



**University of
Leicester**

Leicester Medical School

The Leicester Model of Interprofessional Education

A practical guide for implementation in health and social care

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Authors

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In 1999 Dr Lennox was awarded the MBE for services to medicine and the community. In 2001 she was appointed Deputy Lieutenant of Leicestershire.

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Since 1996 she has developed innovative models of education in the Department of Medical and Social Care Education. In 2002 she was appointed Senior Lecturer in Shared Learning at the University of Leicester. She chairs the regional strategy for Interprofessional Education for Leicestershire, Northamptonshire and Rutland Strategic Health Authority. The 'Three strand model'¹ provides interprofessional education for over 3,000 health and social care students enrolled in the regions three Universities. She has worked with Dr Angela Lennox on developing the Leicester Model of Interprofessional Education based on patient-centred education since 1988.

Dr Anderson is a Board member of the UK Centre for the Advancement of Interprofessional Education (CAIPE) and the Health Council of the Disability Partnership. She was awarded a teaching fellowship from the University of Leicester in July 2005, and nominated for a national teaching fellowship from the Higher Education Academy in 2007, for her contributions to community and interprofessional education.

¹ Anderson, E.S., Knight, T. (2004). The three strand model of interprofessional education in Leicestershire, Northamptonshire and Rutland Workforce Development Confederation. *CAIPE Bulletin*, Winter 2004/5;24:12.

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The former community health care organisation for Leicester and Leicestershire, Fosse Health Trust, under the leadership of the Chief Executive Roger Bettles. Leicester City Social Services and their former Director Andrew Cozens, Leicestershire County Social Services and former Assistant Director John Kershaw. The UK Centre for the Advancement of Interprofessional education (CAIPE). The Leicestershire Centre for Independent Living (LCIL) and the Tenants Association of St Matthews Estate Leicester.

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High Barr, President of CAIPE, for support and advice.

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Foreword

A Model of clarity

Professor Hugh Barr

President, The UK Centre for the Advancement of Interprofessional Education (CAIPE).

Practice learning is *sine qua non* in interprofessional education. Without it, claims that such education can improve collaborative practice ring hollow. Devising, developing and sustaining strategies for interprofessional practice learning, however, often prove to be more difficult than expected. Models that work well enough for small-scale, short-term projects turn out to be too complex and too labour intensive to cater for larger numbers of students in the longer term, whilst those successfully tested in one field of practice founder when transferred to another.

Angela Lennox and Liz Anderson have laboured long and hard to build a practice learning model grounded in principles of best practice in interprofessional education yet adaptable and responsive to the complete package of contemporary health and social care reforms. They have presented the emerging model at countless conferences, sharing their evolving experience, listening and learning from others travelling the same road. Encouraged by the response, they have prepared this guide which, like the Model that it describes, has gone through many iterations.

The outcome is a model of clarity; a guide that leaves no stone unturned, anticipates every question, practical from beginning to end. Angela and Liz are ready, I know, to respond to enquiries that the guide will undoubtedly prompt, to continue to share their experience as it unfolds and to learn from others.

The strength of the Model, for me, lies in its synthesis of practice learning in college and workplace, each reinforcing the other step by step. In Leicester, practice learning is too important to be left to service agencies alone and unaided. College teachers guide the learning throughout; learning that is student-led, patient-centred and change-oriented. Students with patients, supported by teachers, trainers, practitioners and carers, pool their insights and combine their energies to raise the quality of health care as they experience and express collaborative practice in all its fullness.

I am confident that the Model will prove to be as practical, replicable and sustainable, as it has been in and around Leicester, as it is tested and developed further in ever-wider fields of education and practice at home and abroad.

A Model to be commended

Professor Paul Dieppe

Director, MRC Health Services Research Collaboration, Bristol, and Chairman, Health Council of the Disability Partnership.

Crises, precipitated by poverty, infection, malnutrition and injury dominated the demand for health and social services in the UK when our care systems were first established. Not surprisingly, the structure of these systems, and the education of those who worked in them, reflected these needs. Inevitably, the educational emphasis was on the recognition, diagnosis and appropriate interventions required to respond to acute crises. To some extent, the Model persists to this day in some Higher Education Institutions, in spite of the fact that the health and social needs and demands of the population have changed dramatically. For example, in many medical schools the major educational emphasis remains the causes, diagnosis and treatment of acute medical emergencies, with less attention being given to chronic disease and disability. But today, chronic, complex problems dominate the workloads of our health and social care professionals, and their education should reflect this.

It seems to me that we have been slow to adapt our education curricula in response to the changing nature and consequences of disease and disadvantage in our society. One possible reason for such a slow response might well be the fact that it is much more difficult to teach people about multi-factorial, complex chronic problems than it is to show them how to respond to, for example, a cardiac arrest. Furthermore, the response to today's chronic complex problems depends on the utilisation and integration of the multiple skills and services of many different professionals, rather than those of the lone doctor or social worker.

This booklet introduces us to the Leicester Model of Interprofessional Education for health and social care students. It outlines a comprehensive programme of education centred on inequalities, chronic disease and disability and interprofessional working.

Any new approach to education needs to be based on sound theoretical and educational principles, and to have clarity of its learning objectives and assessment methods. In addition, it needs to be practical. The Leicester Model of Interprofessional Education fits all of these criteria and seems to answer the needs outlined above - it gives students the opportunity to learn from people with chronic complex problems, and to contribute to their care through interactions with the professionals involved, as well as the clients themselves. The power of the Model comes from the extensive exposure of students to those with chronic disease and disability, and the fact that they come to have a real understanding of the problems of this client group, as well as the mixing of the student groups and professionals, allowing people to learn appropriately about and through each others' expertise and experiences.

The Health Council of the Disability Partnership is another organisation that has taken a special interest in disability education and awareness amongst health professionals. We have found that much higher education is woefully inadequate in this regard, leading, we believe, to many disabled people being marginalised and disempowered by the professionals who should be there to help them. Those who learn through the Leicester Model of Interprofessional Education are unlikely to mistreat their clients in this way.

I commend this Leicester Model of Interprofessional Education to you. It is clearly presented in this report, which sets out the educational pathways of all key stakeholders, as well as introducing you to the principles of the Model. In addition to being of value to local students and teachers, it will allow educationalists in other Higher Education institutions to develop similar innovative approaches to education.

Working and learning together

Andrew Cozens CBE

Strategic Adviser, Children, Adults and Health Services.

Improvement and Development Agency for Local Government

One of the pleasures of my stint as Director of Social Care in Health in Leicester from 2000-2006 was the sense of shared purpose of colleagues in social care and health in the city. As the growing body of evidence on successful partnership working tells us, much of this flowed from the leadership of those organisations in the public and community sector who wanted to secure good and appropriate services, and how staff were encouraged and expected to change.

There were other reasons too. When resources are tight and needs evident, leaders need to work together and show creativity or quality and morale suffers. There are unacceptably wide health inequalities in the city, and the key to reducing them lies in the wider determinants of health: among them housing, employment, education, income, parenting, air quality and community safety.

But any partnership approach has to work its way through the maze of performance indicators, policies and guidance that seems designed to keep services apart. Indeed it is said by some high performing health and social care organisations that their success is achieved by staying focused on their core business and not being diverted by the complexities of partnership working and community development. Professional training for many health and social care practitioners can reinforce this silo mentality.

I was fortunate to come into social work through community work in the voluntary sector and to start my professional practice at the time when community social work and neighbourhood teams were in vogue. This coincidence helped shaped my approach as a professional and a manager. This, sadly, is a less common route now and a more systematic approach is needed to promote interprofessional education and practice, and models that are people-shaped and patient-focused.

It has been a pleasure to contribute, in a modest way, to the practice-learning model that is set out in this guide. Angela Lennox and Liz Anderson have championed this approach in Leicester and far beyond and I hope this publication continues to strengthen and sustain the impact of their work.

The public are increasingly intolerant and suspicious of professional mystique. Good health and social care practitioners need to see people in the round and know what each other does. I hope this guide will push us much further down that road.

Table of Contents

Authors	i
Acknowledgements	ii
Foreword	iii
<i>A Model of clarity</i>	iii
Professor Hugh Barr	
<i>A Model to be commended</i>	iv
Professor Paul Dieppe	
<i>Working and learning together</i>	v
Andrew Cozens	
Table of Contents	vi-viii
Glossary and terms	ix
Introduction	1
<i>Overview of this guide</i>	1
Who is this guide intended for?	1
What does this guide contain?	1
The guide consists of six parts	1
<i>How does the Leicester Model of Interprofessional Education fit into the range of IPE teaching?</i>	3
<i>Learning styles and student diversity</i>	5
<i>Glossary and terms</i>	5
Part 1: The Leicester Model of Interprofessional Education	7
<i>Introduction</i>	7
The education cycle	8
Distinctive features of the Leicester Model of Interprofessional Education	8
Theoretical education perspectives	9
Interprofessional perspectives	10
Learning objectives	11
Assessment	11
Education potential	12
Evaluation	12
Part 2: Ethical and Funding Issues	13
<i>Ethical principles and their application</i>	13
Introduction	13
Education institution	13
Educational methodology	13
Academic coordinators, tutors and administrators	13
Health and social care organisations	14
Agency representatives	14
Patient identification and induction	15
Students	15

Evaluation	15
The funding infrastructure	16
Part 3: Education Pathways	19
The education infrastructure pathway	19
Introduction	19
Stages of establishing the infrastructure (Figure 4)	21
The educational content pathway	23
Stages of programme development	24
The student pathway	26
Introduction	26
Introductory lectures	27
Education venues	27
Locality induction	27
Student interviews	27
Student confidentiality and code of conduct	28
Student reflections	29
Student presentations	29
Formal student feedback to agencies	30
Student assessments	30
Student evaluation	30
The patient pathway	31
Introduction	31
First patient contact	32
First tutor contact	33
Patient induction	33
Patient interviews	34
Post-interview debrief	34
Post-programme and patient fees	34
The agency pathway	35
Introduction	35
Agency identification and invitation	35
Agency induction	36
Interview strategies	37
Case study presentations and feedback	37
Agency evaluation	38
Extended roles of agency representatives	38
The tutor pathway	39
Introduction	39
Identification of tutors and the teaching teams	39
Tutor training	40
1. The development of tutor education skills	41
2. Programme induction	41
3. Specialist tutor skills	46

<i>The administrative pathway</i>	47
Part 4: The Leicester Model of Interprofessional Education	
Programme Details	49
<i>Pre-registration programmes</i>	50
Inequalities in health	50
Learning from lives	51
<i>Learning beyond registration</i>	53
Working together in health and social care	53
<i>Continual professional development (CPD) courses</i>	54
Interprofessional working to support disabled people	54
Team working along the patient pathway	55
Part 5: Evaluation Methodology	57
<i>Evaluation methodology</i>	57
Introduction	57
Ethics and governance	57
Action research	58
Stages in the evaluation process	58
Conclusion	61
Part 6: Templates of Forms and Letters	63
<i>Template 1: Student feedback form</i>	64
<i>Template 2: Algorithm of patient recruitment</i>	65
<i>Template 3: Patient referral template</i>	66
Health in the community	66
<i>Template 4: Patient information leaflet</i>	67
<i>Template 5: Patient consent form</i>	68
<i>Template 6: Patient contract</i>	69
Department of Medical & Social Care Education	69
<i>Template 7: Confirmation letter to patient</i>	70
<i>Template 8: Example of a thank you letter (patient)</i>	71
<i>Template 9: Agency confirmation letter</i>	72
<i>Template 10: Incident log</i>	73
Issues arisen during running of Health in the Community Course	73

Glossary and terms

All organisations involved in delivery of the programmes are described as '**agencies**'. This includes statutory health services, statutory non-health services (e.g. housing, the Police and education) and voluntary sector (or third sector) services.

Collaborative practice. 'A relationship between two or more people, groups or organisations working together to define and achieve a common purpose'⁶.

Higher Education Institution (HEI) or Higher Education Institutions (HEIs) is the term used to denote a university or universities.

Interprofessional Education (IPE) 'Occasions when two or more professions learn from and about each other to improve collaboration and the quality of care'⁷ (definition adopted by the authors of this guide). In practice, the authors recommend that three or more separate professional groups are required to achieve the interprofessional outcomes described in this guide.

Multi-disciplinary working. 'Refers to the coming together and contribution of different academic disciplines'⁸.

Partnership working. 'A shared commitment where all partners have a right and an obligation to participate'⁹.

For the purposes of consistency the term '**patient**' is used throughout this guide to denote the patient, client or service user.

The term '**programme**' is used throughout this guide to encompass all educational courses described in this guide.

The term '**student**' is used throughout this guide to reflect the learner at undergraduate or postgraduate level or for staff undertaking Continual Professional Development. It encompasses the professional and the non-qualified workforce.

Team work. 'The process by which a group of people with a common goal work together, often, but not necessarily, to increase the efficiency of the task in hand'¹⁰.

⁶ Hornby, S., Atkins, J. (2000). *Collaborative Care - interprofessional, interagency and interpersonal*. Blackwell Science (2nd Ed).

⁷ Barr, H. (2002). Interprofessional education: today, yesterday and tomorrow. *Higher Education Academy subject centre for Health Sciences and Practice*, London.
<http://www.health.heacademy.ac.uk/publications/occasionalpaper/occasionalpaper01.pdf> (accessed August 2005).

⁸ Leathard, A. (2003). *Models of interprofessional collaboration: Chapter 7 in; interprofessional collaboration. From policy to practice in health and social care*. Edited by Audrey Leathard. Brunner-Routledge.

⁹ Carnwell, R., Buchanan, J. (2005). *Effective practice in health and social care. A partnership approach*. Open University Press.

¹⁰ Barr, H., Koppel, I., Reeves, S., Hammick, M., Freeth D. (2005). *Effective interprofessional education. Argument, assumption & evidence*. CAIPE. Blackwell Publishing.

Introduction

Overview of this guide

Welcome to this guide which invites you to adopt a carefully developed, robustly tested and evaluated interprofessional learning model for health and social care students. The guide provides information on the Leicester Model of Interprofessional Education (the Model) and details the practical processes required to replicate the experience. Emphasis is given throughout on the importance of creating a learning environment in which quality interprofessional education can occur.

The Model places students at the centre of current health and social care delivery, learning directly from patients and their service providers, to develop the skills to provide effective, multi-agency care. Learning is underpinned by theoretical perspectives and healthcare policy.

Learning is reflective, experiential and problem solving, with pre- or post-qualified students working together in interprofessional or uniprofessional cohorts of up to 1000, in groups of 3-5 students per patient.

The educational cycle transforms learners into active participants with the potential to change and improve current practice through the identification of ideal future care to benefit the patient. Patients are key partners in the educational pathway, supporting the programme development as well as its delivery. The involved service providers have an opportunity to reflect on service provision alongside the students and tutors. In this regard the Model achieves the “*communities of practice*” as outlined by Etienne Wenger², with the learning gains extending well beyond the student groups. The education model has been widely replicated geographically, across a range of healthcare settings and for a range of learning objectives.

Who is this guide intended for?

This document is written for professionals involved in interprofessional education in health and social care. The Model outlined in it is appropriate for pre- or post-qualified programmes and therefore the guide is relevant for curriculum planners, module leaders, lecturers and clinical education leads or education coordinators in health and social care organisations.

What does this guide contain?

The guide offers a detailed step-by-step analysis of this practical Model of interprofessional education. The education pathway is presented from the perspective of a variety of programme stakeholders, for example education leaders, patients, students and administrators. The guide additionally presents a theoretical basis for learning in the Model of learning.

² Wenger, E. (1998). *Communities of practice - learning, meaning and identity*. Cambridge University Press (2nd Ed).

The guide consists of six parts

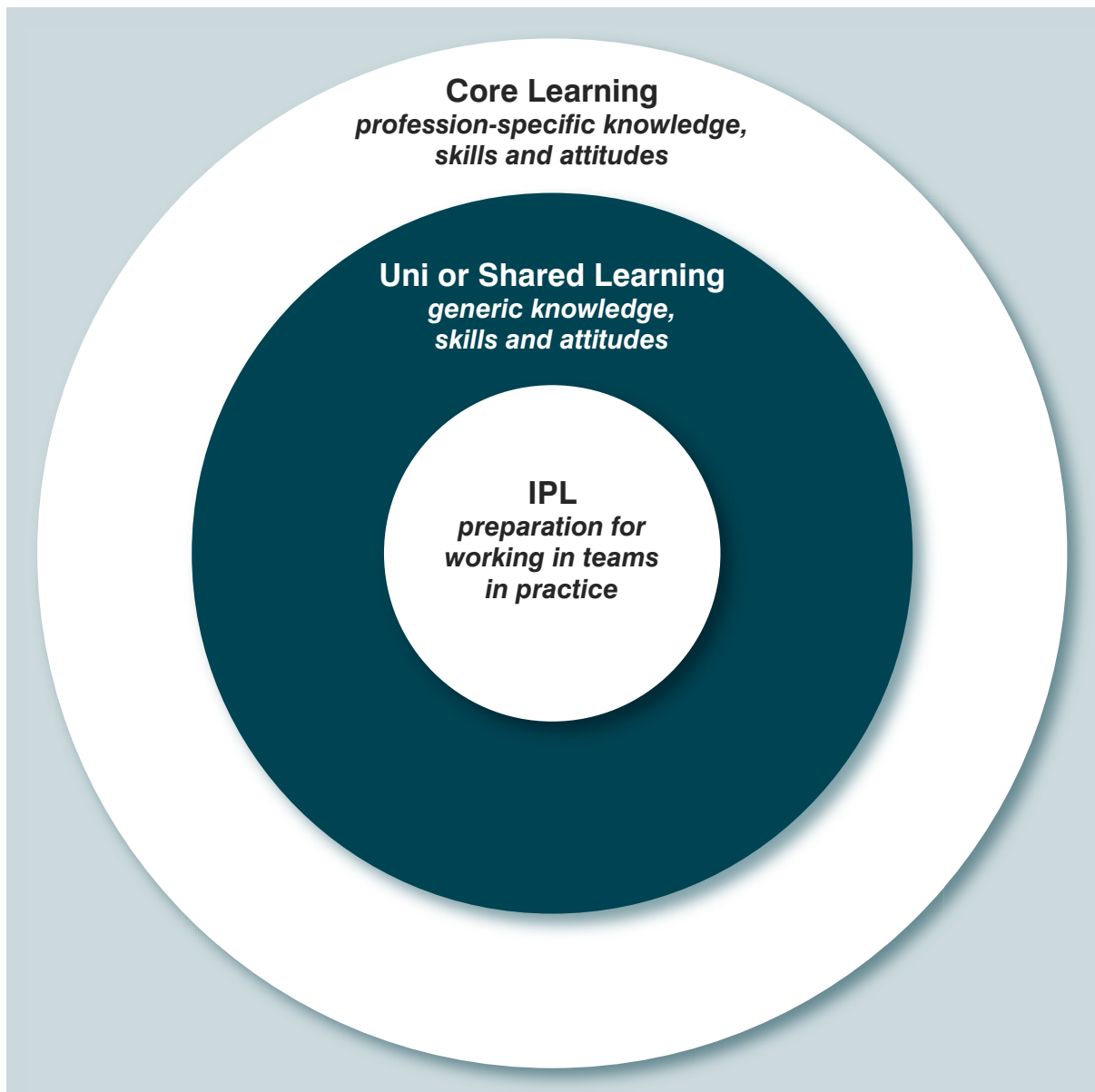
- Part 1** A description of the Model and its application across a range of educational programmes.
- Part 2** The underpinning ethical principles and funding requirements.
- Part 3** A series of detailed pathways illustrating the necessary key stages to replicate the programmes.
- Part 4** Details of the individual programmes.
- Part 5** The evaluation methodology.
- Part 6** Templates of forms and letters used in the programmes.

How does the Model fit into the range of IPE teaching?

The Model is designed to provide a practical, easily reproducible, experience. It is therefore an ideal adjunct to the many traditional methods of interprofessional learning such as competency based learning. Incorporating this Model into your interprofessional programmes will provide your students with an opportunity to apply and practice their interprofessional knowledge and skills in the workplace with real patients and their service providers.

Figure 1 shows the context setting of the Model within the overall health and social care curriculum. The outer circle represents profession-specific learning. The middle circle refers to the core competences in common with other professions. These can be learnt as a shared learning experience or in uni-professional settings, for example, communication skills.

Figure 1: The context setting of the Model within the overall health and social care curriculum.



The inner circle represents interprofessional learning in which students learn with and from one another. This forms the setting of the Model. For undergraduates it is ideally placed between the mid- to late-stages of training since it is essential that students bring their profession specific and generic knowledge to the learning set. It is equally appropriate for the post-qualified period and for continuing professional development. The time commitment required is flexible and may be as little as two days or as long as desired.

The Model is built on a protected learning environment which is as close as it can be to real-life multi-disciplinary practice. Pre-qualified students gain an insight into future practice whilst post-qualified learners are able to look afresh at current practice, and in some programmes, they observe areas of practice with which they are less familiar, to analyse team working and collaborative practice in order to improve their own knowledge, skills and competences. The Model is able to accommodate the varying entry levels of knowledge, skills and competences on team working and collaborative practice as well as clinical practice. The learning outcomes can be easily adapted to reflect the extent of this prior learning and the academic level of the programme.

The Model requires and facilitates HEIs to engage in joint working with health and social care organisations.

The Model forms an integral part of Leicestershire, Northamptonshire and Rutland's '**three strand model of interprofessional education**'¹.

It is placed in strand two (mid-training) and three (training in latter years) after students have developed some uni professional specific and generic knowledge and skills. IPE in strand one is university based.

Learning styles and student diversity

The methodology of the Model (Figure 2) embraces the different ways that individual students prefer to learn, known as learning styles⁴. For example, in this learning cycle students identify and address the problems and needs of patients and their service providers (activists); they explore the links between ideas and situations (theorists); they are enabled to make the links between their uniprofessional core learning and the problems in which they are engaged in their programme (pragmatists); the cycle is completed with reflection, when students are challenged to think deeply about the concepts and activities, formally presenting these as solutions (reflectors)⁵.

The Model also provides a robust learning environment which addresses the wide diversity of its participating student groups, which includes a formal programme of preparation for the facilitators.

⁴ Coffield, F., Moseley, D., Hall, E., Ecclestone, K. (2004). *Learning styles and pedagogy in post-16 learning. A systematic and critical review*. London, Learning and Skills Research Centre.

⁵ Honey, P., Mumford, A. (1982). *The manual of learning styles*. Peter Honey, Maidenhead.

Part 1: The Leicester Model of Interprofessional Education

Introduction

This guide is based on the experiences of delivering interprofessional education, initially developed through the Centre for Studies in Community Health Care, Department of Medical and Social Care Education, University of Leicester. This Model has now been adopted by the Strategic Health Authority and is embedded within pre- and post-registration assessed programmes across the region and involving all health and social care professions.

The educational objectives are driven by the requirements of health and social care organisations to deliver quality integrated services, sensitive to individual needs in a teamwork environment. Emphasis is made throughout on how to create a learning environment which can appropriately support interprofessional education.

The education cycle

Students are grouped into cohorts of 24 - 32 students per teaching venue. They commence their learning with induction into the programme structure, team working and the geographic locality. They follow the Model as illustrated in Figure 2.

Step 1. The cohort is subdivided into interprofessional groups of 3-5 students. Each group begins their programme by interviewing a patient in their home or a care setting to understand medical and social care issues impacting on their physical, psychological and social functioning. The patient's priorities and attitudes are explored, alongside their relationship with the services involved in their current care.

The student group then interview the workers of 3 or 4 agencies providing care to their patient to explore the strengths and limitations of the service, and to compare service priorities with those of their patient.

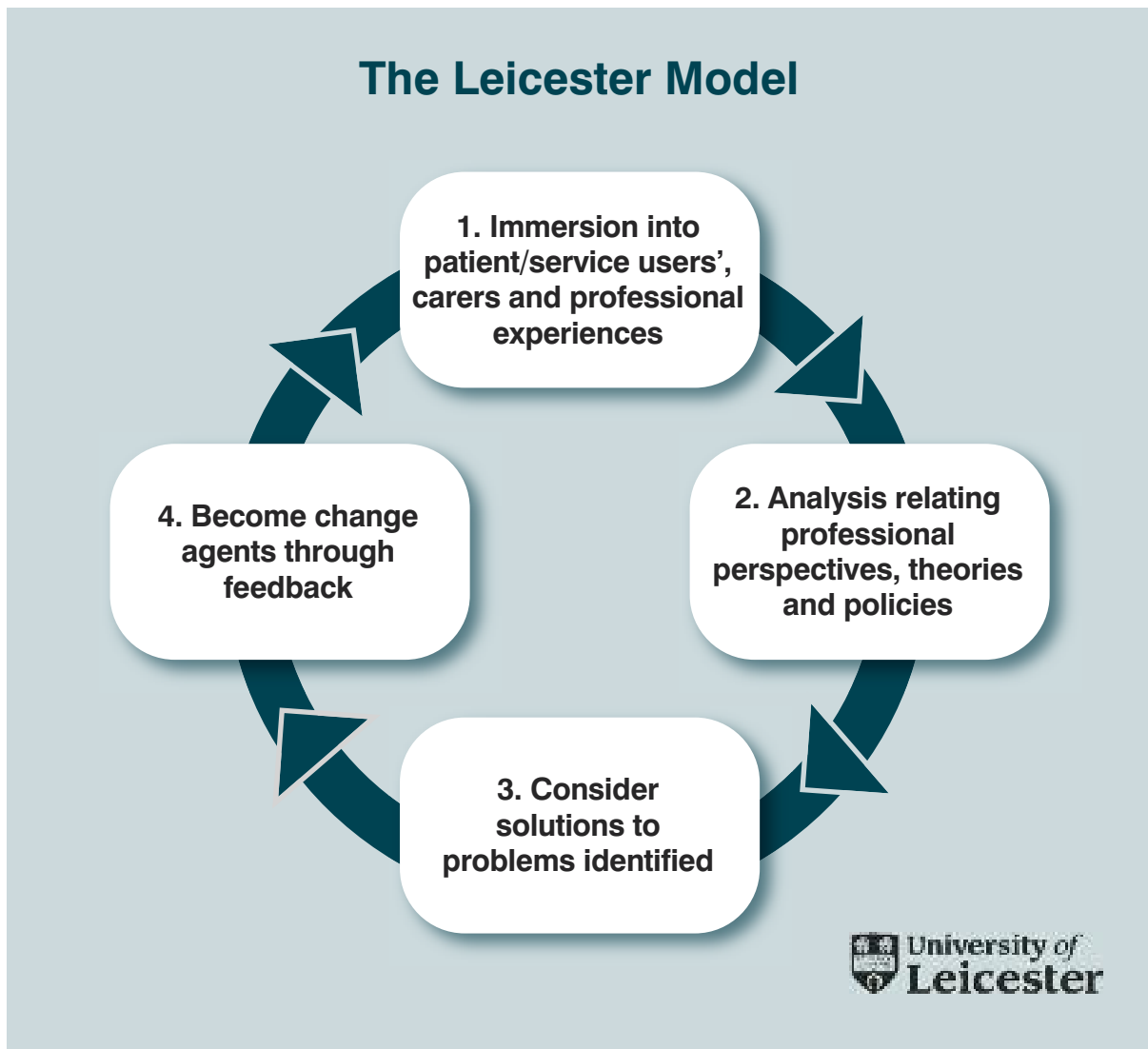
Students additionally meet with representatives of the community in which their patient lives, to gain a wider understanding of the context of service provision, for example the police or tenants' association or with managers from NHS Trusts.

Step 2. Facilitated by experienced clinical and academic tutors, the student group reflects on each interview. They relate service and theoretical perspectives with health and social care policies; they then interpret their findings and prioritise the issues identified. This process is supported by a range of experts which reflect the learning outcomes such as disability trainers, occupational psychologists.

Step 3. Following the interviews the student group analyse the interdependence of different statutory and voluntary providers and critique their team working. They then identify practical multi-agency solutions to improve the patient's quality of service delivery.

Step 4. The education cycle is completed with student solutions formally presented to the agency workers and their managers in an interactive presentation session. Students also provide written feedback to the individual service providers.

Figure 2: The Leicester Model of Interprofessional Education.



Distinctive features of the Model

- students are placed at the centre of service delivery, developing skills to provide multi-disciplinary care, learning directly from patients and their service providers;
- patients are partners in delivering and shaping the programme;
- the learning cycle has the potential to change and improve current practice;
- students gain insights into competing service priorities, communication issues, cultural and language barriers, and its impact on service delivery;
- students learn with colleagues across health and social care settings in interprofessional or uniprofessional groups and across community and hospital based care, with learning underpinned by theoretical perspectives;

- the education method is reflective, experiential and problem solving which encourages active learning and critical enquiry;
- formal presentations transform students into active partners in the development of multi-agency service delivery;
- service providers and managers can reflect on their case with their colleagues from the statutory and voluntary sectors and across the community-hospital interface;
- students learn from patient groups which are known to encounter inequitable access to healthcare, e.g. disabled people and the socio-economically disadvantaged;
- the Model facilitates partnership working between HEIs and organisations delivering care to the public. Academic tutors are immersed in an environment which both experiences and debates current clinical practice. Front line service providers are given opportunities to develop their educational skills as tutors.

Theoretical education perspectives

The Model seeks to enable students to be motivated to learn, to be inquisitive in their search for explanations and to apply their knowledge in a problem solving¹¹ manner to gain new understanding. The Model, including its interprofessional learning opportunities, is grounded in adult learning theory¹² and aims to promote deep thinking rather than learning by rote, and encourage students to apply knowledge to a range of situations and interpret their findings in the context of new situations. This goal is underpinned by constructivist theories¹³ and its components of experiential learning¹⁴ and reflection¹⁵.

There is evidence that deep approaches to learning are more likely to be associated with higher quality learning outcomes¹⁶. These are achieved in the Model by:

- aligning programme outcomes with the overall curriculum content¹⁷;
- the programme methodology of tutor facilitated, small-group activities, where students can learn from their experiences and formulate recommendations;
- assessments that support the aims and outcomes by constructive alignment¹⁸;
- the rigorous, on-going programme of tutor preparation for the teaching method;
- partnership working between HEIs and health and social care organisations;
- the creation of non-threatening, protected learning environments.

¹¹ Knowles, M. (1984). *Andragogy in action*. Gulf Publishing Co, Houston.

¹² Bruner, J.S. (1960). *The process of education*. Harvard University Press, Cambridge, Massachusetts.

¹³ Piaget, J. (1950). *The Psychology of intelligence*. Routledge and Kegan Paul, London.

¹⁴ Kolb, D.A. (1984). *Experiential learning*. Prentice-Hall, Englewood Cliffs, New Jersey.

¹⁵ Shön, D. (1987). *Educating the reflective practitioner*. San Francisco: Jossey-Bass Publishers.

¹⁶ Prosser, M. and Trigwell, K. (1999). *Understanding Learning and Teaching: The experience in Higher Education*. Buckingham, SRHE/Open University Press.

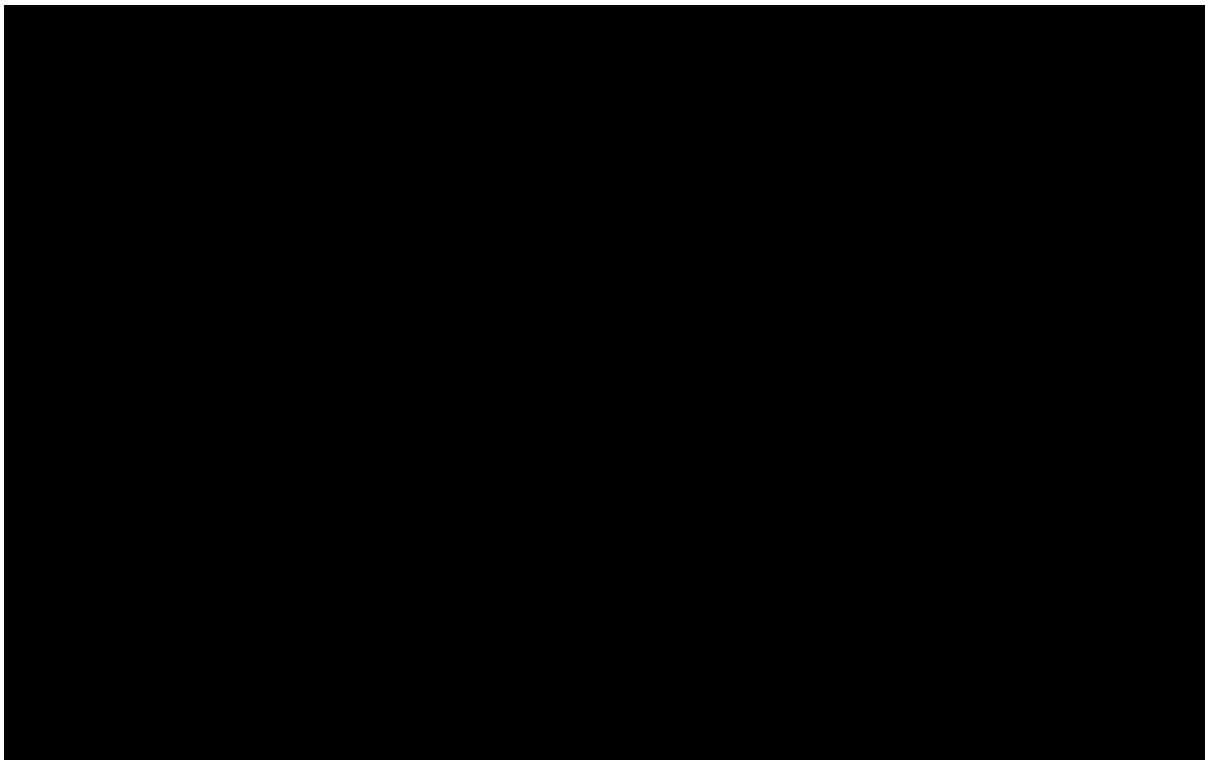
¹⁷ Biggs, J.B. (1987). *Student approaches to learning and studying*. Australian Council for Education Research, Melbourne.

¹⁸ Biggs, J.B. (1996). Enhancing teaching through constructive alignment, *Higher Education*;32:1-18.

Interprofessional perspectives

The Model delivers quality interprofessional learning which achieves the standards set by the UK Centre for the Advancement of Interprofessional Education (CAIPE)¹⁹, through the small interactive group learning that:

- enables students to personally experience, analyse and reflect on interprofessional working in their groups as well as observe others;
- is patient-centred from real-life experiences;
- allows students to explore professional roles and responsibilities in patient care;
- acknowledges that different professions work from different perspectives;
- allows similarities and differences between professionals to be respected;
- is appreciative of each others professional training and roles in the workplace;
- acknowledges terminology and language used by professions;
- ensures a greater understanding of why collaboration improves quality of patient care;
- engages students in the learning partnerships, making a full and positive contribution.



Post-registration students learning together in interprofessional groups including training GP registrars, district nurses, health visitors, practice nurses, school nurses and social workers.

¹⁹ The UK Centre for the Advancement of Interprofessional Education www.caipe.org.uk accessed January 07.

Learning objectives

The Model flexibly delivers a range of educational objectives and learning outcomes, and at different academic levels, to develop:

- knowledge, skills and attitudes of team working within and across organisational boundaries;
- a practical understanding of multi-disciplinary service delivery;
- clinical and interpersonal skills;
- an appreciation of the patient at the centre of service delivery;
- an understanding of the specific needs of marginalised sectors of the population whose access to health and social care is problematic.

Learning outcomes can be applied across the learning continuum from pre- to post-registration and for professional and non-professional groups. The Model allows flexible application of outcomes that are both challenging and reflecting the cognitive level of learning. Evaluation studies, both internal and external^{20,21}, confirm that the learning outcomes are achieved.

Assessment

All programme assessments are aligned with the learning outcomes and the educational methodology. They are generally multi-method, with many programmes having a common assessment of a case study 'report'. This report requires the student to critically analyse the information obtained from the range of interviews and visits in order to develop ideal solutions to improve the care provided to the individual patient and that of the healthcare systems in which the patient is placed. The use of multi-method approaches minimises the disadvantage that some professionals may experience when working within a multi-disciplinary group.

- all pre-registration interprofessional learning is recorded in a case study;
- for post-qualified students, assessments include a reflective component based on the learner's clinical experiences;
- master-level assessments include case studies, reflective portfolios and in some cases competency based problem-solving papers which test the application of the learner's knowledge to clinical practice.

²⁰ Lennox, A., Petersen, S. (1998). Development and evaluation of a community based, multi-agency course for medical students: descriptive study. *British Medical Journal*; **316**:596-9.

²¹ Wykurz, G. (2001). *Shaping your future medical workforce: Developing the NHS role in planning undergraduate medical curricula. National Evaluation of Medical Curriculum Development projects.* NHS Executive Third year Report. October. School of Integrated Health, University of Westminster.

Education potential

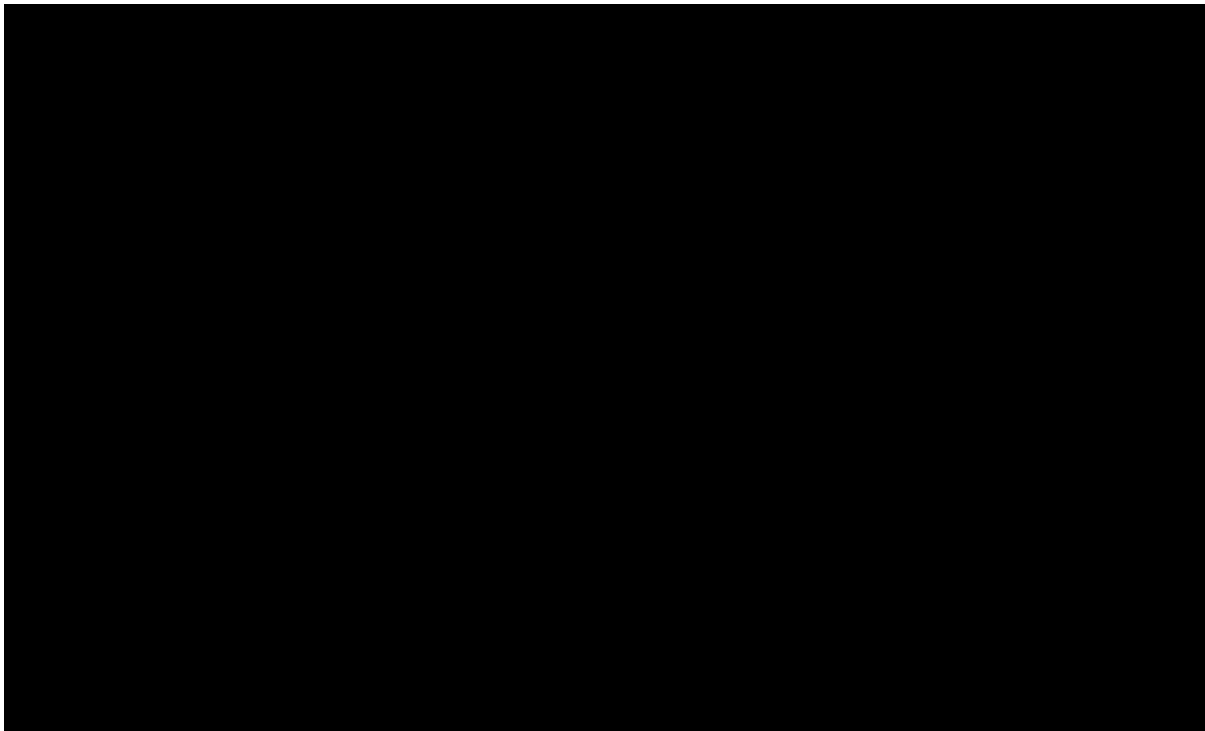
Interprofessional working to achieve collaborative practice can be realised through this Model of education. It can engage with a wide range of professional and non-qualified staff for example health and social care clinical and management staff, therapists, psychologists, pharmacists, healthcare support workers and a range of non-health organisations whose work impacts on healthcare (e.g. housing officers).

There is a great potential for expanding this approach to learning. The Model has already been replicated across urban and rural locations and in hospital and social care settings, using a range of clinical diseases and socio-economic environments.

Evaluation

All programmes undergo robust, quality audit cycles using a variety of methods, involving programme stakeholders and students. See **Part 5: Evaluation Methodology** of the guide for more details.

Post-registration students learning together in interprofessional groups in a community hall.



Students interview a mother in her home.

Part 2: Ethical and Funding Issues

Ethical principles and their application

Introduction

The education programmes developed through this Model are dependent on students learning from the everyday experiences of patients who are currently accessing health and social care services. It is therefore vitally important that robust processes are in place to protect the rights and confidentiality of these volunteer patients, and to ensure that the information discussed in these programmes is sensitively handled and fulfils the requirements of the Data Protection and Freedom of Information acts²². The following processes are in place to provide this level of protection.

Education institution

The educational content and methodology requires approval from the Educational Policy Committee of the HEI.

The ethical sub-committee of the Educational Policy Committee should be consulted.

Educational methodology

It is a requirement of the Data Protection Act (1998) and Caldicott²³ that if questionnaire material is required of patients or health and social care staff supporting these patients, formal ethical approval should be sought.

The Model learning cycle identifies unmet needs or issues affecting patients, formal agreements must be made with organisations that they are willing to receive, and if appropriate, act upon this information for the patient's benefit.

Academic coordinators, tutors and administrators

Compulsory training ensures academic coordinators, lead tutors and administrators responsible for delivering the programme are fully aware of:

- their responsibilities in dealing with confidential patient information;
- processes to record and resolve incidents which may arise during the programme;
- patient induction, including knowledge of patient withdrawal processes;

²² United Kingdom Data Protection Act (1998). <http://www.opsi.gov.uk/ACTS/acts1998/19980029.htm> accessed January 2007; United Kingdom Freedom of Information Act (2000). <http://www.opsi.gov.uk/ACTS/acts2000/20000036.htm> accessed January 2007.

²³ The Caldicott Committee (1997). Report on the review of patient-identifiable Information. Department of Health. <http://confidential.oxfordradcliffe.net/caldicott/report/> accessed January 2007.

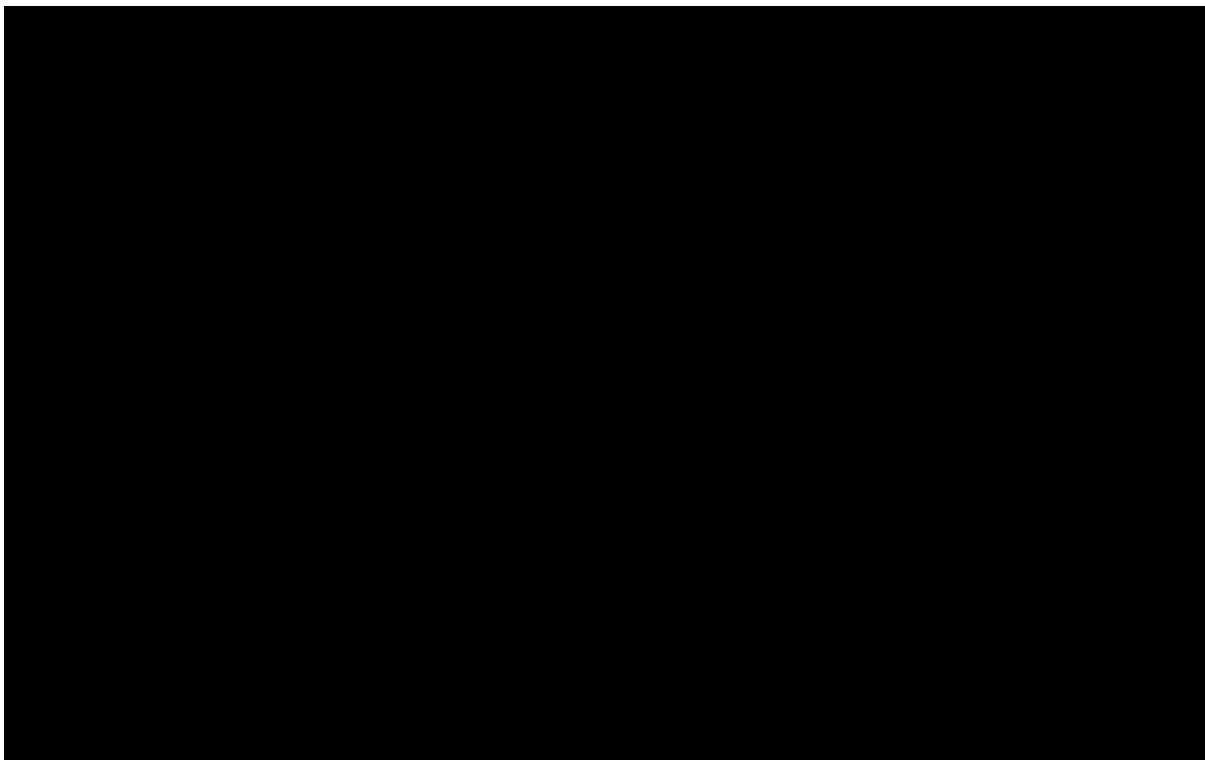
- patient involvement pre- and post-interviews;
- their role in familiarising locality tutors in these ethical principles;
- student induction for these education programmes.

Health and social care organisations

Organisations involved in the educational programmes are provided with a copy of this guide and details are formally presented to their organisational boards.

Agency representatives

Agency representatives and other stakeholders involved in student interviews are informed of these ethical principles during their recruitment into the programme. They are instructed how to respond to the information gained by students during the patient interview. They are aware that they should not discuss any information about the patient unless this has first been raised by the student group.



A tutor enrolls a patient onto the programme

Patient identification and induction

There is a two-stage process for patient identification and enrolment, with exit points in place at every stage of the process as follows:

- the lead tutor obtains the names of potential patients who fit the selection criteria via a secondary referral process from primary care teams or specialist services (e.g. children's care). See **Part 3 - The Patient Pathway**;
- patients are first approached by a professional who knows them best. They are given an introduction about the programme and are asked if they would like to consider their future involvement;
- if the patient indicates a willingness to become involved, the lead tutor arranges a visit to provide more details about the programme and their involvement, they are instructed that at any stage they may withdraw without any impact on their health and social care;
- patients are in full control of the information provided to the student group. They also identify which agency representatives should be interviewed as part of their case study;
- patients know that agency interviews will not divulge any information which has not first been discussed by them, or agreed to be released for inclusion on the case study information sheet;
- patients decide how they wish to be identified, students will never be privy to their full name, only an agreed first name;
- patients sign a contract to confirm their informed consent to taking part.

For patients with learning disabilities and vulnerable patients, enrolment follows the standard guidelines for informed consent. This is normally obtained with a family member or guardian.

Students

Students are informed about their requirement to protect patients' confidentiality. This is provided during their introductory lecture, in their workbook and repeatedly by the tutors throughout the programme.

Students are not allowed to remove details of the patient case study from the education venue, nor write or present details of the patient's name or address in an identifiable format. They are also not allowed to discuss their case in public places. Failure to comply will result in disciplinary action in line with their HEI's conduct policy.

Students are instructed to report any untoward incidents they may uncover during the interviews to the tutor. An incident process is triggered which requires written details to be forwarded to the academic coordinator who will take appropriate action. Students are informed that they should not directly discuss untoward incidents or unexpected findings with the agency representatives involved in their interviews. Tutor debriefing after each interview provides a second opportunity to identify and address these unlikely events.

Evaluation

Routine post-programme evaluation provides opportunities for all stakeholders to reflect on ethical issues arising from their involvement.

The funding infrastructure

The programmes are dependent on involving a range of people who may be employed by health and social care organisations, the voluntary sector or HEIs.

Practitioners involved in programme interviews may differ in requiring backfill to maintain the service demands; some will have an element of teaching within their contract and others will require their time to be compensated. Key academic and clinical tutor roles must be negotiated with employing health or social care organisations.

Funding is generally required to support the following areas.

The teaching team

Academic Coordinator	Ideally jointly employed with the HEI and the health or social care organisation.
Tutors	To backfill their clinical responsibilities.
Administrators	To organise all aspects of the programmes.
Educational Base	To support staff and provide electronic student support.
Staff Training	For tutor programme induction, educational skills development and specialist skills development.

The education steering group

Quality Assurance	To support the programme development, accreditation and annual review sessions.
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The education programmes

Venues	Cost of hire and refreshments.
Patient preparation	Tutor costs for pre-programme enrolment and induction, and post-programme debrief and evaluation.
Tutorials	Tutor time, including preparation time.
Other teaching roles	For example, tutors supporting half or full day programmes.
Locality visits	Organisation and costs of agency participation.
Interviews	Involving statutory and voluntary sector representatives.
Weekly Guest talks	Engaging local expertise.
Educational materials	All programme materials including workbooks, electronic learning and assessment material etc.
Assessment	Costs of holding and marking assessments.
Patients	Fees - where applicable.
Evaluation	Costs of the study.

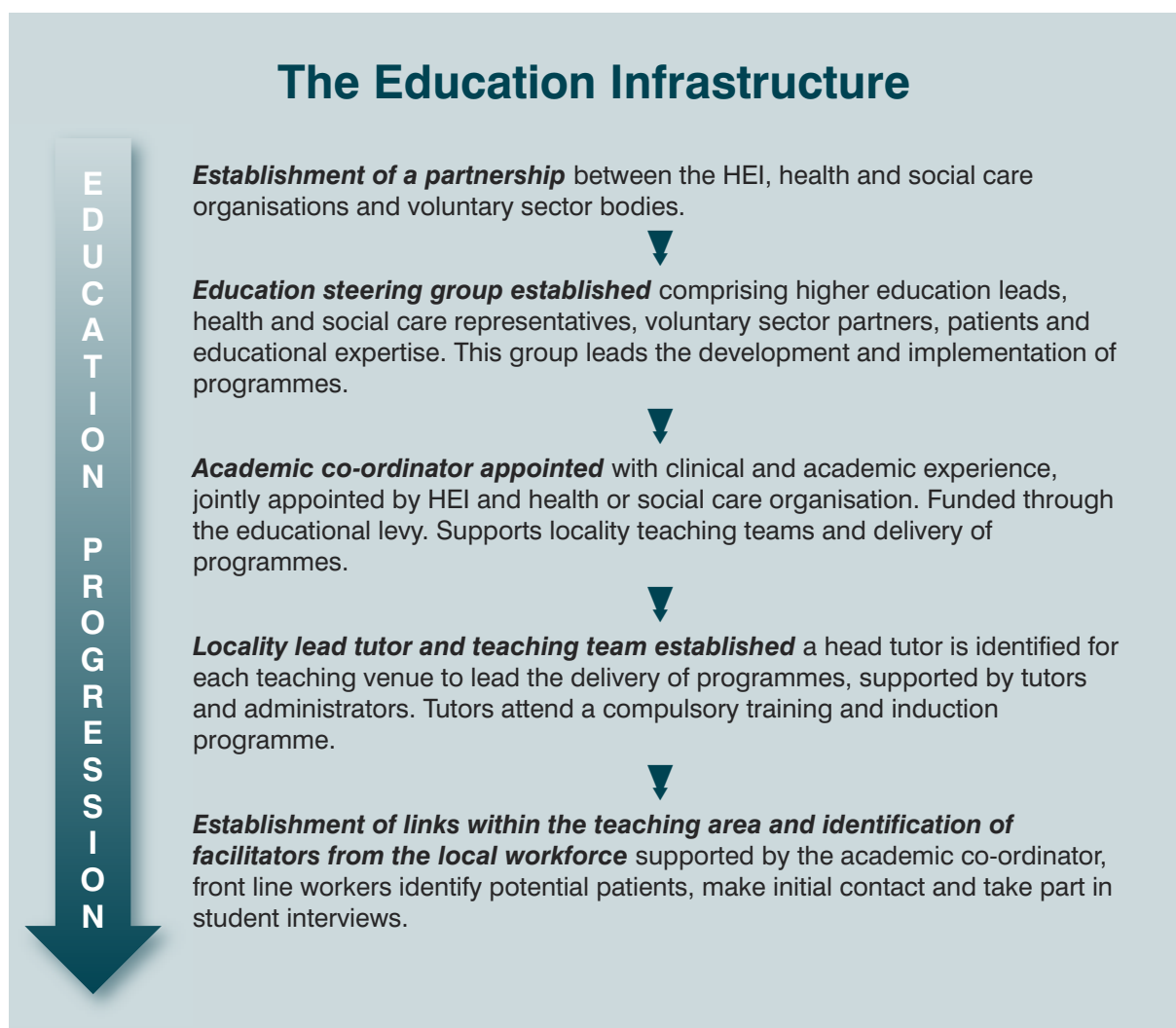
Part 3: Education Pathways

The education infrastructure pathway

Introduction

The successful delivery of the education programmes is dependent on the establishment of partnerships between the HEI, health and social care organisations, voluntary sector bodies and patients. The pathway is summarised in Figure 3.

Figure 3: The education infrastructure pathway in the Leicester Model of Interprofessional Education.



The HEI and health and social care organisations work together to clarify respective roles and responsibilities for funding, educational resources and employment contracts.

The HEI will be required to:

- work with health and social care organisations and other stakeholders to provide information on education programmes and to obtain their support;
- contribute to the steering group and liaise with lead operational staff;
- provide funding from education levies to support health and social care organisations to deliver the education through a service level agreement;
- work with health and social care organisations to recruit the academic coordinator;
- professionally develop and appraise the work of the academic coordinator to deliver consistent academic quality;
- provide administrative support for the academic coordinator and programme delivery;
- support the academic coordinator in the engagement and induction of statutory and voluntary organisations;
- take responsibility for programme evaluation, accreditation and validation;
- disseminate evaluation outcomes and annual reports to all stakeholders;
- disseminate the educational programmes in publications and research.

The host health and social care organisation will be required to:

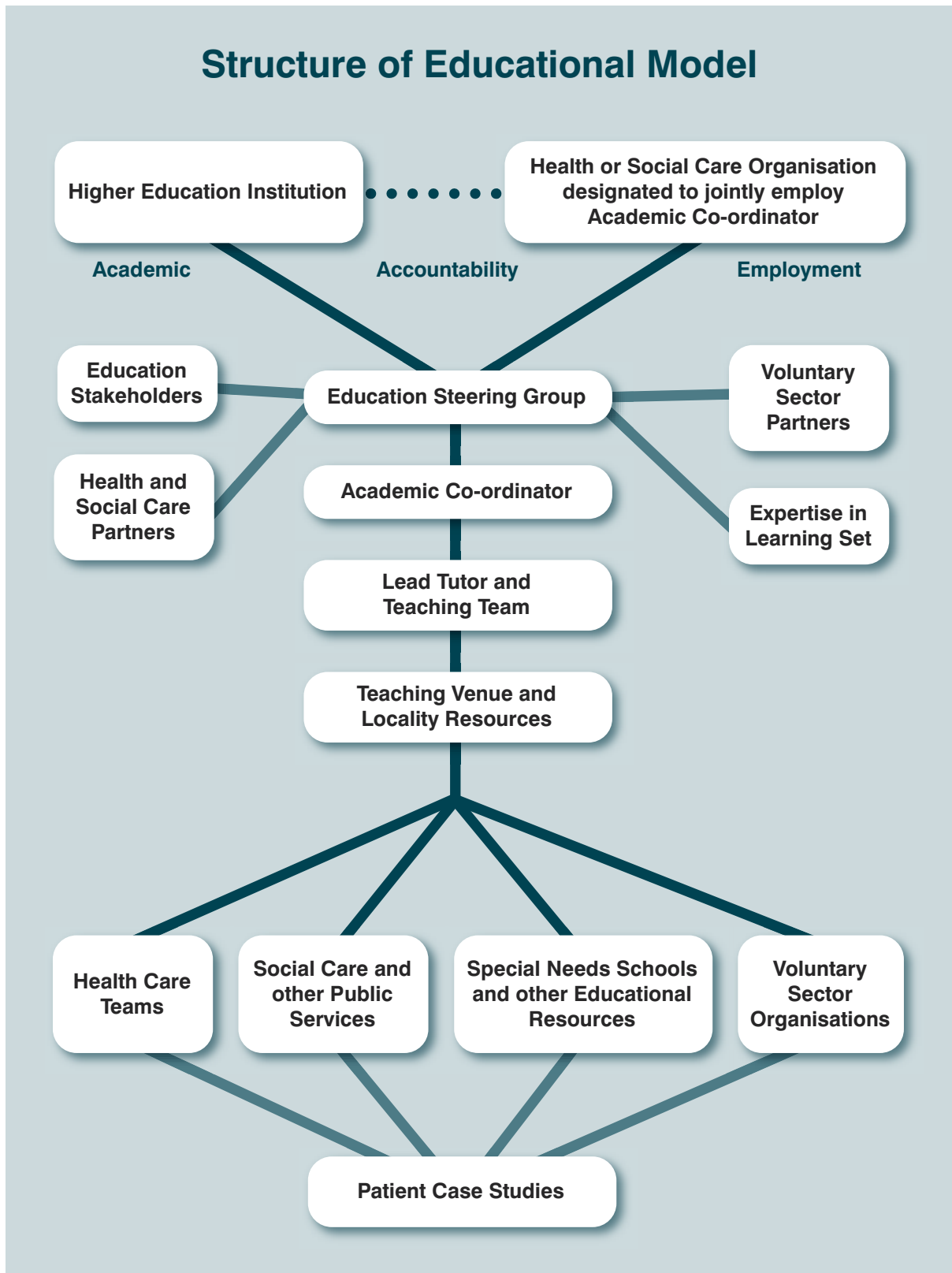
- support locality representatives to attend steering group meetings;
- identify suitable venues for teaching;
- appoint lead tutors;
- release lead tutors and their teaching team from clinical responsibilities to:
 - *attend university based tutor training programmes*
 - *prepare for the student teaching*
 - *deliver the programmes*
 - *collect material for evaluation and audit and where appropriate mark student assessments;*
- value the delivery of these educational programmes as opportunities for staff to engage in reflective practice and to develop new skills and careers;
- ensure managers at all levels of the organisation interact in the student presentation sessions to debate policy and practice.

Stages of establishing the infrastructure

Stakeholder organisations share responsibility for their implementation in the following ways, represented in figure 4 and elaborated sequentially in the following bullet points:

- the HEI's curriculum committee approves the academic content of the programmes at undergraduate and post-registration levels, and ensures their integration and alignment within the curriculum;
- a steering group is established comprising the HEI's, health, social care and voluntary sector partners, patient representatives and education experts. This group drives the development and implementation of the educational experience;
- a health or social care lead is nominated to co-ordinate activity with the HEI;
- the academic coordinator is accountable to the host health and social care organisation for employment and the HEI for academic quality assurance. The post-holder is responsible for identifying teaching localities, lead tutors and for preparing the locality workforce to host the programmes;
- health and social care organisations vary in their employment of lead tutor posts. Some create new posts combining teaching and clinical responsibilities; others provide protected time for lead tutors to contribute annually to the programmes;
- the lead tutor identifies a locality teaching team and administrative support to deliver the educational programmes. Its composition depends on the educational objectives;
- all educational programmes require the professional input of health care teams. In the community setting a strong commitment from family doctors is required, and similarly from medical consultants in hospital settings. Links with social services and voluntary groups should additionally be established;
- specific programme learning outcomes provide the focus for recruiting additional expertise, e.g. the needs of people with life limiting diseases and disabled people;
- the lead tutor meets with the range of local service providers to identify suitable patients. These front line workers make first contact and, with agreement, the tutor meets the patient to gain informed consent.

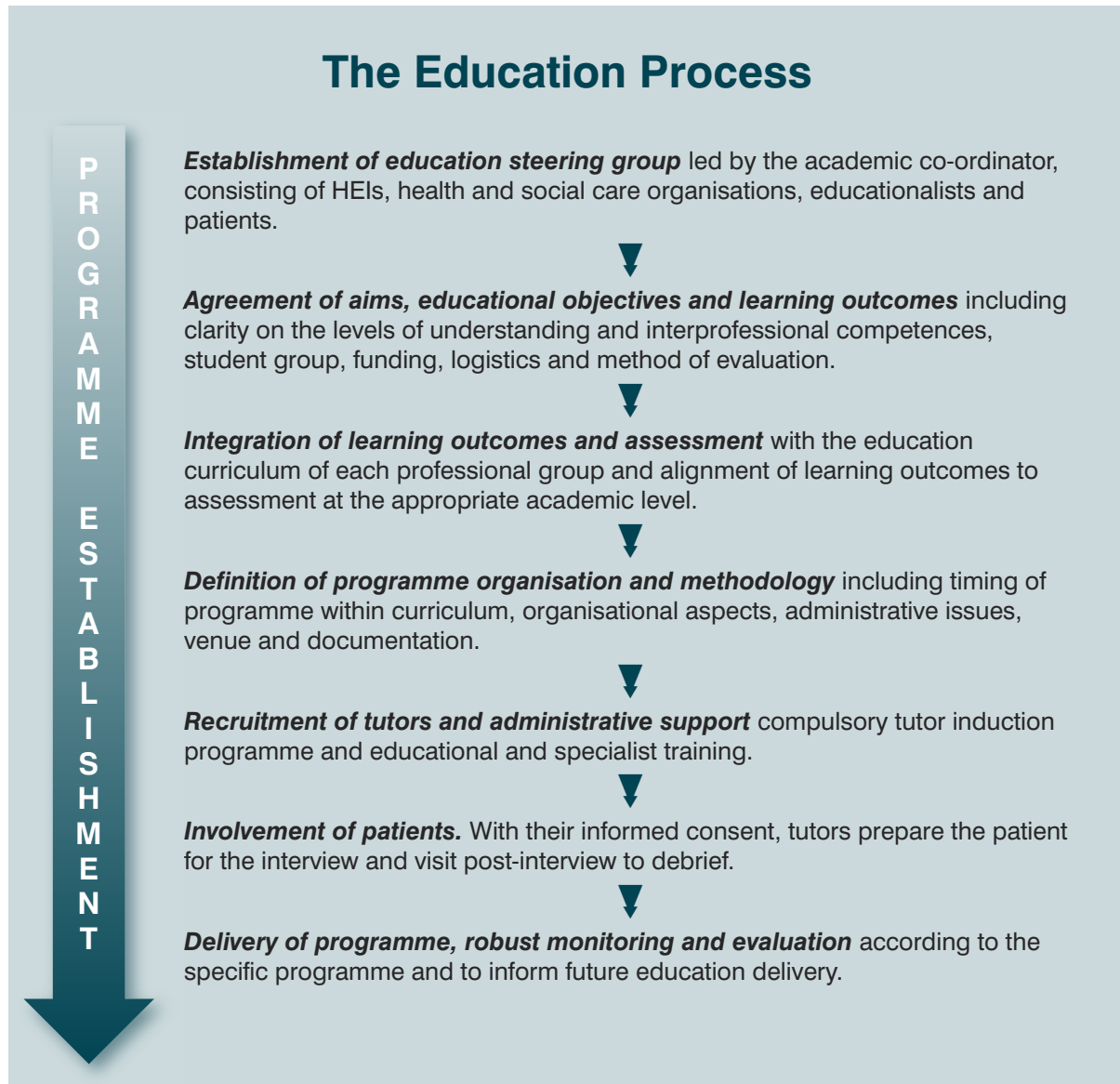
Figure 4: Structure of the educational model.



The educational content pathway

With the educational infrastructure established and academic coordinator in place, the education content is summarised in Figure 5.

Figure 5: The education process.



Stages of programme development

The educational steering group should meet before the programme commences, during or immediately post-programme and once more to receive the programme outcomes, including the results of the evaluation study.

The programme title, aim, outline content, timing in the curriculum, funding, and methodology should be clarified. Entry requirements and pre-requisites should be identified. The content should be influenced by local, national and professional body requirements of the students. The learning outcomes should integrate with the educational curricula of each participating professional group.

For post-qualified learners, a statement should specify how the programme supports the workforce skills of their health or social care organisation. In the UK this is particularly pertinent for non-medical staff working towards an advanced (autonomous) practitioner role.

HEI regulatory processes need to be followed including the engagement of an external examiner.

Learning outcomes should be developed in the following way:

- the level of understanding should be clarified by specifying the type of knowledge required. For example declarative knowledge (e.g. learning about diseases or organisations) is focused more at undergraduate degree (level 3); Masters level knowledge should additionally be rated as functional knowledge, where learners put the declarative knowledge into a problem-solving exercise; and as the learner progresses, conditional knowledge where learners exercise active control over problems and decisions. Knowing why, when and under what conditions one should act;
- Bloom's Taxonomy²⁴ can be applied to the development of learning outcomes to specify the cognitive complexity;
- there are other domains of intended learning outcome. In the UK the Dearing Report recommended four domains of higher education (recommendation 21²⁵) to ensure the development of transferable skills, namely: knowledge and understanding; key skills (communication, IT, numeracy); cognitive skills (critical analysis) and subject specific skills;
- once the learning outcomes and cognitive level of study is identified, the assessment can be specified ensuring the methods align with each outcome and test the cognitive level of understanding.

²⁴ Bloom, B. (1956). *Taxonomy of educational objectives handbook I: cognitive domain*. McGraw-Hill, New York.

²⁵ The Dearing Report (1997). *Higher education in a learning society*. The National Committee of Inquiry into Higher Education. NCIHE publications.

Assessment planning should commence with clarification on the purpose and whether it is summative or formative:

- each programme requires the completion of a case study analysis. These case studies are a valid, reliable and practical assessment which acknowledges the diversity of learners and can be used for peer and self assessment and as part of presentation skills;
- in some programmes case studies will be complemented with a range of other assessment methods for example:
 - *multiple choice questionnaires for declarative knowledge, coverage of syllabus, with ordered outcomes providing hierarchies of understanding*
 - *performance assessment including objective structured clinical examinations (OSCEs) and oral presentations*
 - *reflective portfolios;*
- criterion referenced marking schemes are agreed across the relevant learner disciplines.

Methodology

- the Model is a small-group, problem-based learning, task-orientated, experiential learning experience, immersing students into the real lives of patients and the complexities of delivering integrated support services;
- this form of problem-based learning is highly suited to a wide range of health and social care students across all academic levels because it develops professional attitudes and values. It does this by integrating subject areas which are traditionally taught separately from real practice, such as diversity, cultural sensitivity, patient vulnerability, team working and ethical principles;
- programme educational resources should include workbooks to guide the learners. This should include organisational information, programme content, pre-reading, references, education support, learning styles, activities, timetables, the assessment and evaluation;
- resources should also include provision of literature on locality organisations, academic publications and policy reports;
- students must be made aware of important tutor support roles including how to share concerns identified during the programme.

Processes

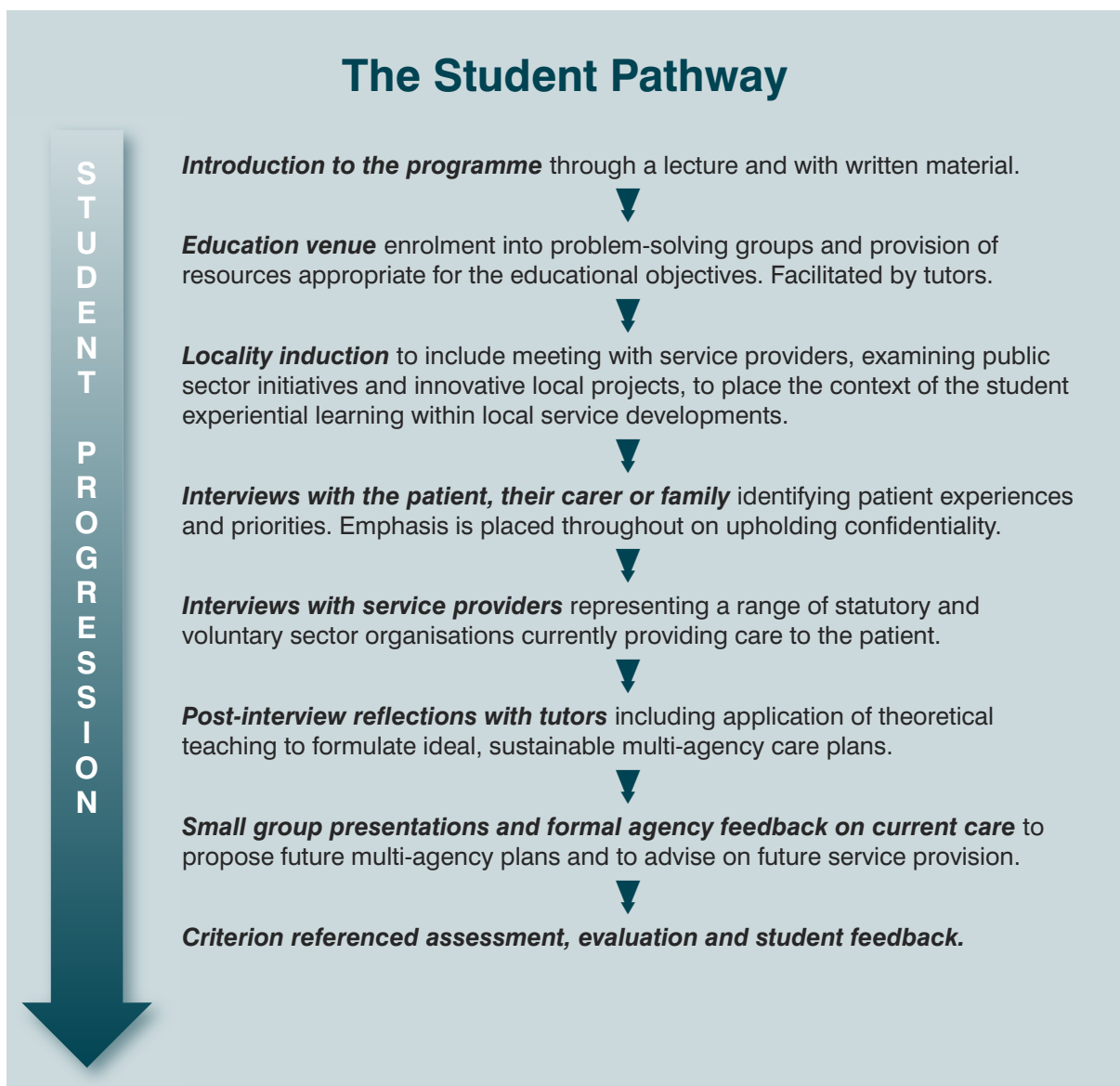
- educational venues and dates of delivery should be identified and booked. Locality representatives should be informed about the programme and presentation sessions;
- tutors, mentors and lecturers should be confirmed. Training and induction programmes should be organised and delivered;
- patients should be identified and given full autonomy in their involvement;
- robust processes should be in place to address and record any untoward incidents or issues. An annual report should be produced;
- an evaluation of the programme should be integral to the programme. The results are received by the education steering group.

The student pathway

Introduction

The Model involves 20-1000 students per programme. The student mix able to access the programmes is now widening to include non-health professions such as teachers. The majority of students are from medical, nursing, therapy and social work backgrounds, with increasing numbers of pharmacy, psychology and health science students. The range of student groups generally reflect the programme's educational objectives. For each student group, programmes are explicitly linked with their cross-modular curriculum connections. The student pathway is summarised in Figure 6.

Figure 6: The student pathway.



Introductory lectures

These provide an outline of the programme, the students' roles and responsibilities and access to educational resources. Local and national experts provide the specialist input, while locality tutors provide details on locality issues. Students are given clear, practical instructions on the dates allocated for their programme and directions to their education base which may be a considerable distance from the HEI. In Leicester the travelling time ranges from 5-60 minutes.

Education venues

Education venues may be dedicated education centres, within a hospital setting, a room in a health or social care centre or a base in a voluntary sector project. The principle is to provide a learning opportunity based on 'real-life' clinical service delivery, ideally in the centre accessed by the patient.

The first stage of preparation for interprofessional learning is generally carried out in these local venues. The learners are randomly allocated into each group, where possible, proportionally to their professional backgrounds. This is followed by an opportunity for students to get to know one another. In line with problem based learning methodology, students are facilitated to set their own ground rules, focus on, and prioritise their goals, work in a mutually supportive environment and monitor their own performance²⁶.

In some programmes, students learn about disability from disabled trainers²⁷. This facilitates students to understand the social model of disability, as well as to learn about legislation which will impact on their future practice. Working with this expert resource is an example of how the Model develops programmes in partnership with a range of specialists across statutory and voluntary sectors.

Locality induction

Tutors welcome students and explore their ideas, concerns and expectations. Students then visit organisations within the locality relevant to the learning outcomes.

Student interviews

Where possible students conduct interviews in patients' homes or clinical care settings to provide a valuable picture of their social circumstances. They identify their patient's medical problems, and the impact on psychological and social functioning and on their family. The patient's priorities and attitudes are explored, alongside their relationship with the agencies involved in their care. Interviews are timetabled for 60 minutes.

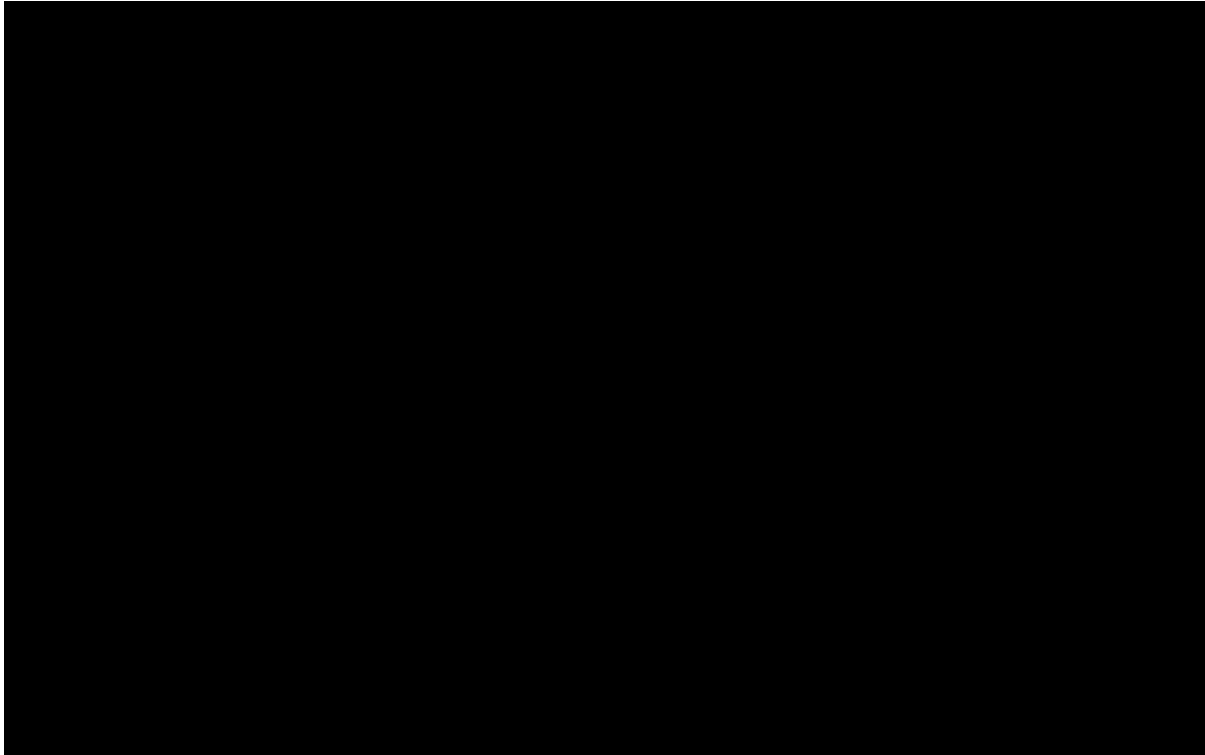
Patient interviews are followed by interviews with representatives of at least three agencies providing support or services to their patient. In hospital settings students interview involved staff across departments. Students discuss points raised from the patient's history, and the role and links of the agencies within the health and social care community. They explore the strengths, limitations, accessibility and priorities of the agencies for their patient, comparing these with those identified by their patient. Agency interviews are timed for a maximum of 30 minutes, challenging the group to plan the most effective questioning strategy.

²⁶ Azer, S.A. (2004). Becoming a student in a PBL course: 12 tips for successful group discussion. *Medical Teacher*, **26**(1),12-15.

²⁷ <http://www.lcil.org.uk/html/about1.htm> accessed January 2007.

Additionally, students meet to interview or listen to presentations with community based organisations, not directly involved with their patient (e.g. the Police, environmental health officers and voluntary sector organisations) or with managers from NHS Trusts, to provide a wider understanding of the context of service provision.

Students are encouraged to learn about cultural, language and attitudinal barriers between organisations and individuals and the complexities of providing integrated care. They identify the components of effective team working, underpinned by theoretical principles.

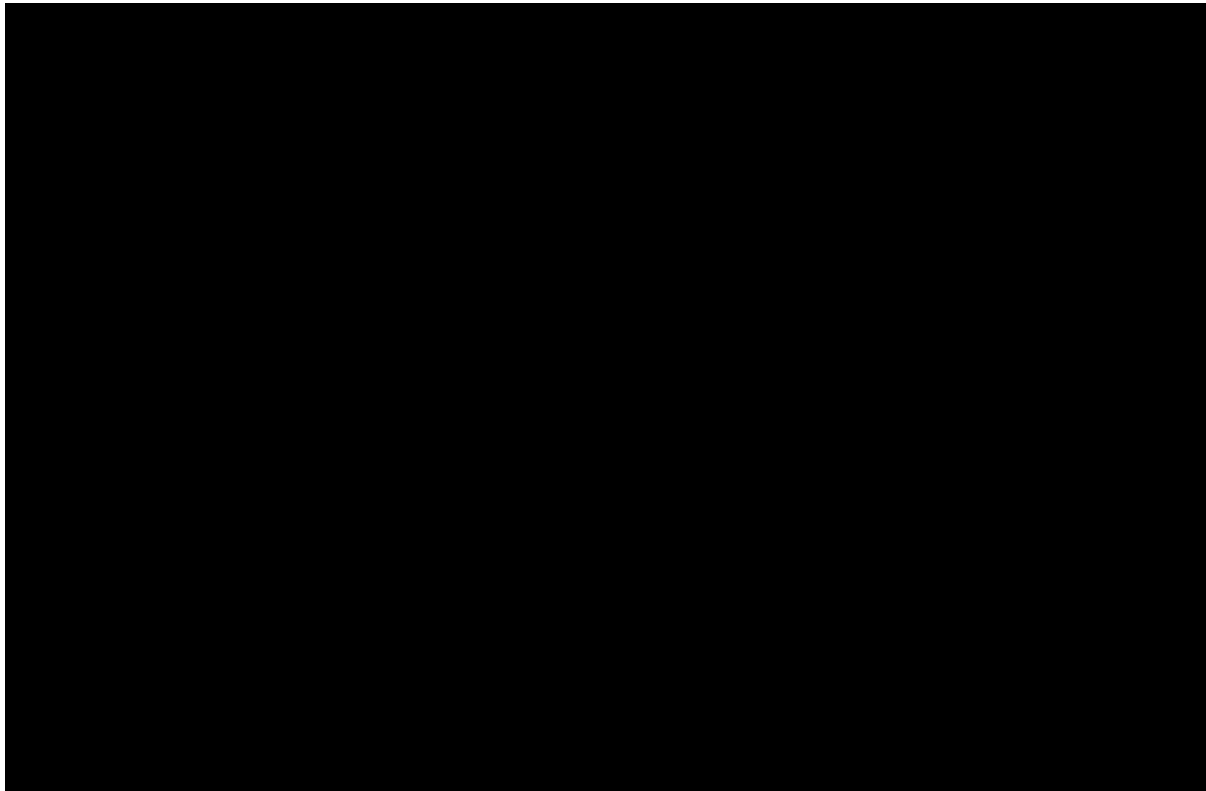


An interprofessional student group interview a patient in her home.

Student confidentiality and code of conduct

Students are ambassadors of their HEI and their profession. They are expected to behave professionally throughout their learning and are repeatedly informed about their responsibility to uphold the patient's confidentiality during and after completing the programme. Full names and details of addresses should never be divulged in writing or in discussions in public places. Patient briefing notes are not removed from the teaching venues. Students are informed that agency representatives will only respond to issues directly obtained from the patient interview.

On the rare occasion where the student group identifies problems affecting safety or well-being, they are informed that this should be discussed with their tutor who in turn will activate the incident process.



Students reflect on their interviews facilitated by a tutor.

Student reflections

Reflection is an essential component of the Model. Students are encouraged to follow the What? Why? So What? and Now What? model²⁸ in terms of interpreting their experiences and making informed judgements. Tutors encourage students to apply evidence based theory to practice in considering multi-agency solutions.

Student presentations

Each student group receives a unique set of experiences from their interviews, the learning potential is maximised by interactive case study presentations to the whole cohort and guests, including the agency representatives and their managers from the settings in which they worked.

They present a short critique (less than 10 minutes) of their case demonstrating how their learning outcomes have been achieved. Students are encouraged to present practical and organisational changes to improve the quality of the individual patient experience and the local healthcare system. These sessions provide valuable opportunities for students to share their findings and debate potential solutions with the local workforce. The professionals facilitate students to relate patients' health and social care problems to service delivery and health and social care policy.

²⁸ Moon, J. (1999). *Reflection in learning and professional development*. KoganPage, London.

Formal student feedback to agencies

Students can directly influence future patient care by recommending changes to current service provision, or in identifying issues which they feel need to be addressed²⁹. This is fed back to agencies involved in the patient care. This stage completes the learning cycle of the Model.

Student assessments

Students are required to develop ideal multi-agency care plans to provide an optimal quality of care for their patient. Explicit assessment criteria are detailed in the student workbook. Students need to accurately interpret the information gained during the interviews, to use reasoning skills to resolve the problems presented, and to make recommendations on optimum collaborative care within the resources available. Students from different disciplines are expected to include aspects of their professional role. Interprofessional competences are specifically assessed using a reflective portfolio methodology.

Student evaluation

Student opinions on the programme aims and objectives, teaching method, content and activities are sought after each programme. Students may additionally complete pre- and post-programme questionnaires to explore their learning expectations and outcomes. Interprofessional programmes also assess the impact of joint training immediately after the programme and long-term follow up continues. Uni professional focus groups are also conducted after some programmes, with students randomly selected to participate.

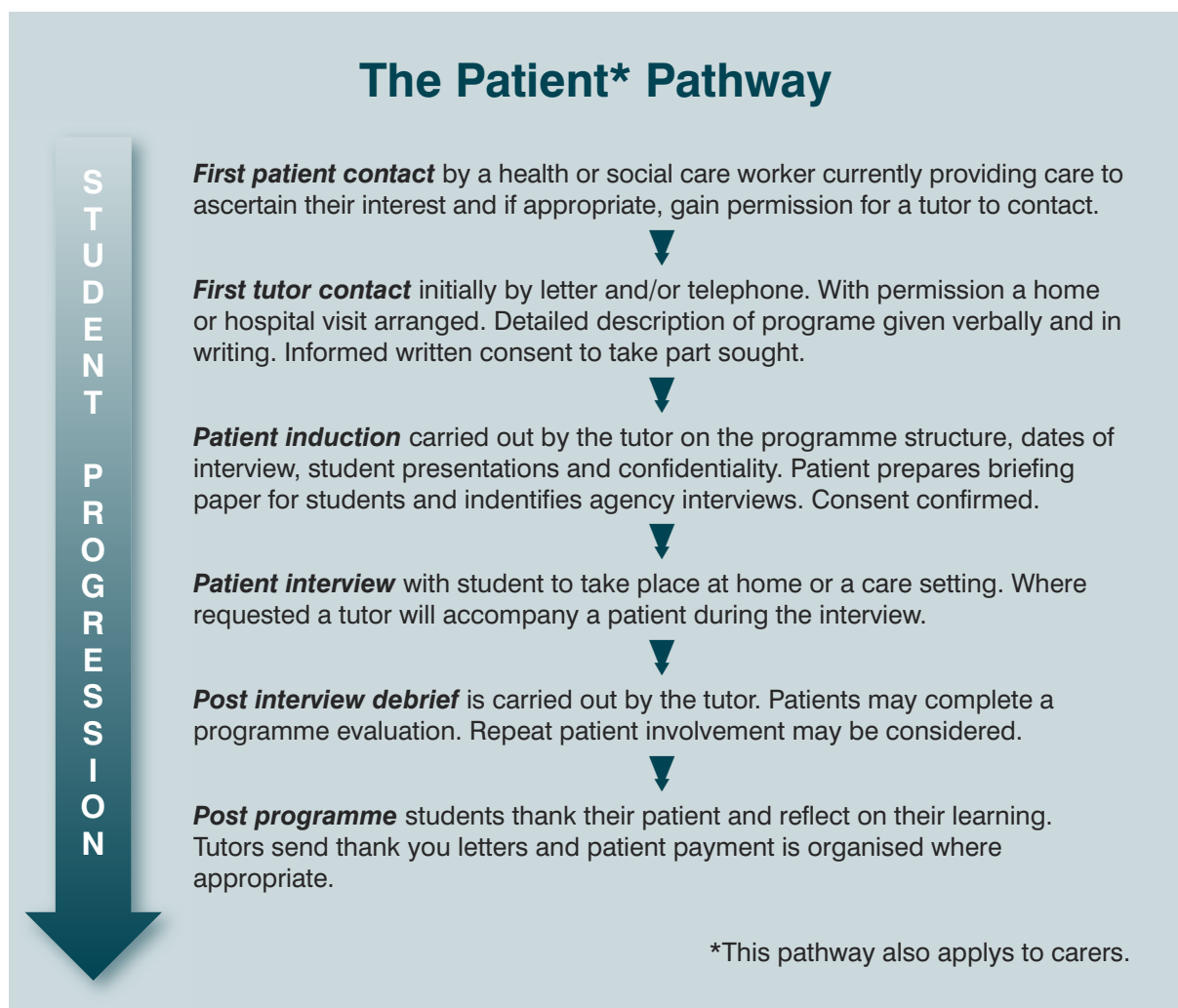
²⁹ See **Part 6: Templates of Forms and Letters** (Template 1: Student feedback form).

The patient pathway

Introduction

Patient involvement is pivotal in the development and delivery of programmes. Patients are given clear guidance and support on all aspects of their role and on how they can opt in and out at any stage. Patients are chosen according to the aims and objectives of the programme and in partnership with their health or social care team. Their pathway is summarised in Figure 7.

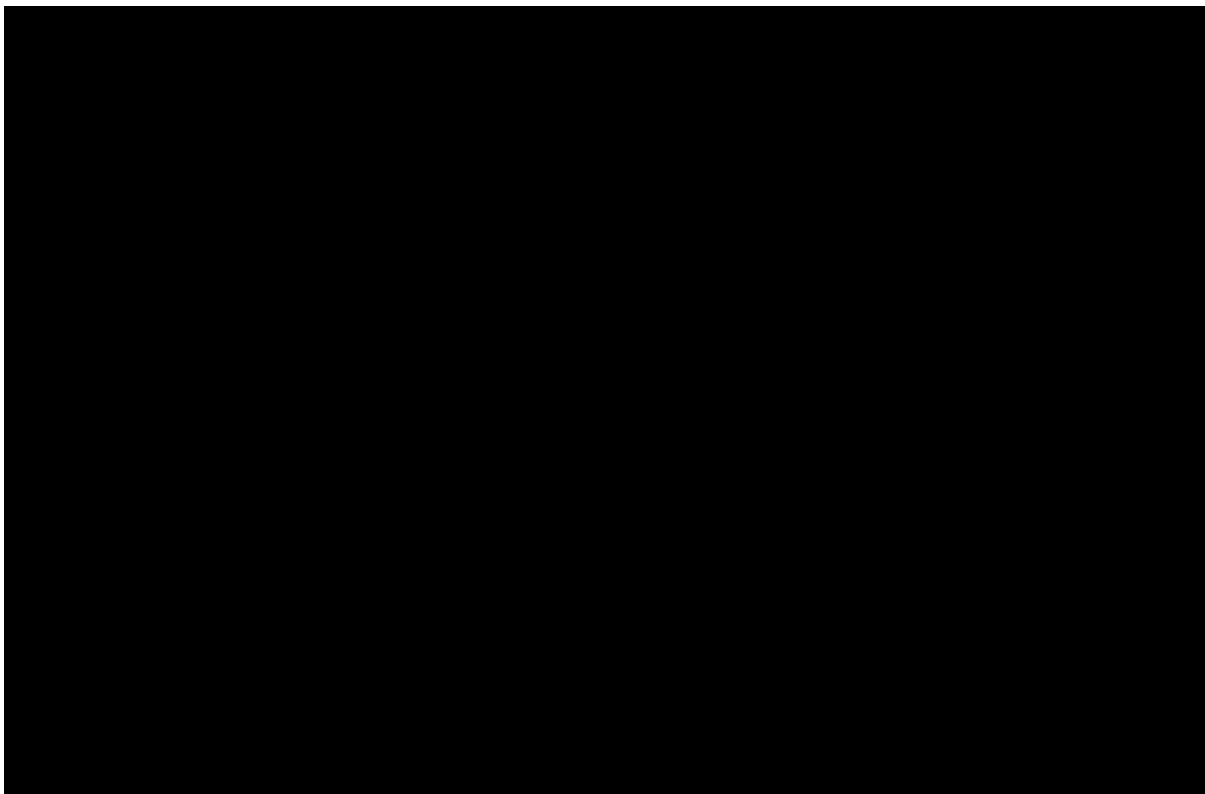
Figure 7: The patient pathway.



First patient contact

A member of the health care team currently working closely with the patient will make the first approach according to the following selection criteria³⁰:

- underpinning health problems relevant to the programme;
- patient available and able to talk with students for a 60 minute interview (interpreters and, or, carers are used in some cases);
- a range of ages and medical, psychological or social problems in each cohort;
- multi-disciplinary working with at least three agencies involved in their care;
- agencies from a range of organisations across statutory and voluntary sectors.



A student group visits their patient.

Following a brief explanation of the programme, patients are asked if they would be interested in learning more about their potential involvement. For those who express a wish to pursue this invitation, their details are entered onto the referral template³¹ and sent confidentially to the academic coordinator. A short leaflet summarising the programme is provided for the patients³².

³⁰ See **Part 6: Templates of Forms and Letters** (Template 2: Algorithm of patient recruitment).

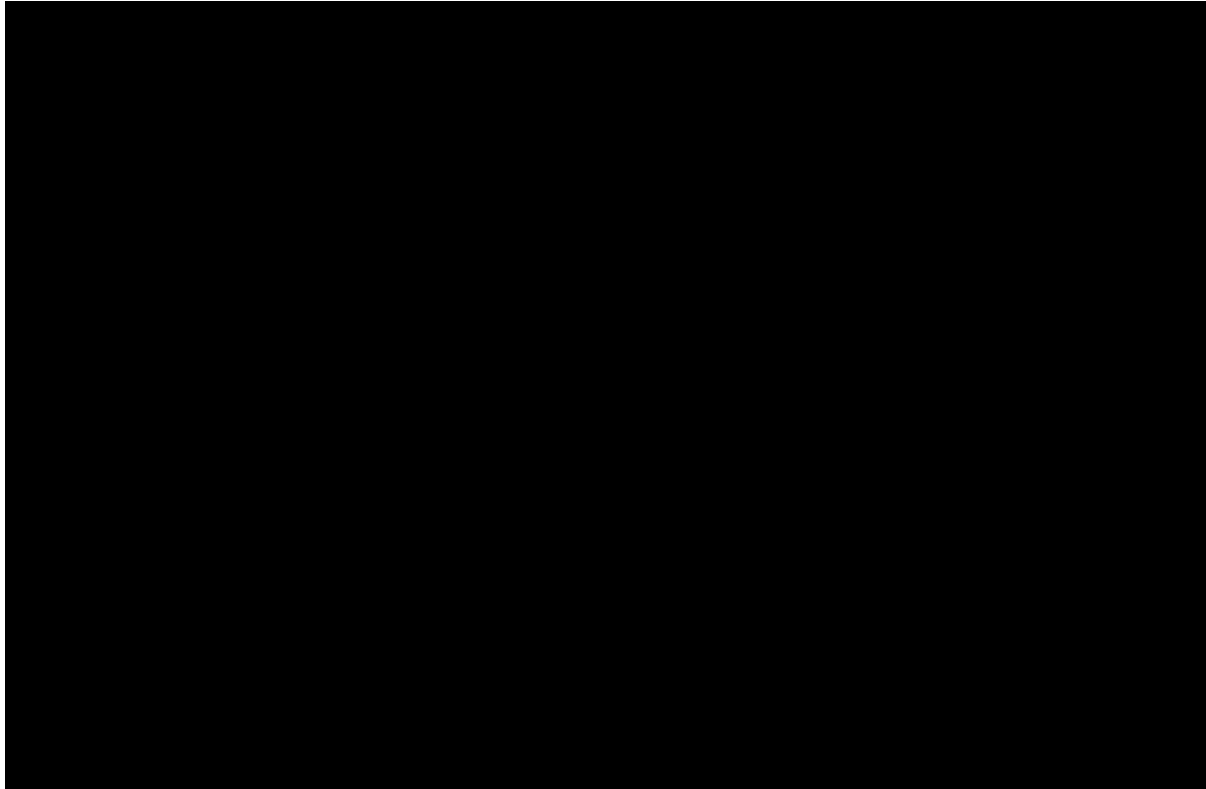
³¹ See **Part 6: Templates of Forms and Letters** (Template 3: Patient referral template).

³² See **Part 6: Templates of Forms and Letters** (Template 4: Patient information leaflet).

First tutor contact

A tutor or the academic coordinator arranges a visit. Patients are informed on the nature of the teaching programme and their story-telling role. They are asked to host the interview in their own home or care setting to provide the students with a better understanding of the social and environmental issues associated with their problems.

Tutors respond to queries and reassure patients about their confidentiality. Patients are informed on how to withdraw at any stage without any impact on their care.



Students learn by listening to the experiences of a disabled patient.

Patient induction

Further visits obtain informed consent³³ and a signed patient contract³⁴. Tutors facilitate the patient to develop a short summary of their health, psychological and social history to form the student briefing paper. In this way, patients are empowered to control the information exchanged during the programme. They are reassured that their briefing paper is confidential, kept secure during the programme and subsequently destroyed.

Patients identify the service providers they wish to be involved. They are informed that the agency interviews will not divulge any information which has not been discussed or released for inclusion in their briefing paper.

³³ See **Part 6: Templates of Forms and Letters** (Template 5: Patient consent form).

³⁴ See **Part 6: Templates of Forms and Letters** (Template 6: Patient contract).

Patients are made aware that their anonymised information will be presented and debated in the student presentation session and written as an assessment. Patients are reassured that the visit of students will not directly affect their care³⁵.

Patient interviews

Each student group conducts an interview lasting approximately 60 minutes. A judgement is made by the patient about whether there is a need for the tutor to be present in a supportive role. Some patients are anxious about taking part and others about the sensitivity of the subject matter to be discussed. Where a programme is repeated with different cohorts over a short time span, patients may be invited to participate again.

Post-interview debrief

Students can be timetabled to re-visit their patient to thank them for their involvement and to feed back on their learning. Informal feedback to patients is regularly provided by tutors which includes a reflection on how well the students achieved their learning outcomes.

Post-programme and patient fees

The university sends each patient a letter to acknowledge their involvement in the teaching programmes³⁶. Based on the rationale that all professionals involved in the programmes are offered funding to back-fill their time, then patients who host a visit in their home are similarly offered a fee. Patients who are accessing services at the time of student contact, for example hospital inpatients or patients attending outpatients are not offered a fee for their involvement.

With ethical approval and consent, patients contribute to the evaluation studies.

³⁵ See **Part 6: Templates of Forms and Letters** (Template 7: Confirmation letter to patient).

³⁶ See **Part 6: Templates of Forms and Letters** (Template 8: Example of a thank you letter).

The agency pathway

Introduction

Interviews with a wide range of organisations provide students with a realistic, up-to-date critique of current issues in the service sector. These agencies and their representatives provide a first hand opportunity for students to see how the service is organised, quality assured and delivered. The agency pathway is summarised in Figure 8.

Figure 8: The agency pathway.

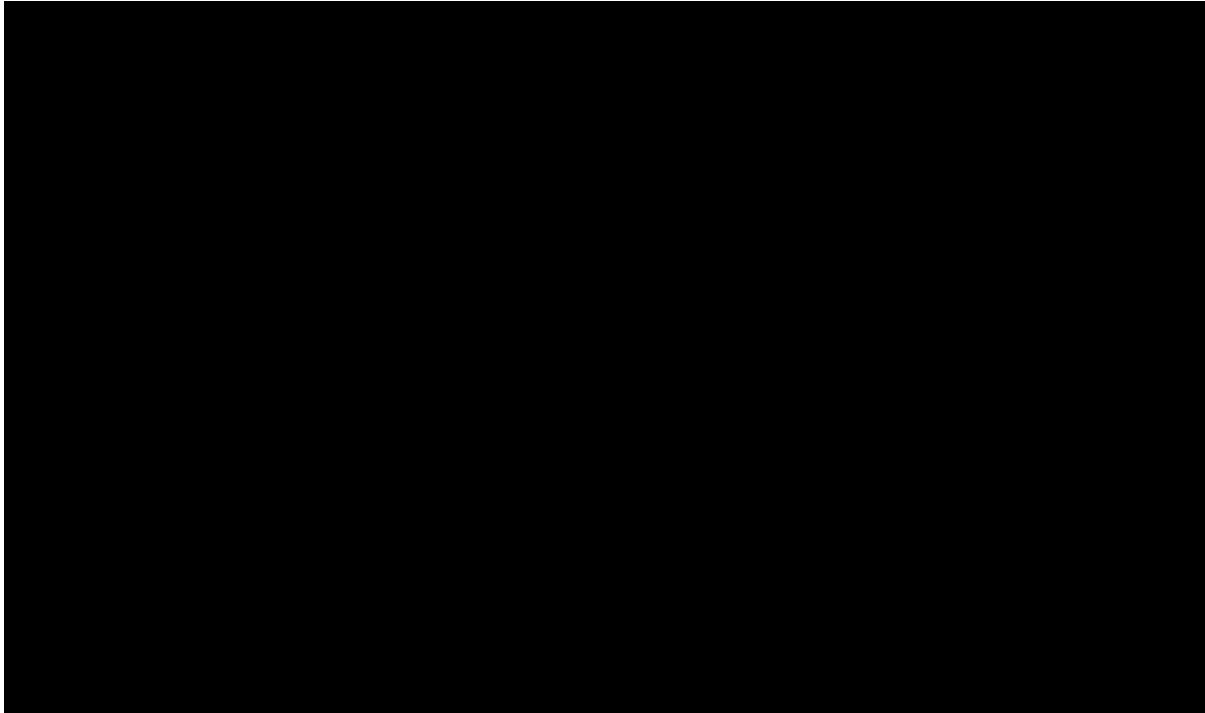


Agency identification and invitation

Agency involvement is identified by the patient. The tutor or academic coordinator will encourage the patient to choose a broad range of agencies across the statutory and voluntary sectors.

Discussions between the academic team and senior managers of agencies have ensured that individual representatives are fully supported throughout their involvement.

The aim of involvement of agency representatives is to facilitate students to explore the range, roles and responsibilities of agencies working to meet the needs of their patient as well as in the wider care setting. Students are expected to examine the quality and impact of their service provision and to appreciate the importance of effective multi-disciplinary, collaborative care.



A student group interviews the general practitioner involved.

Agency induction

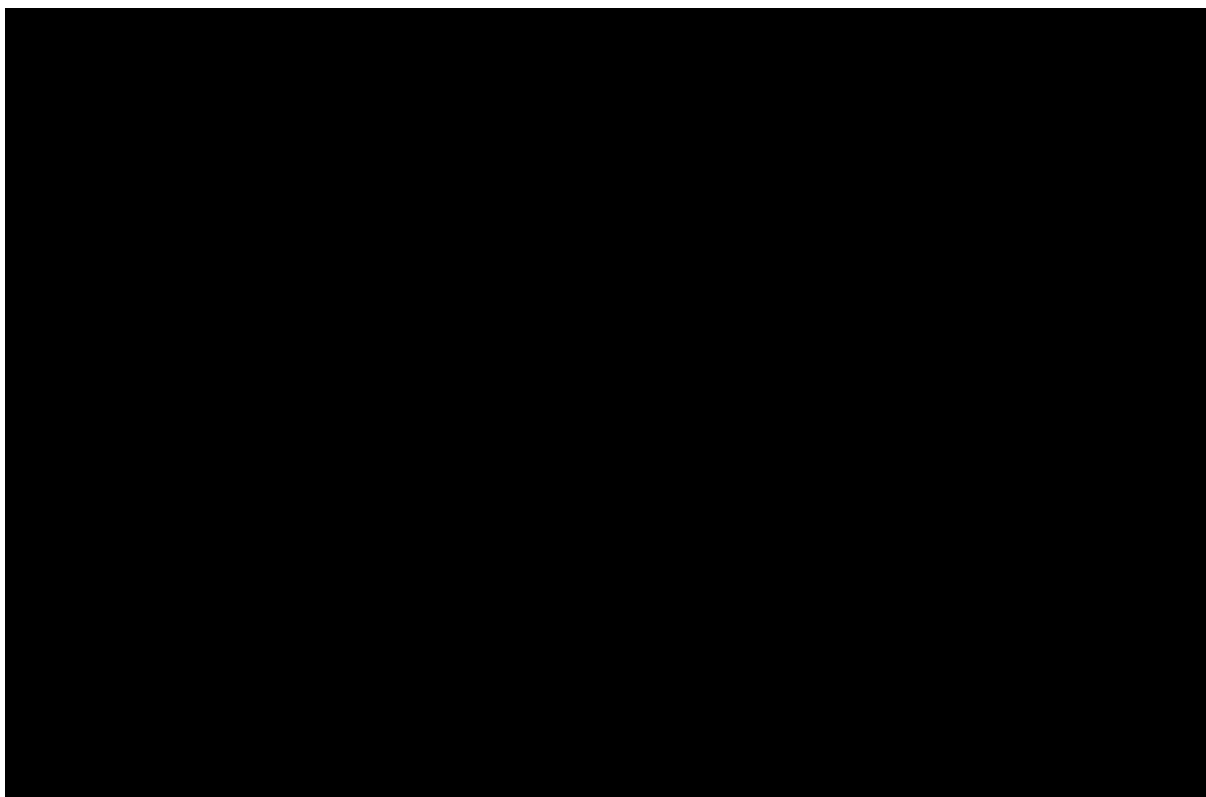
Following identification, agency representatives are visited by the academic coordinator or locality tutor to provide a detailed account of the programme aims and objectives. They are informed on the nature of patient selection and induction, the ethical principles applied and the safeguards in place to uphold patient confidentiality. Information is also provided on their commitment to a 30-minute interview and the timing of this interview within the programme. They are advised that students will have identified the lines of questioning they wish to pursue, formulated by discussions with their patient. Tutors and agencies do not set the subject content of the interviews.

After initial contact, the agency representative receives a standard letter³⁷. Details include the venue, date and time of the interview, as well as providing basic information on the case study and contact details of tutor and university staff. Tutors and administrators plan interviews to accommodate work patterns. Where possible interviews take place in the agency setting to minimise the disruption to daily commitments and to provide students with experience of their working environment. Representatives involved in the programmes are reimbursed to cover the loss of activity to the organisation or individual. Where established relationships exist, arrangements can alternatively be made by telephone.

³⁷ See **Part 6: Templates of Forms and Letters** (Template 9: Agency confirmation letter).

Interview strategies

Agency representatives are instructed that they should only respond to information presented by the students i.e. information students have directly gathered from the patient. They are informed that it is not appropriate to divulge information about their case away from the context of the students' line of questioning. Information held by the agency but not declared by the patient to the student group must therefore be held in the strictest confidence at all times. If the agency representative feels uncomfortable about releasing information it is appropriate for the representative to state that the information cannot be divulged. If the student group has misinterpreted information gained in the patient interview, the agency representative may feel it appropriate to correct the student views. On the rare occasion when the representative has concerns about the interview they are instructed to inform the tutor as soon as possible.



A student group interviews the practice nurse involved in their case.

Case study presentations and feedback

Agency representatives and their managers are invited to the interactive case study presentations. This supports student learning but also provides an opportunity for reflective practice and networking. Agency representatives are also provided with written student feedback which summarises their perceptions of the strengths and limitations of current care and their recommendations for future care³⁸.

³⁸ See **Part 6: Templates of Forms and Letters** (Template I: Student feedback form).

Agency evaluation

With ethical approval, the involvement of agencies is recorded in formal and informal evaluation studies. Informal feedback is sought from the agency representative after each interview; formal evaluation is carried out annually and during the development of new programmes. This information feeds into the education steering group.

Extended roles of agency representatives

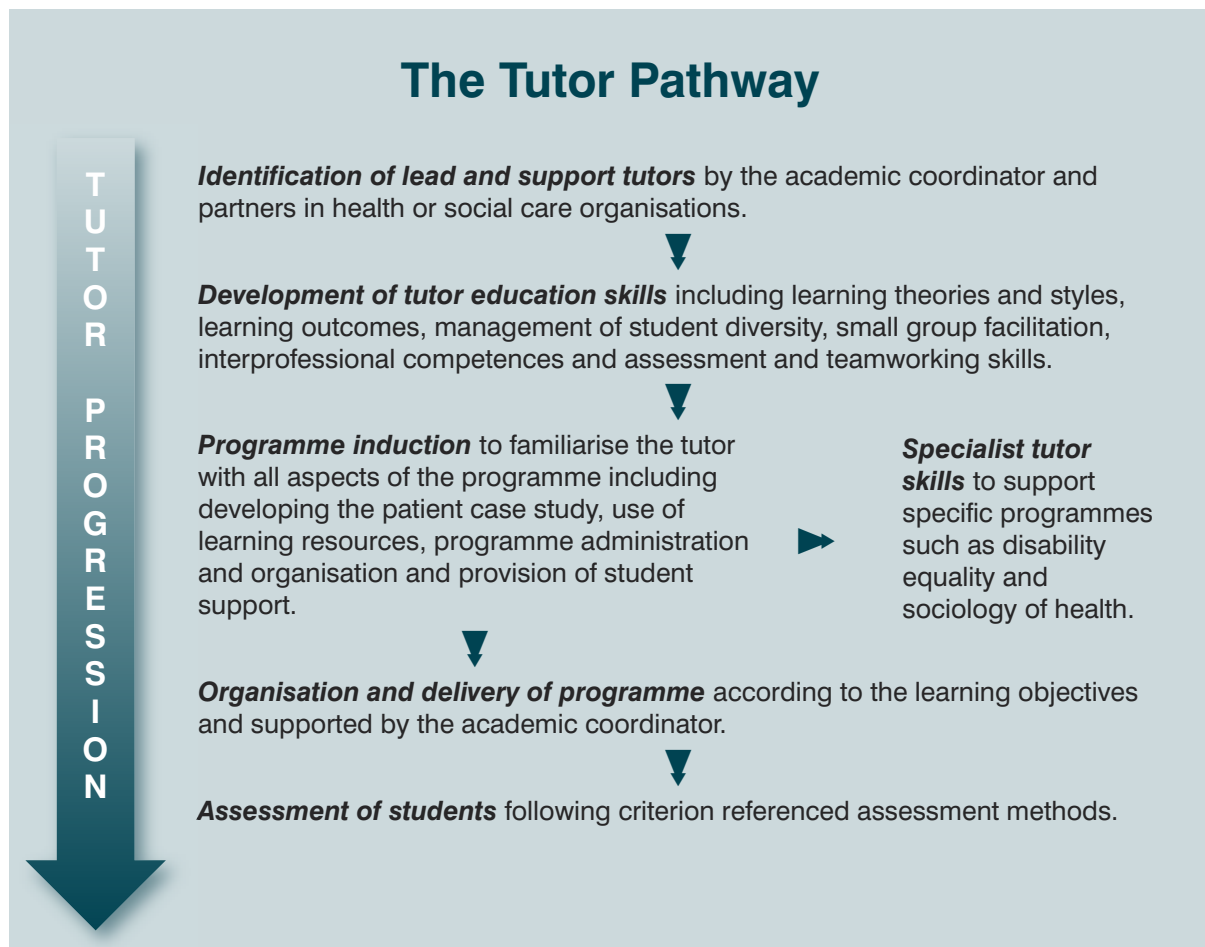
Representatives may additionally be involved in the programme as locality tutors or through the hosting of student induction visits.

The tutor pathway

Introduction

Tutors bring a wealth of up-to-date clinical experience and local knowledge to the programmes. Wherever practical, the professional background of tutors reflects the range of involved health and social care students. The tutor pathway is summarised in Figure 9.

Figure 9: The tutor pathway.

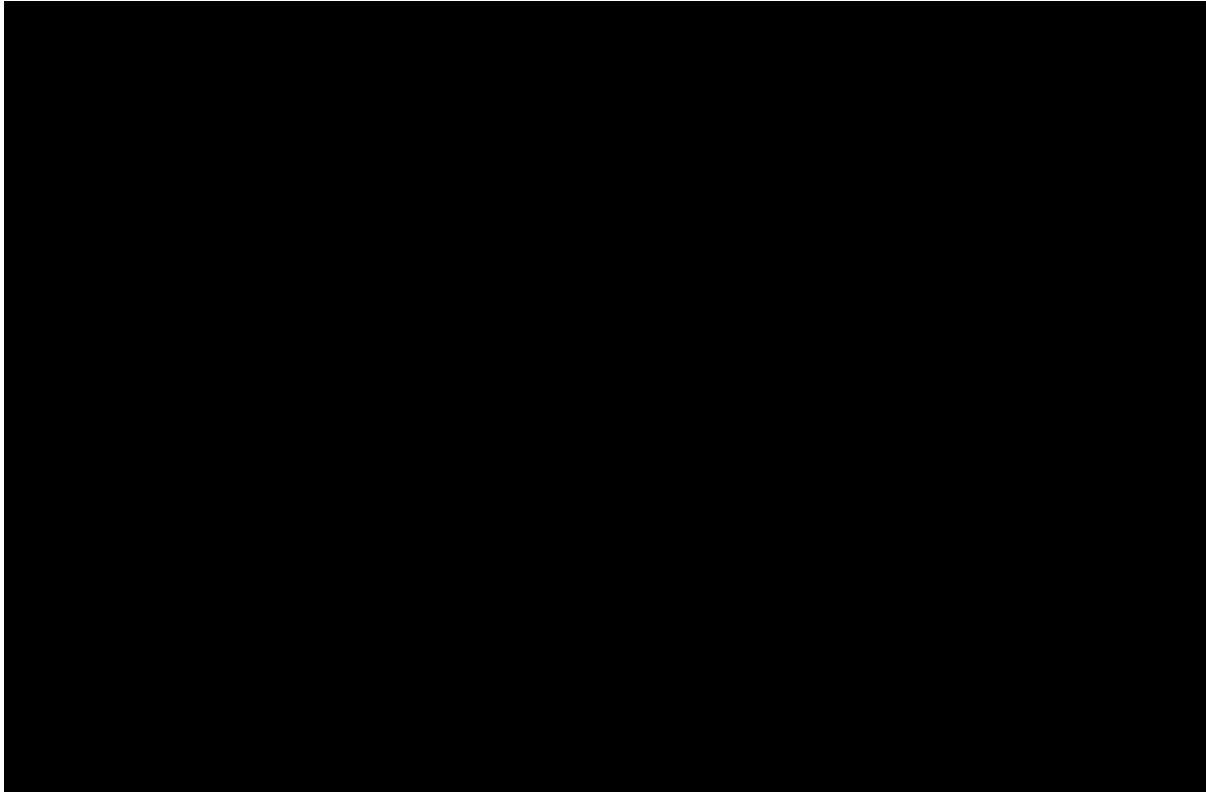


Identification of tutors and the teaching teams

With the locality identified, the academic coordinator liaises with the host health or social care organisation to identify the lead tutor and support tutors.

The selection criteria include:

- experienced clinical staff;
- knowledge of service delivery in the locality in which the programme is based;
- experience in teaching or a willingness to undertake skills development;
- an enthusiasm for interprofessional learning.



A student group, facilitated by an academic tutor.

The composition and size of teaching teams varies according to the programme. On average, two tutors will support a cohort of 24 students working in 6 small groups, with 6 patients.

Tutor training

Training opportunities are available for tutors. All tutors are initially expected to observe and shadow a teaching programme and new tutors are paired with experienced tutors. Educational development for tutors falls into three areas:

- education skills, including interprofessional competences;
- programme induction;
- specialist tutor skills.

1. The development of tutor education skills

Tutors are given access to a 2-day university-based programme of education skills development which is accredited at a Masters academic level. The course is entitled '*Teaching for learning - focus interprofessional education*' and runs throughout the year. The content includes:

- an understanding of the context of interprofessional education regionally, nationally and internationally;
- quality standards for interprofessional education;
- learning theories and their application to the Model;
- constructive alignment of an interprofessional curriculum;
- maximising the student learning and achievement of deep learning;
- learning styles;
- management of student diversity;
- skills for effective small group facilitation including management of dysfunctional groups;
- an overview of the curriculum of professional groups involved in programmes;
- roles and responsibilities of tutors, particularly in an interprofessional setting;
- the context of the educational programmes within local health and social care services;
- assessment.

CAIPE¹⁹ has provided invaluable advice on teaching facilitative skills for interprofessional learning.

2. Programme induction

This is compulsory. The academic coordinator holds regular programme induction sessions which consist of three parts:

- programme processes and responsibilities;
- developing the patient case study;
- facilitation of student experiential learning.

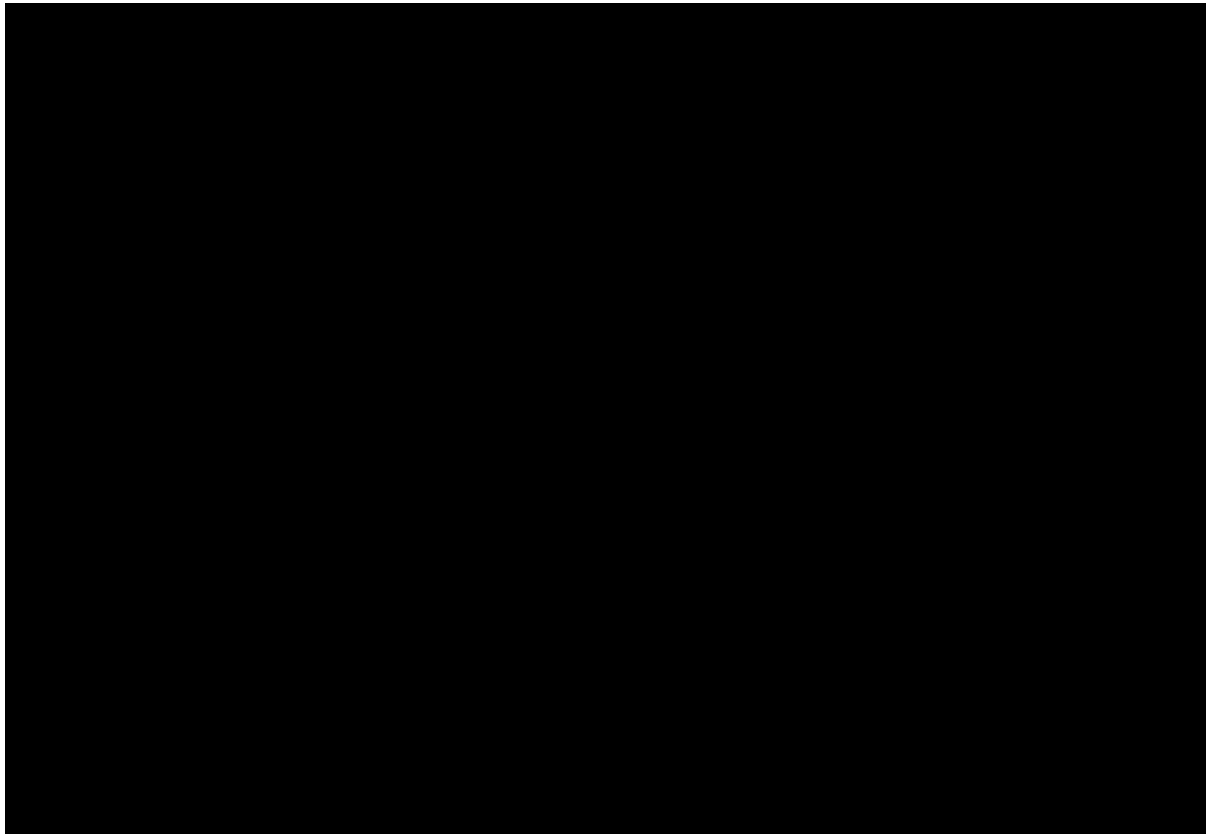
Programme processes and responsibilities

Tutors are provided with information on:

- the aim(s) and learning outcomes, structure, content, delivery and distinctive features of the Model;
- for undergraduates, the timing of the programme in the student curriculum; cross modular links; the knowledge and experience students bring to the programme; and how the programme is timetabled in their weekly work schedule. For post-registration learning, the context of this programme in their career progression;
- administrative responsibilities of the tutor;
- the development of the patient case studies. One tutor will work closely with 3 - 4 patient case studies. Tutors are required to meet with the patient in their home or care setting pre- and post-student interviews to familiarise themselves with the patient's situation;
- involvement of the wider workforce e.g. visits to locality facilities, attendance at student presentation sessions, or by receiving student feedback;
- student resources: tutors are responsible for collecting written and other materials on theoretical knowledge relating to the programme objectives, evidence based practice, educational resources include web-access, texts and academic papers;
- facilitation of student learning and hosting presentation sessions; tutors develop their skills to encourage discussion and debate throughout the programme. Videos of past student presentation sessions are used as a resource, and new tutors are encouraged to attend presentation sessions prior to their involvement;
- an understanding when and how to access the incident process³⁹;
- their specific responsibilities in the programme assessment;
- the development of the programme timetable and delivery plan: detailed booklets with computer discs and activity planners are provided to support this task. Template grids are particularly valuable to organise the timetable of activities;
- the range, and accessibility of HEI academic and pastoral support services for students: tutors are guided on how to manage student diversity and recognise student worries and concerns uncovered during the programme. Opportunities are timetabled for student debriefing sessions and tutors are made aware that for some students their experience of real life circumstances may expose personal issues or cause distress.

Post-programme responsibilities including collecting evaluation material and thanking all stakeholders including the patients and agencies.

³⁹ See **Part 6: Templates of Forms and Letters** (Template 10: Incident log).



A student group presents their recommendations to healthcare professionals.

Developing the patient case study

a) Patient: The locality tutor, supported by the academic coordinator, prepares patients for the programme. In some cases the patient may be known to the tutor.

The patient is normally seen at home, in hospital during an admission or other care settings, and familiarised with their involvement. Confidentiality and ethical principles are emphasised and form part of the patient contract. Tutors are required to complete the paper work, including the consent forms. Tutors help the patient to prepare a briefing paragraph for students and to identify the range of agency involvement.

b) Agency: Tutors contact the identified agencies and inform them of their role.

c) Involvement of the wider workforce: Tutors are required to identify and prepare organisations for locality visits by students according to the programme objectives.

d) Completing the patient and agency timetable: The tutor develops the programme timetable using a template grid (See example in Figure 10). This work is completed with the help of the programme administrator.

Figure 10: Template grid used in the multi-agency inner city course.

A cohort of 24 students is divided into 6 small groups

Dates	Times approx	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Tuesday	Session 1						
a.m.	09.00 - 10.30	Introductory session, students allocated to their small working groups and spend time learning from each other.					
	11.00 - 12.30	Groups examine locality service provision and visit the area.					
	12.30 - 13.00	Student groups assess their learning on partnership working and prepare for their patient interview.					
Tuesday	Session 2						
	13.00 - 14.00	Students plan their patient interviews with tutor facilitation					
p.m.	14.00 Patient interviews	Miss A	Mr B	Master C	Mrs D	Miss E	Mr F
	All student groups return from interviews to debrief reflect on learning and prepare for agency interviews in the next session.						
Tuesday	Session 3						
a.m.	09.00 - 10.00 Agency 1	Miss A	Mr B	Master C	Mrs D	Miss E	Mr F
	10.00 - 10.30	Student group debrief on interview, facilitated by the tutor.					
	10.30 - 11.00 Agency 2						
	11.00 - 11.45	Student group debrief on interview, facilitated by the tutor.					
	11.45 - 12.15 Agency 3						
	12.15 - 1300	Student group debrief on interview and preparation for presentation session. Facilitated by the tutor.					
Tuesday	Session 4						
14.00-15.00	Reflective learning time. Further home visit to thank patient.						
15.00- 17.00	Presentation session. Plenary session to cohort and invited guests.						

Tutor facilitation of student learning

There are two aspects of tutor facilitation required to maximise student learning:

- small group facilitation skills - asking probing questions; helping students to interpret information they gather; steering the group in the appropriate direction; challenging inappropriate thinking and supporting positive ideas;
- linking theoretical principles to the programme objectives - for example, the principles and practice of team working, disability equality and inequalities in health.

Stages of tutor involvement:

- **Pre-patient interview** tutors encourage students to take full advantage of the 60 minute interview. Advice is given on structuring the interview; the communication skills required of welcoming, setting the context, use of questioning style (opening, probing, active listening, receiving and responding to information), sensitivity in questioning (particularly for cultural and emotional issues), closing the interview, demonstrating respect for the patient and upholding confidentiality. Interview guidance is also contained within their workbook;
- **Post-patient interview** tutors support students to reflect on and interpret the information gathered during the patient interview, as well as the quality of the interview process. Tutors encourage students to apply theoretical learning to the context of the case study, and to judge how their findings will influence the subsequent agency interviews. Tutors explore student concerns or any untoward incidents. If untoward issues identified, tutors are instructed to complete the incident forms and liaise with the academic coordinator;
- **Pre-agency interview** tutors guide students through their agency interviews. A more focused approach is required for the 30 minute interview which aims to identify the specific role of the agency in their patient's care and the general role of the agency. Tutors encourage students to carry out a critique of the agency including its strengths, responsibilities, short-comings, quality of multi-disciplinary communication and accessibility. Students compare and contrast the agency's priorities with those of their patient and consider the patient's problems in the context of the agency's wider activities;
- **Post-agency interview** tutors facilitate this process in a similar way to the post-patient interview reflection, encouraging students to reflect on their interviews and to apply new information on the emerging holistic picture of their patient case study. Tutors help students to consider how the agency prioritises its activities, responds to patients' needs, communicates with other agencies and overcomes barriers to service delivery. Finally, a judgement should be made on how well the resource is being utilised, including patient compliance.
- **Case study presentations** tutors guide students to judge the overall effectiveness of the current care packages offered to their patient. They must consider if the patients' needs are being met and the quality of care is of an acceptable standard. Tutors help students to identify current problems and provide advice on solutions for multi-agency care.

Assessment

Tutors are informed about aims and methodology of assessment and offer help to students. Tutors involved in marking are expected to attend the education assessment skills training.

Post-course responsibilities

Unless the tutors are involved in marking, their main role will be to collect evaluation sheets, return student data to the administrator, thank all stakeholders, follow up any incidents recorded and attend a formal debrief which takes place with the academic coordinator.

3. Specialist tutor skills

Many tutors require an advance level understanding of specialist aspects of the programme, for example on team working, disability equality and policies, sociological principles in health and student assessment.

For disability equality, a programme is delivered by experts in the voluntary sector, led by disabled trainers. Evaluation of this programme consistently demonstrates that tutors highly value this learning. The impact of this programme also influences their clinical practice.

The administrative pathway

Robust administrative processes are crucial to the successful development, delivery and sustainability of the Model programmes. The administrator supports the academic team, the academic coordinator and locality tutors. The administrative pathway is summarised in Figure 11.

Figure 11: The administrative pathway.



Pre-programme:

- co-ordinate a 12-month project plan and identify milestones and key dates;
- organise and administer education steering group meetings;
- collate case study timetables for patient and agency interviews;
- liaise with patients, agency representatives and other stakeholders; co-ordinate written information such as letters, contracts and consent forms. All interviews for patients and agencies must be confirmed with letters;
- organise and book venues, plan equipment and educational materials including access to the internet, resource boxes and the printing of student workbooks;
- organise student resource including academic text and locality information;
- prepare confidential patient briefing details and store in a safe place, with instructions that they are not to leave the education venue;
- provide detailed geographical instructions to access interviews;
- organise presentation sessions, including invitations to guests;
- organise refreshments for teaching venues.

During the programme:

- provide clear contact details for students and tutors;
- respond to any problems as they arise;
- record any incidents and inform the academic coordinator;
- be available to deal with any last minute problems with attendance;
- keep in daily communication with tutors and be accessible for other stakeholders;
- remind patients and agencies of their interview details;
- ensure all the teaching materials are available for the programme.

Post-programme:

- thank you letters to be dispatched;
- collect student assessments;
- opportunities may be provided for students to revisit their patient case studies;
- organise payment to patients and agencies, and for education materials;
- collect evaluation questionnaires and electronically collate;
- organise post-programme debrief session and educational steering group meetings;
- complete incident log including actions taken;
- respond to post-programme queries from patients, students, agencies or tutors.

Part 4: The Leicester Model of Interprofessional Education Programme Details

Pre-registration programmes

Inequalities in health

Learning set	The health of populations affected by poverty and deprivation.
Length	4 - 12 half-day sessions.
Venue	Areas of social and economic disadvantage.
Student Details	Interprofessional education.
	Suitable for all health and social care students in their early training. In Leicester, medical, social work, nursing, midwifery, speech & language therapy, clinical psychology, pharmacy and psychology students access the programme.
Aims	Students work in interprofessional groups to:
	<ul style="list-style-type: none"> explore models of partnership working designed to tackle disadvantage in Leicester;
	<ul style="list-style-type: none"> appreciate the range of professionals involved in health and social care in preparation for working in the multi-disciplinary teams of the future.
Learning Outcomes	These are divided into uni professional and interprofessional:
Uni professional:	<ul style="list-style-type: none"> apply basic sociological concepts and theories relevant to professional practice;
	<ul style="list-style-type: none"> describe the impact of economic, practical and environmental factors in illness causation, prognosis and service utilisation;
	<ul style="list-style-type: none"> critique model of multi-disciplinary health and social care directed at tackling inequalities in health;
	<ul style="list-style-type: none"> analyse the quality and impact of service provision.
Interprofessional:	<ul style="list-style-type: none"> describe the range and roles of professionals working to meet the health and social care needs of the patients;
	<ul style="list-style-type: none"> analyse the central role of the patient in interprofessional working;
	<ul style="list-style-type: none"> analyse the importance of good team working relationships which draws on the skills/roles of different professionals to meet identified patient needs;
	<ul style="list-style-type: none"> assess the importance of effective communication within multi-disciplinary teams to ensure collaborative working.
Teaching Method	Small group (4-5 students), experiential, student-directed, problem-solving. Facilitated by tutors, students attend in cohorts of 24-30.
Structure	Students follow the Leicester Model of Interprofessional Education. Each group interviews one patient, chosen to illustrate the diversity of problems encountered in inequalities in health across the life span. Students provide written feedback to representatives of agencies on the strengths and deficiencies of their involvement and suggest recommendations for ideal multi-agency care.
Assessment	Students prepare a case study, demonstrating their achievement of the course outcomes.
Evaluation	As part of quality assurance and course development, students complete a questionnaire and attend focus group feedback.

Learning from lives

Learning set	People living with life-limiting disease and disabled people.
Length	20 days.
Venue	Centres of rehabilitation.
Student Details	Interprofessional education.
	Ideally accessed at the mid-point of training; for medical students at the beginning of their clinical phase. In Leicester medical, nursing, social work and therapy students can access the programme.
Aims	Students work in interprofessional groups to:
	<ul style="list-style-type: none"> provide students with a practical, in depth understanding of the nature and effect of illness and impairment on people's lives and the way in which the individual, family and society react towards disabled people; appreciate the importance of team working across different care settings.
Learning Outcomes	At the end of the course, students should be able to:
Interprofessional	<ul style="list-style-type: none"> describe the psychological effects and social reaction to the onset of an illness or impairment by the patient, their family friends and society; describe the structure, functioning and responsibilities of rehabilitation centres; follow the pathway of care from the perspective of the patient and the professional, across a range of acute and long terms care settings; compare and contrast the bio-medical model with the social model of disability; describe the accessibility, range and roles of health and non-health organisations involved in the care of patients with life limiting illnesses or disabled people; reflect upon professional/society's attitudes towards disabled people; recognise examples of good practice and communication between organisations dealing with disability issues.
Uni professional medical students	<ul style="list-style-type: none"> describe the medical and therapeutic aspects of an illness or impairment using patient case study learning; develop clinical skills and competences in the care setting.
Uni professional social work students	<ul style="list-style-type: none"> identify the contextual and structural factors which impact on definitions and experiences of disability; develop assessment and analytical skills involved in understanding social care needs and planning for effective interventions.
Teaching Method	Small group (2-4 students), experiential, student-directed, problem-solving. Facilitated by tutors. Cohorts range from 4-22.
Structure	In groups, students:
	<ul style="list-style-type: none"> analyse the life experiences of up to 4 disabled people across the age span, following the Leicester Model of Interprofessional Education; with professional supervision, develop and practise their clinical and social care skills;
	For patients admitted to rehabilitation centres, students:
	<ul style="list-style-type: none"> are immersed into the activities of a range of health and social care professionals supporting disabled people to maintain and maximise the quality of their lives; analyse legal and ethical issues in disability equity practice; interact in collaborative, patient-centred decision making; explore their learning environment examining the contribution of health and non-health organisations.

Assessment	Students prepare a reflective and evidence based portfolio for each patient case study which demonstrate the achievement of their learning outcomes.
Evaluation	Students complete a post-course in-depth questionnaire.
	A random sample of patients and agencies also complete evaluation questionnaires to examine the course procedures and quality of the programme.

Learning beyond registration

Working together in health and social care⁴⁰

Learning Set	The health of disadvantaged populations.
Length	8 half-day sessions.
Venue	In areas of social and economic disadvantage.
Student Details	Interprofessional education.
	Accessed by health and social care professionals just before they embark on their careers. The following range of students takes part in the Leicester programme:
	<ul style="list-style-type: none"> from the University of Leicester, family doctor trainees;
	<ul style="list-style-type: none"> from De Montfort University, Students in training for community nursing specialisms of health visiting, district nursing, practice nursing, school nursing and mental health nursing;
	<ul style="list-style-type: none"> from Leicester City Social Services, newly qualified social workers completing post-training awards.
Aim	To develop effective skills in multi-disciplinary team working across health and social care settings.
Learning Outcomes	At the end of the course, students should be able to:
	<ul style="list-style-type: none"> assess the central role of the patient in service delivery;
	<ul style="list-style-type: none"> evaluate the importance of team working in delivering effective health and social care;
	<ul style="list-style-type: none"> analyse the interdependence of different professions through exploration of team working;
	<ul style="list-style-type: none"> analyse the unique contribution of professions from the statutory and voluntary sectors in the provision of health and social care;
	<ul style="list-style-type: none"> reflect on inter-personal skills of individuals and their contributions to team dynamics;
	<ul style="list-style-type: none"> explore the importance of effective communication within multi-disciplinary teams;
	<ul style="list-style-type: none"> apply theoretical understanding to team work to the daily realities of busy professional lives;
	<ul style="list-style-type: none"> analyse where professional responsibilities and patient needs may overlap or be in conflict.
Teaching Method	Small group (4 students), experiential, student-directed, problem-solving. Facilitated by tutors representing the different professions. Students attend in cohorts of 24-30.
Structure	Students begin and end this programme with an in-depth analysis of theoretical aspects of team working linked to working within the complexities of health and social care. Students follow the Leicester Model of Interprofessional Education. Each group interviews one patient, chosen to illustrate the diversity of problems encountered in inequalities in health across the life span. The programme of interviews focuses on a critique of team working. Students are required to assess the quality and potential of multi-disciplinary collaboration to benefit patient well-being.
Assessment	A reflective portfolio using the patient case studies and further analysis of team working in other primary health care teams.
Evaluation	Students complete pre- and post-course learning expectations and outcomes. Post-course they complete a detailed questionnaire on the course content and values. A follow up evaluation takes place after 6 months to reflect on the course outcomes after a period of professional practice.

⁴⁰ Outcomes of the first pilot were reported in the CAIPE Bulletin, 22(8), 2003.

Continual professional development (CPD) courses

Interprofessional working to support disabled people

Learning set	People living with life limiting diseases and disabled people.
Length	A 4-day module accredited at 15 CAT points at Masters level. This module forms one quarter of a postgraduate certificate at 'M' Level in Human Diversity. It can be accessed as a stand-alone module.
Venue	Taught days are delivered through a voluntary sector advocacy training project; Practical, experiential learning takes place in a health or social care setting.
Learners	Interprofessional learning for:
	<ul style="list-style-type: none"> • Medical GP's, public health clinicians, rehabilitation physicians;
	<ul style="list-style-type: none"> • Community nurses practice nurses, district nurses, health visitors, learning disability nurses, community mental health nurses;
	<ul style="list-style-type: none"> • Social workers Adult branch and specialists in the care of the elderly and disabled people. Managers of care homes;
	<ul style="list-style-type: none"> • Therapists occupational therapists, physiotherapists, specialist therapists, dieticians etc.;
	<ul style="list-style-type: none"> • Voluntary sector workers.
	Ideally each cohort contains 2 - 4 places for each professional group giving a total of 24-30.
Aim	To enable health and social care professionals and voluntary sector workers to deliver rapid, effective and holistic care which embraces chronic disabled people's perspectives and optimises quality of life.
Learning Outcomes	By the end of this program, participants should be competent to:
	<ul style="list-style-type: none"> • describe the modern legislative framework;
	<ul style="list-style-type: none"> • reflect on normality and the terminology applied to disability;
	<ul style="list-style-type: none"> • compare and contrast the bio-medical model with the social model of disability;
	<ul style="list-style-type: none"> • analyse the changes in the patient and carer perspectives impacting on professional practice;
	<ul style="list-style-type: none"> • expand their working knowledge on the accessibility, range and roles of organisations involved in the care of patients with an illness or impairment;
	<ul style="list-style-type: none"> • critique team working from patient and professional perspectives along a care pathway;
	<ul style="list-style-type: none"> • recognise examples of good practice and communication between organisations dealing with disability issues;
	<ul style="list-style-type: none"> • explore how models of implementation for collaborative practice improve the quality of patient care.
Teaching Method	Self-directed, reflective, problem solving. Facilitated by clinical and expert tutors in disability. Module size approximately 15-20.
Structure	The Leicester Model of Interprofessional Education takes place during days two and three, with theoretical principles and reflection focused on days one and four.
Assessment	Learners produce a portfolio of work relevant to their professional practice, focused on the learning through the case studies and demonstrating achievement of the learning outcomes.
Evaluation	Involving all stakeholders.

Team working along the patient pathway

For qualified professionals and support staff (variable accreditation).

Learning Set	Multi-disciplinary members of a health and social care team drawn from community and hospital settings, brought together through their involvement with a specific patient. The patient hosts the programme supported by experienced tutors.
Length	A 3-day module, variously accredited from nil to 15 CAT points at Masters level.
Venue	Taught days are delivered in the university, practical sessions follow the patients' journey across hospital and community based settings.
Learners	Multi-disciplinary members of the health and social care team drawn together by the patient pathway. A wide range of participants is encouraged, from reception staff to medical consultants.
Aim	To develop effective team working within and across organisational boundaries and to consider solutions for improving the patient experience.
Learning Outcomes	By the end of this course, you should be able to:
	<ul style="list-style-type: none"> • assess and evaluate the constituents of effective team working;
	<ul style="list-style-type: none"> • apply theoretical understanding of teamwork to the daily realities of busy professional lives;
	<ul style="list-style-type: none"> • recognise your individual and team working strengths and preferences;
	<ul style="list-style-type: none"> • assess the central role of the patient/service user along their multi-disciplinary care pathway;
	<ul style="list-style-type: none"> • evaluate 'real life' multi-disciplinary service delivery in unfamiliar environments directed from the patient/service users pathway;
	<ul style="list-style-type: none"> • evaluate the importance of team working in delivering effective health and social care within and across organisational boundaries;
	<ul style="list-style-type: none"> • analyse the inter-dependence of different professions through exploration of team working;
	<ul style="list-style-type: none"> • explore the importance of effective communication within and between multi-disciplinary teams;
	<ul style="list-style-type: none"> • analyse where differing professional responsibilities and roles may overlap or be in conflict along the patient/service user pathway;
	<ul style="list-style-type: none"> • assess mechanisms for overcoming team working problems.
Method	Self-directed, reflective, problem solving. Facilitated by a patient and a tutor. Supported by simulators and experts in team working. Cohorts range from 15-20.
Structure	The programme applies the Leicester Model of Interprofessional Education. A patient hosts visits to each step of his/her pathway through the community and hospital sectors. The module explores teamwork principles and practice. It is completed with the identification of practical changes to improve the quality of the patient experience.
Assessment	Learners will produce a portfolio of work relevant to their professional practice, focused on the learning through the case study and demonstrating achievement of the learning outcomes.
Evaluation	With ethical approval, all stakeholders are involved in evaluation and results are directed into the educational steering group.

Part 5: Evaluation Methodology

Introduction

Programme evaluation forms an integral part of the delivery of our education programmes. Gathering evaluation data is the responsibility of the programme leader(s). The relevant educational steering group receives the evaluation outcomes and recommends improvements. This cyclical process provides a quality assurance and ensures that the education programmes are continually evolving.

Thorough assessment of the education process is required for quality assurance processes to:

- ensure alignment to the learning and teaching strategies of HEIs;
- fulfil rigorous investigation by external examiners and the quality assurance processes;
- demonstrate and inform on the quality of staff development and progression;
- monitor student progression;
- provide evidence for evolving and improving the programme.

And for the Model to:

- provide feedback to stakeholders, including service organisations and patients, whose unique contributions underpin the learning cycle.

Ethics and governance

Ethical principles guide the collection of all evaluation data. Evaluation studies follow the governance processes on collecting information from students, tutors, stakeholders and across partner HEI academics.

Evaluation study approval is sought from the university ethics committee. In addition, collecting information from patients and health and social care staff requires the approval of NHS ethics committees.

Ethical approval is first sought from the Central Office of Research Ethics Committees (COREC). All evaluation involving clinical settings is submitted for ethical approval through relevant NHS local research ethics committee (LREC).

For larger, multi-site evaluations, approval should be sought from the Multi-site Research Ethics Committee (MREC).

The research ethics committee for social services is the Research Group of the Association of Directors of Social Services (ADSS)⁴¹.

⁴¹ Freeth, D., Reeves, S., Koppel, I., Hammick, M. and Barr, H. (2005). *Evaluating interprofessional education: a self help guide*. The Higher Education Academy for Health Sciences and Practice, <http://www.health.heacademy.ac.uk/> accessed August 2005.

Action research

Our evaluation studies are multi-method in their structure. They generally consist of a combination of semi-structured questionnaires, focus groups and assessment outcomes. However underpinning our methodology is the application of action research models.

Action research models have been applied to the evaluation of the Model, ‘to improve education by changing it and learning from those changes’⁴².

Traditional action research methods were applied as a collaborative problem-solving approach, which would generate new knowledge and follow four stages: planning, acting, observing and reflecting⁴³.

This method is ideal for these small-scale education interventions, taking place in real-life delivery and providing a close examination of the effects of such an intervention⁴⁴.

Action research has been described as ‘a self-reflective inquiry’ by participants⁴⁵ and is the preferred methodology for group activities since those closest to the problems are in a best position to identify and work towards its solutions⁴⁶.

In addition to contributing new knowledge, action research crucially aims to ‘forge a link between intellectual knowledge/theory and action’³³.

Stages in the evaluation process

The following stages contribute to the evaluation process:

1. defining the aim and objectives of the programme evaluation;
2. selecting and designing the methodology, including data collection instruments;
3. collection of data;
4. analysis and dissemination of the findings.

1. Defining the aim and objectives

The purpose of the evaluation may focus on any aspect of the education programme from the preparation for teaching - ‘presage factors’; the process of teaching - ‘process factors’; to the product or impact of the teaching - ‘product factors’^{47,48}.

⁴² Kemmis, S. and McTaggart, R. (eds) (1992). *The action research planner* (3rd Edition). Geelong, Victoria, Australia: Deakin University Press.

⁴³ Lewin, K. (1946). Action research and minority problems. *Journal of Social Issues*;2(4):34-46.

⁴⁴ Cohen, L. and Manion, L. (1994). *Research methods in education*, (4th Edition). London: Routledge.

⁴⁵ Carr, W. and Kemmis, S. (1986). *Becoming critical*. Lewes: Falmer.

⁴⁶ Heron, J. and Reason, P. (1997). ‘A participatory inquiry paradigm’, *Qualitative Inquiry*;3(3):274-294.

⁴⁷ Biggs, J. (1993). From theory to practice: a cognitive systems approach. *Higher Education Research and Development* (Australia);12(1):73-85.

⁴⁸ Freeth, D. and Reeves, S. (2004). Learning to work together using the presage, process and product (3P) model to highlight decisions and possibilities. *Journal of Interprofessional Care*;8:3-56.

Presage

data has examined the impact of the programme planning on service delivery and includes examining the time required by front line health and social care staff to prepare for the programmes. Unpublished data is also currently being collected to examine the impact of pre-programme training on the delivery of the programmes.

Process

data from tutors and students on the content of the teaching and its relevance to their programmes is routinely collected^{49,50,51}.

Product

data is routinely collected both pre- and post-programme on the professional attitudes and knowledge change of students. This is compared with their assessment outcomes⁵².

The Model has examined all stages, although there is limited data on longer-term outcomes, for example the impact on learners' subsequent professional practice.

Selecting and designing the methodology

Evaluation methodology is normally multi-method. Practical issues must however be considered in the design, e.g. availability of staff time, funding and research support.

The following methods have been used with students, health and social care staff, programme stakeholders and patients:

- semi-structured questionnaires using rating scales to assess pre- and post-attitudinal change, presage and process factors. Scored questions are balanced with opportunities to express qualitative comments;
- focus groups;
- postal questionnaires to patients and agencies;
- follow up questionnaire feedback of students just prior to qualification;
- analysis of student assessments;
- analysis of student recommendations to agencies for ideal patient management plans.

⁴⁹ Anderson, E.S., Lennox, A.I. and Petersen, S.A. (2003). Learning from lives: a model for health and social care education in the wider community context. *Medical Education*;37:1-10.

⁵⁰ Lennox, A.I. and Petersen, S.A. (1998). Development and evaluation of a community based multiagency course for medical students: descriptive survey. *BMJ*;316:596-599.

⁵¹ Anderson, E.S. Lennox, A.I. and Petersen, S.A. (2004). New opportunities for nurses in medical education: facilitating valuable community learning experiences. *Nurse Education in Practice*;4:135-142.

⁵² Anderson, E.S. and Lennox, A.I. (2003). Leicester launches its first Interprofessional course for GP registrars, health visitors, district nurses and social workers. *CAIPE Bulletin*, Winter;8(22). *Journal of Interprofessional Care*;8:3-56.

An extract from a questionnaire testing student knowledge and attitudes pre- and repeated post-programme.

Please score (circle) the following relating to your experience prior to the course, where 1 indicates little knowledge or ability and 5 a great deal.

My ability to describe the range and roles of professionals working to meet the health and social care needs of the community	1	2	3	4	5
My ability to analyse the central role of the patient in interprofessional working	1	2	3	4	5
My ability to analyse the importance of good team working relationships which draw effectively on the skills and roles of different professionals to meet patients' needs	1	2	3	4	5
My ability to assess the importance of effective communication within multi-disciplinary teams to ensure productive joint working	1	2	3	4	5

An extract from a questionnaire delivered prior to the programme and aimed at examining the students' perceptions of the teaching process.

Please note: 5 is the highest positive response and 1 the lowest indicating a poor outcome. Some questions start with a positive response others a negative -take care when marking the form.

I was not looking forward to studying alongside other undergraduate health care professionals	1	2	3	4	5	I was looking forward to studying alongside other undergraduate health care professionals
I felt prepared for studying with other students from different health care professions	5	4	3	2	1	I did not feel prepared for studying with other students from different health care professions
The small group tasks were not appropriate for interprofessional learning	1	2	3	4	5	The small group tasks were appropriate for interprofessional learning

Collection of data

Tutors are responsible for the administration and collection of questionnaires and for the identification and organisation of recruits for focus groups.

In our experience, valuable data can be lost with student attrition and when there is concurrent teaching in more than one geographic area. For this reason tutor training programmes emphasise the importance of adopting a disciplined approach to completing the programme data collection evaluation tools.

Analysis and dissemination

Qualitative data is analysed for thematic responses using computer programmes such as NUDIST or more than one researcher.

Quantitative material is analysed using statistical packages e.g. SPSS for statistical significance and trends.

In many instances triangulation of data is possible where information on the process of a programme is collected from the patient, the student group and their tutor.

The outcomes of the evaluation are disseminated as follows:

- to the educational steering groups and as a contribution to the quality assurance processes of the HEI;
- to annual education reports. In some programmes these reports are provided to external, or independent evaluators, for example the Learning from Lives Programme⁴⁹ prepared reports for an NHS commissioned external evaluator. These external evaluation reports endorsed the quality of the learning experience²⁹;
- as feedback to stakeholders and patients. Patients additionally receive thank you letters, which can provide an overall comment on the progress of the student cohort. Patients also receive feedback visits from student groups to reflect on their learning. Health and social care organisations also receive reports;
- outcomes form the basis of national and international conferences and papers for publication.

Conclusion

Evaluation Studies contribute to the quality assurance process and ensure that the Model is continually evolving.

Evaluation outcomes identify that the Model positively impacts on students' learning, professional attitudes and knowledge of team working and it prepares students for future practice⁵³.

Learning in interprofessional groups enriches all programmes.

Patients enjoy taking part and feel supported.

Health and social care staff and their managers respect the ability of the Model to inform on their practice and reflect on the quality of their collaborative working.

⁵³ Cole, A. (2002). *A multi-disciplinary training programme on a deprived estate in Leicester is giving students an understanding of the type of social and health problems faced by residents- and opportunity to challenge service provision*. Health Development Today. April/May.

Part 6: Templates of Forms and Letters

Template 1: Student feedback form



Health in the Community - Student feedback

Summary of case information

Date:

Case:

Base:

Key issues:

Agencies involved:

Issues identified by student groups that may require consideration

Future management plan (3 bullet points)

1

2

3

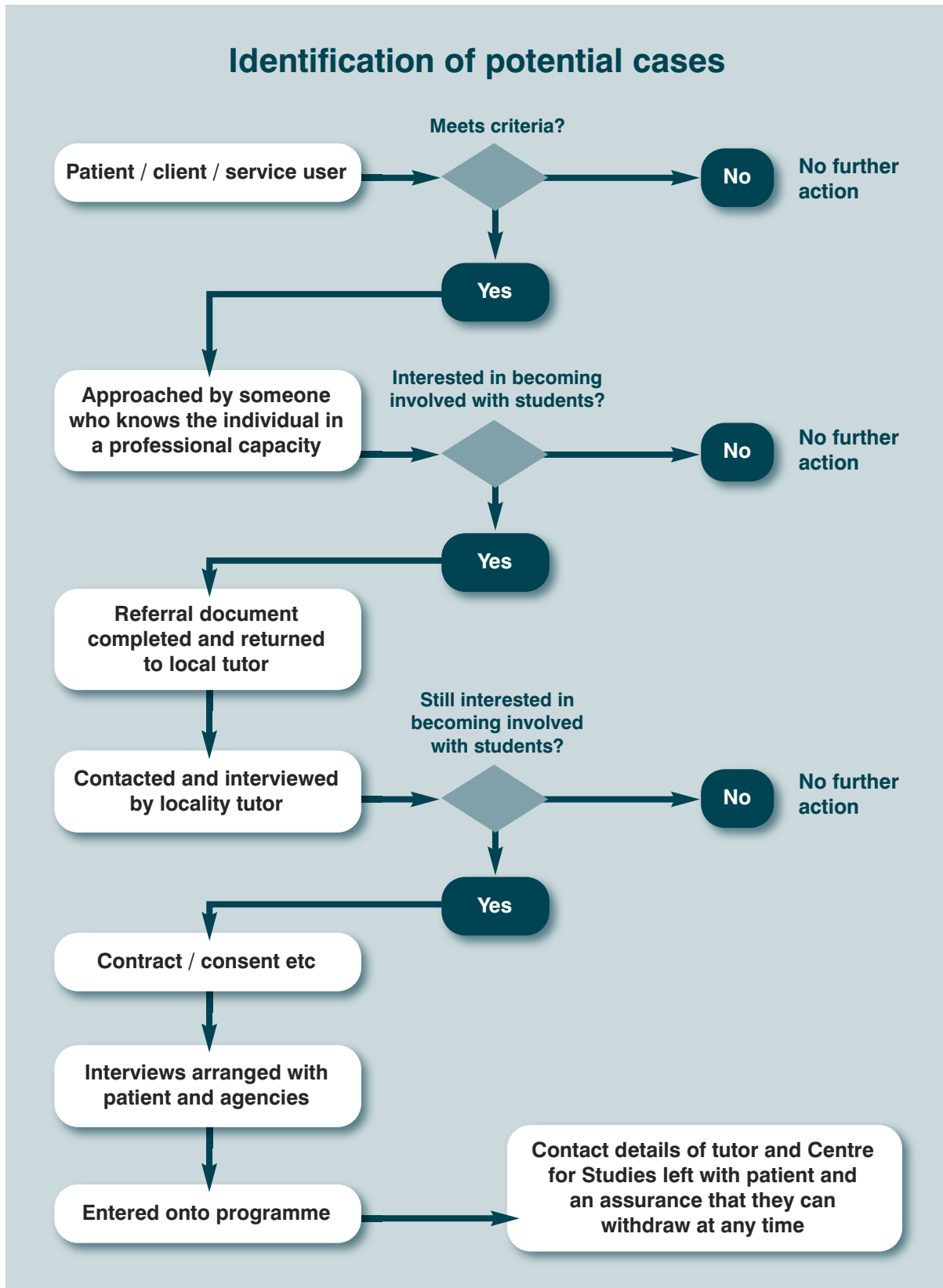
Any referrals of issues to be discussed with agencies (new or currently involved)?

Completed by:

PLEASE HAND COMPLETED FORM TO YOUR TUTOR

Template 2: Algorithm of patient recruitment

Figure 12: Algorithm of patient recruitment.



Template 3: Patient referral template

Health in the community

Referral proforma

Referring agency	Name: Address: Telephone number:
Details of potential case	Name: Address: Telephone number: Have you contacted the above person and sought permission for referral to the University module? <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>
Details of other agencies involved	Name: Address: Telephone number: Name: Address: Telephone number:
Issues that this case explores	
Any other circumstances or RISKS?	

Signature

Name (please print)

Date

PLEASE GIVE THIS INFORMATION TO THE COURSE ORGANISER

Contact XXXXXXXXXXXX (for collection): Tel: 0116 295 4668 / sharon.toon@elpct.nhs.uk

Template 4: Patient information leaflet

Figure 13: Patient information leaflet.

Over 300 patients have helped medical students in Lancashire — they said:

"I think it is important to carry out these interviews, so that we can improve on anything that our help people such as myself, through lives".

"It's good to have the opportunity to give our views to future medical people".

"I've always appreciated the care received over the years from many doctors and I am therefore delighted to be able to give something back, if only in a small way."

Students value the time you give to their learning they said:

"Talking to our patients in their own homes was the best part".

"Patients and families were inspirational".

"I learnt a great deal from the patients".


"It was an incredible learning experience as there is dual value and care for patients with a disability".

Course Summary

From 2010, third year medical students are placed in the eight Mersey Tames of Lancashire including Liverpool, to learn about patients care.

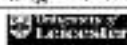
Students will visit five general practices, see services it provides and its relationship with General Practitioners of Community Healthcare Teams.

Meeting patients using these services and the agencies working with them provides students with up to date knowledge of health and social care.




Students talk with a patient in her home

Information for Patients 'Learning From Lives'



The Course is coordinated by:
Lancaster University. Contact:
Dr. E. Robinson and Nicola Larkin
Faculty of Medicine
Faculty for Quality & Community
Health Care
New Street House
Mather Road, St. Mary's
LA1 4YW, UK
Tel: 01524 22 4600
Fax: 01524 224608



For more information contact:
Nicola Larkin
Healthcare Development Team
Lancaster University Hospital
Foulk Way
Lancaster, LA1 4YW
Tel: 01524 224608
Fax: 01524 224607


The Patient's Role

You may be approached at home or in hospital and invited to meet with medical students and staff who you would probably have seen at GP or hospital this, for example, and in some cases your own GP or other health professional may be invited.

What will this involve?

A small group (max of 4) of students will ask you about your health, (for children, parents are invited).

- What are your main problems?
- How do you feel?
- What is most important to you?
- How might we be best helped to help you?



A student talking to a patient in their home

When you agree to participate, you will be in control of:

- the information given to the student
- the information you wish to share in detail with the student
- the length of the visit, the number of and the location to meet you for this occasion.


You can choose when you wish the student to visit you, for example, on the phone, or have the opportunity to meet them at another place such as your local health centre, or the parents at your child's school. The way which our team come to visit you.

What happens after the interview?

- your local team will ask you how the meeting went and for any feedback
- we write to thank you for your time
- once your views are taken we then a sample of complete questionnaire from the University to send your views on using you, which you can return to the college president.

With your permission, after meeting the students they will:

- meet a number of people who help you with your health and social care to find your best opportunity to:
 - learn about their role
 - appreciate how they bring their unique skills to help you
- talk with local services and medical teams about what they have learnt
- write up their impressions, as an ongoing local care, summarising what they have learnt about community care for patients with your condition. This will be done with a view to improve patient care in the future and the experience of meeting at your home.



A student talking to a patient in their home

Template 5: Patient consent form



**Department of Medical
& Social Care Education**

I,

	Yes	No
Consent to participate in medical and social care education in the community		
I have received information about medical and social care education in the community	n	n
I agree to hold a small group interview with students in my home, or another agreed place for one hour	n	n
I know that students will be provided with written information about my past health records, shared with me, before my interview	n	n
I am happy to talk with the students about my health problems and the role of health and community staff involved in my care	n	n
I am aware that students will talk about the care I have received with the main workers involved in my care	n	n
I am aware that my case will be discussed anonymously in a feedback presentation session	n	n
I am aware that all information will be treated strictly confidentially and is not allowed to be removed from the medical centre	n	n
I understand that written information will be stored in accordance with the data protection act		
I agree to participate in medical and social care education in the community	n	n
I am aware that I can withdraw from the programme at any time and I know whom to inform to do so	n	n
I know how to contact my tutor if I have any queries or concerns	n	n

Patient Signature

Patient name (please PRINT)

Tutors Signature

Date:

For Office Use Only

D.O.B.

N.I. No:

Address:

Template 6: Patient contract



**Department of Medical
& Social Care Education**



Patient Contract to the University	University / Trust Contract to the Patient
<p>I (the patient) agree to:</p> <ul style="list-style-type: none"> • host an interview with health and social care students; • sign a consent form; • be available on the date and time agreed with the tutor; • be in a stated venue or at home for the interview; • respond to the student questions, as I feel able. <p>I am aware that I do not have to divulge personal details.</p> <p>To inform the tutor if there are any concerns about the interview.</p> <p>Where possible let the administrator know if I can no longer keep this agreement.</p> <p>I know how to withdraw from the programme.</p> <p>Date</p> <p>Signature</p>	<p>We (the University and PCT) agree to:</p> <ul style="list-style-type: none"> • support you in your teaching role; • identify suitable times and dates convenient to you for the interview; • enable you to write the students' brief; • ask you to identify the agencies that will be interviewed; • confirm to you how your confidentiality will be maintained; • ensure students do not have access to your professional records; • provide you with an information leaflet on the course; • brief agencies about not divulging your personal confidences; • where possible, provide access to the students, at the end of the course, to thank you and inform you about what they have learnt; • ensure you understand how to exit the course at any time should you so wish. <p>Date</p> <p>Signature</p>

Template 7: Confirmation letter to patient



Department of Medical & Social Care Education

<Name>
<Address,>
<Address,>
<Address.>
<Date:>

Dear <name>

Re: Health in the Community

Thank you very much for agreeing to help us with the education of medical, nursing and social work students.

The interview is as I described when we recently met. A small group of students (4 or 5) will visit you in your home, to ask you some questions about your health and how it influences other parts of your life. They will want to know about the doctors, nurses and other people who play a part in your care. The interview will last for no more than 60 minutes.

Students will keep all your information strictly confidential. They will not examine you or change your treatment.

The students would like to interview you on:

Thursday At

And

Thursday At

After speaking to you, the students will be speaking to 3 other agencies which are involved with your care. On this occasion these will be your GP, the and your

Both the University of Leicester and De Montfort University greatly value your contribution to this course. Without your involvement and your willingness to teach our health and social care students the course would not be able to take place!

If you have any queries please do not hesitate to contact me on 0116 295 4723.

Thank you once again for all your help.

Yours sincerely,

Academic Coordinator

Template 8: Example of a thank you letter (patient)



Department of Medical & Social Care Education

Date,

Dear,

Thank you so much for helping us with the student teaching. Your contribution has been invaluable in raising awareness amongst a wide variety of students about how people cope with health issues in the community. Also, please convey my thanks to your wife who has also been a brilliant teacher. The students all really enjoyed meeting you both, and you made them feel very welcome as visitors in your home.

I do hope you found this an interesting and enjoyable experience. Our next course is starting in (DATE) and if we are teaching groups of students at the (NAME) site, I will speak with Dr (GPs NAME) to see if you might want to become involved again.

I have processed the final payments, so you should receive any outstanding money within the next few weeks. If there are any problems, please do not hesitate to contact me.

I wish you both the very best for the future and hope we may work together again.

With best wishes,

Senior Academic Coordinator

Tel: 2954723

Template 9: Agency confirmation letter



Typical letter to agencies involved in the health in the community programme

Dear

Re: Undergraduate Interprofessional Teaching - Prince Philip House

Thank you for agreeing to participate in this important interprofessional education programme.

The aim of your involvement is to facilitate students to explore the range, roles and responsibilities of agencies working to meet the needs of their patient as well as in the wider care setting. Students are expected to explore the quality and impact of service provision and to appreciate the importance of effective multi-disciplinary, collaborative care. The programme is carried out in <state venue locality> and case studies are chosen from the community.

Each small group of students will interview a patient. This is followed by interviews with three or four agencies representatives involved in the patient's care. They will also undertake additional interviews with agencies' based in the community but not directly involved in their patient.

Following completion of the interviews each student group will present a short critique of their experiences, and suggest ideal future management for successful multi-agency teamwork.

Their audience will comprise representatives of the agencies involved in providing community care. I do hope you and your colleagues are able to attend.

In essence, your role is to be interviewed by a small group of students. Each agency interview is scheduled for 30 minutes (max); time keeping will be strictly observed.

Students have been instructed: Firstly, to clarify the specific role of your agency in this case, Secondly, to explore the role of your agency in the community as a whole.

You should only respond to information presented by the students (i.e. information students have directly gathered from the patient). It is not appropriate to divulge information about their case away from the context of the students' line of questioning. If you feel uncomfortable about releasing information it is appropriate to share this with the student group and inform the tutor if you have any concerns about the interview.

Your case is Students will meet at home, then interview the following agency representatives, your interview will complete the case study.

The time and date of your interviews are..... and student presentations involving your patient's case.....

Because of the structure of the timetable, it is vital that you attend punctually. We realise that this is a great deal to expect, however the students and course organisers greatly value your contribution. We realise that your involvement may result in a reduction in other commitments, we can therefore arrange funding to cover any inconvenience (contact details given for all queries).

Kind regards,

Programme Tutor
Documentation on the programme is attached

Template 10: Incident log

Issues arisen during running of Health in the Community Course

Feb - May 2006

No	Date	Concerning Patient/ [person/s]	Issue	Outcome
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				