Nurse Education in Practice (2008) **8**, 276—282

ELSEVIER

Nurse Education in Practice

www.elsevier.com/nepr

Developing sustainable models of interprofessional learning in practice — The TUILIP project

Helen Armitage [a,*], Jim Connolly [b], Richard Pitt [c]

[a] *Faculty of Health and Wellbeing, Sheffield Hallam University, 11-15 Broomhall Road, Sheffield, S10 2BP, United Kingdom*
[b] *Institute of Multiprofessional Education, East Midlands Healthcare Workforce Deanery, United Kingdom*
[c] *Faculty of Medicine and Health Sciences, University of Nottingham, United Kingdom*

Accepted 15 October 2007

KEYWORDS
Interprofessional learning;
Practice;
Facilitators

Summary This paper will describe the background and development of the Trent Universities Interprofessional Learning in Practice Project (TUILIP). It will review some of the contributing literature on recent policy initiatives for interprofessional learning (IPL) and in particular the literature that supports the case for IPL to be embedded in the practice learning environment. The impact of IPL on health outcomes is discussed and on team working in practice.

The modernisation of the National Health Service in the UK is explained and how the East Midlands Strategic Health Authority has commissioned the TUILIP project that will promote and facilitate the interprofessional skills of students through collaborative working within the practice setting.

The TUILIP project is described, in particular, staff development for practitioners, the centrality of service users and the innovative approach of IPL Facilitators in pilot sites across the Trent region.

The case for interprofessional learning in practice

Over the last decade in the UK there has been an extensive drive to modernise the delivery of health and social care services. Government has been determined to see the demise of a systems-led organisation in the NHS (National Health Service) to one that is service user centred, seamless, responsive to local need, accountable and adaptable to change. The *NHS Plan* (DoH, 2000) and *Making a Difference* (DoH, 1999) and more recently Wanless (2004); *The NHS Improvement Plan* (DoH, 2004), *Choosing Health* (2004a) and *National Standards, Local Action: health and social care standards and planning framework 2005/06—2007/*08 (DoH, 2004b)

* Corresponding author. Tel.: +44 07795304708.
E-mail address: h.r.armitage@shu.ac.uk (H. Armitage).

1471-5953/$ - see front matter
doi:10.1016/j.nepr.2007.10.004

emphasise the need to provide coherent, integrated and patient centred (or patient driven) services and in turn develop a modernised approach to the educational input for future health professionals. Indeed the Department of Health recently demanded 'an even greater focus on clinical teams and multi-disciplinary working' (DoH, 2005, p. 27). Commitment to new ways of working has been demonstrated through the commissioning of a national three year program 'Creating an Interprofessional Workforce', which provides a structured framework for all organisations to utilise when designing the future workforce in health and social care (http://www.eipen.org). The framework proposes systems and models for mainstreaming IPL and has a clear focus on practice based learning.

Currently the majority of structured, planned IPL in the UK takes place within the university setting. These learning experiences are valuable and provide a foundation for practice placement learning but there is evidence that it is in practice where students really learn about collaboration (Barr, 2003). Canada provides us with examples of IPL models successfully used in practice but in general these are confined to a small proportion of health workers (Cook, 2005).

Further drivers for embedding IPL in practice from student and qualified practitioner perspectives are national and international adverse health and social care events; such as in the UK; *The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995* (Kennedy, 2001) and *The Victoria Climbié Inquiry* (Laming, 2003). Britain is not alone with this problem as adverse events have occurred in approximately 10.6% of Australian hospital admissions (Thomas et al., 2000); the Institute of Medicine in the United States has reported that as many as 100,000 Americans die each year as a result of medical error (Kohn et al., 1999) and adverse events have reportedly occurred in over 10% of Australian hospital admissions (Thomas et al., 2000). Also data collated in a Tokyo Hospital during 2000 demonstrated adverse healthcare events to include medication errors and nonsocomial infections (Yamagishi et al., 2003). *The Canadian Adverse Events Study* indicated that the incidence rate of adverse events in hospitals in Canada was 7.5%, echoing findings from similar studies (Baker et al., 2004). These statistics confirm what health and social care professionals have been trying to address for years: namely, that even in the best health and social care systems, patient safety is compromised by system frailties. In a significant proportion of these reports breakdown in communication and problems in professional collaboration are cited as mitigating factors. It can be deduced from this that although long-term impact on service delivery is as yet speculative, interprofessional learning is considered a key component of the UK government's modernisation agenda and is encouraged as a mechanism to break down barriers and enable effective teamwork in the NHS.

Another driver for the development of IPL in practice has been the increased emphasis on practice learning by professional organisations. A number of documents from UK professional bodies have emphasised that mentoring in practice is crucial in developing and supporting students and is a key part of every professional practitioner's role (DoH, 2000a; ENB and DoH, 2001; BMA, 2004). Although produced by specific professional bodies, the issues raised in these documents are pertinent to all health and social care professions and provide multiprofessional guidance to those who facilitate student learning in practice. In particular the Nursing and Midwifery Council (NMC) in the UK are encouraging further development of practice based mentors by stating recently that mentors must select and support a range of learning opportunities for students from all professions not just their own (NMC, 2006).

It is widely accepted that the delivery of effective IPL should employ a repertoire of learning methods and that it should focus on bridging the gap between theory and practice. With respect to the context of learning, Barr (2000) found that work-based IPL was markedly more likely than college-based teaching to improve the quality of service and/or bring direct benefits to patients. Involving the service user in health and social care education is a central theme of recent UK government policy statements (DoH, 2000, 2001, 2004, 2005, 2006) and so one of the keystones of interprofessional learning and partnership working is the positioning of service users as a central force in enhancing quality care.

The move toward IPL and patient partnership is reflected in current education programmes e.g. Le Var (2002), but again these are often classroom based. In order to centralise the service user in learning it is crucial that IPL takes place where the service user is normally found, on a hospital ward, in theatre, in a clinic and sometimes within the home. In addition it prepares students to actively use patient feedback as a central part of their clinical practice in order to improve quality (O'Neill, 2005).

The impact of IPL

Literature concerning IPL is diverse and includes both research reports and a larger number of