social care in order to facilitate their career decisions for the future or they are using it to facilitate career progression in practice or managing projects and/or people. In Year 1, the students on the BSc Health and Social Care learn with other professional groups such as nursing and social work. In particular within a module called Health and Social Care Organisation (20 credits), they learn with social work and nutrition, exercise and community health students whilst learning about the many organisations, roles, methods and tools of working together. In order to develop their understanding of the whole system of health and social care, students are introduced to various practitioners (e.g. practice nursing) and organisations (e.g. MIND). This helps to prepare them for their placement in Year 1. BSc Health and Social Care students experience a week in a social care placement and one week in a health care placement. These observational experiences are chosen by the award team in order to provide the student with a wide experience of the care system. Most students will visit a hospital ward during their health week and a day care setting in their social care week. These are observational in Year 1, giving students an opportunity to shadow practitioners and witness firsthand how they work together and compare the diversity of roles and health and social care organisations. This placement provides an opportunity for students to gather experience and information for assessments within Year 1, for example an anonymous care plan from practice. Students bring these back to the classroom where they explore the principles and features of working together in preparation for their assignment.

The course philosophy

The course takes on a systems thinking approach. It considers the whole system's ten essential core values for development identified by Attwood et al (2003) in addition to Sellman's (2010, p159) most recent acknowledgement of the 'willingness condition' as the starting point which enable people to work together across health and social care. These values are optimism, empathy and humility, tenacity and courage, learning, relationships, whole system perspective, local knowledge for local solutions, building social capital, celebrating small steps and the long view. The 'Willingness Condition' is considered necessary in order that a team can most

effectively meet an individual's needs. It is described as 'the willingness to do whatever is required to contribute to effective teamworking'.

In order to develop this philosophy within the classroom setting and 'learn with, from and about each other' (CAIPE, 2002), the **emphasis is on social interaction** and so groups are facilitated in a number of ways throughout the academic year. (Bandura, 1977; Vygotsky, 1962). This commences with the guidance for interaction within the classroom at the beginning of the academic year, introducing students to one another, encouraging students to sit with a different person and so promoting learning about one another as individuals. This provides the first steps of learning and developing relationships. The wider aspect of this approach is developed in the first term when students learn from our partners from practice (e.g. interdisciplinary teams, voluntary organisations etc) about the different roles/services working and the networks required to problem solve across the health and social care systems. This integrative/partnership approach to teaching (Hunsberger et al, 2000) links the theory taught within the class to an understanding of what occurs and needs to occur in practice to meet service user needs. Tools for learning 'from' and 'with' one another together include scenario based learning in groups, developing care plans and 'building poems' in pairs. This last tool is used to simulate the relationship required for coordination in practice as students work together in pairs to develop a poem, taking it in turn to alternatively add a word. This identifies the importance of clarity, leadership, relationship, tenacity, trust, optimism and empathy.

The new approach to Year 1 is included in the prospectus for the award and discussed at interview for all awards involved. In addition the last year 1 and 3 of the social work programme identified that they should be learning with in addition to about other professional groups in their award and module evaluation.
The preparation at the beginning of the course ensured that they were introduced to one another and had the opportunity to explore why they were on the course and what they expected to gain from learning with and about one another.

What worked well

The **inclusive integrative/partnership approach** (Hunsberger et al, 2000) used for planning, inviting partners to participate in the validation process and identify/deliver valuable teaching opportunities ensured a robust award document and plans for delivery were developed. Where opportunities for teaching and placement have been identified, this has ensured that the award team have been able to provide valuable learning opportunities both in the classroom and in placement. These have enabled students to make decisions about their future career pathways and to forge relationships with future employers. This requires a considerable amount of effort on behalf of the award leaders to maintain relationships in practice. Students once returned from their placement experiences in term two and year 2 have since reported the value of the interprofessional approach to learning.

What could have been better

A lack of detailed, interprofessional training for the lecturers at the beginning of the academic year was an over-sight, which will be remedied at the beginning of the next academic year. The effect of the stages of group development such as 'storming and norming' were more pronounced than with uni-professional learning groups. The

lecturers would have benefitted from prepared sessions prior to commencing the award to ensure that they were prepared for the differing effects on group dynamics.

The end of Year 1 evaluation, on the whole, demonstrated that this approach has been a positive experience for students. However, worryingly a very small number of students from one of the awards participating did not feel that learning with and about one another was relevant to their current and future professional practice. They did not feel that the other students had anything to offer their professional development. This was demonstrated as a 'hidden tension' throughout the first term which became apparent towards the end of the term when the conflict between the small number of students became visible (Bray, 2008). The module leader had to challenge the presenting behaviour in a positive and constructive way by using scenarios from practice to demonstrate the value of people from diverse professional backgrounds (Howkins & Bray, 2008).

Plans for the future

The BSc Health and Social care award has already attracted a large number of applications and will continue to run the award as a whole with 60% learning with students from other awards such as social work, nursing, specialist public health nursing, nutrition, exercise and community health. This will comprise of both shared learning and IPE. There are a number of key themes through this learning experience which includes child protection, working together in its various forms, assessment, disability, social issues, law and policy. Within the child protection theme a case confernece academy approach is utilised. This award winning approach prepares students (midwifery, social work, health and social care, school nursing, health visiting and occupational health nursing) for witnessing a child protection case conference which includes role play from key lecturers and an independent chair. Students are then given the opportunity to question the panel and discuss this expeirence together. After which they are seperated into their professional cohorts for debriefing.

During Year 3 it is anticipated that nursing, social work and health and social care students will learn about discharge planning using 'passing the baton' and a carefully prepared case study utilising role play within a multidisciplinary setting.

An evolutionary approach to interprofessional learning is proposed within the Faculty of Health Sport and Science in order to embedd IPE into undergraduate learning. Over the last couple of years an interprofessional group have met to plan a way forward across the faculty. We are aware that througout the faculty there are informal experiences of shared learning and IPE for example social work and police sciences. However, it is anticipated that a more formal approach will be adopted over the next few academic years.

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