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H BARR.

REPORT OF A NATIONAL SURVEY ON INTER-PROFESSIONAL EDUCATION IN PRIMARY HEALTH CARE

Commissioned by the Centre for the Advancement of Inter-Professional Education in Primary Health Care

Conducted by the Institute of Community Studies

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SECTION 1 - INTRODUCTION

1.1 Background

In January 1988 the Council of the Centre for the Advancement of Inter-Professional Education in Primary Health Care (CAIPE), commissioned a study, to be undertaken by the Institute of Community Studies (ICS). Its purpose was to establish the extent and nature of recent initiatives* in inter-professional education (IPE) involving primary health care professionals in mainland UK.

CAIPE proposed that the study should take the form of a nationwide postal survey. It was agreed that the exercise, though not purporting to be either scientifically valid or totally comprehensive, would nonetheless provide sufficient information to give a reasonably accurate indication of the level of activity taking place. In the light of this, the results of the survey have been used to draw up a map and compile an information-base including all known examples of IPE taking place within a specified period. This is intended to provide a foundation for the Centre's planned programme of activities: in particular the development of an effective network linking organisers of IPE; the establishment of a resource centre, and the promotion of IPE through research, conferences and learning materials.

1.2 Aim of the report

This report describes the research carried out by ICS: its scope, the method used and the results. In analysing the statistical findings of the survey, it puts forward a number of conclusions regarding current trends within this field of education.

[* This term has been used throughout the report to describe examples of inter-professional education. It was chosen in preference to the term "courses" which has a narrower meaning and may therefore have been misleading.]

2.1 Definition of inter-professional education

For the purposes of the survey, the term "inter-professional education" was taken to include any activity which fulfilled each of the following criteria:

a) its primary objective was education;

b) it involved participants from two or more of the selected professional groups (see 2.2 below);

c) the participants in b) were learning together within a multi-disciplinary context.

The validity of each example of IPE submitted in the survey was decided by testing it against these criteria.

2.2 Professional groups

The main study was focussed on educational activity involving five professional groups, known to be either working in or otherwise involved with the provision of primary health care. These were:

a) general practitioners (GPs)

b) social workers

c) district nurses

d) health visitors

e) community midwives

In addition, students and trainees in each of the five groups were included. Activities involving medical students, student nurses or student midwives were also accepted as valid, on the basis that these groups might opt to enter one of the selected professions after qualifying.

It was recognised at the outset that by limiting the scope of the survey to these five groups, other important primary health care professions would inevitably be excluded from it: in particular, practice nurses; community mental handicap nurses and community psychiatric nurses. Unfortunately resource limitations precluded consideration of a broader spectrum of professions at this stage of the research. Partly to overcome this, however, it was decided that limited information on the involvement of other professions in IPE could be obtained by inviting respondents to list all other participants, i.e. those falling outside the five key groups. Whilst this still excluded from the study any activities not involving two or

more of the selected professions, it nonetheless gave some indication of the involvement of other groups without shifting the main emphasis of the survey.

2.3 Timescale

So as to collect data on recent initiatives only, a time limit was specified: only activities taking place between June 1987 and May 1988 (inclusive) were considered. Cases where only part of the activity took place during this period - i.e. those starting or finishing outside it - were also included.

2.4 Type of information

Although CAIPE intends eventually to obtain evaluative information on certain specific IPE initiatives by drawing up criteria for success and measuring individual examples against these, it was agreed that the initial survey should concentrate on the collection of factual, non-evaluative data. A discrete second study is proposed to address qualitative issues.

In this context, the survey aimed to collect the following information for each example of IPE:

- Title
- Subject matter
- Objectives
- Organising agency
- Professions responsible for organisation
- Location
- Frequency
- Duration
- Educational methods used
- Number of participants
- Professional background of participants
- Educational context/level
- Attendance: whether optional or compulsory
- Evaluation: whether or not it took place
- Continuation: whether it is proposed to repeat or continue the initiative

Where an activity had taken place more than once in the specified time, recipients were asked to describe the most recent occasion on which it had taken place. From these details, it was possible to draw up a profile on each initiative, and to extract statistics indicating broad trends in IPE.

2.5 *Geographical boundaries*

The survey was limited to those activities taking place within mainland UK: namely those in mainland England, Scotland and Wales.

3.1 Data collection

a) Questionnaire design

In order to obtain the required information, a questionnaire was designed (Appendix A) incorporating questions on each of the aspects listed in 2.4 above.

b) Identification of survey population

Rather than undertaking a sample survey of possible participants in shared learning, in this case practitioners from the selected professions, the questionnaire was targetted at those people likely to have organised or taught in IPE activities. This option was preferred for two reasons. Firstly, a random sample of practitioners would, in all probability, have provided information on fewer initiatives than was obtained by complete coverage of organisers and teachers; secondly, the latter group would be better placed to provide comprehensive details of activities.

The target groups chosen were, therefore, educators from each of the key professional groups:

- Directors of nurse education
- Heads of midwifery services
- Course organisers in district nursing) in colleges, universities & polytechnics
- Course organisers in health visiting) in colleges, universities & polytechnics
- Course organisers in social work) in colleges, universities & polytechnics
- Training officers in social work departments
- Undergraduate deans of medical schools
- Regional advisers in general practice
- Course organisers in general practice
- General practice tutors

Also included were heads of education centres, professional bodies and other organisations which might be involved in the education and training of primary health care professionals. (See Appendix B)

c) Mailings

i.Target groups

A mailing list of all those in the specified target groups was compiled. Personal names were used for doctors; elsewhere titles were used, as personal names were not available. The list was divided into categories according to NHS region; the education centres/professional bodies formed an additional category.

Each questionnaire was given a serial number corresponding to a name on the mailing list. This was done to facilitate the booking-in of returned questionnaires, and to provide a unique number for each computer record which could then be linked easily with the appropriate questionnaire.

All those on the mailing list were sent a questionnaire, a prepaid reply envelope, a copy of the CAIPE publicity brochure and a covering letter explaining the purpose of the survey and signed by the Chairman of Council. The letters to deans and regional advisers in general practice were personalised; the remainder were addressed to the holder of the respective post, although in the case of general practitioners, the envelope was then addressed to a named individual. The first mailing took place in June 1988 and respondents were given approximately three weeks in which to respond. This deadline was set only to encourage an early response; completed questionnaires arriving after this date were accepted.

In early July, a reminder letter was sent to all those who had not yet responded. Recipients were invited to 'phone for a second questionnaire if the first one had been mislaid or gone astray. A second reminder, enclosing a further copy of the questionnaire and another prepaid reply envelope, was mailed to all remaining non-respondents in September 1988. Requests for replacement blank questionnaires were received up to the end of December 1988, after which no further forms were sent out.

ii. Other sources

In Part A of the questionnaire, respondents were asked to name the organiser of any other IPE initiatives known to them. With these details, ICS was able to contact the organisers direct and, in consequence, 191 additional questionnaires were issued. These were sent out in two separate mailings which took place in September and November 1988. After the second mailing the names of any further new contacts were necessarily disregarded. All non-respondents from the two mailings were sent one reminder letter only.

d) Testing of methods

The data collection methods described above are those used in the main survey in June 1988. Prior to this, a pilot survey was carried out to test the proposed questionnaire design and data collection methods. Following the pilot, a number of modifications were made for the main survey. The pilot is described and the modifications listed in Appendix C.

3.2 Sorting of responses

The returned questionnaires were sorted into the following categories:

YES	those giving details of valid IPE initiatives (see Section 2.1 above).
NON-VALID	those giving details of non-valid IPE initiatives; those giving insufficient information to determine whether or not the initiative was valid.
NO	those indicating that the respondent had not been involved as either organiser/teacher in any valid examples of IPE.
REFUSALS	those in which the recipient of the questionnaire was either unable or unwilling to assist with the survey.
GONE AWAY	those where the addressee had died, moved away or retired/resigned from the relevant post.
OTHER	any other responses (e.g. those lost in transit).

3.3 Data processing and entry

The data from each of the responses in the "yes" category described above was processed in preparation for entry onto a computerised database. During this stage, certain minor problems became apparent, most of which related to the way in which the questionnaire had been completed. Where possible, these were resolved by contacting respondents again by telephone. The main problems encountered are listed in Appendix D. The data was then classified and entered onto computer. The method for this is described in Appendix E.

As with any survey, there may have been undetectable errors in the data, those arising, for example, from a lapse of memory

on the part of a respondent. It was not possible to carry out validity-testing of the data by contacting independent sources because of resource constraints.

3.4 Data analysis

Following processing and entry of all valid responses, statistical analysis of the data was undertaken. The results of this stage are described in Sections 4 and 5 of the report.

4.1 Level of response

The overall response rate to the survey, including the pilot, was 75 per cent. This figure was reached as shown below:

Questionnaires sent	1518
Less:	
Duplicates - two questionnaires sent to same person inadvertently	13
Addressee gone away/no longer in post	23
Other - response lost in transit or received too late	3
Total (after deductions)	1479
Refusals	19
Completed questionnaires received	1105

FINAL RESPONSE RATE $\frac{1105}{1479} = 75\%$

Table 1 shows the variation in the level of response from each of the professional groups targetted in the survey.

Professional group	Responses received / Questionnaires sent	
Nursing, midwifery & health visiting	391/480	(82%)
Social work	124/202	(61%)
General practice & other medical	450/586	(77%)
Heads of education centres & professional bodies	27/31	(87%)
Other contacts (see 3.1 c) ii)	113/180	(63%)

Table 1: Breakdown of response rate by profession

The other contacts receiving questionnaires were not classified by profession prior to mailing. However, valid responses from this group were subsequently classified in this way (see 4.2). The figures in Table 1 reveal that the response from social workers was significantly lower than that from the other two categories. This may have had some bearing on the final results, in particular those relating to participation by each professional group (see 5.1), but it is not possible to substantiate this theory.

The level of response also varied considerably between regions. A detailed breakdown (Appendix F) reveals that the region with the highest response rate was South Western (83 per cent). Even higher, however, was the level of response from the education centres and professional bodies, 87 per cent of which replied. The region with the lowest response rate was East Anglia, at 51 per cent.

4.2 Nature of response

Of the 1105 respondents who returned a completed questionnaire:

- 470 (43 per cent) gave a NO response, indicating that they had not taken part, either as teacher or organiser, in any IPE initiatives within the specified period.
- 156 (14 per cent) gave a YES response, but gave details of non-valid initiatives i.e. initiatives which failed to meet the criteria specified for inclusion in the survey (see 2.1).
- 479 (43 per cent) gave a YES response and gave details of one or more valid examples of IPE.

In total, information on 695 valid examples of IPE was received. In addition to this, 149 duplicate responses were received, i.e. responses giving details of an initiative already reported by one or more other respondents. So the total number of valid notifications, including duplicate responses, was 844. The number of these received from each professional group is shown in Table 2.

Professional group	No. of notifications
Nursing, midwifery & health visiting	474 (56%)
Social work	90 (11%)
General practice & other medical	202 (24%)
Other	78 (9%)

Table 2: Notifications from each professional group

5.1 Participants

Respondents were asked to indicate which groups took part as learners in the IPE activity described. Of the 695 initiatives notified, the level of participation by the five selected professions was as shown in Table 3.

Profession taking part	No. of initiatives
Health visitors (HV)	612 (88%) *
District nurses (DN)	504 (73%)
Social workers (SW)	318 (46%)
General practitioners (GP)	256 (37%)
Community midwives (MW)	224 (32%)

Table 3: Level of participation by selected professions

This shows that health visitors and district nurses took part in considerably more initiatives than the other professions. Further analysis demonstrates that 668 (96 per cent) of all initiatives involved either one or both of these two professional groups. It could be argued, however, that this result was influenced by the survey methodology or by the response rate from these particular professions. But in the context of the survey as a whole, nurses, midwives and health visitors accounted for only 31 per cent of the people to whom questionnaires were sent, they submitted 35 per cent of the total responses received and provided 56 per cent of all valid notifications. So the fact that considerably more initiatives involving health visitors and district nurses were reported does not appear to have been influenced by method or response rate. It is therefore reasonable to conclude that these two professions participated in IPE more frequently than the other selected professions. Unfortunately there is no means of knowing whether this was because more initiatives were of relevance to them, or because they more readily attend IPE activities.

[* All percentages given in this section of the report are calculated as a proportion of the total number of initiatives, unless otherwise specified.]

The student groups selected for inclusion in the survey took part as shown in Table 4.

Student group taking part	No. of initiatives
Medical students	13 (2%)
Student midwives	8 (1%)
Student nurses	7 (1%)

Table 4: Level of participation by selected student groups

It should be noted that information on activities involving these student groups was not specifically requested in the questionnaire. Therefore respondents may not have given details of relevant initiatives where they were known to them.

The number of selected professional groups taking part in individual IPE initiatives is shown in Table 5.

Number of selected professions	No. of initiatives
2	315 (45%)
3	246 (35%)
4	81 (12%)
5	43 (6%)

Table 5: Number of the selected professional groups taking part in IPE activities

In addition, ten initiatives (1 per cent) involved only one or none of the selected professions, together with one or more of the selected student groups. From the figures in Table 5, it is evident that the vast majority of initiatives involved only two or three of the chosen professional groups. A relatively small proportion involved all members of the primary health care team.

The actual combinations of participants which occurred most frequently are shown in Table 6.

Combination of professions	No.of initiatives
DN and HV	136 (20%)
DN, HV and MW	74 (11%)
DN, HV and SW	74 (11%)
HV and SW	56 (8%)
DN, HV and GP	47 (7%)
DN, HV, SW and GP	46 (7%)
DN, HV, MW, SW and GP	43 (6%)
HV and MW	41 (6%)

Table 6: Most common combinations of professions taking part in IPE initiatives

The combinations listed in Table 6 account for 76 per cent of the total number of initiatives. Clearly, the combination of district nurses and health visitors was the most common, both where only the two professions took part in IPE together, and also where one or more other professions took part. This is consistent with the finding outlined and discussed earlier, that district nurses and health visitors participated in considerably more initiatives than the other professions. The greater number of examples involving these two professions only may arise from the fact that certain agencies have responsibility for educating both professions. In support of this, 77 per cent of district nurse/health visitor initiatives were organised by colleges which train both district nurse and health visitor students, or by schools of nursing which train qualified staff in both professions. In the light of this, it would seem likely that the education and training arrangements for these groups present greater opportunities for shared learning.

Table 7 shows which groups other than the five selected professions took part in IPE most frequently.

Profession taking part	No. of initiatives
Hospital nurses	168 (24%)
Hospital doctors	93 (13%)
Hospital midwives	80 (12%)
School nurses	72 (10%)
Community psychiatric nurses	63 (9%)
Teachers	60 (9%)
Voluntary agency staff and volunteers	59 (9%)
Police	55 (8%)
Practice nurses	54 (8%)
Physiotherapists	48 (7%)
Occupational therapists	46 (7%)
Medical officers	43 (6%)

Table 7: Other groups taking part in IPE most frequently

Interestingly, of all the groups listed in Table 7, only half work specifically in the field of primary health care. It is evident that hospital-based professionals frequently took part in shared learning with the selected primary health care groups. One of the reasons for this may be the relevance of certain topics to both hospital and community staff from the same professional background. It may also be due in part to the way in which training is organised, particularly within the nursing profession. Analysis shows that 71 per cent of initiatives involving hospital nurses and 83 per cent of those involving hospital midwives were organised by schools of nursing or midwifery. The role of these two agencies in organising IPE is discussed further in 5.3. Here, however, it is sufficient to note that their area of responsibility frequently covers both hospital and community-based staff, which may account for the high incidence of initiatives involving both groups.

The frequent involvement of both police and teachers relates to the considerable number of initiatives on child abuse (see Section 5.5). 73 per cent of initiatives involving teachers, and 87 per cent of those involving police focussed on this particular topic.

5.2 Educational context

Respondents were asked to specify the educational context(s) in which the IPE activity took place. The results were as shown in Table 8.

Educational context	No. of initiatives
Undergraduate training (e.g. MB ChB; MB BS)	10 (1%)
Initial professional training (e.g. RGN; CQSW)	52 (8%)
Post-qualifying/vocational training (e.g. District Nursing/ Health Visiting Certificate; General Practice Vocational Training Scheme)	124 (18%)
Continuing education/professional development (i.e. educational activities for qualified practitioners)	576 (83%)
Degree/diploma course (i.e.courses leading to a degree or diploma other than those in the first three categories listed above)	9 (1%)
Other	2 (<1%)

Table 8: Educational context of IPE initiatives

A number of initiatives fell into more than one of the above categories. This occurred where the activity had been organised for participants from different educational levels e.g. social work students (classified under initial professional training) and general practitioner trainees (classified under post-qualifying/vocational training). Where this occurred, it was not always possible to determine which educational context related to which group of participants because this information was not requested from respondents. The combination of contexts arising most frequently was, in fact, initial professional training and post-qualifying/vocational training, of which there were 46 examples.

The results indicate that IPE took place most commonly as part of continuing education and professional development programmes for qualified staff. However, there was also considerable activity within the context of initial professional training and post-qualifying or vocational training. Looking specifically at the latter two levels, Table 9 indicates the

number of initiatives arranged specifically as part of established courses leading to qualification in one of the five selected professions.

Course	No. of initiatives
Health visiting certificate/diploma	87 (13%)
District nursing certificate/diploma	72 (10%)
GP vocational training scheme	44 (6%)
CQSW or equivalent course	44 (6%)
Registered midwife qualification	3 (<1%)

Table 9: IPE activity taking place as part of initial professional or post-qualifying/vocational training

The most common combinations of students taking part in these initiatives to some extent reflect the mix of professions as a whole (see 5.1). There were 35 joint initiatives which involved district nursing and health visiting students only; in a further 12 cases these two groups joined with GP vocational trainees. In addition, 18 initiatives involved health visiting and social work students only, whilst in nine examples they were joined by district nursing students.

Analysis of educational context in relation to participants reveals that the percentage of initiatives in each category is approximately the same for each of the selected professions. However, of the 224 activities in which community midwives took part, 220 (98 per cent) fell within the category of continuing education/professional development. So correspondingly few IPE initiatives were found to have involved student midwives.

5.3 Organising agency

The range of agencies involved in organising multidisciplinary education is shown in Table 10, together with the number of initiatives organised by each category.

Type of agency	No. of initiatives	
School of nursing/midwifery	226	(33%)
College/polytechnic/university	147	(21%)
Health authority (other)	113	(16%)
Postgraduate medical centre/local RCGP faculty/postgraduate dept. of general practice	56	(8%)
GP vocational training scheme	47	(7%)
Social services department	47	(7%)
Joint health authority/social services	43	(6%)
Voluntary agency	40	(6%)
Education centre/research body/ professional organisation	33	(5%)
Medical practice/health centre	29	(4%)
Undergraduate medical school	8	(1%)
Professional support/interest group	7	(1%)
Other	11	(2%)

Table 10: Agencies responsible for organising IPE

The agencies most commonly involved in organising IPE were schools of nursing and midwifery, colleges and universities, and health authorities. A considerable number of initiatives were organised by more than one agency. For example, of the activities organised through GP vocational training schemes, 75 per cent also involved colleges and/or universities.

As one would expect, the degree of involvement by each type of agency bears some relation to the level of participation by each professional group. For instance, district nurses and health visitors took part in the greatest number of initiatives, 668 (96 per cent) involving one or both professions. Of these, 56 per cent were organised by either

schools of nursing and/or midwifery, or colleges and/or universities. This corresponds with the level of activity by these agencies overall.

Whilst some agencies, such as schools of nursing, organise education for one particular profession or group of related professions, others, for example health authorities, have a broader remit. It could therefore be argued that the latter type of agency has a greater interest in, or is at least more likely to organise educational activity involving several professions. In practice, the survey showed that, whilst the greatest number of initiatives were organised by schools of nursing and midwifery, these were almost invariably for the nursing professions only. GPs only attended 10 per cent and social workers 19 per cent of initiatives. In contrast, 45 per cent of initiatives organised by postgraduate medical centres were attended by social workers, 63 per cent by district nurses and 73 per cent by health visitors. There is no indication of whether the non-nursing professions were invited to activities organised by schools of nursing and midwifery and did not attend, or whether the initiatives were not open to them.

In total, 466 individual agencies organised some form of shared learning activity. Table 11 shows how this figure is broken down between each type of agency. The percentages are calculated as a proportion of the total number of agencies organising IPE.

Type of agency	No. organising IPE
School of nursing/midwifery	102 (22%)
College/polytechnic/university	73 (16%)
Health authority (other)	64 (14%)
Postgraduate medical centre/local RCGP faculty/postgraduate dept. of general practice	49 (11%)
GP vocational training scheme	40 (9%)
Social services department	37 (8%)
Joint health authority/social services	22 (5%)
Voluntary agency	14 (3%)
Education centre/research body/ professional organisation	18 (4%)
Medical practice/health centre	26 (6%)
Undergraduate medical school	5 (1%)
Professional support/interest group	6 (1%)
Other	10 (2%)

Table 11: Number of each type of agency organising IPE

Here the pattern of activity by the various types of agency is similar to that shown in Table 10. The categories organising the greatest number of activities are, therefore, the same as those containing the most individual agencies.

Table 12 shows which agency organised the most activities in each professional field.

Profession taking part	Agency organising most initiatives
General practitioners	Postgraduate medical centre or related agency
Social workers	College/university
District nurses	School of nursing/midwifery
Health visitors	School of nursing/midwifery
Community midwives	School of nursing/midwifery

Table 12: Agency organising most IPE activities in each professional field

Table 13 shows how many initiatives each professional group was actually involved in organising.

Profession of organiser	No. of initiatives
Health visitors	202 (29%)
General practitioners	161 (23%)
Social workers	157 (23%)
District nurses	149 (21%)
Community midwives	27 (4%)

Table 13: Number of initiatives organised by each professional group

As a proportion of the number of initiatives in which they actually participated, GPs organised more than the other professions: 161 of 256 (63 per cent). This no doubt relates to the way in which education is organised within the various professions. In general practice, GPs themselves are closely

involved in organising both vocational training schemes and postgraduate education. In the nursing and related professions, education is more often organised specifically by educationalists rather than by practitioners.

5.4 Objectives

Respondents were asked to rank the four objectives given in order of priority. The relative importance of each objective gave some indication of why the initiative was organised on a multidisciplinary basis: whether it was merely for convenience, or specifically to promote teamwork and develop understanding between professions. Clearly those organised for the latter reasons, from now on referred to as inter-professional aims, were of most interest in the context of the survey. It is, of course, possible that respondents ranked inter-professional aims more highly in view of the nature of the survey, thus distorting the results. But it is impossible to say whether this occurred, and if so, to what degree.

In 367 cases (53 per cent), respondents ranked "promoting teamwork" and/or "increasing understanding of the roles and views of other professionals" amongst the two most important objectives of the activity. However, of those initiatives involving GPs, 64 per cent ranked one or both objectives highest. This is considerably above average and indicates that more initiatives involving GPs had specifically inter-professional aims.

Some agencies organised a significantly higher than average percentage of initiatives with inter-professional aims. These included medical schools (88 per cent), vocational training schemes (83 per cent), social services (77 per cent) and colleges and universities (72 per cent). In contrast, of those organised by schools of nursing and midwifery and voluntary agencies, the percentage with these objectives was considerably lower than average: 39 per cent and 40 per cent respectively. This suggests that, although schools of nursing and midwifery organised more multidisciplinary activities than any other type of agency, a greater than average proportion of these were arranged for reasons other than the promotion of teamwork and inter-professional understanding.

Linking this to educational context, over 80 per cent of initiatives organised as part of initial professional training and/or post-qualifying/vocational training rated these objectives highest. This contrasts sharply with 47 per cent of those in the continuing education/professional development category and 33 per cent of degree/diploma courses. So it appears that IPE activities involving students in the selected professions were more often arranged expressly to increase inter-professional understanding and cooperation than those organised for qualified practitioners.

Analysis of objectives in relation to subject reveals that initiatives on certain topics were more frequently organised with inter-professional aims. Not surprisingly, 92 per cent of initiatives about roles and teamwork came into this category, as did 65 per cent of those on child abuse. The latter can perhaps be explained by the current emphasis on the importance of teamwork in child abuse cases. Conversely, only 19 per cent of initiatives on management topics and 36 per cent on education and training rated inter-professional aims highest.

5.5 Subject

The subjects arising most frequently are shown in Table 14.

Subject	No. of initiatives
Child/family abuse	105 (15%)
Teamwork/professional roles	71 (10%)
Multiple subjects *	56 (8%)
General medical (including heart disease, diabetes & continence)	48 (7%)
Terminal care/dying/bereavement	45 (7%)
Education and training	33 (5%)
Management issues	31 (5%)
Childbirth	29 (4%)
Child health	29 (4%)
Elderly	28 (4%)
AIDS	28 (4%)
Mental health/mental handicap	24 (4%)

Table 14: Subjects occurring most frequently in IPE

The above ten subjects account for 70 per cent of all initiatives. Child and family abuse was evidently the most common topic: more than one in seven initiatives focussed on

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[multiple subjects: those initiatives where a variety of subjects (more than four) were specified or where a different subject was studied each time the initiative took place. In cases where up to four different subjects were mentioned, each subject was entered separately (see Appendix E, paragraph 3).]*

it. The high level of activity surrounding this topic no doubt reflects its topicality, and more particularly the DHSS draft guidelines on inter-agency cooperation and joint training, issued in June 1986.

One in ten initiatives centred on teamwork and professional roles. Here the link between objectives and topic is very apparent. 92 per cent had primarily inter-professional aims which were clearly reflected in the subject matter.

The relationship between subject and participants is also of interest. Looking at the ten most popular topics, the number of initiatives attended by each of the selected professions generally reflects the levels of participation across all IPE activities. However, there were some notable exceptions. Of the 256 initiatives attended by GPs, more than the average percentage were on teamwork and roles (16 per cent) or on multiple subjects (13 per cent); but very few were on education and training (1 per cent) or management issues (2 per cent). 31 per cent of the 318 initiatives attended by social workers were on child abuse and 7 per cent were on mental health/mental handicap; but a lower than average percentage were on education and training (2 per cent), management issues (1 per cent), childbirth (less than 1 per cent), child health (2 per cent) and AIDS (2 per cent). Of the 504 initiatives attended by district nurses, less than the average percentage were on child abuse (10 per cent), childbirth (less than 1 per cent) and mental health/mental handicap (2 per cent). Participation by health visitors corresponded to the percentages shown in Table 14 above. Finally, as would be expected, 13 per cent of the 224 initiatives attended by midwives were on childbirth, only 2 per cent were on general medical issues, and only 1 per cent were on either the elderly or mental health/mental handicap. But interestingly, 10 per cent of all the initiatives involving midwives were on management issues. Only 4 per cent, however, were on teamwork and professional roles.

Within the various educational contexts, the distribution of subjects differs considerably from the percentages shown in Table 14. Of the 52 occasions where IPE took place as part of initial professional training and the 124 examples within post-qualifying/vocational training, 39 per cent related to teamwork and roles in each case. This links with the high incidence of inter-professional aims in these educational contexts, as discussed in 5.4. In addition, four of the ten undergraduate initiatives (40 per cent) focussed on teamwork and roles, but only 5 per cent of those in continuing education. Child abuse courses accounted for 31 per cent of those activities organised as part of initial professional training. In practice this usually meant CQSW courses, so this finding is consistent with the frequent participation of social workers on child abuse courses as discussed in the previous paragraph. It is interesting that nearly all the examples on education and training, management issues, childbirth, child health, mental health/mental handicap, AIDS and the elderly fell within the context of continuing education. Less than the average percentage of initiatives on these subjects had inter-professional aims. This is consistent with the fact that over half the initiatives in the initial professional training

and post-qualifying/vocational training categories were on child abuse or roles and teamwork, these being the topics where inter-professional aims were most common.

The subject matter of those initiatives in the degree/diploma course category included: management issues, ethics, health education, counselling, social studies, social research, philosophy and public health.

5.6 Scale

Respondents were asked to indicate the number of people taking part in each initiative by selecting one of four options. The results are shown in Table 15.

No. of participants	No. of initiatives
Less than 10	35 (5%)
10 - 19	222 (32%)
20 - 50	249 (36%)
More than 50	142 (20%)

Table 15: Scale of IPE initiatives

From this it is evident that the greatest number of initiatives had 20 to 50 participants, though in almost as many cases between 10 and 19 people took part. In comparison, very few activities involved small groups i.e. less than 10 people, though in relation to topic, more than the average number of initiatives with multiple subjects came into this category. Activities on education and training, management issues and childbirth were more frequently run on a smaller scale: 58 per cent, 71 per cent and 52 per cent, respectively, had 10 - 19 participants. Conversely, initiatives focussing on certain other topics tended to be larger: 73 per cent of child abuse courses and 75 per cent of those on teamwork and roles had 20 participants or more, as compared to an overall average of 56 per cent.

In relation to educational context, the percentage of initiatives in each size category differs from that shown in Table 15. In particular, activities arranged as part of either initial professional training or post-qualifying/vocational training were more frequently run on a larger scale. In each case, over 80 per cent of initiatives involved 20 people or more. Correspondingly few activities involved 19 participants or less. Undergraduate courses also tended to be larger, with 70 per cent having 20 participants or more. The degree/diploma

courses always had 10 or more participants, though in only one case did more than 50 people take part. The distribution within continuing education courses reflects that shown in Table 15.

5.7 Educational Methods

The various educational methods used in IPE and the incidence of their use are shown in Table 16.

Method used	No. of initiatives
Group work/discussion	597 (86%)
Formal input (e.g. lecture or video)	505 (73%)
Experiential methods (roleplay etc.)	97 (14%)
Individual study/project work	30 (4%)
Visits (domiciliary or to agencies)	13 (2%)
Exhibitions	7 (1%)
Presentations/demonstrations	6 (1%)
Tutorials	5 (1%)
Other	8 (1%)

Table 16: Educational methods used in IPE

Most activities involved atleast two methods. Of those with inter-professional aims, however, 26 (7 per cent) used formal methods only. This invites the question of how effective this method alone can be in promoting teamwork and developing understanding between professions. It could be argued that these objectives can only be achieved where interaction between the various professional groups takes place in the learning situation, whether this be through discussion, group work or specifically experiential methods.

In considering method in the context of scale, it is evident that experiential methods were used in a higher than average percentage of activities involving 10 - 19 participants. But of those initiatives involving less than 10 people, only 9 per cent employed this type of learning. A slightly higher than average percentage of the larger activities i.e. those with over 50 participants, involved the use of formal methods, with a correspondingly lower proportion including group work and discussion. Other than this, the incidence of each method did not vary considerably across the various educational contexts.

5.8 Duration

The amount of time each IPE initiative lasted is indicated in Table 17. The categories relate to the number of hours spent in shared learning. So where a single initiative consisted of a number of separate but related sessions taking place over a period of weeks or months, the duration was calculated as the number of days or weeks equivalent to the total hours involved.

Duration	No. of initiatives
1 day (6 hours) or less	369 (53%)
2 - 4 days	195 (28%)
1 week (5 days)	38 (6%)
6 - 19 days	50 (7%)
4 weeks (20 days) or more *	32 (5%)

[* Of those initiatives in this category, 22 lasted between 4 and 8 weeks; 10 lasted 12 weeks or more.]

Table 17: Duration of IPE activities

The figures demonstrate that a significant majority (81 per cent) of initiatives were short i.e. lasting four days or less. In turn, a majority of these lasted only one day or less. In terms of educational context, 80 per cent of undergraduate initiatives lasted one day or less and, as would be expected, all the degree/diploma courses lasted more than four weeks. Those taking place in the context of initial professional training were almost invariably short: 94 per cent lasted four days or less. In the post-qualifying/vocational training group, all those initiatives lasting four weeks or more were common core modules forming part of District Nurse and Health Visiting Certificate courses. Continuing education initiatives corresponded to the percentages shown in the table above. Of these, the initiatives lasting four weeks or more were largely English National Board/Welsh National Board courses organised by schools of nursing (63 per cent), and Fieldwork/Practical Work Teacher courses for qualified health visitors and district nurses, run by colleges (32 per cent).

As far as participants are concerned, GPs mostly attended shorter initiatives: 92 per cent of those attended by them lasted four days or less. Social workers tended to favour shorter initiatives, though not to quite the same extent: 88 per cent lasted four days or less. Participation by the other professional groups was consistent with the percentages given in Table 17 above.

The degree of use of particular educational methods varied from one category of duration to another. Experiential methods were used less in activities lasting one day or less (18 per cent), but proportionally more in those lasting 2 - 4 days and 6 - 19 days (53 per cent). Individual study and project work were more commonly used in longer activities: of the 30 cases in which these methods were used only 3 per cent lasted one day or less.

5.9 Frequency

Table 18 shows how often the reported IPE activities occurred.

Frequency	No. of initiatives
Once/one off	201 (29%)
Once a year	71 (10%)
2 - 5 times in specified period	60 (9%)
2 - 5 times a year	125 (18%)
More than 5 times in specified period	27 (4%)
More than 5 times a year	51 (7%)
Occasional	6 (1%)
One or more sessions as part of established course*	128 (18%)

Table 18: Frequency of IPE initiatives

The figures indicate that 375 initiatives (54 per cent) took place on a regular basis or as part of an established course. However, this particular result may not be altogether reliable because respondents were not specifically asked whether the initiative took place regularly, only how often it occurred. It is interesting to note that 75 per cent of initiatives not said to have taken place on a regular basis were, nonetheless, to be repeated or continued. Overall, 67 per cent of initiatives took place five times or less within the specified period; 39 per cent of all initiatives took place only once during this time.

Considering the frequency of activities in relation to the agency which organised them, those consisting of one or more sessions as part of an established course were mainly organised by colleges and universities, vocational training schemes and undergraduate medical schools. The majority of postgraduate

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[* Any course leading to either i) an approved qualification necessary for entry into a profession e.g. CQSW or ii) a higher degree or diploma e.g. MSc.]

medical initiatives (55 per cent) occurred on a once/one-off basis. Of those activities organised by voluntary agencies, 78 per cent took place five times or less and not on a regular basis; 65 per cent were run once only or once a year. Similarly, 60 per cent of initiatives run by education centres and professional bodies took place once only or once a year. Most activities organised by medical practices or health centres (55 per cent) took place more than five times a year, in other words regularly and frequently. More than the average proportion of initiatives run by social services departments, either alone or in cooperation with health authorities, occurred more than once.

5.10 Type of participation

Respondents were asked to indicate whether attendance at the IPE initiative was compulsory or optional for participants. In 481 (69 per cent) of activities, participation was optional for all participants; in 87 (13 per cent) attendance was compulsory for all groups, and in 85 cases (12 per cent) it was optional for some, but compulsory for others. However, less than the average proportion of initiatives involving GPs were compulsory (4 per cent only). The same applied in activities where community midwives took part.

In terms of educational context, only 5 per cent of continuing education activities were compulsory. In turn, more than the average proportion of initiatives organised as part of initial professional, post-qualifying/vocational or undergraduate training were compulsory: 39 per cent, 46 per cent and 40 per cent respectively.

5.11 Evaluation

In 72 per cent of initiatives, some form of evaluation had taken place or was proposed. Respondents were not asked to specify what form this took, or what criteria were applied. However, some volunteered information on the type of evaluation used. This ranged from informal discussion between participants to more systematic and detailed evaluation by both organisers and participants.

5.12 Continuation

In 86 per cent of cases respondents indicated that the IPE activity described would either probably or definitely be repeated or continued. Only 9 per cent stated categorically that it would not; the remaining 5 per cent did not specify either way. Again, reasons for the continuation or discontinuation of activities were not requested. But the response to this question could nonetheless be taken as a crude

indicator of the success or failure of individual initiatives, however this may be defined and measured. It has been suggested that organisers are reluctant to repeat activities which patently do not work, for whatever reason. However, it could also be argued that organisers will repeat activities, though in a modified form if they have not previously been successful.

5.13 Geographical distribution

All the initiatives reported in the survey where given a geographical classification according to the NHS region in which they took place. The distribution of activities is shown in Table 19.

Location of activity by NHS region	No. of initiatives
Northern	39 (6%)
Yorkshire	35 (5%)
Trent	46 (7%)
East Anglia	19 (3%)
North West Thames	59 (8%)
North East Thames	43 (6%)
South East Thames	37 (5%)
South West Thames	21 (3%)
Wessex	39 (6%)
Oxford	31 (5%)
South Western	73 (11%)
West Midlands	52 (8%)
Mersey	28 (4%)
North Western	67 (10%)
Wales	59 (9%)
Scotland	40 (6%)
More than one region	7 (1%)

Table 19: Geographical distribution of initiatives

Those regions organising the most initiatives were South Western, North Western, North West Thames, Wales and West Midlands. In all but one case (Wales), these were the regions to which the highest number of questionnaires were sent. Scotland, however, was a notable exception. Questionnaires were sent to more organisers here than in any other region, yet only 6 per cent of all reported activities took place in Scotland.

In terms of population size, only two of the five regions listed above (North Western and West Midlands) are amongst the six largest regions. A correlation is therefore apparent between the number of initiatives reported in each region and the number of questionnaires sent, though not between these figures and the regional population size.

The number of individual agencies organising IPE in each region is shown in Table 20. The figures relate to the region in which the initiative took place, although in some instances the organising agency was based elsewhere. Agencies running IPE in more than one region have been counted once for each region involved, so the total does not correspond to that in Table 11.

Location of activity by region	No. of agencies organising IPE
Northern	28
Yorkshire	24
Trent	24
East Anglia	17
North West Thames	42
North East Thames	32
South East Thames	24
South West Thames	19
Wessex	27
Oxford	26
South Western	45
West Midlands	36
Mersey	21
North Western	40
Wales	37
Scotland	37
More than one region	3

Table 20: Number of agencies organising IPE in each region

The pattern here is similar to that shown in Table 19. The regions organising the greatest number of initiatives are also those involving the most individual agencies. Interestingly, the figures indicate that there are a considerable number of active agencies in Scotland, although in relation to this, the number of initiatives taking place there is not especially high.

The degree of participation in IPE by each of the selected professions differs on a regional basis from that across the United Kingdom as a whole (see 5.1). GPs were more frequently involved in activities taking place in Northern and Wessex regions, though less often in South Western. Social workers took part in a greater than average proportion of initiatives in South West Thames, Wessex, Yorkshire, South East Thames and West Midlands, but again, less than average in South Western. District nurses participated more frequently in Trent, Oxford and Mersey regions, though in fewer than the average percentage of initiatives taking place in South East Thames and East Anglia. There was no marked regional variation in the level of involvement by health visitors. Community midwives, however, took part in a higher than average percentage of activities in Mersey and South Western, but in a lower proportion of those in South East Thames, West Midlands and Scotland. It should be noted, however, that in the pilot areas, which included South East Thames and Dumfries and Galloway, those recipients of the pilot questionnaire were not specifically asked about the participation of community midwives (see Appendix C, paragraph 7). This will, no doubt, have had some bearing on the final figures.

5.14 Summary of main findings

a) 695 examples of inter-professional education took place within the specified period, involving a total of 466 individual agencies.

b) The shared learning activities were distributed broadly across the United Kingdom, though in certain regions the number of initiatives was noticeably higher: South Western, North Western, North West Thames, Wales and West Midlands.

c) In the majority of initiatives only two or three of the selected professional groups participated; relatively few cases involved all five professions.

d) 96 per cent of all reported IPE activities involved district nurses and/or health visitors; almost half involved social workers. General practitioners and community midwives each took part in approximately one third of cases.

e) The most common combination of professions was district nursing and health visiting: one in every five initiatives involved these two groups only. However, in a further one in five cases these two professions were joined by either community midwives or social workers.

f) The majority of shared learning (83 per cent) took place in the context of continuing education for qualified practitioners. However, in over half these cases, the two most important objectives of the activity did not include the promotion of teamwork or the development of inter-professional understanding. The multidisciplinary element appears, therefore, to have been incidental.

g) 130 initiatives took place as part of training courses for students of the selected professions. In four out of five cases, these activities were designed specifically to develop inter-professional understanding and cooperation. This was reflected in the fact that 40 per cent of all the activities in this educational context focussed on the themes of teamwork and professional roles.

h) The three types of agency responsible for organising the most activities were schools of nursing and midwifery, colleges and universities, and health authorities. However, less than half of those

initiatives organised by schools of nursing and midwifery had primarily inter-professional objectives, and relatively few involved the non-nursing professions.

i) In 53 per cent of all reported initiatives the two most important objectives included the promotion of teamwork and/or the advancement of inter-professional understanding. However, a greater proportion of those activities involving GPs ranked these aims highest.

j) One in seven activities focussed on the topic of child abuse, and one in ten on professional roles and teamwork. Of the initiatives in these two categories, 76 per cent had specifically inter-professional aims. The other most popular subjects included general medical issues, care of the dying and bereavement, education and training and management topics.

k) Approximately one in three initiatives had between 20 and 50 participants, though in almost as many cases between 10 and 19 people took part. Activities organised as part of established courses for students of the selected professions tended to be larger, four out of five involving more than 20 participants.

l) The majority of initiatives (53 per cent) lasted one day or less. A further 28 per cent lasted between two and four days. GPs and social workers attended a proportionally greater number of short initiatives than did the nursing and related professions.

m) Two in every three shared learning initiatives occurred five times or less in the specified period. Two in five examples took place only once during this time.

n) 69 per cent of all IPE activities were optional for all participants, though the percentage was higher in those initiatives involving GPs.

o) Most shared learning activities (72 per cent) were evaluated in some way.

p) In 86 per cent of cases, respondents indicated that the IPE activity would be repeated or continued. Only 9 per cent stated categorically that it would not.

SECTION 6 - CONCLUSION

The CAIPE national survey has revealed an encouragingly high level of activity in the field of inter-professional education amongst primary health care professionals. This has certainly surpassed the expectations of both Council members and others involved with the research. But it is not only the extent of the activity which is encouraging. The diversity of the examples reported in the survey, in terms of participants, context, subject matter and format, demonstrates the scope which exists for developing new shared learning initiatives in other areas through the creation of an effective national network and the dissemination of information on good practice.

The study itself has already contributed to the formation of this network, by establishing contact with organisers throughout the United Kingdom. The high response rate to the survey and the considerable good will and enthusiasm expressed by many respondents indicates that the potential for further development is there, awaiting realisation. The information-base compiled as a result of the survey provides the means by which this process can now begin.

QUESTIONNAIRE USED IN MAIN SURVEY

☐☐☐☐

SURVEY TO ESTABLISH THE NATURE AND EXTENT OF INTERPROFESSIONAL EDUCATION IN PRIMARY HEALTH CARE IN MAINLAND UK

NOTES 1. In this survey, the term "interprofessional education" is understood to include only activities which:

a) Have education as their primary objective.
b) Involve two or more of the following professional groups working in or concerned with primary health care (i.e. organised health care activity taking place predominantly outside hospitals): GPs; health visitors; district nurses; community midwives; social workers.
c) Entail the professions in b) **learning together in a multidisciplinary context.**

2. Please tick the appropriate answer/s for each question unless otherwise specified.

PART A

1. Name.....

2. Position/title.....

3. Employer/agency (please give name, full address and your telephone number if we may phone you about any queries)

.....

.....

.....

4. From **June 1987 - May 1988 inclusive**, were you involved as organiser/teacher in any examples of interprofessional education (see Note 1.)?

Yes..... ☐
No..... ☐

5. If you know of any other examples of interprofessional education taking place locally during this period but not covered by Q4.,please give the name and address of the organiser.

.....

.....

.....

IF THE ANSWER TO Q4. WAS YES, PLEASE TURN OVER TO PART B.
(If not, there is no need to continue. But we would still value the information given so far, so please return the form in the prepaid envelope provided. Thank you for your help.)

PART B

Please give the information requested below for each example of interprofessional education in which you have been involved. Please use a separate sheet for each example, making extra copies if necessary.

If the shared learning activity took place more than once, please give details of only the last occasion it was run.

Office use only

1. Title What was the title of the shared learning activity? (If it was part of an established course, such as DN/HV Cert., please specify in brackets which one.)

   .....

2. Subject What was the main topic of the shared learning activity (if not evident from title)?

   .....

3. Objectives What were the main aims and objectives of the shared learning activity? (Please rank the aims listed below from 1 - 4 in order of importance.)

   To increase knowledge of the topic..... a
   To develop practical skills..... b
   To increase understanding of the roles/views of other professions..... c
   To promote teamwork/cooperation between professions.... d

4. Agency Which agency/organisation organised it? (please give name and full postal address)

   .....

   .....

   .....

5. Originators Which professional group(s) was/were involved in organising it?

   General practitioners..... a
   Social workers..... b
   District nurses..... c
   Health visitors..... d
   Community midwives..... e
   Other health professionals (please specify f

   ..... g
   Non health professionals (please specify).

   .....

6. Location Where did the shared learning activity take place? (please give full postal address)

.....

.....

.....

7. Frequency How often did the shared learning activity take place?

One off.....	☐	a
Once a year.....	☐	b
One or more sessions as part of established course..	☐	c
Other (please specify).....	☐	d

.....

8. Duration How long did it last in total? (if the activity was run on a sessional basis as part of an established course, please estimate the total time spent in shared learning during the entire course)

Less than 1 day.....	☐	a
1 day.....	☐	b
More than 1 day but less than 1 week.....	☐	c
1 week.....	☐	d
Other (please specify).....	☐	e

.....

9. Format What form(s) did the shared learning activity take?

Formal input (e.g.lecture/video).....	☐	a
Group activities (e.g.seminar/workshop/discussion)..	☐	b
Other (please specify).....	☐	c

.....

10. Scale How many people took part?

Less than 10.....	☐	a
10 - 19.....	☐	b
20 - 50.....	☐	c
More than 50 (please specify).....	☐	d

11. Participants Which professional groups took part?

General practitioners.....	☐	a
Social workers.....	☐	b
District nurses.....	☐	c
Health visitors.....	☐	d
Community midwives.....	☐	e
Other health professionals (please specify	☐	f
.....		
Non health professionals (please specify).	☐	g
.....		

12. Educational context Was the shared learning activity part of:

Undergraduate training?.....	☐	a
Initial professional training? (eg CQSW,RGN).....	☐	b
Post-qualifying/vocational training? (eg DN/HV Cert.	☐	c
In-service/continuing education?.....	☐	d
Other? (please specify).....	☐	e
.....		

13. Option Was it:

Optional for all professional groups?.....	☐	a
Compulsory for all professional groups?.....	☐	b
Optional for some, compulsory for others?.....	☐	c

14. Evaluation Was the activity evaluated in any way?

Yes.....	☐	a
No.....	☐	b

15. Continuation of course Is it intended to repeat or continue the shared learning activity?

Yes.....	☐	a
No.....	☐	b

Thank you very much for your help in completing the questionnaire. Please return the form in the prepaid envelope provided to the Institute of Community Studies, 18 Victoria Park Square, London E2 9PF.

APPENDIX B

ADDITIONAL ORGANISATIONS TO WHICH QUESTIONNAIRES WERE SENT

Age Concern England
British Association of Social Workers
British Paediatric Association
Centre for Health Services Management, Leicester Polytechnic
Continuing Education Group (NHS), Institute of Advanced Architectural Studies, University of York
Counsel and Care for the Elderly
Health Economics Research Unit, University of Aberdeen
Health Services Management Centre, Birmingham
Health Services Management Unit, University of Manchester
Health Visitors Association
Institute for Health Service Development and Management, University of Wales
Institute of Child Health, University of London
Institute of Health Studies, University of Hull
Institute of Health Services Management
Institute of Organisation and Social Studies, Brunel University
King's Fund College
National Association for Maternal and Child Welfare
National Institute for Social Work
NHS Training Authority
NHS Training and Studies Centre, Harrogate
Nuffield Institute for Health Services Studies, University of Leeds
Nuffield Provincial Hospitals Trust
Office of Health Economics
Royal College of General Practitioners
Royal College of Midwives
Royal College of Nursing of the UK
Royal College of Obstetricians and Gynaecologists
Scottish Health Visitors Association
York Health Economics Consortium

PILOT SURVEY

1. Purpose

In order to test the questionnaire design and proposed data collection methods, a pilot survey was conducted between March and May 1988. This is described in paragraphs 2 to 7 below.

2. Areas covered

The target areas for the pilot were selected at random: Trent Regional Health Authority, South East Thames Regional Health Authority and Dumfries and Galloway Health Board.

3. Questionnaire design

The pilot questionnaire (Appendix C.1) differed slightly in format and content from that eventually used for the main survey (Appendix A). The changes made to it following completion of the pilot study are described in paragraph 7 below.

4. Target groups

The groups to whom the questionnaire was sent were:

- Course organisers in schools of nursing
- Course organisers in district nursing) in colleges, universities & polytechnics
- Course organisers in health visiting) in colleges, universities & polytechnics
- Course organisers in social work) in colleges, universities & polytechnics
- Training officers in departments of social work
- Undergraduate deans of medical schools
- Regional advisers in general practice
- Course organisers in general practice

5. Mailings

These were carried out in March and April 1988 using the method subsequently adopted in the main survey, as described in Section 3.1 c) of the main report.

6. Response

Of 136 questionnaires sent out, 96 replies were received. In addition, there were six refusals. This gave a final response

rate of 71 per cent. The responses were sorted and the data from them processed, after which various modifications were made to improve the questionnaire. Detailed analysis of the data was deferred until after the main survey, when the results of both the pilot and the main survey were analysed together.

7. Modifications

The most significant changes arising from the pilot were:

a) The addition of community midwives to the selected professional groups.

b) The addition of directors of midwifery services and general practice tutors to the target groups receiving questionnaires. Individuals from these groups in the pilot areas were later sent questionnaires as part of the main survey.

c) Alterations to the questionnaire. A number of respondents suggested improvements to the wording of the questionnaire and the instructions for completing it; these were incorporated in the revised version. The other main changes to the pilot questionnaire were as follows:

Question No.	Amendment
A4	The timescale was amended to June 1987 - May 1988 inclusive, to cover a twelve month period exactly.
A5	Respondents were asked to give the name and address of the organisers of other initiatives, rather than giving details of the initiatives themselves.
B1	Where the subject of the activity was not apparent from the title, respondents were asked to specify this separately.
B3	"Nurses" was amended to "District nurses", to avoid confusion. "Community midwives" was added to the list of options.
B4	The open-ended question on objectives was substituted with a choice of four aims which respondents were asked to rank in order of priority.
B6	The "once a month" option was omitted.
B8	Examples of "group activities" were added for clarification.
B9	The number of options was reduced.

B10)) and)) B11)	*These two questions were amalgamated. Respondents were only asked to indicate which professional groups had actually taken part in the activity. In addition, changes were made as in B3.*
B12	*Examples of some of the options were added to avoid misunderstanding.*
B14	*Respondents were only asked to indicate whether or not evaluation had taken place.*

These changes were introduced mainly because respondents had misunderstood particular questions or had given poor quality answers. Some of the information received from respondents had proved difficult to process and so the relevant questions were subsequently amended. Minor changes were also made to the layout and question order, in order to improve the appearance and readability of the questionnaire. Unfortunately time limitations meant that the revised version of the questionnaire could not be retested prior to the main survey.

QUESTIONNAIRE USED IN PILOT SURVEY

Survey to establish the nature and extent of initiatives in interprofessional education in primary health care within mainland UK.

Explanatory notes:

1. For the purposes of this questionnaire, the term "interprofessional education" is understood to include only those activities which:

    a) Have education as their primary objective.
    b) Involve two or more of the following professional groups working in or concerned with primary health care (i.e. organised health care activity taking place predominantly outside hospitals*): GPs; health visitors; district nurses; social workers.
    c) Entail the professions in b) learning together in a multidisciplinary context.

2. **Please tick the appropriate answer/s for each question unless otherwise specified.**

[* We attribute this meaning as an operational definition, and recognise that it differs from that of the World Health Organisation.]

SECTION A

Office use only

1. Name.....

2. Position/title.....

3. Employer/agency (please give name, full address and your telephone number if we may phone you about any queries)

    .....

    .....

    .....

4. Between June 1987 and June 1988, were you involved, either as planner, organiser or teacher, in any interprofessional education initiative (as defined in Explanatory Note 1.) ?

    Yes..... ☐ a
    No..... ☐ b

5. Do you know of any other examples of interprofessional education taking place during this period but not covered by Q4. ?

    Yes..... ☐ a
    No..... ☐ b

If the answer to **both Q4. and Q5.** is "No", there is no need to continue. Please return the questionnaire in the prepaid envelope provided. Thank you for your help.

PLEASE GIVE THE INFORMATION REQUESTED IN SECTION B FOR EACH EXAMPLE OF INTERPROFESSIONAL EDUCATION:

A) IN WHICH YOU HAVE BEEN INVOLVED PERSONALLY OR
B) OF WHICH YOU ARE AWARE

IF THE COURSE HAS TAKEN PLACE MORE THAN ONCE, PLEASE GIVE DETAILS OF ONLY THE LAST OCCASION ON WHICH IT WAS RUN.

PLEASE USE A SEPARATE SHEET FOR EACH EXAMPLE, MAKING EXTRA COPIES IF NECESSARY.

Office use only

SECTION B

1. Title What was the name of the course?

   .....

2. Agency Which agency/organisation was responsible for organising it? (please give name and full postal address)

   .....

   .....

   .....

3. Origins Which professional group(s) was/were responsible for organising it?

   General practitioners..... [ ] a
   Social workers..... [ ] b
   Nurses..... [ ] c
   Health visitors..... [ ] d
   Other health professionals (please specify) [ ] e

   ..... [ ] f
   Non health professionals (please specify).

   .....

4. Objectives What were the main aims and objectives of the course? (please give brief summary)

   .....

   .....

   .....

5. Location Where did the course take place? (please give full postal address)

   .....

   .....

   .....

6. Frequency How often did the course take place?

One off	☐	a
Once a year	☐	b
Once a month	☐	c
Other (please specify)	☐	d
.....		

7. Duration How long did it last in total?

Less than one day	☐	a
One day	☐	b
More than one day but less than one week	☐	c
One week	☐	d
Other (please specify)	☐	e

8. Format What form(s) did the course take?

Formal input (e.g.lecture)	☐	a
Group activities	☐	b
Other (please specify)	☐	c
.....		

9. Scale For how many participants was the course designed?

Less than 10	☐	a
10 - 19	☐	b
20 - 29	☐	c
30 - 39	☐	d
40 - 49	☐	e
More than 50 (please specify)	☐	f

10. Participants For which professional groups was the course intended?

General practitioners	☐	a
Social workers	☐	b
Nurses	☐	c
Health visitors	☐	d
Other health professionals (please specify)	☐	e
.....		
Non health professionals (please specify)	☐	f
.....		

11. Balance of participation How many members of each professional group took part in the course? (please indicate approximate number in box)

General practitioners	☐	a
Social workers	☐	b
Nurses	☐	c
Health visitors	☐	d
Other health professionals	☐	e
Non health professionals	☐	f

12. Educational context Was the course part of:

Undergraduate training?.....	☐	a
Initial professional training?.....	☐	b
Post-qualifying / vocational training?....	☐	c
In-service / continuing education?.....	☐	d
Other? (please specify).....	☐	e

.....

13. Option Was the course:

Optional for all professional groups?.....	☐	a
Compulsory for all professional groups?...	☐	b
Optional for some, compulsory for others?.	☐	c

14. Method of evaluation How was the course evaluated?

Not evaluated.....	☐	a
Evaluation form/questionnaire.....	☐	b
Review meeting for organisers/teachers....	☐	c
Review meeting for organisers/teachers and participants.....	☐	d
Other (please specify).....	☐	e

.....

.....

15. Criteria for evaluation If evaluation took place, what criteria were used to measure the success of the course? (please give brief summary)

.....

.....

.....

.....

16. Continuation of course Is it intended to repeat or continue this course?

Yes.....	☐	a
No.....	☐	b

Thank you for your help in completing the questionnaire. Please return the form in the prepaid envelope provided to the Institute of Community Studies, 18, Victoria Park Square, London E2 9PF.

DATA PROCESSING PROBLEMS

1. Misreading/misinterpretation of questionnaire

As in most postal surveys, a proportion of respondents misunderstood or misread the explanatory notes in the questionnaire, giving inaccurate or incorrect data as a result. The most common of these were:

a) Providing details of initiatives which failed to meet all three of the specified criteria (see section 2.1 of main report). This arose most frequently where only one of the key professional groups had participated in a learning capacity. In addition, some activities were classed as non-valid because they fell outside the stipulated timescale. However, since the date of the activity was not actually requested, it was not necessarily evident when it had taken place. It was therefore assumed that the respondent had taken account of the time limitation unless a date outside it was specified.

b) Giving multiple answers for questions warranting only one response e.g Question 6 and Question 10. Where an activity had taken place more than once during the specified period, respondents had been asked to describe the last occasion only. Some had, however, described a number of different occasions on which the activity took place. Therefore in some cases it was necessary to compile a typical profile of the activity rather than entering details of one specific occasion on which it took place.

c) Confusion of Question 5 and Question 11. Certain respondents gave identical information for these two questions which suggests that, in some instances, the two may have been confused. The fact that some respondents had evidently completed Question 5 and subsequently altered it on reaching Question 11, supports this theory.

d) Misinterpretation of terms: e.g. "established course"; Clearer definitions might have prevented this problem.

2. Ambiguous or inconsistent data

This was particularly common where a respondent had given details of two or more initiatives on the same form. In this case, it was not always possible to tell which information related to which course. Certain respondents gave inconsistent answers when describing a single initiative. Poor handwriting was another source of difficulty. Where possible, deductions were made from the information provided, or from duplicate responses (see 5. below). Alternatively, where practicable, the respondent was contacted again for clarification.

3. *Omissions and partial responses*

In some instances not every question was answered. In addition, some respondents did not actually complete the questionnaire but sent information in another form e.g. a course programme. This frequently occurred with organisers running large numbers of initiatives who were not able to provide full details of all activities.

These cases were handled as in 2. above. Where it was not possible to obtain the missing data for one or more questions, a "not specified" response was entered on the computer record, or, where appropriate, the response was deduced from other details given.

4. *Collective responses*

Some respondents gave details of a number of activities as though they were a single initiative, e.g. a series of similar study days were described collectively. Using this particular example, another respondent might have described each study day separately. In the former case, the data would have been entered as one initiative; in the latter as several. In some cases, respondents described one initiative only, giving this as an example of various activities taking place locally.

The way in which iniatives were entered, i.e. collectively or individually, was, therefore, largely dependent on how the respondent had provided the information. However, where respondents had described separately a number of virtually identical examples, differing only in subject matter but involving exactly the same participants, these were entered as one initiative. For example, several different lecture series, each involving the same health visiting and district nursing students in a polytechnic, would be entered collectively. Again, if a particular initiative was repeated for different participants, this would only be entered as one example. So the total number of examples entered cannot be taken as a definitive figure. A more accurate indicator of IPE activity is the number of agencies engaged in organising initiatives.

5. *Duplicates*

In a number of cases, information on one particular initiative was provided independently by more than one respondent. Where this occurred, the responses concerned were matched up and marked as duplicates. The details of the initiative were then entered as one main record only, the serial numbers and personal details of the other respondent(s) being cross-referenced to this record. In most cases the information received from the various sources was not identical, so a profile of the initiative was drawn up as accurately as possible, based on all the available data.

DATA CLASSIFICATION AND ENTRY METHODS

1. Personal details

The name and title of the respondent and the address of the employing agency were entered as given, except where the address of the employing agency evidently differed from that of the respondent's working base, in which case the latter was entered. The respondent was also given a professional classification. This corresponded to the professional background of the person to whom the questionnaire had originally been sent, even though it may have been returned by someone else.

2. Title

The title was entered in full as stated by the respondent. Where the shared learning activity formed part of an established course*, an abbreviation of the name of that course was entered in brackets after the title. However, where the entire course consisted of shared learning, the name of the established course was entered as the title.

3. Subject

The subject given was classified according to a limited list and entered using the appropriate code. Where more than one subject was stated for a single initiative, each subject was entered, up to a maximum of four. Where a single initiative had covered more than four subjects, the classification "var" (various) was entered. Some subjects could reasonably have been classed under either of two categories (e.g. bereavement counselling under bereavement or counselling). Here, the category was selected which most accurately reflected the main theme of the activity.

4. Objectives

Respondents had been given four objectives and asked to mark them 1 - 4 in order of priority. Where this was done as requested, only the first two choices (i.e. those marked 1 and 2) were entered. If, however, the four options were rated equally, all four were entered.

5. Organising agency

Where stated, the full name and address of the organising agency was entered. Names of individuals were not included except in cases where they had organised the initiative in a personal capacity rather than on behalf of any agency or organisation. Where only one agency was named, but it was evident from responses to other questions that more than one was involved, the respondent was contacted again to obtain

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[* Any course leading to either i) an approved qualification necessary for entry into a profession e.g. CQSW or ii) a higher degree or diploma e.g. MSc.]

details of the other participating agencies. All names and addresses were then entered. Each agency was classified and the appropriate code entered.

6. *Organisers*

Organisers from the five key professional groups were coded according to their professional background, irrespective of whether they were educationalists, managers, practitioners or students. Any other organisers were classified and entered separately.

7. *Location*

The location of the activity was entered as fully as possible. This was then given a geographical classification, by NHS region, to enable mapping of initiatives and to facilitate subdivision of the final directory. Where the respondent gave a multiple answer for this question, indicating that the activity took place in more than one location, the term "various locations" was entered, followed by the name of the common town or county. This term was also used where the respondent had only given the name of the town and not a specific address.

8. *Frequency and duration*

The frequency was entered according to the number of times the activity had taken place during the specified timescale. If one of the given options had been selected, the appropriate code was entered; other responses were entered as stated, according to the number of days or weeks spent in shared learning. One day was taken to be 6 hours, one week as 5 days. Responses were rounded up or down to the nearest day. Initiatives lasting 20 days or more were rounded up or down to the nearest week. Where an activity consisted of a number of related sessions taking place over a period of time for the same participants e.g. a four day course taking place over four weeks, this was regarded as a single initiative, the duration being taken as the sum of all the sessions. Shared learning activities which took place as part of an established course were classified separately under frequency; the duration was then calculated as the total time spent in shared learning between the stated groups during the entire course. Where a range was given e.g. 2 - 3 times a year, the upper limit was entered.

9. *Methods*

The educational methods were entered according to the categories indicated on the questionnaire, under the appropriate code. Any other methods stated were entered under a separate classification and entered.

10. *Scale*

Respondents indicated the number of participants on the last occasion the activity took place by selecting one of four ranges. Where respondents gave a multiple response, further enquiries were made. In some instances it was necessary to

typical or average number rather than the number attending the most recent session.

11. Participants

Participants from the five key groups were entered under the appropriate code, irrespective of whether they were educationalists, managers, practitioners or students. Others were classified as appropriate. In certain cases collective terms were used by the respondent, e.g. nurse tutors, nurse managers, training officers. Here it was not possible to tell whether or not these referred to members of the five key groups; they were therefore entered separately as other professionals.

Rather than being classed into broad categories, other participants were entered in some detail. This was because the computerised record was intended primarily as a comprehensive profile of the activity for future reference, and only secondarily as a means of statistical analysis. Again, some respondents described more than one occasion or gave a typical breakdown of participants rather than describing the last occasion only. Here again, a typical profile was compiled from the information given. Where certain professions appeared to have taken part only on occasions, these were included, unless it was clear that they had not participated on the last occasion.

12. Educational context

The data was entered either under one of the given categories or under a separate classification. Activities taking place as part of an established course, such as Registered General Nursing courses, were entered consistently under the relevant category, in this case initial professional training, even though, in some cases, they also formed part of an undergraduate degree course e.g. Bachelor of Nursing. Where the category selected by the respondent was clearly inconsistent with the other answers, the classification was amended and the correct response entered where it was apparent.

13. Option

This was entered under the relevant code as either optional, compulsory or a combination of the two.

14. Evaluation

The relevant code was entered indicating whether or not the activity was evaluated. Where evaluation had not taken place but was proposed, or where the respondent thought that evaluation had probably or possibly taken place, a yes response was entered.

15. Continuation

The relevant yes or no code was entered, depending on whether or not the activity was to be continued or repeated. Again, responses stating "probably" or "possibly" were entered as yes.

APPENDIX F

BREAKDOWN OF RESPONSE RATE BY REGION

The level of response from each region was as shown below:

Trent	$\frac{69}{91}$	*(76%)*
South East Thames	$\frac{67}{91}$	*(74%)*
Northern	$\frac{62}{83}$	*(75%)*
Yorkshire	$\frac{66}{96}$	*(69%)*
East Anglia	$\frac{25}{49}$	*(51%)*
North West Thames	$\frac{82}{102}$	*(80%)*
North East Thames	$\frac{64}{94}$	*(68%)*
South West Thames	$\frac{60}{80}$	*(75%)*
Wessex	$\frac{55}{69}$	*(80%)*
Oxford	$\frac{49}{61}$	*(80%)*
South Western	$\frac{85}{102}$	*(83%)*
West Midlands	$\frac{89}{126}$	*(71%)*
Mersey	$\frac{39}{53}$	*(74%)*
North Western	$\frac{79}{99}$	*(80%)*
Wales	$\frac{64}{93}$	*(69%)*
Scotland	$\frac{123}{159}$	*(77%)*
Education centres and professional bodies	$\frac{27}{31}$	*(87%)*