

# Trent Universities Interprofessional Learning in Practice

Project Report 2005-2009





This is the final report for the Trent Universities Interprofessional Learning in Practice Project (TUILIP). The report details the background to the setting up of the project, how the project was managed, how the project outcomes were achieved in each of the eight pilot sites and a summary of the findings from the evaluation carried out in each site.

To view all pilot site summary and evaluation reports please go to the project website

<http://tuilip.hwb.shu.ac.uk>



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# Foreword

I am amazed how the acronym of a project sounds suitably like its work.

Indulge me for a moment as I explain. TUILIP, minor spelling difference sounds like the flower which grows from a bulb. I see the bulb, which is multi-layered, representing different healthcare professionals surrounding and interacting with each other, protecting at its centre the heart of the bulb - the service user. The bulb uses all its resources both stored and raw from its environment to grow a beautiful flower, the student.

This flower is the work of many layers of interprofessional collaboration. The flower becomes a beacon to wildlife – pollination occurs or sharing of knowledge and a new or stronger breed is born. Think about how much work has gone into that bulb to produce its flower. It knows it is essential for survival. Interprofessional education is key to caring for our service users safely, effectively and innovatively.

The interaction between those layers is the bulb's lifeline, without it, no flower would be produced. We work interprofessionally so why do we put hurdles in front of us to make it difficult to use our resources to educate interprofessionally? Our working practice, like the bulb is interprofessional, no one professional can care for the service user on their own. No single layer of the bulb can produce the flower. Those that

have grown from interprofessional education in practice will attract others and the practice will develop as the norm. If this becomes the norm, the heart of what we do, the service user will **always** benefit.

Finally, as you know a bulb is sustainable. Like this metaphor the TUILIP project offers sustainable examples of interprofessional education in practice. I would like to thank all those who co-ordinated the project, contributed to the resources, expertise and practise interprofessional education, and of course the final production of this document. Please use it, adapt it and develop what you need to grow from your own bulb.



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# The Project

## Background

The Faculty of Health and Wellbeing at Sheffield Hallam University, in collaboration with the Faculty of Medicine and Health Sciences at the University of Nottingham, were awarded funding of over half a million pounds in 2005 by Trent Multiprofessional Deanery (*previously Trent Workforce Development Confederation*) to take forward interprofessional learning (IPL) in the Trent region.

The main aim of the project was to develop sustainable models of IPL that would promote and facilitate the professional skills of students through collaborative working within the practice setting.

The project has entailed collaborative working by the two Universities, and involved NHS Trusts across the Trent Region and students from 13 professions in health and social care. The original proposal was focused on IPL in practice settings across primary and secondary care. The outcome of the four year project has been the development of sustainable models of IPL in practice that contribute to the development of students as

effective interprofessional practitioners for modern health and social care services. A four year plan was created to establish eight pilot sites developing interprofessional learning opportunities for all students on placement. A key feature of the project was the appointment of an IPL Facilitator in each pilot site to work with staff and students within the site, taking these developments forward. Each IPL Facilitator was seconded to the TUILIP project for between six and twelve months.

## Management of the TUILIP Project

It was agreed by the two universities that a Project Lead would be appointed from Sheffield Hallam and a Project Coordinator from the University of Nottingham. These posts were taken up in June 2005 with the appointment of Helen Armitage as Project Lead and Richard Pitt as Project Coordinator. A small team of representatives from both universities was quickly established to plan the operation of the project. This team became the Management Group and continued to meet approximately every 6 weeks



over the life of the project. *(See appendix A for group members and terms of reference).*

An overarching steering group was set up and consisted of senior academics from each university, representatives from Trent Multiprofessional Deanery, senior managers from each pilot site (whilst the site was running) and students from both universities. Whenever possible representatives were chosen to join this group from a range of professional backgrounds. The steering group met three times each year. *(See appendix B for group members and terms of reference).*

Project outcomes were developed based on the original bid submitted to Trent Multiprofessional Deanery. *(See Project Outcomes).*

Subsequently action plans and a proposed time line were developed by the Management Group. *(See appendix C and D).*

## Project Outcomes

- *Embed interprofessional working and learning within the Trent region so that all practice in health and social care adopts an interprofessional philosophy*
- *Enrich and inform the curricula of all participating professional undergraduate courses*
- *Provide learning opportunities for staff to develop appropriate skills to support interprofessional learning in practice*
- *Utilise the Combined Universities Interprofessional Learning Unit interprofessional capability framework (Gordon and Walsh, 2005) to formulate resource packages and training templates*
- *Evaluate the impact of the project in the pilot areas, comparing outcomes across the sites*
- *Disseminate the findings from the project and influence national strategy by recommending sustainable models of interprofessional learning*

## Achieving the TUILIP Project Outcomes

The TUILIP Project funding was awarded to Sheffield Hallam University and the University of Nottingham by Trent Multiprofessional Deanery, a part of Trent Strategic Health Authority (*Trent SHA*), in February 2005. Trent SHA served the three East Midland counties of Derbyshire, Lincolnshire and Nottinghamshire with a combined population of 2.7 million people and a total NHS budget of £2.5 billion. From 1 July 2006 Trent Strategic Health Authority joined with Leicestershire, Northamptonshire and Rutland Strategic Health Authority to form the NHS East Midlands. However the TUILIP project has continued to focus on the Trent region as this was the original remit for the funding. Meanwhile strong and productive links have been made with colleagues, both in practice and in academia, in the southern part of the new organisation.

Trent is diverse and covers the rural areas of the Peak District National Park in Derbyshire and the sparsely populated communities in Lincolnshire, together with the more densely populated, multi-cultural cities of Lincoln, Nottingham and Derby. In order to influence the development of interprofessional learning across the region the TUILIP project established pilot sites throughout the region, spanning the five health communities.

The TUILIP project began in April 2005 and completed in June 2009. Following this period the evaluation of the last three sites was completed over the following six months. This time scale has limited the extent to which the outcomes can be achieved over the whole of the Trent region and so it was decided to focus resources in eight sites

in total. The sites cover as much of the region geographically as possible and aim to be beacons of interprofessional learning and working for the surrounding locality.

Selecting the TUILIP pilot sites was a collaborative process involving the TUILIP Management and Steering groups and colleagues working in NHS Trusts and Independent and Voluntary Services.

### Choosing pilot sites was based on the following criteria:

- *Interprofessional or multiprofessional working was operating*
- *At least 2 professions worked closely together*
- *The site took students from at least 2 professional groups*
- *Trust Chief Executive (or Independent Organisation Lead) supports the project pilot site*
- *If an acute area, the site had links to either intermediate or community care and social care*
- *A strong commitment to modernisation*
- *Enthusiasm to improve services for service users*
- *Motivated to develop new learning opportunities for students*



In addition the team tried to plan sites which spanned as many different facets of health and social care as possible. These have included primary and secondary care, social services, district general hospitals, teaching hospitals, acute emergency, medical and surgical services, intermediate care, mental health services, learning disabilities support, women's health and midwifery.

The first step in establishing a pilot site was agreement from the Trust Chief Executive. Normally a management champion was then appointed who was familiar with the allocated area and able to influence the developments. Experience in the Forging Ahead project (*Armitage and Bywater, 2004*) highlighted the importance of the role of the management champion. Without the support of a local, enthusiastic, influential manager the project would flounder. This person was able to allocate and release staff, participate in the appointment of the Interprofessional Learning Facilitator and ensure the project was publicised throughout the Trust or organisation.

Once a Trust had agreed to become a TUILIP site, a specific area or department was chosen to be the pilot site. This was usually done in collaboration with senior members of the interprofessional team. They were able to recommend a suitable area which fulfilled the above criteria. A local steering group was then set up which consisted of as many different professionals as possible who operated within the pilot site. This group then met approximately every 1-2 months.

The next step was then to organise some introductory workshops for staff working in the area to attend. These were open to all staff and enabled useful discussions to take place about how the project would proceed. The TUILIP project did not have a set way of introducing interprofessional learning; instead models were developed in collaboration with the team who operated within the pilot area. In this way we were able to fully utilise local resources and to develop different ways of working. It was hoped that this will result in sustainable models which would help to develop an interprofessional culture and enable students to develop interprofessional capability (*Gordon & Walsh, 2005*).

While introductory staff development took place, the seconded post of Interprofessional Learning Facilitator was advertised throughout the health and social care locality. (*See appendix D for the role specification for this post*). Once the post was filled interprofessional learning began in earnest.



### TUILIP pilot sites established during the life of the project

- *Bayliss Ward, Mansfield Community Hospital*
- *Orthopaedic Care, Grantham and District Hospital*
- *Acute Mental Health Services, Queen's Medical Centre, Nottingham*
- *Emergency Management Unit, Chesterfield Royal Hospital*
- *Enable Housing Association*
- *Maternity Services, Derby Hospitals NHS Foundation Trust*
- *Derby Women's Services (Including acute and community)*
- *2 GP Practices, one in Derby and the other in Belper*

### Assessment Tools

The Project Team were keen to ensure that learning opportunities in each site were underpinned by learning frameworks such as the Knowledge and Skills Framework, Ten Essential Shared Capabilities (*NIMHE / SCMH, 2004*) and the CUILU (*Gordon & Walsh, 2005*) Capability Framework.

The TUILIP Facilitators encouraged students and supervisors/mentors to use these to help students to self assess their progress and to provide evidence for collaborative learning in practice. In particular the CUILU Capability Framework was promoted as a validated tool as it was already being used by Sheffield Hallam University students in the classroom setting. However many practitioners found the tool lengthy and difficult to interpret so a shortened version, the TUILIP Areas for Learning, was produced in an attempt to make it more accessible. It was intended that this should be used in conjunction with the full document. (*See appendix E for the TUILIP Areas for Learning*).

Students attending any TUILIP learning opportunity were encouraged to demonstrate evidence of meeting their specific learning outcomes whilst on practice placement considering which placement outcomes they may have met, identify which of the TUILIP Areas for Learning this related to, composing a reflective account and using this as evidence for assessment.



## Staff Development

Staff development took place in each site prior to appointment of the TUJLIP IPL Facilitator(s). This took the form of informal meetings, workshops, distribution of flyers and one-to-one discussions. This helped to publicise the project, engage staff, advertise the forthcoming post, map out current learning opportunities and how these could be incorporated into the project and explore the best way of developing interprofessional learning opportunities in that particular area.

The project team deliberately approached each site as a 'clean slate'. In other words, the team did not arrive in each area with a list of learning opportunities that they wished to develop there. Instead it was hoped that a collaborative approach would result in developments being unique to that site and would fit best with the culture of learning already established. However the intention was also to influence that culture through the exploration of different ways of delivering learning opportunities. Inevitably experience in preceding sites influenced the developments in subsequent sites but the team tried not to just replicate models developed elsewhere. This aspect of the project received mixed results in the evaluation.

## Interprofessional Learning Opportunities created in each site

As explained above each site was treated as unique. Consequently once the IPL Facilitator/s was in post a period of time was spent exploring the possibilities for interprofessional learning in that area. This was through examining existing learning opportunities, assessing the learning culture and harnessing the ideas of all staff involved.

Each Facilitator reported that progress was slow and that service needs understandably often hindered the pace of change. Consequently changes were usually small scale and took a long time to implement. In some sites the short pilot period meant that concrete new activities did not come to fruition during the pilot. However there have been developments in IPL after the pilot period has come to an end.



## Individual pilot site reports contain detail of each initiative so a summary only is provided here

- *Weekly interprofessional interactive sessions for all students on placement. Run by a range of professionals and focused on patients in the Stroke Unit*
- *Interprofessional student led, practice based mini projects on an Orthopaedic ward. e.g. production of an information leaflet for patients*
- *Integrating Learning into Practice Programme. Problem based learning 4 week programme whereby students acted as an interprofessional team, working together on practice based scenario with service user input.*
- *Interprofessional Practice Learning Forum. Staff from the department meeting together once a month for an interactive session on an aspect of service delivery*
- *Group of students who do not usually access an area (Dietetic students to Learning Disabilities placement) visiting for a half day for structured learning opportunities with service user involvement*
- *Practice based interprofessional learning package. Midwifery and medical students working together on activity based package whilst placed on Delivery Suite*
- *Integrated community based nursing team meeting monthly to develop learning opportunities (District nurses, midwives, health visitors)*
- *Ward based interprofessional learning events for staff and students focused on learning about primary care, aiming to provide seamless services (Women's Health)*

### Service User Involvement

Service user involvement was a key focus of the original project bid and was one of the project outcomes. However this became one of the most difficult outcomes to achieve, as can be seen in the evaluation.

Each pilot site IPL Facilitator was encouraged to develop strong links with service users early on as it was anticipated that this would take considerable time to develop. Contact was made with existing service user and carer groups

and ideas explored with staff. It was hoped that service users would contribute to the direction of the project in each site by joining the pilot site steering group and by providing unique insights into the issues in each site in relation to collaborative working and divisions between services. In addition the project team wished to involve service users in the development of learning resources and to use their expertise in designing all practice based interprofessional learning activities.

There were two main ways that service users became involved, these were through participation in sessions, such as the Integrating Learning into Practice programme, and through recording of their experiences on audio or video. Recording experiences offered many benefits to all involved and it was hoped would contribute to the sustainability of the developments in each site.

## Showcase Events

In most of the pilot sites a half day event was organised at the end of the pilot period. The purpose of this was to showcase the achievements of all those involved and to plan for sustaining the practice based learning opportunities and to plan for future developments. Usually lunch was provided, presentations by the team and the opportunity to discuss a way forward. Detailed reports for each event held can be found in the individual site reports on the TUILIP website.

A Final Project Event was held in June 2009. This event included keynote speeches from Hugh Barr (*CAIPE*) and Ian Clarke (*East Midlands Healthcare Workforce Deanery*), and presentations from members of the TUILIP team.



*Richard Pitt, Helen Armitage, Ian Clarke and Hugh Barr*

## Sustainability

Achieving allocation of pilot sites was an on going process throughout the first three years of the project. Once the final three sites had been confirmed the project team realised that there was enough money remaining in the budget to run a ninth site. However after consultations with the overarching project steering group, the management group and others, it was agreed that a ninth site would probably not provide significant amounts of new learning for the team.

It was agreed that the remaining funds would be used to help previous sites to sustain TUILIP project developments and to consider new developments where possible. Therefore discussions were held with the first five sites as to how best support sustainability in each area. In some sites it was agreed that a further period of secondment of a facilitator would be paid for by the TUILIP project. In most this was the same person as had been employed by the project previously but in two a new person was seconded to the role.

One site requested help in providing an area for students to learn together that was adjacent to the ward, rather than a staff resource.

It is hoped that some follow up evaluation can take place in the near future to try to capture any changes that have occurred in the five sites that received support in this way.

## Publications

The following articles have been published in relation to the TUILIP project. There are plans to publish further during the next year now that all evaluation results are collated.

**Armitage, H., Pitt, R. & Connolly, J. (2008)** Developing Sustainable Models of Interprofessional Learning in Practice - The TUILIP Project  
Nurse Education in Practice, Volume 8, Issue 4, Pages 276-282

**Armitage, H., Pitt, R. & Jinks, A (2009)** Initial Findings from the TUILIP Project  
Journal of Interprofessional Care, 23(1):101-103

**Jinks, A., Armitage, H. & Pitt, R. (2009)** A qualitative evaluation of an interprofessional learning project.  
Learning in Health and Social Care, 8,4,263-271

**Furness, P. J., Armitage, H., Pitt, R. (in press)** An Evaluation of Practice-Based Interprofessional Education Initiatives Involving Service Users.  
Journal of Interprofessional Care.



## Conference Presentations

The Project team have been pleased to have been invited to present at conferences both within the UK and internationally.

### May 2006

***Developing sustainable models of interprofessional learning in practice.***  
1st International Nurse Education Today Nurse Education in Practice Conference. Vancouver, BC, Canada. (Richard Pitt, Jim Connolly and Helen Armitage)

### September 2006

***Interprofessional Learning – The TUILIP project***  
Universitas 21 conference, University of Nottingham. (Helen Armitage)

### September 2007

***The Challenges and Successes of Facilitating Service-User Centred Interprofessional Learning in Practice.***  
EIPEN Conference. Krakow, Poland.  
(Helen Armitage, Richard Pitt and Trevor Simpson)

### November 2007

***Authenticity to Action. Involving Service Users and Carers in Higher Education.***  
Authenticity to Action Conference. University of Central Lancashire.  
(Helen Armitage, Paul Fitchett and 2 Service Users)

### May 2008

***Interprofessional Education and Practice Seminar for staff members.***  
Oslo University College, Norway.  
(Helen Armitage and Richard Pitt)

### June 2008

***Interactive Workshop: the challenges and successes of facilitating service-user centred interprofessional learning in practice.***  
***Poster - Interprofessional Learning in Practice - Perspectives of Supervisors and Managers***  
***Poster - Changing Perceptions and Crossing Boundaries***  
All Together Better Health 4 Conference, Stockholm, Sweden.  
(Helen Armitage, Richard Pitt, Penny Furness and Annette Adsetts)

### June 2008

#### ***Developing Great Nurses in Pre-registration Education.***

University of Nottingham.

*(Helen Armitage and Richard Pitt)*

### July 2008

#### ***Staff Perspectives on Developmental Models of Practice Based IPE - Challenges and Solutions.***

1st International Interprofessional Health and Social Care Conference, University of Salford.

*(Helen Armitage, Richard Pitt and Penny Furness)*

### November 2008

#### ***Public Involvement in Research.***

Involve Conference, Nottingham.

*(Poster presentation Helen Armitage, Penny Furness and Annette Adsetts)*

### June 2009

#### ***Workshop - How hard can it be?***

#### ***Implementing IPE in Practice***

Interprofessional Learning in Health and Social Care (CAIPE). Institute of Technology. Tralee, Ireland.

*(Helen Armitage and Richard Pitt)*

### July 2009

#### ***How hard can it be?***

#### ***Implementing IPE in Practice.***

Interprofessional Healthcare Education Conference. Edge Hill University.

*(Helen Armitage)*

### September 2009

#### ***Evaluating Interprofessional Learning Initiatives in Practice: Perspectives and Experiences of TUILIP Facilitators.***

European Inter Professional Education Network Conference, Finland, Sept 17-18, 2009.

*(Penny Furness, Helen Armitage, Richard Pitt)*

### January 2010

#### ***Developing new ways of working through interprofessional education in the workplace: the impact of the TUILIP project.***

New Types of Working in Health and Social Care. Second International Research Conference - Skills for Health, Skills for Care.

*(Helen Armitage, Penny Furness, Richard Pitt)*

### April 2010

#### ***Promoting a collaborative practice learning experience through interprofessional models of education: the impact of the TUILIP project.***

All Together Better Health Conference 5, Sidney, Australia.

*(Richard Pitt, Helen Armitage, Penny Furness)*

## Budget

The fund that was awarded to the TUILIP project from Trent Multiprofessional Deanery totalled £510,000. A summary of expenditure is provided in the table below.

|  |                    |
|--|--------------------|
| Project Team Staffing.....   | 257,700.40         |
| IPL Facilitators .....   | 157,394.60         |
| Administrative Support .....   | 35,468.99          |
| Non-pay related expenditure<br><i>(Travel, staff development, equipment,<br/>conference attendance, hospitality) .....</i> | 58,828.46          |
| <b>TOTAL .....</b>   | <b>£509,392.45</b> |

## Website

The project website was developed by staff at the University of Nottingham and hosted by Sheffield Hallam University. The site address is:

<http://tuilip.hwb.shu.ac.uk>

All pilot site reports can be downloaded from this site.

# Project Evaluation

## Aims and Methods

The aim of the evaluation was to gather perceptions from key stakeholders (*facilitator(s), clinical manager(s), practitioners, students, service users*) of the success of the pilot in achieving its aims, learning and changes in behaviour resulting from initiatives, and its long-term impact and sustainability. All eight pilot sites were evaluated as follows:

- *Meetings between the researcher, project lead and facilitator to identify potential evaluation participants*
- *Letters or emails to potential participants with invitation to participate in evaluation and information sheet; follow-up to non-responders*
- *Individual interviews or focus groups with consenting participants, using established semi-structured interview schedule*
- *Transcription and anonymisation of data; copy offered to participants to check for errors and retain*
- *Analysis in NVivo of uploaded transcripts, coding for themes based upon Kirkpatrick's evaluation framework (*reaction, learning, behaviour, impact, sustainability*)*
- *Preparation of site evaluation report for dissemination and uploading to TUILIP website.*

## Participants

76 people were interviewed for the evaluation, comprising:

- *10 facilitators*
- *12 clinical managers*
- *29 practitioners*
- *9 students (*over 120 learner evaluation forms were also included in the dataset*)*
- *13 service users and*
- *3 carers.*

Among the facilitators, clinical managers, practitioners and students interviewed for the evaluation, 9 professional groups were represented: nursing, medicine, physiotherapy, occupational therapy, radiotherapy, dietetics, midwifery, social work, and medical administration.

The following report will summarise and discuss the key findings from the evaluation. Detailed results from each site are available on the TUILIP website. In keeping with Kirkpatrick's evaluation framework (Kirkpatrick, 1996), the report will be divided into five sections: Initiatives, Reactions, Learning, Behaviour Change / Impact, and Sustainability.

## Initiatives

Facilitators were not provided with specific instructions but were asked to develop IPL initiatives appropriate to and workable within their own pilot site. A range of initiatives was developed by the facilitators, although there were common themes. These included:

### Service user-based IPL initiatives

*These placed priority upon service user perspectives on care and upon encouraging students and qualified practitioners to discuss with and learn from both the service users / carers and one another. One pilot built this into a problem-based learning programme; another ran service-user led discussion workshops.*

### Programmes of IP teaching sessions

*These were designed to bring learners and / or qualified practitioners from different professional groups together, provide information about professional roles or healthcare issues, and encourage learning with, from and about one another.*

### IPL resource packs

*Packs provided, for example, information, worksheets, exercises and props designed to engage learners in IPL activities, made available to all learners accessing the site during and beyond the pilot phase.*

### Tutorials with individual / small groups of students

*Individual tutorials were offered by facilitators during development of larger initiatives or when significant problems limited scope of pilot.*

## Reactions

Evaluation data corresponding with this category were rich and numerous. As a result, five subcategories were created, focusing on perceptions of TUILIP and its initiatives; perceptions of the facilitator and his / her role; support and acceptance within the organisation; factors which aided or hindered progress of the initiatives; and suggestions for improvement.

### Perceptions of TUILIP and initiatives

#### *General ideas of TUILIP*

In all sites TUILIP and its broad aims were considered to be 'interesting' and an 'important idea', 'useful' and particularly 'timely' within the current healthcare climate and priorities. At sites considered largely successful, TUILIP generated a great deal of enthusiasm and was welcomed as 'unique' and a 'great idea', which some practitioners and students said they were 'lucky' and 'honoured' to be involved with.

In less successful sites, some participants had less favourable reactions. A few perceived it as 'totally academic' and externally driven. Most people had experienced high hopes initially but, for some, these expectations were not realised in reality. Some were, overall, 'disappointed' with the outcomes but still perceived it had been 'worthwhile.'

### **Specific Initiatives**

Initiatives which focused upon the service user experience were very well evaluated. Everyone involved had greatly valued the opportunity to tell their stories and offer their opinions, as well as to deepen their appreciation for others' perspectives. Participants were highly positive about the interprofessional and practitioner-service user exchanges arranged by the facilitator(s). They were also impressed by the facilitators' attempts to maximise inclusivity and fully involve vulnerable service users in their plans and activities, describing the resulting initiatives as '*respectful*' and '*empowering*' to everyone involved.



Some sites where service users were not central were nonetheless very positively received. Students and staff valued the opportunities to listen to and share ideas and experiences, with the common aim of mutual understanding and service improvement. Lecture programmes were well evaluated, with both contributors and attendees pleased with the experience, which had proved useful and enjoyable, although level of attendance was not always high. In one site, the series of teaching sessions aimed at delivering knowledge was perceived to have been inadequately

designed to meet needs of a broader audience, with sessions sometimes too profession-specific or complex; so that some felt they hadn't met the needs of the audience. Interprofessional workshops were considered '*interesting*', '*informative*', as well as '*friendly and relaxed*', and encouraged interprofessional networking and reflection. Packs left for the ward to use with students went down well and continued to be used beyond the pilot phase although, in one site, some tweaking was required by staff to ensure materials were '*user-friendly*'.

### **Perceptions of facilitator and his / her role**

Most evaluation participants perceived the facilitator role, with time dedicated to the task, as essential to the success of the pilots '*because most people haven't got time in their day jobs to take that on.*'

Where projects were perceived, overall, to have been successful, facilitators received a lot of credit for the effectiveness with which they undertook the task, for example, two were described as '*excellent*', showing '*empathy*' and '*understanding*' and another pair as '*fantastic*' and '*good, approachable and non-judgemental.*' They were also praised for the running and facilitation of their initiatives, which were robustly researched, well organised and smoothly executed, adding to the quality of the experience. Another facilitator was commended for his '*passion for the vision*' of IPL and his '*proactive*' approach, which maximised interest and involvement within the site, as well as his '*determination to see things through to the end.*'

In all sites, even where outcomes had been disappointing, facilitators were acknowledged without exception to have tried hard, and most were praised for their achievements. Participants perceived the task of trying to initiate change in short period of time to have been highly challenging and potentially frustrating, since facilitators' priorities often differed from those of others within the organisation.

### ***Support and acceptance within organisations***

Support for TUILIP, its initiatives and facilitators varied considerably between settings. In some sites, the evaluation suggested support levels were good within the organisation and remained high throughout the pilot. The facilitators in these cases were both well aware of and grateful for others' valuable support, time and efforts on behalf of the project. In other sites, the evaluation suggested that pilots were supported by a few keen individuals, with other practitioners less engaged. Sometimes, enthusiasm dwindled during the pilot phase, with a detrimental impact upon otherwise successful initiatives; for example, falling attendance at pre-arranged lectures impaired people's perceptions of them.

Senior managers seemed largely supportive but those who hadn't been involved in early meetings with the TUILIP team were harder to engage later in the process. Some couldn't see how the organisation, its professionals or students would benefit from the initiative, and were happy with existing practice and training. As a result, they were reluctant to devote time and energy and, although not obstructive, did little to engage with the facilitator and reciprocate his / her efforts, which slowed down progress. More

junior managers were occasionally perceived to have less support for TUILIP, especially because these were the people who made the decisions about day-to-day staff involvement in the project, balancing educational and clinical priorities - it was considered that clinical needs always took priority with this group.

There were comments from sites which had enjoyed good levels of practitioner support that the lack of medical engagement had proved disappointing; however it was typically acknowledged that this had arisen through lack of time rather than lack of interest. Where medical involvement had happened, it was perceived to have had beneficial effects upon credibility of and attendance at events.



Students who took part in the evaluation were all positive about their experiences with TUILIP. There was a perception among practitioners, even in some of the more successful sites, that some students had considered their involvement with TUILIP as extra to their existing placement commitments and had been reluctant to take it on. However, practitioners from a few sites felt that offering TUILIP as an extra to learners and practitioners was a way of demonstrating that they were valued by the organisation.

## **Factors which aided or hindered progress of initiatives.**

### **Reasons for success.**

#### ***Fertile ground for IPL***

Some areas were perceived as representing favourable settings for IPL initiatives because of pre-existing positive attitudes and good practice in the field of IP working. In these settings, the ideas underpinning TUILIP were not new but the pilot offered the organisation the opportunity to focus and formalise their existing efforts toward effective interprofessional working. In one setting, a charitable organisation rather than within the NHS, it was noted that the absence of lengthy bureaucratic procedures had allowed decisions to be made more easily and speedily, which was considered to have had benefits for the pilot phase and beyond.

#### ***Facilitators employed from within setting***

Not surprisingly, familiarity with the workings of the organisation, established relationships with staff members and service users gave facilitators drawn from within the organisation a considerable advantage in appreciating what could be achieved,

understanding how best to organise initiatives and making contact with potential attendees.

#### ***Facilitators working in pairs***

The two sites in which a pair of facilitators was employed were both very successful. This was in part attributed to their ability to support, encourage and motivate one another, and the facts that two experienced individuals from different professional backgrounds could generate a broader range of ideas, which they could share with and 'bounce off' one another, and refine, before taking them for consideration to the local practitioners. It seemed that this process allowed the facilitator team to more effectively translate the aims of the project and reach a clear focus at a comparatively early stage of the pilot.

#### ***Local champions***

Some sites were helped by the presence of individuals willing to support a facilitator (*especially from outside the organisation*) in developing initiatives and links, and to maintain and continue developing the initiatives after pilot.

#### ***Facilitator characteristics***

In no site did participants consider that personal characteristics of the facilitator(s) had actively hindered the project; however, in a few sites, practitioners, students and service users identified some key traits which they felt had had a very positive influence upon the success of what occurred. These included openness, flexibility, enthusiasm, drive and communication skills.

## Barriers

### *Facilitator employed from outside the area*

A few people felt having an *'outsider'* involved allowed the area to be viewed with fresh eyes and not be overly influenced by local *'politics.'* However, most evaluation participants commented that facilitators unfamiliar with a site before their employment by TUILIP required considerable time to learn about the site, to *'meet and greet'* staff and *'information-gathering'* about what was already taking place there. Sometimes these efforts received little response. In certain cases, coming from outside meant there was no office for the facilitator locally, so more of his / her time was spent away from the site, contacting people remotely rather than face-to-face.



### *Delays getting started*

Delays between initial meetings to introduce practitioners to and engage them with the project and employment of the facilitator caused a drop in awareness and enthusiasm, which seemed to have a lasting impact upon the success of some pilots.

### *Choice of setting*

Some settings were perceived as less than ideal for educational initiatives like TUILIP, especially

complex, busy, unstable acute environments or geographically and clinically broad-based community settings. The evaluation suggested that the project team and senior managers had made the decision to set TUILIP there, but that staff felt the setting was unsuitable.

In some community-based pilots, participants described complexities of the primary healthcare arena, which had challenged the facilitator(s). For example, it proved especially difficult to make contact with relevant practitioners and bring them together, despite considerable efforts from the facilitators and support from key individuals because they were *'all scattered and working independently'*; *'the community is just huge and broad and works very differently.'* Practitioners did not want efforts to carry out IPL project in the community to be abandoned; rather they felt the practicalities of research should be carefully considered and projects designed specifically for that setting, rather than the same design being applied to both acute and community settings.

### *Lack of focus and direction*

TUILIP's broad aims needed translating into ideas which were useful, meaningful and workable within each site. This often took some time and created anxieties for facilitators, even in the most successful sites. In most, this seemed to be resolved after a few weeks of reflection, research and discussion. In others it seemed to have been an ongoing issue, and some practitioners and managers remained confused about the exact aims of the project in their area. The remit was described by some as *'incredibly vague'* and *'rather woolly in its objectives.'* Also, most facilitators carried out a scoping exercise

to gather ideas from relevant people within the organisation, and some complained that the diversity of ideas and priorities from different individuals meant the pilot either failed to identify a clear route or tried to follow too broad a remit or to achieve too many outcomes: *'we seemed to get distracted and go off in a number of different directions instead of just focusing on one.'*

### ***Logistics and 'red tape'***

Some initiatives were hindered by the logistics of, for example, matching student timetables and commitments in order to facilitate interprofessional learning: *'there just wasn't the opportunity to get people in the same place at the same time.'* Sometimes, local bureaucracy and procedures which had to be followed in order to make small changes such as, for example, the erection of notice boards to advertise educational opportunities proved a further hindrance.

### ***Time limitations and clinical priorities***

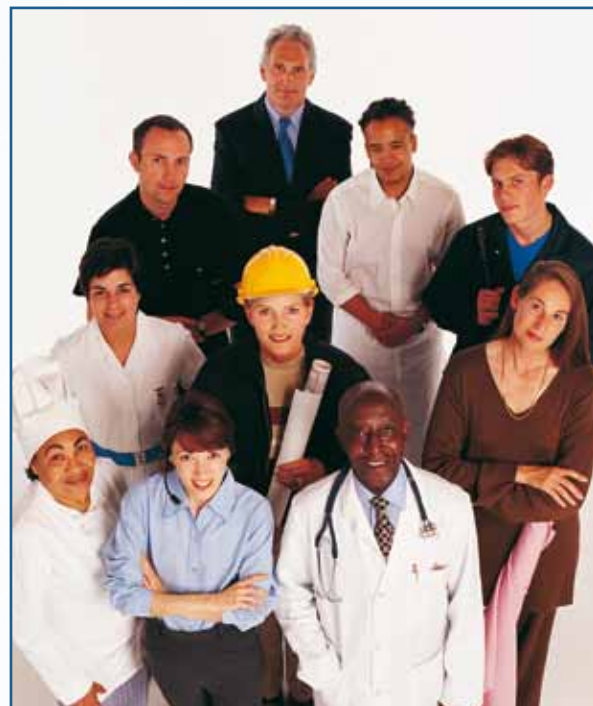
Most TUILIP pilots identified this as a barrier to progress, in that practitioners were very limited in the time they had to devote to initiatives like TUILIP. Clinical priorities and heavy workload meant that practitioners and managers had to *'deal with patients first'* and were *'already too stretched'* to take on new responsibilities and commitments.

Facilitator time was also identified by some as inadequate for the task, especially where the familiarisation process had taken up to half of the pilot time. Some projects had been unable to develop initiatives or had developed some but been unable to trial them prior to the evaluation. A number of facilitators commented that more

time (*'another six months' for example*) would have been very valuable.

### ***Lack of resources***

Sometimes, pilots were hindered by a lack of space or teaching resources. It was perceived in a number of pilots that educational initiatives like TUILIP were not accorded high priority within organisations. In addition to employment of the TUILIP facilitator by the project team, most felt additional financial resources to *'back this initiative'* would have been vital in raising support, allocating time and maintaining progress beyond the pilot. In some pilots, plans for IPL activities depended upon funding to cover services for staff attending, and had to be abandoned when funding was changed or withdrawn.



### ***Running two pilots simultaneously***

In one case, the facilitator ran two smaller pilot sites; however, splitting her already limited time between two sites limited the scope for each.

### ***Timing of pilot***

Practitioners and management sometimes commented that the period during which TUILIP was taking place was a particularly difficult one for the site. At some, re-grading processes were underway; other sites were affected by organisational or staffing changes or unusual levels of absence. These factors were considered to have impacted directly upon organisational stability and staff availability, morale and motivation for the project. In some sites, practitioners ruefully commented that things had since improved and that the project would have been more successful, had it arrived months or a year later.

### **Suggestions for improvement**

#### ***Greater guidance by the project team***

Hearing what had happened and proved useful in other sites, rather than *'starting from scratch'*, and being offered more direction at an early stage to facilitate progress was seen by some as potentially very useful. Although many commented that they perceived the project as exploratory, some felt more could have been achieved at their site with a little more guidance and intervention. It was considered that this assistance could have helped reach an achievable focus and direction for the project earlier in the pilot.

#### ***Employing someone from within the site as facilitator***

Employing someone with a good level of understanding of the setting, the services involved and effective modes of contact between staff was seen by some as important. Alternatives to

this were to allow a period of preparation and familiarisation for an *'outsider'* beyond the pilot phase or to identify a *'champion'* within the site at an early stage to support the facilitator, help engage colleagues, encourage the project forward and help maintain it after the pilot.

#### ***Longer pilot period***

A number of facilitators struggled to achieve their aims within the pilot period of up to one year and there was a perception that outcomes would have been more successful and better established, had the pilot phase lasted a few months longer.

#### ***Higher risk setting***

In one successful site, it was commented that greater gains might have been made had the pilot been set within a more challenging part of the organisation, one which was currently less amenable to IPL. However its success within this fertile setting gave great ground for continuing support and extending to areas of the organisation perceived as *'tougher.'*

#### ***Involving related areas***

Successful pilots - some suggested that it would have been even better had the pilot encompassed other related services or had a higher profile within universities, to improve educational links for students and staff.

#### ***Using existing resources more effectively***

For example, adapting existing materials such as student booklets, rather than *'inventing something new'*; this would have demonstrated value for pre-existing IPL efforts and reduced the amount of work by facilitators.

### ***Increasing inclusivity of service users or carers***

Only two pilot sites had developed service user-focused initiatives. Although these were evaluated very positively, it was considered that inclusivity could be extended in future to include, for example, additional mental health service users, their carers or more service users with profound learning disabilities. It should be noted, however, that within the limited scope of the pilot phase, great efforts had been made to involve this last group. There were few suggestions as to how those with profound learning disabilities could be involved but a belief that it was possible and a determination to extend inclusivity beyond the pilot phase.

### ***Greater prioritisation of educational opportunities by commissioners / senior management***

It was perceived in some settings that more could be done to prioritise and facilitate educational initiatives like TUILIP: *'it needs to be invested in, long-term, I think.'*



## **Learning**

All sites - even those which were perceived to have been largely unsuccessful - emerged from the pilot phase with new understandings and insights. This section will be divided up according to the different groups who participated in the evaluation.

### **Students**

#### ***Interprofessional awareness***

Students gained awareness of and respect for the different professionals involved in caring for patients and what their roles were. They learned what expectations others had of their own profession and considered professional stereotypes. Students developed an understanding of the value of learning and working with other professional groups, and the role of teamwork in patient care. It was considered that this learning would improve cooperation and make it more likely that the team would work more effectively, for example, by encouraging practitioners to make full use of their colleagues to meet clients' needs.

#### ***Communication skills***

One aspect of students' communication which had improved in a number of cases was their confidence to speak and have clinical discussions with qualified practitioners of all professions.

#### ***Knowledge or skills gain and academic development***

Students attending teaching sessions identified specific new information or skills they had acquired and considered that their experience of TUILIP would help in future academic work, especially reflective or interprofessional assignments.

### ***Holistic view of service users and carers***

The workshops or IPL exercises gave students a greater sense of the *'whole'* person underneath the *'patient'* they were looking after, and the *'journey'* they had taken through the system. Where the initiatives had offered the opportunity to meet and talk with service users or carers, students felt they were better aware of their perspectives upon and experiences of care and could better empathise in future. This aspect of learning was perceived as particularly valuable. Practitioners, managers and facilitators

### ***Increased role awareness***

Even among qualified practitioners, their involvement with TUILIP had made them more aware of different services available to support client care, the nature of others' caring roles, *'how to work together as a team'* and provide a *'seamless service.'* Even in less successful sites, it was perceived by some participants that *'the seed'* of interprofessional awareness had been *'sown'* among practitioners.

### ***Deeper awareness of service user and carer experiences and needs***

Where TUILIP had offered them the opportunity to meet with service users or carers, qualified professionals reported having acquired fresh insights into issues affecting the client group they worked with, which they hadn't fully considered before.

### ***Professional and practice development***

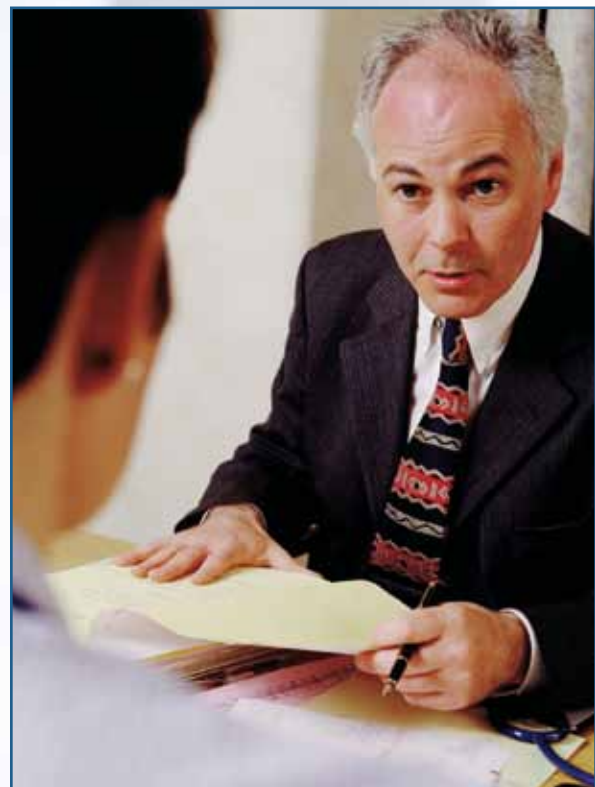
TUILIP had offered valuable opportunities to take time to learn new things, question practice and discuss ideas with colleagues; for some, this provided inspiration to consider changes to practice and service improvements.

### ***Awareness of learning opportunities***

Practitioners learned more of what their team already had to offer to students, and came away with new ideas about creating opportunities in the future.

### ***Understanding of research processes and limitations***

Facilitators and managers in particular reported learning considerable lessons about the research process and the difficulties and challenges of bringing about new initiatives and change in practice.



## **Service Users and Carers**

### ***Confidence***

Vulnerable service users with learning disabilities and mental health problems reported that their involvement with TUILIP, especially having been taken seriously and listened to, have increased their confidence and willingness to represent the client group to health and social care professionals.

### ***Sense of their own value to professionals***

Service users and carers who participated came away with a clear sense of how important a resource they were in the training of professionals and the development of effective services. They reported having greatly enjoyed telling their stories and talking about their experiences. They were delighted to think that their involvement might have a lasting impact upon the students and practitioners who heard them and, thereby, upon the quality of practice.

## **Behaviour change and Impact upon the setting**

The evaluation took place soon after the pilot phase, which was arguably too soon to identify a great deal of change in clinical practice. However, participants at most sites felt that changes in behaviour were either likely as a result of TUILIP or had already begun to occur. There were 2 sites where evaluation participants could see no appreciable positive impact upon behaviour or practice.

### ***Better preparation for individual and team roles***

It was perceived that students attending initiatives like TUILIP would be better prepared for their

future professional roles, both individually and as part of the MDT. In one case, it seemed that this had already happened with a newly qualified occupational therapist who was included in a TUILIP initiative as a learner – this person was perceived to have settled more rapidly into her role than otherwise.

### ***More effective collaboration between professionals***

Some felt students and clinicians would have a better understanding of why, when and from who to seek help or referral for a client; they also felt that closer collaboration would reduce repetition and omission in care, thereby improving the client's experience. Among the qualified staff in TUILIP pilot areas, some had already noticed reduced interprofessional barriers and better partnership working within the clinical team.

### ***New working relationships beyond clinical team***

As a result of their involvement with TUILIP, some facilitators and practitioners had forged new relationships with people outside their own setting, which they hoped would strengthen the educational opportunities available to their existing students or allow them to offer opportunities within their service to new student groups.

### ***Practitioners more active in their teaching roles***

The increased focus during TUILIP upon educational issues raised awareness within the clinical team of what each person, including unqualified practitioners, had to offer to students, and created greater enthusiasm within the whole team about teaching.

### ***Teaching extended to new students***

The interprofessional education focus of TUILIP made educators within some of the clinical settings think more broadly about education within their organisation. For example, sessions and learning opportunities traditionally open to a single student group were being opened up to other students.



### ***Better care and communication with service users***

Meeting other practitioners had given some participants new ideas of how to care for their client group, which they were planning to put into action. A few service users considered that communication from staff, especially information-giving, had improved as the staff gained greater understanding of their perspectives.

### ***Review of education strategy and funding***

The evaluation suggested that senior managers in one Trust had arranged for medical and nursing education to become more closely integrated by adopting a joint, interprofessional strategy; the Trust was also considering piloting a new scheme for staff budgeting based upon clinical need, rather than focused on specific professions. The clinical manager felt that these planned changes were as a direct result of the change in thinking and approach initiated by their involvement with TUILIP.

## **Sustainability**

### ***A top priority for all concerned but acknowledged as difficult beyond the pilot***

All sites were concerned with sustainability but acknowledged that it was a challenge.

Most facilitators had been keen to develop initiatives which could be continued post-pilot.

Where little was perceived as having been achieved, evaluation participants were pessimistic about the likelihood of developing or sustaining what had been attempted beyond the pilot phase. However, at other, more successful, sites, participants were keen to keep things going but expressed concerns about how this could be maintained.

### ***Dependent upon continued input by the facilitator or another 'champion'***

Some pilots had employed a clinician from the setting to run TUILIP and this person remained in post afterwards. Although mostly unfunded, these individuals were motivated to maintain their achievements during the pilot. In other sites, a person who had been involved with TUILIP was keen to keep the momentum and progress going. Resourcing this person's time proved problematic for most, although in some cases, an existing educator had taken this on in addition to his / her existing educational responsibilities. In some sites, however, no such champion was identified and sustainability seemed unlikely. This was a particular issue where the outcomes from TUILIP were perceived as unsuccessful.

### ***Evidence of extension of TUILIP 'blueprint' to other areas***

In sites where the initiative was considered to have been largely successful, there were clear plans to take it forward into other clinical areas.

### ***Funding agreed to support efforts at sustainability***

In many sites, the TUILIP team offered financial help in sustaining initiatives. In some cases, this paid for a little time for a key champion of the project; in others, it paid for resources to be used interprofessionally within the setting. At one site, funding was agreed from within the organisation to continue TUILIP's work under one of the existing facilitators for a year.

## **Discussion**

### **Issues arising**

#### ***Learning***

In all sites where initiatives were successfully developed and provided for learners and staff, it was clear that everyone involved had gained useful insights, knowledge and skills. Some of these were directly relevant to interprofessional working, including a better understanding of and appreciation for others' roles and increased confidence in interprofessional communication. This finding was in keeping with recent reports in the literature about potential gains for students provided with interprofessional learning opportunities. For example, Pollard et al. (2008) observed that students actively involved in IPL in their training were more aware of the importance of interprofessional working and better able to identify instances of good or poor inter-disciplinary communication in practice.

Pollard et al.'s students felt their communication skills had improved, their knowledge of different professional roles and perspectives had increased and misperceptions and barriers had been eroded. Similar student gains were reported in many TUILIP sites and, as in Pollard et al.'s report, students seemed to value their interprofessional experiences in practice over those gained in simulated environments in the University setting. However, there were suggestions from mentors that students perceived IPL tasks through TUILIP as '*extra*' to their existing placement objectives, and were reluctant to engage at times for that reason. This suggests more could be done to integrate placement competency outcomes and practice initiatives to provide a more coherent and efficient clinical education experience for students.

#### ***Service User Involvement***

What emerged from a consideration of the eight TUILIP pilots was a clear message that service user involvement, first, was a challenge which few facilitators were able to meet and, second, contributed greatly to the learning outcomes and perceived success of the project. Service user involvement in two sites offered students and other learners a rare opportunity to learn from and discuss with service users with a focus on perceptions of care and service improvements. There are few similar reports in the literature; however Miller et al. (2006) observe that, service user inclusion in IP education can be highly beneficial to learners, especially when it is congruent with their learning outcomes, as it was in these two TUILIP initiatives. Furthermore, two other sites included service users in the development of learning resources, in one case through recorded stories. Although students in

these pilots had no direct contact with service users, they were still able to gain greater appreciation for the users' experiences and perspectives.

It was evident that all service users who were involved in TUILIP had benefited from the experience, through the enjoyment of relating their experiences, development of greater confidence in communicating with healthcare professionals, and a sense of making a real contribution to training and care delivery.

### **Facilitation**

Two sites employed a pair of facilitators with intimate prior knowledge of the site. In contrast to other facilitators, the teams did not spend a lot of their limited time trying to learn about the area and gain staff trust and support. They were also able to support each other, practically and emotionally, through the demands of developing the TUILIP initiatives and, coming from different professional disciplines, complemented one another well. Following a period of consideration and clarification of ideas, facilitators made relatively rapid progress with their initiatives, and trialled them on several occasions, resulting in a very well evaluated '*product*' by the end of the pilot phase. Key factors in the speed and success of their initiatives were teamwork, 'insider knowledge' and great support from within the organisation.

Other pilots were typically facilitated by an experienced practitioner from outside the setting, often with little knowledge of the environment or practitioners. In some cases the evaluation suggested facilitators did not have long enough,

as lone workers from outside the area to perform the groundwork and develop initiatives which could be trialled in the pilot area, especially in the context of varying levels of support.

### **Support**

Certain barriers emerged consistently through the TUILIP project, including variable support for the initiatives and facilitators from practitioners within the pilot sites. It seemed in some cases that '*hearts and minds*' had not been won over, and in others that a lack of time eroded initial enthusiasm for and engagement with what was being attempted. There is little in existing literature with which to compare these findings since little research has been published considering IPL in practice settings.

However there are similarities with University-based IPL research: Freeth et al. (2002) note that delivering IP education places demands upon staff, who often have insufficient time and resources and may be concerned about the impact upon their workload of their commitment to IPL (Glen & Reeves, 2004; Rees and Johnson, 2007). Rees and Johnson (2007) have reported both scepticism and resistance to IPL initiatives at least in the initial phases.



Sites in which support issues were least problematic were those in which the facilitators were familiar, respected, figures within the organisation and enjoyed some power to facilitate practitioner attendance. In these pilots, local knowledge and teamwork meant facilitators did not rely heavily upon staff input in the development of their ideas or the running of initiatives. Thus, the impact upon staff time may not have been viewed as quite as onerous as in some other pilot sites. Further, the benefits of service user involvement as perceived by staff may have outweighed their concerns about workload. It seems facilitators' decisions to take on the brunt of the development work and avoid overloading the practitioners paid off in terms of maintaining their goodwill and support. Also, those sites experienced fewer delays in getting their initiatives up and running and, because they were remaining in post after the pilot, concerns that TUILIP would be an academic, unsustainable 'flash in the pan'-type venture were less prevalent.

### **Setting and Timing**

The evaluation indicated that pilots occurred at difficult times for some organisations, when change and uncertainty eroded enthusiasm. Also, certain settings chosen for TUILIP pilots were, in retrospect, considered less than ideal for the specific objectives of the project. For example, several pilots were set within community healthcare environments and the evaluation suggested that this context proved especially challenging, with funding issues, geographical spread and practitioners' independent working as particular problems. Although there is little existing evidence regarding IPL initiatives in community settings with which to make

comparisons, researchers have reported upon the complexities and challenges inherent in community healthcare research (*Harrison, 2005; Herber et al. 2009*). Like some of the practitioners interviewed for this evaluation, Harrison (*2005*) urges researchers to address the objectives and perspectives of PCT managers, but also suggests that managers of community services could do more to strengthen the support, opportunities and structures for research within their organisations.

### **Sustainability**

Sustainability is often a concern expressed by staff within organisations where interprofessional education initiatives have been trialled (*e.g. Miller et al., 2006*), as it was in all pilot sites. One site had agreed ongoing funding and, in some others, TUILIP-funded resources and / or local practitioner commitment were put in place after the pilot. These resources were committed and likely to be most effective where the pilots themselves were perceived as successful, valuable and with long-term potential.

# Recommendations for Future Interprofessional Learning in Practice Initiatives

## Learning environment

- Consider pragmatically the appropriateness of the setting for educational initiatives and the potential barriers to / benefits from IPL developments in that environment
- Avoid setting the initiative in an unstable environment or trying to establish it during periods of change or upheaval in that environment
- Prepare the staff to maximise understanding of and support for initiatives at all levels of the organisation, preferably including both managers and practitioners in the consultation process
- Research and make use of existing IPL / educational opportunities in designing new initiatives
- Develop a system to identify availability of different student groups to participate in the initiative
- Embedding IPL in practice ensures relevant and authentic learning. Resources should be flexible, reusable and transferable
- Encourage autonomous, independent learners through the creation of learning opportunities that are student-led
- Provide a physical space, with technological support, to enable group learning to take place and to house learning resources for IPL

## Facilitation of IPL

- Employ facilitators either from within the organisation or, if this is not possible, allow a person drawn from outside the organisation extra time to familiarise themselves with the setting and staff
- Select for recruitment IPL facilitators with evidence of enthusiasm for IPL,

*creativity, motivation, project completion and communication skills*

- Ensure facilitators have enough time to thoroughly research, plan, implement, evaluate and embed the initiative: one year may be insufficient
- Consider ongoing support for the IPL facilitator, either by employing two facilitators to work alongside each other or encouraging key individuals from within the organisation to act as supportive links with them
- Where possible involve facilitators from different professional backgrounds to enable a truly interprofessional approach to learning and to allow collaboration and learning from each other
- Where available, provide information (or encourage research) about previous successful and unsuccessful initiatives within same or similar setting to facilitate effective planning and implementation

## Service users

- For maximum engagement and impact, design initiatives around service users and include them in the design process, making their involvement meaningful to them as well as valuable to learners and service delivery
- Ensure this involvement is integrated into the planning and evaluation stages of the learning experience
- Developing interprofessional learning resources that do not always require the presence of a service user will help to prevent problems with privacy and overload of those involved. The use of audio and video recording should be extended so there is better inclusion of a range of service users and their families

## Staff engagement

- *Include practitioners in the design and delivery of initiatives to encourage their enthusiasm, commitment and long-term involvement whilst remaining mindful of their time limitations and clinical priorities*

## Organisational commitment and Workforce planning

- *Encourage the organisation to facilitate staff involvement and commitment by ensuring the initiative is considered important to the organisation at all levels*
- *Evaluate the process and outcomes of initiatives in order to maximise their efficiency and impact*
- *Consider how the initiatives will be maintained, resourced and embedded in the long-term and consider transferability of the IPL outcomes to other areas of the organisation*
- *Organisations need to commit to reimbursement of service users who contribute to learning in practice*
- *Cultivate an educational environment which is conducive for interprofessional service user focussed learning by allowing time out for staff on a regular basis to enable 'taking stock' and reflection*



## Role of Higher Education Providers

- *Enable practitioners to liaise with education providers to facilitate links between their expectations of placement activities / outcomes and students' involvement with the initiatives when on placement*
- *Enable practitioners to liaise with education providers to inform students about the planned initiatives, highlight the anticipated benefits to / expectations of them, and engage their enthusiasm*
- *Support the development and evaluation of learning resources in practice that complement theoretical components of the course*
- *Establish communication channels between placement providers and higher education providers that support organisation of learning events*
- *Prepare students for IPL in practice and encourage students from different Higher Education Institutions to learn together*

## Underpinning knowledge

- *Underpin IPL learning experiences with an interprofessional framework that enables learners to reflect on and evidence their learning*
- *Incorporate relevant local and national initiatives, for example service improvement, into IPL learning and engage with existing educational priorities*

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# Appendix A

## TUILIP Management Group

### Terms of Reference:

#### *Remit*

- *To provide the overall management and successful implementation of the TUILIP project*
- *To provide reports to the Steering Group*

#### *Frequency of Meetings*

This group meets every 6 weeks.

#### *Membership*

##### **Helen Armitage**

Project Lead, Sheffield Hallam University (Chair)

##### **Sarah Smith**

AHP and SHU representative

##### **Kirsty Hyndes**

AHP and UofN representative

##### **Fiona McCullough**

AHP and UofN representative

##### **Glenise Yellott and Tina Worboys**

Trent Health Communities representative

##### **Richard Pitt**

Project Co-ordinator, University of Nottingham

##### **Carol Kay/Selena Grant**

Administrator

##### **Penny Furness**

Research Fellow

# Appendix B

## TUILIP Steering Group

### Terms of Reference:

#### *Remit*

- To provide the overall steer of issues relating to the TUILIP Project;
- To hold overall responsibility for the effective management of budget and delivery of the TUILIP Project.

#### *Frequency of Meetings*

This group will meet tri-annually.

#### *Membership*

**Frances Gordon**  
SHU

**William Atimo**  
Undergraduate Medical School, UofN

**Helen Armitage**  
Project Lead (Chair)

**Richard Pitt**  
Project Coordinator, UofN

**Rachel Hawley**  
TMPD

**Jim Connolly**  
TMPD

Pilot sites representatives

## Appendix C Action Plans

| PROJECT OUTCOME   | HOW WILL WE ACHIEVE OUTCOME?   | HOW DO WE KNOW WHEN IT IS ACHIEVED?  | WHO IS RESPONSIBLE (GROUP/LEAD) | DATE TO BE COMPLETED                        |
|---|--|--|---------------------------------|---|
| <b>Embed interprofessional working and learning within the Trent region so that all practice in health and social care adopts an interprofessional philosophy</b> | 1. Identify project pilot sites within the Trent region where IPL occurs naturally and placements for students from at least 2 professions are provided. | Minimum of 8 pilot sites established by completion of project.   | HA                              | 31.03.08                                    |
|   | 2. Develop a responsive and motivated interprofessional team who will implement IPL opportunities.   | Evidence of interprofessional collaborative team working and student learning.                                 | HA                              | Ongoing as each pilot site is set up.       |
|   | 3. Identify IPL champions in each pilot site who are responsible for IPL strategy and development.   | Each pilot site has a champion identified who is working in management role and able to influence development. | HA                              | Ongoing as each site is set up.             |
|   | 4. Set up pilot site interprofessional group to steer the project locally.   | Group established representing all groups involved in the project pilot site                                   | HA                              | Ongoing as each site is set up.             |
|   | 5. Appoint IPL Facilitators in each pilot site for minimum 6 month secondment. Provide support and development opportunities.                            | IPL Facilitators appointed. Staff development provided. Role review with appointee.                            | HA                              | Ongoing as each IPL Facilitator appointed.  |
|   | 6. Utilise service user/carer centred learning opportunities. Incorporate members of local service user group where possible.                            | Portfolio of case studies, narratives etc available in each pilot site.  | HA<br>IPL Facilitator           | Ongoing during the life of each pilot site. |
| <b>Enrich and inform the curricula of all participating professional undergraduate courses</b>  | 1. Project Lead to be member of IPL curriculum planning groups at SHU.   | Ongoing review of developments.  | HA                              | Ongoing                                     |
|   | 2. Project Management Group members to be members of FAGILE at U of N.   | Ongoing review of developments.  | RP<br>GY<br>KH                  | Ongoing                                     |
|   | 3. Identify aspects of curriculum where practice focussed, service user centred interprofessional learning can be strengthened.                          | Review of learning methods employed by each module team.   | HA<br>RP                        | Ongoing                                     |
|   | 4. Utilise CUILU Capability Framework with students in pilot sites.  | Review student progress against CUILU outcomes to assess IPL achievements.                                     | HA<br>RP<br>IPL Facilitator     | Ongoing                                     |
|   | 5. Work with module leaders on introduction of service-user centred learning opportunities. Eg case studies, scenarios.                                  | Review module content and learning methods in participating universities.                                      | HA<br>RP                        | Ongoing                                     |

| PROJECT OUTCOME   | HOW WILL WE ACHIEVE OUTCOME?  | HOW DO WE KNOW WHEN IT IS ACHIEVED?                                    | WHO IS RESPONSIBLE (GROUP/LEAD) | DATE TO BE COMPLETED                         |
|---|---|--|---------------------------------|--|
| <p><b>Provide learning opportunities for staff to develop appropriate skills to support interprofessional learning in practice</b></p>                | <p>1. Appoint IPL Facilitators in each pilot site and provide with staff development opportunities including course delivery and content at SHU and UofN.</p>           | <p>IPL Facilitators appointed and staff development provided.</p>      | <p>HA<br/>RP</p>                | <p>Ongoing</p>                               |
|   | <p>2. Provide pilot site staff with initial development opportunities, both formal and informal, based on the training needs as identified by the pilot site group.</p> | <p>Review of initial staff development opportunities in each site.</p> | <p>HA</p>                       | <p>At end of each pilot site period.</p>     |
|   | <p>3. Provide ongoing support and development opportunities to pilot site staff in facilitating IPL in practice.</p>  | <p>Review of opportunities provided.</p>                               | <p>HA<br/>IPL Facilitators</p>  | <p>Ongoing</p>                               |
|   | <p>4. Support staff in utilising these opportunities as part of CPD and PREP requirements.</p>  | <p>Review of staff achievements</p>                                    | <p>HA<br/>IPL Facilitators</p>  | <p>At end of each pilot site period.</p>     |
|   | <p>5. Enable staff to access modules at SHU or UofN relevant to the skills required.</p>  | <p>Pilot site staff enrolled on appropriate modules.</p>               | <p>HA<br/>RP</p>                | <p>At end of each pilot site period.</p>     |
| <p><b>Utilise the CUILU interprofessional capability framework (Gordon and Walsh, 2005) to formulate resource packages and training templates</b></p> | <p>1. Introduce pilot site staff to the framework during staff development.</p>   | <p>Evaluate staff development in each pilot site.</p>                  | <p>HA</p>                       | <p>After each staff development session.</p> |
|   | <p>2. Support staff in utilising the framework when planning IPL opportunities in practice.</p>   | <p>Review of learning opportunities</p>                                | <p>HA<br/>IPL Facilitators</p>  | <p>Ongoing</p>                               |
|   | <p>3. Introduce students to the framework and support them in mapping their own practice learning outcomes against the framework.</p>                                   | <p>Review of learning experiences of students in pilot sites</p>       | <p>HA<br/>IPL Facilitators</p>  | <p>Ongoing</p>                               |
|   | <p>4. Evaluate the use of the framework with the collaborating universities involved in the project in each site.</p>   | <p>Review of IPL opportunities and achievements</p>                    | <p>HA<br/>RP</p>                | <p>Ongoing</p>                               |

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|---|--|--|---------------------------------|--|
| <b>Evaluate the impact of the project in the pilot areas, comparing outcomes across the sites</b>   | 1. Produce a research proforma to submit to the Ethics Committee and relevant Research and Development group in each pilot site. | Successful applications to local Ethics and R and D committees.  | HA                              | Ongoing for each pilot site                          |
|   | 2. Appoint Research Assistant to collect data in each site as per proforma.  | Successful appointment and completion of data collection.  | HA                              | Appointment by November 05. Data collection ongoing. |
|   | 3. Utilise an action research approach by taking forward findings from each site to subsequent pilot areas.                      | Review of objectives in research proforma and evaluation of outcomes.                                  | HA Research Fellow              | Ongoing  |
|   | 4. Form a service user/carer group in each pilot site. Ensure that this group informs the direction of the project.              | Group holding regular meetings and inputting into project development. Involvement in data collection. | HA Research Fellow              | Ongoing  |
| <b>Disseminate the findings from the project and influence national strategy by recommending sustainable models of interprofessional learning</b> | 1. Utilise an action research approach to evaluate the impact of the project and report the findings.                            | Completion of evaluative report.   | HA Research Fellow              | December 2008  |
|   | 2. Disseminate final report both locally and nationally.   | Dissemination completed.   | HA Research Fellow              | January 2009   |
|   | 3. Link with DoH 'Creating an Interprofessional Workforce' programme and feed findings into national strategy for IPL.           | Completion of regular input into the strategy.   | HA                              | April 2007   |
|   | 4. Submit papers to appropriate conference   | Acceptance of papers   | HA                              | Ongoing  |
|   | 5. Publish findings in appropriate local publicity and in international journals   | Acceptance of articles for publication   | HA                              | Ongoing  |

## Appendix D

### Time line

- A** Agreement with Trust Chief Executive  
Appointment of management champion
- B** Setting up of interprofessional pilot site group  
Allocation of particular department / area  
Introductory staff information sessions  
Formation of service User group
- C** Appointment of IPL Facilitator  
Staff Development Sessions  
Planning of interprofessional student learning opportunities
- D** IPL Facilitator in post  
IPL in Practice taking place  
Further staff development  
Regular pilot site group meetings and service user group meetings
- E** Evaluation of project outcomes through data collection with pilot site staff and service users  
Agreement of on-going support mechanisms for sustainability of IPL

**1 = MANSFIELD COMMUNITY HOSPITAL**

**2 = GRANTHAM AND DISTRICT HOSPITAL**

**3 = ACUTE CARE NETWORK, QUEEN'S MEDICAL CENTRE**

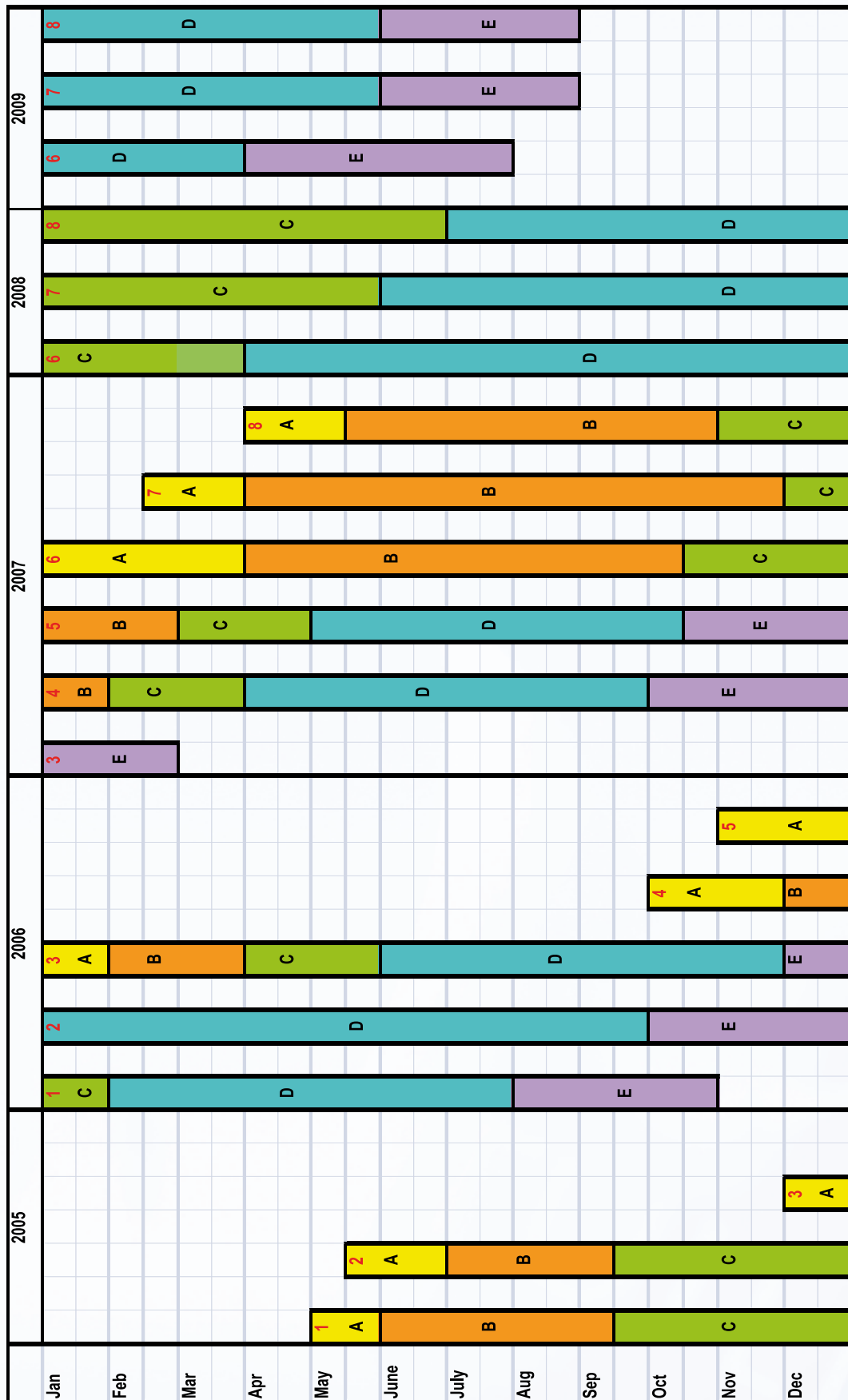
**4 = EMERGENCY MANAGEMENT UNIT and CLINICAL DECISIONS UNIT,  
CHESTERFIELD ROYAL HOSPITAL**

**5 = ENABLE, ASSISTED LIVING SCHEME, CHESTERFIELD**

**6 = DERBY CITY HOSPITALS - MATERNITY**

**7 = DERBYSHIRE GP PRACTICES**

**8 = DERBY WOMEN'S SERVICES**



# Appendix E

## The TUILIP Project Areas for Learning

**Adapted from the Combined Universities Interprofessional Learning Unit (CUILU) Framework, February 2004**

|  |  |
|--|--|
| Ethical Practice<br>EP1<br>EP2<br>EP3<br>EP4                 | <p>Understanding and respect for others' culture, values and belief systems.</p> <p>Promotion of patient participation and autonomy using informed decision-making and exercise of choice.</p> <p>Interprofessional approach to a duty of care within a legal and ethical framework.</p> <p>Critically evaluates policy and practice in respect of patient focussed care, role boundaries and quality assurance.</p>   |
| Knowledge in Practice<br>KP1<br>KP2<br>KP3                   | <p>Knowledge of legal frameworks and statutory regulation for each profession in the practice team.</p> <p>A critical understanding of team structures, group dynamics and the professional role of all team members.</p> <p>Participation in care management decisions using non-judgemental and anti-discriminatory practice.</p>  |
| Interprofessional Working<br>IW1<br>IW2<br>IW3<br>IW4<br>IW5 | <p>Participation in interprofessional teamwork – focussing upon and being responsive to the needs of the patient.</p> <p>Creates an integrated assessment and plan of care in partnership with the patient.</p> <p>Consistently communicates sensitively, demonstrating effective interpersonal skills for patient focussed care.</p> <p>Sharing of Uni – Professional knowledge with the team to contribute and enhance service provision.</p> <p>Adopt a co-mentoring role to peers of own or other professions, in order to enhance service provision, personal and professional development.</p>   |
| Reflection<br>R1<br>R2<br>R3<br>R4                           | <p>Utilises reflective processes in order to work in partnership with patients and colleagues, ensuring the provision of patient focussed and integrated care.</p> <p>Utilises a reciprocal process of reflection and supervision to support the continuing development of the interprofessional team.</p> <p>Responds to the needs of the service by utilising problem solving approaches and evidence based practice to identify and anticipate future changes in the interprofessional team role.</p> <p>Addresses professional development and lifelong learning needs in the interests of personal, professional and service development.</p> |





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