H BARR

INTERPROFESSIONAL EDUCATION IN HEALTH AND SOCIAL CARE IN THE UNITED KINGDOM

REPORT OF A CAIPE SURVEY

By

Hugh Barr

and

Sarah Waterton

ABOUT CAIPE:

the UK Centre for the Advancement of Interprofessional Education.

CAIPE, the UK Centre for the Advancement of Interprofessional Education, seeks to promote high quality developments in the practice and research of interprofessional education and training in primary health and social care. This is in order to foster and improve user and carer focused collaborative care.

It was founded in 1987 and became a registered charity in 1991. It is an independent body with some 500 individual and organisational members, comprising advisers, educators, managers, practitioners and researchers from medicine, nursing, the professions allied to medicine, social work and related professions.

Through its members, CAIPE provides a network for discussion and information exchange by means of conferences and seminars, a bulletin and occasional papers. It also promotes research, represents members' views in national and international forums, and works closely with other bodies to promote and develop interprofessional education and practice.

For more information or to join please contact

CAIPE
344 Gray's Inn Road, London WC1X 8BP.

phone: 0171 278 1083
fax: 0171 278 6604

Published by

CAIPE

the UK Centre for the Advancement of
Interprofessional Education
344 Gray's Inn Road, London WC1X 8BP

First published April 1996

ISBN 09520830

CONTENTS

Lists of Tables and Figures 4

Foreword 5

Acknowledgements 6

Summary 7

Putting the Survey in Context 8

Introduction 9

Methodology 12

Findings from the First Questionnaire 16

Findings from the Second Questionnaire 26

Discussion 39

Some Questions for Future Investigation 42

References 43

APPENDICES

A. The Methodology Reviewed 44

B. Supplementary Tables a-e 47

C. CAIPE's Database 51

D1. Explanatory Notes

D2. First Questionnaire

D3. Second Questionnaire

LIST OF TABLES

1 Organisations instigating and running initiatives 20

2 Location of initiatives by country and for England by Health Authority region 23

3 Venues for initiatives 24

4 Means of assessment 34

5 Credits towards Qualifications and Awards 35

6 Content of evaluation 37

LIST OF FIGURES

1 Combinations of organisations jointly instigating and running initiatives 21

2 Length of initiatives 24

3 Year when initiatives were first held 25

4 Number of teachers/trainers per initiative 29

5 Number of initiatives including each Profession/Discipline amongst its Teachers/Trainers 30

6 Number of participants per initiative 30

7 Number of initiatives including each Professional Group amongst its Participants 31

SUPPLEMENTARY TABLES

(see Appendix B)

a First questionnaires sent and replies received 47

b Titles of initiatives 48

c Reasons for launching initiatives 48

d Number of participants from each profession 49

e Combination of participants by type of initiative 49

FOREWORD

By Dr John Horder, CBE

President of CAIPE and
Chairman of the Survey Steering Group

This paper reports on the first United Kingdom (UK) survey of interprofessional education for six years, the first since radical reforms in health, social care and education took effect, the first to cover community care as well as primary health care and the first to include Northern Ireland.

The survey sought to obtain an indication of the incidence and nature of interprofessional education initiatives in the UK. From the outset the steering group recognised that this was an ambitious task. Despite a low response rate to the first of the two questionnaires, there is much to be learned from the total response. The information obtained provides many pointers to the state of the art in interprofessional education, even though it is not possible to deduce its present scale from this survey or to make comparisons with CAIPE's earlier survey in 1988/89.

Many of the findings are encouraging. Initiatives involved almost every health and social care profession, during pre-qualifying and post-qualifying education, throughout all parts of the UK. Topics covered a wide range of contemporary health and social care issues, while many initiatives addressed the need for collaboration within and between professions and services. Many had also won the imprimatur of validating bodies, enabling participants to count their interprofessional learning towards qualifications in their respective fields. Nearly all had been evaluated. An encouragingly large number were being repeated and developed.

There is much that calls for closer study, including means to stimulate interactive learning, types of assessment and methods of evaluation. There is also much which teachers and trainers may learn from one another via the pages of this report.

Here then are findings which are full of implications for future developments, policy and planning, yet honest and realistic about the problems of investigation in this field.

April 1996

ACKNOWLEDGEMENTS

We are indebted to all who have helped in facilitating, designing and undertaking this survey: to the Department of Health for funding the work; to members of the Steering Group, Dr John Horder, Margaret Thwaites, Lonica Vanclay and Jenny Weinstein, for their support and comments; to CAIPE members who piloted the questionnaire; to Dr Ian Shaw for analysing the data, assisting in its interpretation and presentation, and for commenting on successive drafts; and to members of the CAIPE Executive Committee for comments on the final draft.

Especial thanks are, however, reserved for the respondents, without whose readiness to provide such a wealth of data this report could not have been written. Some were already closely associated with CAIPE; others have become so as a result of the survey. CAIPE looks forward to continuing collaboration with them in promoting and developing interprofessional education.

Hugh Barr

Sarah Waterton

April 1996

SUMMARY

This survey investigated interprofessional education and training in community-based health and social care throughout the UK. It was designed to:

- provide an up-to-date overview of interprofessional education and training
- facilitate networking
- provide a database accessible to CAIPE's members and interested others
- inform CAIPE's future policies and priorities
- enable CAIPE to target its services.

Two postal questionnaires were administered. The first was sent to managers, teachers and trainers in statutory and voluntary health and social care organisations and educational institutions, thought either to be running, or to know who would be running, initiatives in interprofessional education or training. The second was sent to respondents to the first questionnaire who reported initiatives that included two or more professions amongst their participants and that lasted two days or longer.

The first questionnaire requested basic information about initiatives plus the name and address of a contact person. 2,498 copies were sent out. A fifth were returned, reporting on 455 valid initiatives. For several reasons, given later (see Appendix A. The Methodology Reviewed) it was decided not to follow up the non-respondents. The second questionnaire sought more detailed information. Of the 231 copies of the second questionnaire sent out, 184 were returned (four fifths) reporting on 200 valid initiatives.

The majority of initiatives reported had started during the preceding three years. The most highly ranked reason for starting them was "meeting common learning needs across professions" followed by "responding to new/changing health/social problems". Topics ranged from audit to ethics, from collaboration to counselling, and from childbirth to palliative care.

Most were run by universities and colleges, followed by health and local authorities, but a tenth were run jointly between different organisations. They lasted from less than a day to 2 to 3 years part-time. Some were complete in themselves; others brought together participants for parts of uniprofessional courses, sometimes within modular systems.

The professional mix for participants and for teachers was similar, including education, management, medicine, nursing groups, professions allied to medicine, psychology, social work and numerous others. Some initiatives also included administrators, receptionists, voluntary workers, as well as service users and their carers.

Curriculum content emphasised learning common to the professions. Use of practice-based learning varied. Participants' learning was assessed in most cases and satisfactory completion counted towards qualifications. Most initiatives were validated, internally or externally. Most had also been evaluated, mainly in terms of process and participants' satisfaction, but few reports of evaluations had been published.

PUTTING THE SURVEY IN CONTEXT

Since the late sixties, numerous initiatives have been taken throughout the UK to enable practitioners, managers and educators from different health and social care professions to learn together. Some respond to needs held to be common across a number of professions. These include updating knowledge, eg work with the same group of service users, acquiring additional practice skills, eg in counselling, and preparation for teaching/training, research and management roles. Others create opportunities for the professions to learn from and about one another, enabling them to compare roles and responsibilities, powers and duties, and opportunities and constraints as means to cultivate mutual respect and collaboration, whether within the same team or through looser networks. These purposes are not mutually exclusive. They co-exist, more or less comfortably by design or by accident.

Initiatives are to be found in the workplace, in educational settings and elsewhere. They are commissioned and run by employing bodies, universities and colleges, validating bodies, professional associations, trade unions, voluntary organisations and pressure groups amongst others, either individually or in partnership.

Many contribute to continuing professional development and post-qualifying studies, fewer so far to pre-qualifying studies, although resistance to their development seems to be diminishing.

At one level, the drive towards interprofessional education springs from reforms in health and social care. Government policy statements, audit reports and official enquiries have called for closer collaboration within and between health and social care professions in community care, primary health care, health education, child protection, mental health and other fields.

Invariably, interprofessional education has been commended to promote collaboration (Barr, 1994; Leathard, 1994; Soothill, 1995; and Weinstein, 1994). As service needs and policy trends create greater pressure for interprofessional working, both managers and practitioners value it more highly and increasingly want to undertake shared learning. (Baker & Wilmer, 1995; Tope, 1994; Vanclay, 1995). At a more profound level, it can be seen to spring from the need to counter trends towards elitism, rivalry and inflexibility resulting from the process of professionalisation (Carrier and Kendall, 1995).

Interprofessional education also has to be understood within the context of wide-ranging reforms in education and training. These include the integration of specialist professional schools into the mainstream of higher education, the extension of modularisation to include professional education, the expansion of open learning, the devolution of training budgets, the application of the purchaser/provider split and, by no means least, the extension of Scottish and National Vocational Qualifications to include professional education. (Barr, 1994; Weinstein, 1994).

A bewildering array of terms describe initiatives, ranging from "joint training" to "shared learning" and from "multidisciplinary education" to "interprofessional education". All too often they are used interchangeably, less often with precise meanings which enjoy general currency. Consistent with CAIPE's title, interprofessional education is the preferred term throughout this report.

INTRODUCTION

An Earlier Survey

In 1987 CAIPE commissioned the Institute of Community Studies to establish the extent and nature of recent "initiatives" in interprofessional education in Great Britain which involved primary health care professionals. A postal questionnaire was sent to people likely to have organised or taught on such initiatives held during 1987/88 (Shakespeare et al. 1989).

An Interim Review

Pending an opportunity to mount another survey, CAIPE commissioned the School of Social Studies at the University of Nottingham to undertake a "Review of Shared Learning". This comprised interviews with people at the leading edge of developments to identify trends and issues (Barr, 1994), telephone surveys in two English counties (Shaw, 1995) and a critique of evaluations of initiatives reported in the UK literature (Barr and Shaw, 1995).

The interviews highlighted the impact of recent reforms not only in health and social care, but also in higher and vocational education. This seemed to account for a marked increase in the number of occasions when health and social care professions learned together. There were, however, competing agendas. While some initiatives seemed to have been launched to facilitate collaborative practice, others seemed to have been inspired by the need to rationalise education and training systems, to effect economies of scale and to ensure viability in cost-conscious times.

The telephone surveys provided an early warning of growing difficulties in picking out shared learning which aimed to improve collaboration. The problem was seen to lie in distinguishing between those occasions when professions simply learned side-by- side and those when they learned from and about one another, about their respective values, perceptions, roles and responsibilities.

The review of UK literature summarised 19 selected evaluations of interprofessional education. This prompted questions about the extent to which other initiatives had also been evaluated, the issues addressed and the methods employed, questions about which findings of the present survey shed light.

Findings from the review reinforced the need to undertake another survey and provided pointers for its design.

A New Survey

While the Review was in progress, CAIPE had made a successful application to the Department of Health "to repeat and extend the (earlier) survey to cover professionals working in both primary health and community care and, by comparative analysis, measure changes, innovations and developments in shared education". This second survey was to "include information about subject and

content of courses, participation levels, the nature of professional mix, the cost and professional time factors, purchasers of education, frequency and duration of courses, geographical distribution, educational methods and evaluation of outcomes". This time CAIPE decided to undertake the survey itself.

Funding available from the Department was, however, less than requested. In consequence, the researchers' time was reduced by more than half, ie three person days per week instead of the seven person days originally proposed (for one year). One of us (HB) was retained for one day per week and the other (SW) made available for two days per week (out of four for which she was employed by CAIPE). Cuts in the proposal were, however, kept to a minimum.

Within these constraints, plans began to take shape during the summer of 1994. A Steering Group was appointed, with which all decisions were taken regarding the form and scope of the survey.

Consistent with the agreed brief, methodology followed closely that for the previous survey (see Section 2). Comparable methods would, it was anticipated, produce comparable findings.

Purposes

CAIPE had five purposes in mind:

- to obtain an up-to-date overview of the incidence, aims, form, methods and content of interprofessional education throughout the UK, while monitoring changes since the earlier survey;
- to use the data obtained to facilitate networking and cooperation between initiatives in neighbouring areas and engaged in similar tasks;
- to establish an operational database accessible to its members and to interested others, including policy makers, managers, teachers, trainers, practitioners and researchers;
- to use those data to inform its own policies and priorities in promoting and developing interprofessional education;
- to assist in targeting its information, advisory and educational services.

While comparisons between the 1988/89 and the present survey were seen to be important, they were not seen to be over-riding. The survey would be repeated, not replicated in the strict sense of the term, although some of the same questions would be retained to provide bases for comparison.

A Definition

It was decided to collect data about education and training initiatives:

- where two or more health and/or social care professions learn together;
- during basic or continuing education and training;
- whether in the workplace, college or university, or elsewhere;

- whatever the duration;
- in any part of the United Kingdom;
- in respect of any service based in the community;
- without restriction in terms of types of service user;
- completed between 1 October 1993 and 30 September 1994.

Occasions when health and social care professions studied alongside one another seemed to be on the increase. While the focus for CAIPE was those which aimed to promote collaborative practice, it was interested in knowing about as many occasions as possible where professions studied together, from which it might be able to determine later which held the potential to be developed to promote collaboration. CAIPE would then be better placed to target information and formulate priorities.

Boundaries

Since 1989, CAIPE had extended its remit to take in community care, in addition to primary health care. While the earlier survey had covered community care (and other fields) only when primary health care professions participated, it now seemed appropriate to include it in its own right, alongside primary health care. Indeed, merit was seen in including as many initiatives as could be found where health and/or social care professions learned together for whatever purpose in community-based (but not institutionally-based) services.

The earlier survey (Shakespeare et al. 1989) had covered initiatives which included one or more of five professions known to be either working in or otherwise involved with primary health care, namely community midwives, district nurses, general practitioners, health visitors and social workers. To have stuck with these would have been incompatible with the decision to treat health and community care evenly. It would have also excluded many professions known to be included in current initiatives. It was therefore decided to include all health and social care professions, without listing them, for fear of inadvertent omissions.

Finally, all concerned were keen to include Northern Ireland which forms part of CAIPE's UK remit, not least because its Health and Social Services Boards provided a unique opportunity to see how initiatives had been developed in relation to their unified structure.

The resource implications of these decisions were acknowledged at every stage, recognising that little would be held in reserve for contingencies.

Preliminary Consultations

During the preparatory stages of the survey, CAIPE was in consultation, amongst others, with the National Health Service Executive, the Social Services Inspectorate, the Association of Directors of Social Service (which gave its formal endorsement), and the Central Council for Education and Training in Social Work.

METHODOLOGY

Postal Questionnaires

A single questionnaire was devised in the first instance. This was derived from the one used for the 1988/89 survey, but included many additional questions. It therefore needed to be piloted. Accordingly, the draft was sent to 29 CAIPE members asking them to fill it in for an initiative which they had run or in which they had participated.

Sixteen copies were returned completed. Other comments took the form of letters. The consistent criticism was that the questionnaire took too long to fill in and that this would be off- putting for potential respondents. It was therefore decided to reduce the overall number of questions and to divide the collection of data into two phases using separate questionnaires.

The first questionnaire was sent to the following groups throughout the UK between November 1994 and January 1995:

Health Service Trainers

Facilitators in Primary Health Care
Trainers in Community-based Trusts

Joint Appointments

Joint Trainers for Health and Social Services
Tutors of Joint Practice Teaching
Initiatives for Nursing, Occupational Therapy and Social Work

Medicine

Undergraduate Medical School Deans
Postgraduate Medical School Deans
General Practice – Regional Advisers
General Practice Tutors
General Practice – Course Organisers

Nursing Groups

Directors of Nurse Education
Directors of Courses in District Nursing and Health Visiting
Directors, Tutors and Teachers in Midwifery Education

Professions Allied to Medicine

Course Organisers

Social Work

Tutors of Qualifying Courses
Post Qualifying Coordinators
Training Officers in Social Services/Social Work Departments

Voluntary Sector

Members of the Training Network of the National Council of Voluntary Child Care Organisations

Other

Trainers for Community Care
Contacts provided by Respondents to the Pilot Questionnaire
Teachers in Membership of CAIPE

As a further means to identify initiatives, a proforma was interleaved in the November 1994 mailing of the CAIPE Bulletin and the Journal of Interprofessional Care, asking readers to draw attention to initiatives.

Information volunteered, with additional names suggested by respondents to the questionnaire, provided more than a hundred further people to whom questionnaires were sent. Copies went out in January to contacts who had been notified in time to be included in the survey. Contacts suggested too late for inclusion in the survey have been followed up subsequently so that information about their initiatives can be included in CAIPE's operational database.

A covering letter asked respondents to complete a questionnaire for each initiative which they had run during the year under review. In some instances, this entailed a considerable amount of work. The first questionnaire asked for the title of the initiative, its place in basic or post-qualifying education, organisations which instigated and ran it, location, duration, when first run and professions included.

The follow-up questionnaire to the longer initiatives asked whether they constituted the whole or part of participants' learning, and for information about factors influencing the decision to launch them, the pattern of study, frequency, professionals represented as teachers and participants, content, learning methods, assessment, credit for awards, validation, evaluation and future plans.

Both questionnaires included a mix of closed and open-ended questions. Closed questions were preferred, wherever practicable, to simplify coding and analysis, and with a view to making comparisons with the previous survey. Open-ended questions were used, however, where earlier research provided few pointers to likely answers, and to avoid arbitrary restriction of responses.

Copies of the questionnaires and explanatory notes can be found in Appendix D.

Some Key Questions

The choice of questions was informed by developments in education and practice since the 1988/89 survey, including outcomes from the Review of Shared Learning (Barr, 1994; Barr and Shaw, 1995; and Shaw, 1995) and from a survey of interprofessional masters courses (Storrie, 1992).

Some of the key issues in the first questionnaire were:

- implications of the purchaser/provider split for interprofessional education (questions 3 and 4);
- partnership in purchasing/providing interprofessional education (questions 3 and 4);

Some of the key issues in the second questionnaire were:

- competing arguments for launching interprofessional education (question 4);
- mixing and matching teachers and participants (questions 8, 9, 10 and 11);

- addressing commonalities and differences between professions (question 12);
- use of didactic teaching or interactive learning methods (question 13);
- means of assessing individual and group learning (question 15);
- crediting interprofessional education towards qualifications (question 16) ;
- validation of interprofessional education (questions 17 and 18);
- bases for evaluation (question 21).

Response rates

- **to the first questionnaire**

Of 2,498 copies of the first questionnaires sent out, a quarter were returned. Of these, 188 were returned blank. A further 53 reported initiatives included only one profession, and one was a duplicate. This left 251 valid responses, reporting on 316 initiatives in separate questionnaires, with a further 139 reported on the same questionnaires. This added up to 455 initiatives. A breakdown of respondents by category is given in Table a, Appendix B (page 47).

Some respondents sent prospectuses, either for the initiative reported in the questionnaire or for others. Some also sent annual calendars listing numerous initiatives. It would have been neither reasonable nor practical to ask respondents to complete additional questionnaires for each of these initiatives. Nor, on the basis of the information provided, could the researchers always be certain that the initiatives would have met their criteria for inclusion in the survey. Nevertheless, it became increasingly clear that respondents were responsible for substantially more initiatives (ranging from day workshops to masters courses) than they had recorded on their questionnaires. This indicates that the survey's findings substantially understate the actual incidence of interprofessional education, without making any allowance for returns which non-respondents might have made.

Lack of time and funds precluded sending written reminders and telephone calls as originally envisaged. The steering group was advised that even with reminders, the response rate might not increase significantly and decided to concentrate on seeking more detailed information about reported initiatives. Possible explanations for the limited response are discussed as part of the review of methodology in Appendix A.

- **to the second questionnaire**

A copy of the second questionnaire was sent to each of the respondents to the first questionnaire who had indicated that his or her initiative had lasted two days or longer (having first checked that they had indeed included two or more professions).

An extra copy was sent with a reminder letter to all those who did not respond by the deadline. These were followed up by phone calls to those who still had not replied. 184 replies were received in total which provided information about 200 interprofessional initiatives. The second questionnaire therefore achieved an 80% response rate.

Analysis and Interpretation

Although respondents had been asked to complete a separate questionnaire for each initiative, information provided took a variety of forms. Course brochures and letters were sent as well as single questionnaires filled in for two or more initiatives. This made analysis difficult.

Data from the multiple replies supplied on a single questionnaire were analyzed where possible. While the brochures and letters could not be analyzed as part of the survey, they have proved to be invaluable in compiling CAIPE's database (see Appendix C, Page 51). Furthermore, information about initiatives in the planning stage (which therefore fell outside the period covered by the survey) has been followed up for inclusion in that database.

The process of analysis included the coding of open-ended questions by the researchers. Responses were grouped into categories for each question following intensive scrutiny of replies. Data entry and computer analysis were then undertaken for CAIPE by Dr Ian Shaw in the School of Social Studies at the University of Nottingham. He used the Statistical Package for the Social Sciences (SPSS), which is a comprehensive and integrated system for entering, managing, analysing and displaying data.

Within the constraints of the budget, a limited number of cross tabulations were tested. They included an attempt to find correlations between reasons for launching initiatives, curriculum content, learning methods and types of evaluation. None reached a statistical level of significance. In view of this, they have been excluded from this report.

Interpretation of findings was a collaborative effort between the researchers and Ian Shaw. The findings from those initiatives reported in questionnaires completed and returned to us are now outlined.

FINDINGS FROM THE FIRST QUESTIONNAIRE

Titles and Topics

Initiatives covered a wide range of topics, which defied easy classification. Reference was made to patients or clients by life stage, or by care appropriate at that stage (childbirth, paediatrics and midwifery, children, elderly, terminal illness, palliative care), to chronic illnesses (asthma; epilepsy; diabetes; multiple sclerosis), to community care, to collaboration, to health education and promotion (including sexuality; HIV; women), to disabilities (learning; physical; sensory), to mental health, to research, to health, community or welfare studies, to counselling, to management (including audit; information systems), to education and training (general and continuing), and to ethics. Frequencies are grouped under these headings in Table b, Appendix B (see page 48).

A selection of the initiatives, giving both titles and participating professions, are listed below in order to give a flavour of the range reported.

Short initiatives that lasted less than two days

Titles and topics of initiatives under two days included the following:

- disability awareness workshops for occupational therapists and social workers;
- child protection seminars for health visitors, teachers, social workers; and police;
- outdoor education for the mentally handicapped for social workers, teachers and community nurses;
- epilepsy and asthma for social workers, nurses and teachers;
- clinical exercises for medical and pharmacy students;
- cardiopulmonary resuscitation for nurses, medics and paramedics;
- impact on young children of maternal postnatal depression for GPs, health visitors, school nurses, psychologists and social workers;
- collaborative community care planning for nurses, GPs, social workers and the voluntary sector;
- achieving positive health in old age for nutritionists, nurses and GPs;
- patient communication and basic counselling for nurses, GPs, paramedics, social workers, clergy and the voluntary sector;
- managing depression in primary care for GPs, nurses and counsellors;
- joint study days for GP trainees and midwifery students and for social work and nursing students;
- managing change, team development and team building for GPs, nurses; receptionists and practice managers

- HIV/Aids study days for social workers, GPs, nurses, youth workers and occupational therapists;
- managing aggression for dentists, doctors, pharmacists, nurses, practice managers and optometrists;
- changing childbirth for midwives and GPs;
- care of the elderly for GPs, hospital doctors, occupational therapists and nurses;
- use of statistics for clergy, solicitors, GPs, surgeons and nurses;
- black mental health issues for community nurses and social workers;
- multidisciplinary study day for tutors of general practice, social work and nursing students;
- weekly lunchtime clinical meetings for practice staff including GPs, counsellor, acupuncturist and osteopath.

Initiatives that lasted over two days

Professional Development

Of the two hundred reported initiatives lasting over two days, just over half comprised a continuing professional development. One third of these carried credit towards a qualification (which was sometimes PGEA – the postgraduate education allowance for doctors). While almost half of those concerned with primary care and mental health carried some credit towards a qualification, few did so in community care or child protection.

Just under a third of the reported initiatives in continuing professional development were concerned with team development in primary health care, team building and management and a similar number were concerned with specific primary health care topics such as communication skills, HIV/Aids, asthma, diabetes and cancer. Just under a fifth were concerned with community care, including topics such as joint foundation, needs led assessment, community care in context, planning and managing community care. The remainder were concerned with child and family services and mental health and learning disability. One example dealt with palliative care, one with bereavement and one with research and evaluation skills.

Interprofessional Degrees

Almost one sixth of the 200 reported initiatives over two days long were interprofessional degrees. Two initiatives provided a joint qualification (a nursing and a social work qualification for working in learning disability). Four were undergraduate/top up degrees (BSc Health Studies and BA Hons Social and Professional Studies being two examples) while the remainder were postgraduate degrees.

Some examples of the titles of the postgraduate interprofessional degrees were:

- MSc Health Professional Education;
- MSc in Interprofessional Studies;
- MA in Health and Social Policy;

- Masters Primary and Community Care;
- PGDiploma/MA in Collaborative Community Care;
- MA Ed. Health Education and Promotion;
- Diploma/MA in Child Protection;
- Diploma in Family Therapy/ Certificate in Family Counselling;
- MSc/PGDiploma in the Care of Elderly People.

Interprofessional Modules

One fifth of the 200 reported initiatives were interprofessional modules which comprised part of an undergraduate degree.

Those counting towards undergraduate degrees included:

- health promotion, child protection and communications skills shared by nursing and medical students;
- community studies shared by community nursing and social work students;
- foundations of health and problem based learning shared by nursing, radiography and occupational therapy students;
- aspects of anatomy and physiology shared by orthoptics, speech therapy and dentistry students;
- multidisciplinary induction for radiography, physiotherapy and midwifery students;
- common foundation and core subjects shared by students of the different nursing specialisms;
- mental health and professional practice and partnership with users shared by social work and occupational therapy students;
- multidisciplinary foundations and healthcare studies shared by dietetics, speech therapy, podiatry and occupational therapy students;
- study skills shared by nursing and radiography students;
- basic counselling skills shared by nursing, management, education students and students of the professions allied to medicine;
- health care ethics shared by nursing, midwifery and medical students;
- helping professions workshops for GP and health visitor trainees and social work students;
- interprofessional issues for nurses and social workers;
- working collaboratively in the community for social work and education students.

Just two counted towards a postgraduate degree: organisational cultures and teams shared between nursing, physiotherapy, dietetics, speech therapy and radiography students; and working with mixed parentage children and families shared by health visitors and social workers.

Practice Supervision

Fourteen of the 200 reported initiatives were concerned with practice supervision. These included joint practice teaching for nursing, social work and occupational therapy clinical placement supervisors; introduction to practice teaching for physiotherapy, occupational therapy, dietetics and radiography supervisors; medical mentors workshops for GPs, community nurses and practice nurses; trends in medical education for GPs, surgeons, radiographers and pharmacologists and training the trainers workshops for GPs, consultants and practice managers.

Pre-qualifying and post-qualifying studies

Of the 447 initiatives for which information to this question was provided, three quarters comprised post-qualifying studies or continuing professional development and far fewer, an eighth, provided basic professional education and training. Modular initiatives were sometimes used at both pre-qualifying and post-qualifying stages.

Organisations instigating and running initiatives

It was thought helpful to see how the institution of the purchaser – provider split had affected the manner in which interprofessional education was "instigated" and "run". The initiatives reported were most often instigated by universities or colleges, or by health authorities, trusts or boards, very few by local authority social services departments (see Table 1).

Most initiatives seem to have been run either by the same organisation, or within the same category of organisation, as instigated them. Colleges, universities and voluntary organisations seem to have been commissioned by health authorities, and to a lesser extent local authorities, to run some initiatives in addition to those which they had instigated. More initiatives were jointly instigated than jointly run.

Table 1.

Organisations instigating and running initiatives

	Instigating Number	%	Running Number	%
Universities and Colleges *	154	33.8	186	40.9
Regional/District Health Authorities, Trusts and Boards **	146	32.1	126	27.7
Joint between any groups ***	66	14.5	49	10.8
Voluntary Bodies	29	6.4	34	7.5
Local Authority Social Services	21	4.6	19	4.2
Professional/Validating Bodies	14	3.1	12	2.6
Individual Tutors/Trainers	8	1.8	7	1.5
Practice team/workplace	7	1.5	6	1.3
Commercial/Private Bodies	2	.4	4	.9
Other Single Bodies	1	.2	3	.7
Not Known/No Information given	5	1.1	9	2.0
Totals	455	100	455	100

* Includes postgraduate medical centres.

** Includes Health Boards in Scotland, and Health and Social Services Boards in Northern Ireland. Also includes initiatives reported as being within the Vocational Training Scheme or comprising Continuing Medical Education, of which there were 13 and 12 respectively.

*** See Figure 1.

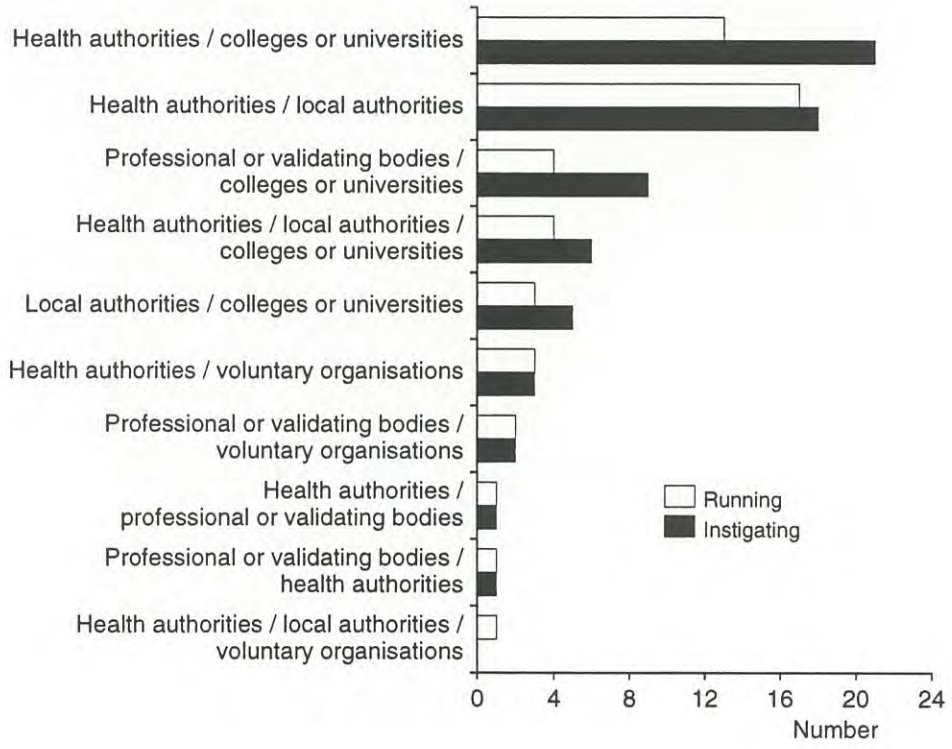
Instigating and Running Initiatives Jointly

Sixty six initiatives were instigated jointly by more than one type of organisation (see Figure 1). The most common combinations were health authorities with universities/ colleges or with local authority social services departments.

Not all of these were run jointly. Having instigated an initiative together, health and local authorities nearly always ran them together (with just one exception). On the other hand, when health authorities had jointly instigated courses with universities/ colleges, they were less involved in the running of them. Nevertheless, for the initiatives reported, a significant proportion of them (over half) still played a role in running the initiatives. Although a much smaller number are reported, a similar proportion of local authorities continued to help with the running of initiatives they helped plan.

Professional/validating bodies, having contributed to the planning for an initiative with a college or university, were less likely to be involved with the running of it.

Figure 1 Combinations of Organisations Jointly Instigating and Running Initiatives



NB. Health authorities includes boards and trusts.

The following is an example of a shared learning initiative jointly instigated by health authorities and local authorities. It is the first of a number of examples taken from the literature returned with the questionnaires and included in this section to help describe the range of initiatives and illustrate comments made.

The Inter-Agency Community Care Training Team comprised representatives from the District Health Authority, the Family Health Services Authority and the Social Services Department. It had been set up with a 21 months lifespan to promote and coordinate joint training to implement the NHS and Community Care Act. Members were accountable to senior managers in their respective authorities, who comprised the Steering Group.
Following internal consultations with trainers and operational managers in each authority, workshops and seminars were to be promoted to facilitate closer collaboration between hospitals, community health services and social services in implementing community care policies.
Short term aims included developing a network for information exchange, devising a holistic training strategy, and updating and reviewing that strategy, and preparing for the new assessment arrangements.
Long term aims included developing structures for inter- agency collaboration, identifying facilitators, co- ordinating developments, monitoring and evaluating impact and effectiveness of the Training Team, and identifying shortfall in training provision.
Particular attention was to be paid to discharge planning. One of the key philosophies of the Training Team was that by providing information and forums for people to exchange ideas, interprofessional barriers would be eroded and staff themselves empowered to provide a quality service for their consumers.

NB Since the time of collecting information for the survey, the initiative has developed and has been integrated into the social services staff development unit, which has a multi-agency steering group.

Regions and Countries

Table 2 gives the distribution of the initiatives between the four countries of the UK, with a breakdown for England by region. It shows that they were widely spread.

Table 2.
Location of Initiatives by Country and for England by Health Authority Region.

Country	Number	% of Total
Scotland	41	9.0
Wales	28	6.2
Northern Ireland	14	3.1
Breakdown for English Regions		
Northern and Yorkshire	73	16.0
North Thames	56	12.3
North West	58	12.7
South Thames	40	8.8
South and West	40	8.8
Anglia and Oxford	36	7.9
Trent	34	7.5
West Midlands	23	5.1
More than one country/region	9	2.0
Question not answered	3	0.6
Grand Total	455	100

Venues

Of the 455 valid initiatives, approximately the same number were in the place of employment (149) as in college or university (147) and a further 88 in hotels or conference centres (see Table 3). Many of the remaining 71 elsewhere were in post-graduate medical centres, others including: a magistrates court, sports and leisure centres, and community and neighbourhood centres. Convenience and circumstance seemed often to determine choice.

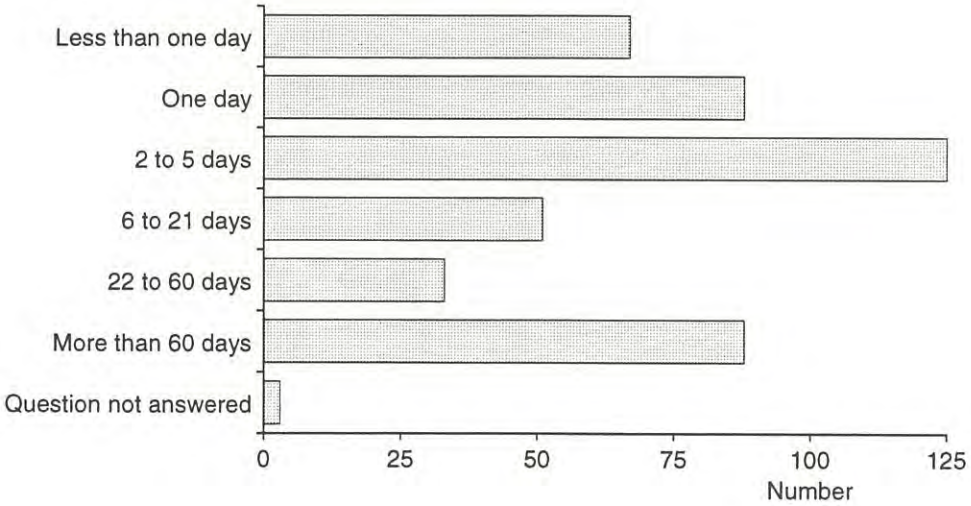
Table 3.
Venues for initiatives

Venue	Number	%
College or University (C/U)	147	32.3
Employer's Training Centre (ETC)	92	20.2
Hotel or Conference Centre	88	19.3
The Workplace	57	12.5
Both in C/U and in ETC	2	0.4
Other	65	14.3
Question not answered	4	0.9
Total	455	100

Length of Initiatives

A third of initiatives reported lasted less than two days. However, the modal length of initiatives was two to five days. Nearly one in five lasted 60 days or longer including some where this was spread over a period of two years.

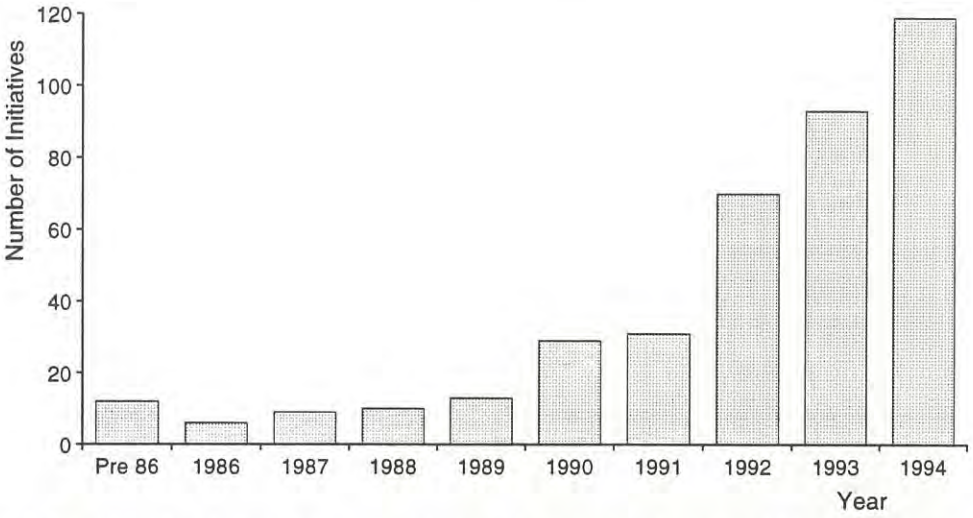
Figure 2 Length of Initiatives



When initiatives started

Most initiatives operational during the year under review (October 93 to September 94) were of recent origin (see Figure 3). Seven out of ten had started within the preceding three years.

Figure 3 Year when Initiatives were First Held



While some had simply been repeated, others had evolved in the light of experience and changing circumstances. The following example shows how an interprofessional education and collaborative research initiative evolved from a day release course and project work for separate professions.

At first the University ran courses on research methods for one or other of the helping professions. These comprised half a day per week over 12 weeks. Each participant was helped to devise a research plan on an issue arising from his or her practice. Support was provided in carrying out the research over the following 12 months. Some participants completed their projects, others not. Failure to complete was attributed variously to such reasons as the participant's position in the agency, staff shortages, and changing jobs to a setting where the research topic was no longer relevant nor enjoyed the support of management.

A structure was seen to be needed which avoided isolating participants from their agencies. The introductory course was abandoned. Instead of seeking to attract individual participants, discussions were held with managers about their current interests and concerns, from which research topics and potential researchers emerged.

Each project was in three phases: tapping the knowledge of practitioners; undertaking the research; and disseminating findings and utilising research. As projects developed, they became more than research and included elements of staff development and team building.

These developments encouraged University staff to reintroduce research courses for individual participants with substantial modifications. A two year programme was devised for managers and senior staff in health, social services and related fields who wanted to pursue their own research projects in the workplace. Senior managers were involved from the outset in defining the research topic and were invited to regular meetings during the programme to review progress.

Focus groups brought together participants engaged in the same task, often across professions, agencies and work settings. University staff were alive to possibilities for parallel projects in different agencies and for consortia to engage in "partnership research".

FINDINGS FROM THE SECOND QUESTIONNAIRE

The second questionnaire was sent to all respondents to the first who reported that their initiative had lasted two days or longer. Replies totalled 200, although not all questions were answered in each case. Hence, the number of valid replies varied for each question and was often less than 200.

Reasons for Launching Initiatives

Respondents were asked to rank ten statements from the most to the least influential in deciding to launch the initiative. The statements were derived from interviews during the earlier review of shared learning (Barr, 1994). Some referred to health and social care, others to higher and vocational education with the object of seeing which of the two sets of issues was the more influential in the opinion of respondents. Of the five health and social care statements, two referred to effecting change (implementing policies and dealing with problems), two to collaborative practice (coordinating services and promoting teamwork) and one to flexibility and transferability in the workforce. Of five educational statements, one referred to marketing and viability, one to commonalities of learning needs across professions, one to learning from and about other professions, one to widening the choice of available studies and one to implementing education policies.

Starting with the statements most often ranked top, the order was as follows:

1st	meeting common needs across professions;
2nd	responding to new/changing health/socialproblems;
3rd	enlarging markets/ensuring viable numbers;
equal 4th/5th	integrating and coordinating services to users and promoting teamwork;
6th	implementing health and social policies;
7th	implementing educational policies;
equal 8th/9th	widening choice of studies and creating a flexible/transferable workforce;
10th	learning from and about one another.

No clear patterns emerged regarding the relative influence of the health and social care statements compared with the education statements. Most striking was the bottom place occupied by "learning from and about one another". However, using an alternative analysis, based upon the frequency with which each statement appeared in the top five (See Table c, Appendix B), "learning from and about one another" occupied third place.

Few respondents wrote in other factors influencing the decision to launch the initiative. Amongst other factors given were promoting research thinking in the workplace and developing advanced practice.

Some respondents added comments. One said the initiative had been prompted by concern to bring together top managers to develop a "real understanding" of professionals and service users. A second emphasised responding to users' needs, not organisational needs or coordination.

Patterns of Study

Whole and Part

Of the 164 initiatives for which information was provided, nearly two thirds constituted the whole learning for the participants. The remainder comprised part of the learning shared between two or more discrete courses.

Block, Intermittent and Modular

Of the 189 initiatives for which information was provided, about a third comprised a single and discrete block of learning, a third included intermittent periods of shared learning spread over a period of time, and a third were provided as units of shared learning within a modular system.

Some respondents provided descriptions of their modules. A few initiatives reported included a sequence of modules for two or more professions over a period of time. The following example describes one such recently developed integrated approach.

The undergraduate courses for occupational therapy (OT) and physiotherapy offered in one university interlocked. Twelve modules (including some options) were completed in their entirety by both groups of students. Parts of a further seven modules were studied together, with other parts kept separate. The remaining ten modules were wholly separate, five for OTs and five for physiotherapists. By year three the optional modules offered were a mixture of profession specific and those studied together.

As the following outline shows, studies became more integrated as the three years progressed.

MODULES

Shared modules	Joint modules	PT or OT specific	
		OTs	Physiotherapists
Year One			
Biological science	Communication/ Frames of reference	Needs analysis/ Applied social sciences	Manual therapy
Behavioural science		Independent living	Electrotherapy
Teaching and learning		Creative activities	Human movement
Methods of inquiry		Work and leisure	Kinesiology/ Applied anatomy
Managing in the workplace			
Biomechanics			
Year Two			
Teaching and learning	Group work and ethics	Mental health	Respiratory
Methods of inquiry	Musculoskeletal		
Managing in the workplace	Community focus		
	Neurology		
	Lifestyle		
	Cardiovascular		
Year Three			
Optional modules			
Teaching and Learning			
Methods of inquiry			
Managing in the workplace			

NB. To date for the three third year optional modules a large number of students have chosen profession specific options.

Residential and Non-Residential

Of the 194 initiatives for which information was provided, four fifths were non-residential. One tenth were offered as residential and non-residential.

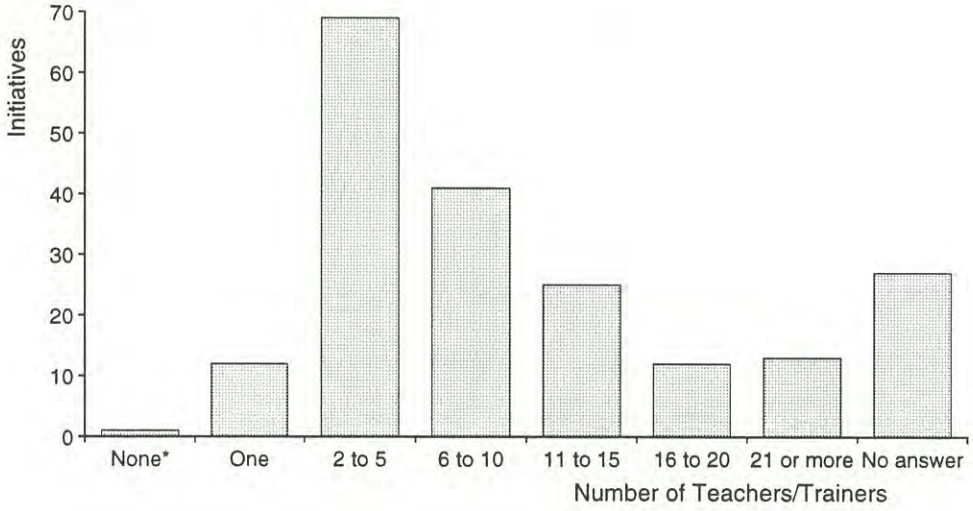
Times Run

Of the 180 initiatives for which information was provided, almost half had been run only once so far, a quarter had been run four or more times and the remainder had been run two or three times.

The Teachers

The number of teachers/trainers ranged from one to 60 (see Figure 4). At one extreme, brief and small-scale initiatives were reported which called upon help from a solo facilitator or tutor. At the other extreme, complex modular systems were reported to which many teachers contributed to greater or lesser degree.

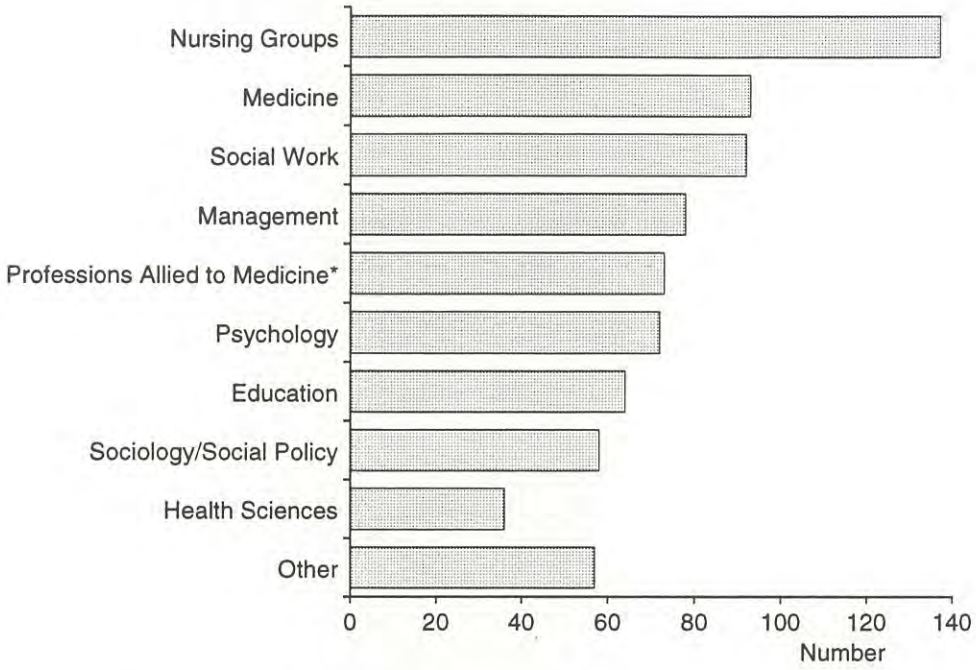
Figure 4 Number of Teachers/Trainers per Initiative



* self-directed group using open learning materials

The professions and disciplines of the teachers and trainers are given in Figure 5. Nursing was the most frequently represented profession amongst teachers. (137 initiatives out of 200 had nurse teachers). They were followed by medicine (with 93 initiatives out of 200 having teachers of medicine) and social work (with 92 initiatives out of 200 having social work teachers), with substantial numbers from management, professions allied to medicine, psychology, education, sociology/ social policy, and health sciences in that order. "Other" included dentistry, housing, law and research. In addition, one respondent mentioned involving users and their advocates, as well as voluntary sector workers.

Figure 5 Number of Initiatives including each Profession/Discipline amongst its Teachers/Trainers

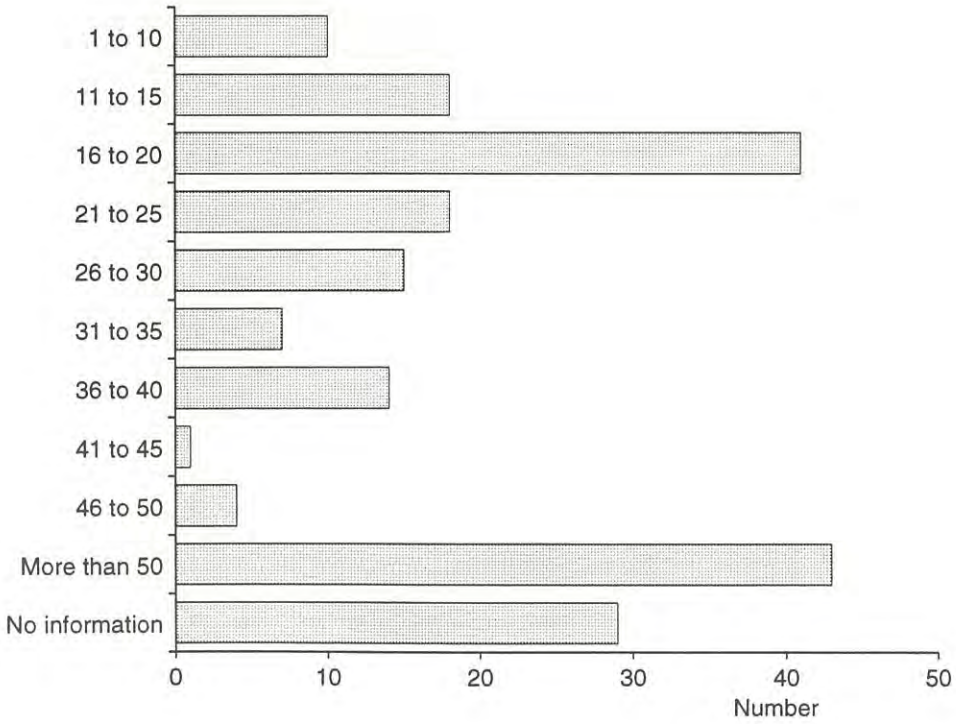


Medicine and nursing groups were included amongst the teachers in 41 initiatives. Medicine, nursing groups and social work were all involved as teachers in a further 34 initiatives. Nursing groups and social work were both included as teachers in 34 initiatives and two initiatives included medical and social work professionals as teachers.

The Participants

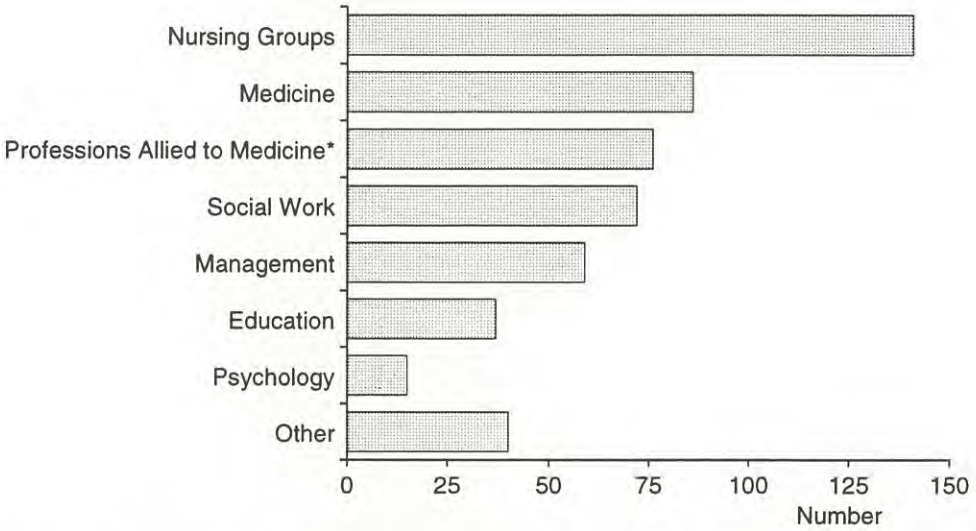
The total number of participants per initiative ranged from eight to over 50 (see Figure 6).

Figure 6 Number of Participants per Initiative



Nursing groups (e.g. community psychiatric nurses, district nurses, health visitors, mental handicap nurses and practice nurses) made up the largest category of participants, followed by medicine, professions allied to medicine, social work, management, education and psychology in that order (see Figure 7). "Other" included banking, counselling, clergy, dentistry, housing, police, reception, social security and voluntary sector, as well as service users.

Figure 7 Number of Initiatives including each Professional Group amongst its Participants



* Includes physiotherapy, occupational therapy, radiography, podiatry, chiropody etc.

Respondents were also asked to give the number of participants in their initiative from each profession. Some only ticked the box, in which case they have been recorded as having "some or one" in Table d (Appendix B, p 49).

Combinations of Participants

Between them, initiatives covered almost every conceivable health and social care profession (See breakdown in Appendix B, Table e, p 49). Some spread wider to include clergy, community educators, school teachers, police officers, counsellors and social security officers.

Comparing Professions of Teachers/Trainers and Participants

With the exception of nursing groups and professions allied to medicine, each profession was more likely to be included amongst teachers/trainers than amongst participants - markedly so for managers, educators and psychologists. The reverse was, however, also sometimes the case as the following example illustrates.

Organised by the University's Department of General Practice, the MSc in Primary Health and Community Care included community development workers, educators, health visitors, GPs, nursing groups, physiotherapists and social workers as participants. The teachers were health economists, health service managers and GPs.

Curriculum Content

Each respondent was asked to rate on a three-point scale the extent to which the content of the initiative provided a common value, knowledge and/or practice base. Of the 190 replying to the question, just over four fifths said "a lot". None said "not at all".

Each was also asked to rate the extent to which the initiative addressed differences in value, knowledge and/or practice bases. Of the 186 replying, just over half said "a lot". Only six said "not at all".

As the following example shows, the process by which curricula were devised is complex, taking into account contributions from many groups, including participants and service managers.

> *Given that Mental Health Support Workers were a newly created resource, there were no precedents upon which to call in designing the mental health certificate course for them. Information necessary to devise the curriculum resided in the practitioners themselves. A cross-section of workers and line managers from a range of agencies in the region worked to develop the initiative over a period of six months.*
>
> *The notion of competence was supported although the emerging NVQ system was found to be of limited value. An analysis of tasks could not capture a creative practice model. Instead, core characteristics of practice and what constitutes a competent worker were identified by studying it over time.*

Learning Methods

Each respondent was asked to rate on a three point scale the extent to which teaching was didactic. Of the 179 replying, just under two thirds said "a little" and slightly over one fifth said "a lot".

188 replied to the question about the extent to which the learning methods were interactive between the professions. Of these, just over four fifths said "a lot". Only one said "not at all".

The following example shows how learning materials can be augmented by interactive learning in tutorial groups for participants from different professions and agencies.

> *The study programme for health and social services managers included ten workbooks, each representing between two and three weeks of study. These workbooks included many exercises and activities. Some of these were used in tutorial groups, enabling participants from one or more type of agency to work through management problems in the company of one another.*
>
> *Participants were also referred to recommended reading and to audio and video tapes. The reading was of three sorts: a resource book on developing communication skills, essential and optional reading reproduced from other texts, and set books. Videos sequences provided case material, while audio-cassettes amplified topics introduced in the workbooks.*

Practice-Based Learning Methods

The same question asked respondents to rate the extent to which the initiative included practice-based learning. Of the 164 who replied, just over two fifths said "a lot", just under a third said "a little" and a quarter said "not at all".

The following example illustrates ways in which students from different professions drew on their practice.

Assignments during the masters and diploma programme in Health Information Management gave each student an opportunity to understand and illustrate principles of good practice by undertaking a case study in the workplace. Examples of such studies included:

* *helping to develop the information and IT strategy for a Combined Purchasing Consortium, by a District Information Manager;*
* *a study of information needs to implement the Patient's Charter, by a Nurse Manager;*
* *an analysis of the use of the CD-ROM database in the Medical School, by a Medical Librarian;*
* *developing a method for studying information needs of a specialty in an acute hospital, by a Resource Management Project Manager.*

Dissertations for students proceeding to the masters degree also reflected workplace needs, but in broader terms. Examples included:

* *devising an information strategy for a Mental Health Unit;*
* *identifying information needs of managers in support of the contracting process in an NHS Trust;*
* *providing nursing informatics training in the UK;*
* *using a geographical information system within an urban community health service NHS trust;*
* *applying Total Quality Management to information management in general practice.*

Assessment

In over half the 200 initiatives participants' learning was formally assessed (see Table 4).

Respondents were asked about the means of assessment. Many initiatives included a mix. Dissertations, theses, portfolios and assignments were most frequently reported, followed by essays.

Respondents were also asked whether assessment was for each student individually or in groups. Nearly all were individual. Group assessments were most likely to be oral presentations or assignments.

Table 4 also shows the relative use of individual and group assessment when that part of the question was answered.

The number replying differed for each part of the question.

Table 4.

Means of Assessment

Method	No. of respondents replying from 200	Individual Work	Group Work
Essays	64	61	3
Assignments	72	60	12
Dissertations/theses/ portfolios	49	44	5
Observed practice	44	39	5
Oral presentations	59	34	25
Examinations	33	32	1

An example of an initiative which included a mix of assessment methods follows.

A variety of assessment methods had been chosen for the BSc in Health and Community Studies, which provided an entry into health and social care.

Examinations were minimal. Assessment strategies reflected the emphasis of the course upon the acquisition of core skills and competencies. They included the use of written, oral and poster presentations, plus portfolios and profiling. Presentations were either individual or in groups. The value of a variety of assessments was seen to allow students to demonstrate the integration of knowledge, skill, attitudes and competence learned from their studies.

Credit

In just over half the initiatives, participants' learning carried credit towards qualifications or awards. Some initiatives carried credit towards more than one qualification or award (see Table 5).

Table 5

Credit towards qualifications and awards

Qualification/Award	Number of Initiatives
Higher National Certificate	1
National Vocational Qualifications	1
First degrees	31
Continuing professional development	10
Practice teaching awards	3
Post-Graduate Certificates/Diplomas	45
Masters degrees	23
Other	7

Professional fields in which these credits were awarded included counselling, district nursing, health visiting, management, medicine, occupational therapy, radiography and social work.

Some respondents drew attention to credit accumulation systems that enabled participants to progress from one qualification to another. An example of this follows.

> *The distance learning programme in medical education was open to participants from a range of professions. An "Introductory Trends Unit" raised awareness of key issues in medical education. The Certificate provided an overview of those issues. The Diploma provided further study of key issues. The Masters Degree provided in-depth study of one aspect of medical education.*
>
> *The programme comprised units of study, each carrying two credits towards the total of 40 required for the Certificate and 80 for the Diploma. A further 40 credits were required to gain the Masters Degree.*

Validation

Two thirds of the initiatives were validated or approved. In some cases this was undertaken locally or regionally, for example, by a college or university, or by a post-qualifying consortium, or towards the Post-Graduate Education Allowance for General Practitioners. In others validation or approval was by national bodies including:

- the City and Guilds Institute of London;
- the Central Council for Education and Training in Social Work;
- the (former) Council for National Academic Awards;

- the Institute of Health Services Management;
- the National Boards for Nursing, Midwifery and Health Visiting;
- the Open University
- the Royal College of Nursing.

Joint or parallel validation had sometimes been obtained, as in the following example.

Based in a Research Centre, the course in learning disabilities had been validated by both the English National Board (ENB) and Central Council for Education and Training in Social Work (CCETSW), and the Diploma had been recognised by the University. In consequence, successful students were eligible for the award of the ENB 705 certificate and could claim credits towards the CCETSW advanced award, as well as gaining the University's Diploma. The course also enjoyed the support of three neighbouring health authorities and the local College of Nursing.

Evaluation

Nearly all (nine tenths) of the respondents reported that their initiatives had been evaluated. In almost every case, organisers, teachers or trainers were involved, but nearly half also involved an independent person or organisation. Far fewer evaluations had been written up (just one quarter) and fewer still published.

Table 6 reports the areas covered by the evaluation. The number of respondents completing each part of the question is given.

Evaluation most frequently referred to participants' satisfaction, followed by the course process. However, over half of those replying (and over a third of all initiatives reported) said that they employed before and after measures of change in participants' attitudes or perception. Nearly as many took the views of people other than participants into account. 61 respondents reported that attempts had been made to evaluate observed impact on collaborative practice.

Table 6

Content of Evaluation

Aspect	Number replying	Yes	No
Participants' expressed benefits from/ satisfaction with the initiative	171	170	1
Planning, organising and/or running the initiative	163	154	9
Before and after measurements of change in participants' attitudes, perceptions or behaviour	142	78	64
Views of others about the merit of the initiative	130	74	56
Observed impact of learning on collaborative practice	133	61	72

Repeating Initiatives

Four fifths of the respondents said that there were plans to repeat the same initiative. Just over four fifths also said that other initiatives were being planned. Operationalising those plans would, however, be dependent upon organisational commitment being maintained following Health Service reorganisation, financial support continuing following changes in responsibilities for funding education and training, and participants being released by their employers.

Requirements for Further Developments

Many respondents answered the final question on the second questionaire which invited comments about the salient issues in interprofessional education. Most comments were on the need for shared learning to continue developing an increased understanding of the roles and responsibilities of different professions, while identifying and valuing the particular and separate contribution of each profession. Breaking down the myths, misunderstandings and inappropriate expectations between the professions were considered important aspects.

Organisational obstacles and profession specific systems were seen as significant barriers to developing interprofessional education. Respondents suggested that increased cooperation between statutory and professional bodies would facilitate developments. Funding and time for research and development were also needed.

Calls for the identification of common learning needs, knowledge and competency across professions and for greater user participation in and influence on interprofessional education were made in order to enhance collaboration, improve the quality of care and ensure coordination.

Problem based, interactive and experiential learning rather than shared lectures was advocated. So was making interprofessional education rather than sole profession or agency training the norm. Regular monitoring and evaluation were encouraged. It was suggested that introducing a training "ecu" between agencies would facilitate wider access to internal agency initiatives.

Suggestions for practical help and support included assistance with publishing reports and research; advice on appropriate timing and topics for shared learning; guidelines for frameworks; facilitating networking; regional initiatives and identifying key people to facilitate linking between professions.

Some respondents also noted the need for continued evaluation of interprofessional education and greater focus on the outcomes on practice of interprofessional education. Some sought guidance on methods.

The value of beginning interprofessional education early was mentioned, as was the need to make interprofessional education part of mainstream education and to support and develop the skills and confidence of the teachers and trainers providing interprofessional education.

DISCUSSION

The Purposes Revisited

The survey has provided an overview of the aims, form, methods and content of some of the interprofessional education taking place throughout the UK. It has gathered a considerable amount of interesting and illuminating information which provides some useful insights into the continuing development of interprofessional education.

The findings show that the pattern of interprofessional education seems to be becoming more complex, and the need to explore which forms of shared learning are most appropriate in which circumstances emerges from them. They provide a useful and rich starting point for more detailed investigation using a range of research methods into particular aspects of interprofessional education.

The data obtained are already proving invaluable in facilitating networking and cooperation between initiatives in neighbouring areas and in similar fields. The foundations have been laid for CAIPE's operational database, which is now being expanded and is already being accessed by its staff on behalf of members and interested others.

Not least, findings are being put to use to inform CAIPE's policies and priorities in promoting and developing interprofessional education, including the targeting of its information, advisory and educational services.

Estimating the Scale of Activity

The survey indicates the minimum number of interprofessional education initiatives that are being undertaken throughout the UK. 455 initiatives were reported, of which 200 were longer than two days. The wealth of supplementary material sent by respondents indicated that initiatives known to them substantially exceeded the number reported on the questionnaire, without making any allowance for non-respondents.

Unfortunately, given the response rate to the first questionnaire and the variety of forms in which information was provided, it was not possible to gauge what proportion of interprofessional education in the UK replies represented. Nor was it possible to indicate how representative the initiatives reported in this survey were.

Comparisons between the 1988/89 and the present survey would have provided, at best, crude indications of change in the location, form and incidence of interprofessional education, given the low response rate on this occasion.

Nevertheless, the data gathered provide important pointers.

Grounds for Encouragement

There is much in the findings to encourage people who are committed to the development of interprofessional education. Initiatives were identified in all parts of the UK. Commitment had been demonstrated across the spectrum of relevant bodies in education and practice, in health and social care, in statutory and voluntary sectors, and across the purchaser/provider split. Experience had been gained in jointly instigating and running initiatives, experience which bridged both health and social care, and education and practice.

Few contemporary issues in health and social care seemed to have escaped attention, while all the major professions were involved, and in almost every conceivable combination. Contrary to occasional criticism, the medical profession did take part and in substantial numbers, although usually in work-based learning relating to their own practices. Substantial participation by social workers held the promise to address issues of collaboration across the health and social care divide. Similarly, participation by managers held the promise to address issues across the managerial and professional divide.

Initiatives were more often than not assessed, enabling participants to claim credit towards academic and professional qualifications. They had also gained internal and external validation. Nearly all were said to have been evaluated. Interprofessional education had, it seemed, come in from the cold.

The number of reported initiatives which started since 1991 can be read as grounds for encouragement, but this does not necessarily represent an increase on previous years as other initiatives in earlier years may have been discontinued before the year under review.

Impressions gained from the present survey do, however, reflect those gained from the interviews undertaken for the Review of Shared Learning (Barr, 1994) and suggest that occasions when health and social care professions learn side- by-side have increased, and continue to increase. Information about initiatives that has come to the attention of CAIPE since the period covered by this survey also suggests that developments are continuing and new initiatives are planned.

Developments that reinforce these impressions include:

- the extension of modular systems into undergraduate and postgraduate professional education;
- the integration of studies across professions which may develop more easily as a number of different professional schools come into the same university;
- the creation of cross-disciplinary units within universities and colleges;
- the production of an increasing variety of open learning materials designed for a range of professions and their use in mixed professional groups;
- the preference of purchasers for education and training which responds to organisational rather than single profession needs;
- the inclusion of multiprofessional education as a priority for local consortia and Regional Education and Development Groups (NHS, 1995).

Although opportunities for health and social care professions to learn together seem to have been increasing steadily since the late eighties, the number aiming to promote collaborative practice and, to that end, facilitate participants' learning from and about one another, remains uncertain and is likely to be fewer. These are the ones which CAIPE most wants to locate in order to learn from their experience, to support their development and to encourage networking. CAIPE also has an interest in identifying those initiatives which hold the potential to promote collaborative practice so that it can advise and support them.

Common Principles

As the survey has shown, interprofessional education initiatives are wide ranging, varied, increasing and constantly evolving and developing. Nonetheless, they share common aspirations and principles (CAIPE, 1996). These principles can be summarised as follows. Effective interprofessional education:

- works to improve the quality of care
- focuses on the needs of service users and carers
- involves service users and carers
- promotes interprofessional collaboration
- encourages professions to learn with, from and about one another
- enhances practice within professions
- respects the integrity and contribution of each profession
- increases professional satisfaction.

SOME QUESTIONS FOR FUTURE INVESTIGATIONS

As this survey goes to print, a fresh wave of research into aspects of interprofessional education is getting under way, some supported by the Department of Health and some by the English National Board for Nursing, Midwifery and Health Visiting. In the light of the survey, questions on aspects of interprofessional education meriting investigation include the following.

Classification of Interprofessional Education

How can occasions when health and social care professions learn together be classified? Semantic problems would then need to be resolved.

Working jointly

What has been the experience of organisations jointly instigating and running initiatives? What have been the dividends? What have been the problems? How may they be avoided in the future?

Involving service Users

How have service users and their carers been involved, and to what effect?

Common and comparative curricula

How have curricula been constructed to meet participants' common, and comparative learning needs in relation to different levels/stages and lengths of initiatives?

Interactive learning methods

Which interactive learning methods have been chosen and why? Which have proved to be effective and how?

Practice-based learning

How have initiatives developed practice-based learning to include experience of collaborative practice?

Assessment

How has the assessment of participants' learning, including the assessment of group learning, been applied to collaborative practice? What criteria have been adopted and how have they been applied?

Validation

How have initiatives experienced internal and external validation? What lessons does this hold for planning initiatives, for validating bodies and for collaboration between them?

Evaluation

How have initiatives been evaluated, with particular reference to the relationship between purpose, content, process and outcomes, and their impact on professional practice and services from the perspective of users? What recommendations emerge for future approaches and methodologies?

Funding

What funding is available for interprofessional education and training, including joint funding?

REFERENCES

Baker, A. and Wilmer, M. (1995) Agenda for Change. London. Institute of Health Services Management

Barr, H. (1994) Perspectives on Shared Learning. London. CAIPE.

Barr, H. and Shaw, I. (1995) Shared Learning: Selected Examples from the Literature. London. CAIPE.

CAIPE (1996) Principles of Interprofessional Education. London. CAIPE.

Carrier, J. and Kendall, I. (1995) Professionalism and Interprofessionalism in Health and Community Care: Some Theoretical Issues. In: Owens, P. Carrier, J. and Horder, J. Interprofessional Issues in Community and Primary Health Care.
London. Macmillan.

Funnell, P. (1995) "Exploring the value of interprofessional shared learning" In Soothill, K. et al. op cit.

Leathard, A. (1994) Inter-Professional Developments in Britain: an Overview. In: Leathard, A. (ed) Going Inter- Professional: Working Together for Health and Welfare. London. Routledge.

NHSE (1995) EL (95)96 Non-Medical Education and Training. Planning Guidance for 1996/97 Education Commissioning.

Shakespeare, H, Tucker, W. and Northover, J. (1989) Report of a National Survey on Inter-Professional Education in Primary Health Care. London. CAIPE.

Shaw, I. (1995) Locally Based Shared Learning: Surveys in Two English Counties. London. CAIPE.

Soothill, K, Mackay, L and Webb, C. (1995) Interprofessional Relations in Health Care Edward Arnold

Storrie, J. (1992) Mastering Interprofessionalism – an Enquiry into the Development of Masters Programmes with an Interprofessional Focus. Journal of Interprofessional Care. Vol. 6 No. 3.

Tope, R. (1994) "Integrated Interdisciplinary Learning Between the Health and Social Care Professions: A Feasibility Study". A PhD Thesis available through InterLibrary Loan from the School of Education Library, UWCC, Cardiff.

Vanclay, L. (1995) Developing Postqualifying Multiprofessional Education in the South West: A Report for the Post Qualifying Consortia (CCETSW).CAIPE.

Weinstein, J. (1994) Sewing the Seams for a Seamless Service: A review of Developments in Interprofessional Education and Training. London. CCETSW.

APPENDIX A.

THE METHODOLOGY REVIEWED

There are lessons to be learned about the peculiar difficulties of investigating interprofessional education to ensure that future research is as efficient and effective as possible.

The Sample

With the intention of comparing findings with those from the 1988/89 survey, essentially the same groups of personnel were approached in this survey (allowing for changes in designation and some additions to cover community care). The authors of the earlier survey took the view that approaching informed groups of personnel was most likely to maximise the number of initiatives reported, while calling upon help from people able to provide the necessary detail about them. Sampling of educational institutions was considered, but rejected (Shakespeare et al. 1989). Much the same arguments applied in planning the present survey.

The Questionnaires

Like all surveys using postal questionnaires, this one had to work within the limitations of the method. Hard choices had to be made about which questions to include and ways had to be found to reduce complex issues to manageable questions. On reflection, open-ended questions might have been better posed in interviews. However, interviews were not part of the brief and would have increased costs.

The Response Rate

A number of explanations may be posited to explain the limited response to the first questionnaire.

First, as more categories were added to the mailing list, so recipients were more likely to receive two or more copies. Where only one was returned, the others would have been counted amongst the non-respondents.

Second, some of those approached were unwilling to make multiple returns for a number of initiatives, while others may have seen little point in making a nil return if they had no initiatives to report (in spite of the request to return blanks).

Third, respondents were given a broad definition of interprofessional education and were left to decide for themselves whether, on the basis of that information, they knew about occasions when professions learned together.

Fourth, efforts to make the first questionnaire as short and simple as possible may have robbed it of content to capture attention and interest. The more thought-provoking questions were held back for the second questionnaire.

Fifth, it is possible that some non-respondents were reluctant to be included on CAIPE's database, and to allow even the most rudimentary information to be in the public domain.

Sixth, questionnaires went out at a time when health, social services and education were all in the midst of stressful change, and filling out questionnaires may not have been welcome.

How many more of the first questionnaires would have been answered if reminders had been sent can only be a matter for conjecture. Apologies were volunteered by some recipients who assured the researchers that it had been their intention to reply and that they would have done so with a reminder. The cost of dispatching about 2,000 additional copies did, however, exceed available funds. The issue was one of cost/benefit. With reluctance, and after consulting the Department of Health about the possibility of supplementary funding, it was decided to work with the returns received.

On a more positive note, the markedly higher response rate for the second questionnaire does identify a constituency willing to make time and take trouble to contribute their experience towards a wider understanding of interprofessional education. That augurs well for future research.

The Data

What confidence can be placed in the data? They describe a self-selected sample demonstrably willing to contribute to a wider understanding of interprofessional education. They are indicative, given the method by which initiatives were located and the limited response rate. Many readers will, however, be able to test them against their own experience, while future research projects may be able to provide harder evidence.

Where an organisation which is active in the field under investigation (such as CAIPE in this case) opts to conduct a survey itself, that is liable to influence who responds and what information they volunteer. The outcome may therefore be biassed.

Future Investigations

How then should research or surveys be conducted in future? That depends upon the bodies commissioning or undertaking them, and what questions and aspects they wish to explore.

Recent years have seen the establishment of two kinds of consortia, one involving education and service providers to support the development of pre- and post-qualifying social work education and training, and the other to plan and commission education and training for most non-medical health professions. Both have been called upon to consider and support interprofessional education (CCETSW, 1992; CCETSW, 1995; NHS Executive, 1995). Both will have to gather information about the need for, and provision of, interprofessional education, in order to inform the planning and provision of developments.

The Regional Education and Development Groups (REDGs)will need to collate that information and to undertake their own region wide enquiries. There would be many benefits to be gained from adopting similar approaches and formats across areas

and regions, as this would expedite preliminary work, reduce costs, enable comparisons to be made and, in time, build up a composite picture.

As the number of occasions when professions learn together continues to grow, all-embracing surveys at UK or national level become increasingly complex and costly. Persuasive arguments can, however, be advanced for more focused research, including surveys, to inform enquiries on behalf of central government departments, accrediting bodies, professional associations, academic bodies and other organisations into aspects of interprofessional education.

References:

CCETSW (1992) The Requirements for Post Qualifying Education and Training – Paper 31 CCETSW

CCETSW (1995) Assuring Quality in the Diploma of Social Work –1. CCETSW

NHS Executive (1995) EL 95/27 Education and Training in the New NHS.

Appendix B.

SUPPLEMENTARY TABLES

Table a. First Questionnaires Sent and Replies Received.

	Sent	Received	%
Health Service Trainers			
Facilitators in Primary Health Care	274	45	16.4
Trainers in Community-based Health Trusts	252	18	7.1
Joint Appointments			
Joint Trainers, Health/Social Services	22	7	31.8
Tutors of Joint Practice Teaching Initiatives ***	20	4	20.0
Medicine			
Undergraduate Medical School Deans	35	12	34.3
Postgraduate Medical School Deans	24	3	12.5
General Practice – Regional Advisers	29	8	27.6
General Practice Tutors	273	45	16.5
General Practice – Course Organisers	350	67	19.1
Nursing Groups			
Directors of Nurse Education	189	52	27.5
Directors of Courses in District Nursing and Health Visiting	60	19	31.7
Directors, Tutors and Teachers in Midwifery Education	129	31	24.0
Professions Allied to Medicine			
Course Organisers	162	45	27.8
Social Work			
Tutors of Qualifying Courses	135	25	18.5
Post Qualifying Coordinators	21	3	14.3
Training Officers in Social Services/ Work Departments	135	10	7.4
Voluntary Sector			
Members of the NCVCCO** Trainers Network	53	10	18.9
Other			
Trainers for Community Care *	83	15	18.1
Respondents to the Pilot Questionnaire	14	8	57.1
Teachers in Membership of CAIPE	138	37	26.8
Contacts provided by Journal/Bulletin Readers	100	45	45.0
Total:	**2,498**	**509**	**20.4**

* Taken from the CCETSW Community Care Database

** The National Council of Voluntary Child Care Organisations.

*** Pilot initiatives mounted for CCETSW, the ENB and the College of Occupational Therapists to prepare practice teachers.

Copies were also sent at the request of the Social Services Inspectorate to its 12 regional offices for information.

Table b. Titles of Initiatives

	Number	%
Life Stage		
Childbirth	8	1.8
Children	24	5.4
Ageing	13	2.9
Palliative care/terminal illness	3	.7
Chronic Illnesses	20	4.5
Community Care	48	10.7
Collaboration:		
Primary Health Care	41	9.2
General	33	7.4
Health Education and Promotion	45	10.1
Disabilities	16	3.6
Mental Health	18	4.0
Research	8	1.8
Health, Community and Welfare Studies	21	4.7
Counselling	22	4.9
Management:		
General	9	2.0
Audit	16	3.6
Information and Management Systems	4	.9
Education and Training		
General	14	3.1
Continuing	20	4.5
Ethics	4	.9
Professions Allied to Medicine	8	1.7
Other	25	5.6
Not Specified/Not Known	35	7.7
Total	455	

Table c. Reasons for Launching Initiatives

	Ranked top		Ranked 1 to 5	
1. Enlarging markets /ensuring viable numbers	12	8.2%	39	26.%
2. Meeting common needs across professions	60	34.5%	150	86.2%
3. Learning from/about each other	1	.6%	132	69.1%
4. Widening choice of studies	5	3.6%	54	38.6%
5. Integrating /coordinating services	12	8.4%	78	54.6%
6. Promoting teamwork	11	7.5%	94	63.8%
7. Responding to new/changing problems	24	15.7%	111	72.5%
8. Creating a flexible/transferable workforce	5	3.9%	48	37.7%
9. Implementing health/social policies	8	5.7%	65	46.4%
10. Implementing educational policies	6	4.5%	49	36.9%

Table d. Number of Participants from Each Profession

	Some/one	2–5	6–10	11–15	16–20	21+
Education	20	11	4	–	–	2
Management	25	17	7	7	1	2
Medicine	25	25	19	4	5	8
Nursing Groups	39	23	32	13	8	27
Professions Allied to Medicine	33	22	7	–	–	14
Psychology	12	2	–	–	1	–
Social Work	25	16	13	8	1	9
Others	16	10	3	3	1	6

Table e. Combination of participants by type of initiative

Combination of participants for courses not leading to an award included the following:

- practice managers, practice nurses and receptionists;
- general practitioners and nurses;
- audit staff, clinical tutors, FHSA trainers, GP course organisers and practice managers;
- day care workers, physiotherapists and social workers;
- midwives and nurses;
- general practitioners, health visitors, managers and nurses;
- clergy, medics, nurses and social workers.

Combinations of participants for courses leading to awards or registration included the following:

for Registration/Post Registration:

- district nurses, general practitioners and health visitors;
- general practitioners and health visitors;
- occupational health nurses, occupational health and safety officers and occupational hygienists.

for Diplomas:

- midwives and nurses;
- district nurses and health visitors.

for Diplomas/Professional Registration:

- general practitioners and practice nurses;
- general practitioners and health visitors.

for First Degrees:

- community health workers, nurses and social workers;
- occupational therapists and physiotherapists;
- dentists, orthoptists and speech therapists;

- orthoptists, prosthetists and physiotherapists;
- nurses, occupational therapists and radiographers;
- podiatrists and radiographers;
- health care workers, health visitors, midwives and nurses.

for First Degrees/Diplomas:

- occupational therapists and social workers;
- occupational therapists, physiotherapists and social workers;
- dietitians, nurses, occupational therapists, physiotherapists, podiatrists, radiographers and speech therapists;
- midwives, nurses and radiographers;
- community educators, primary teachers and social workers.

for Practice Teaching Awards:

- social work practice teachers and community nursing practice teachers;
- community health care nurses, occupational therapists and social workers.

for First/Masters Degrees:

- nursery nurses, nursery teachers and social workers.

for Masters Degrees:

- midwives, nurses and social workers;
- dietitians, environmental health officers, nurses, physiotherapists, radiographers and speech therapists.

for Registration/Post Registration/Masters Degrees:

- general practitioners, health visitors and social workers.

APPENDIX C.

CAIPE'S Database

CAIPE now has a database of initiatives in interprofessional education and training, incorporating selected information from each reply to this survey and material drawn to its attention subsequently. It is being revised and augmented regularly.

The object is to provide a dependable, up-to-date and systematic source from which to disseminate information, to facilitate networking and to provide pointers for good practice.

The following table summarises some examples from this survey which are on the database. Each entry records the name of organisation responsible for the initiative (made anonymous on this occasion), the region in which it took place (not given here) the level, the title, length, year first held and mix of professions amongst participants, and address of contact person (not given here).

Example	Type of organisation/organiser	Level	Title	Length	Year begun	Mix of professions amongst participants
1	A department of general practice in a university	Post-qualifying or continuing professional development	MSc in Primary and Community Care	1 year	1991	Community Development, Medicine, Nursing, Physiotherapy, Social Work
2	A training manager in an institute based in a university	Post-qualifying or continuing professional development	Modules in continuing education programme	6–21 days	1989	Clinical Psychology, Domiciliary Care, General Practice, Hearing Therapy, Law, Nursing, Ocupational Therapy, Physiotherapy, Residential Care, Social Work
3	A college of health in collaboration with a social services department	Post-qualifying or continuing professional development	Child protection training - multiprofessional teamwork -	2–5 days	1992	Education, Medicine, Nursing, NSPCC, Police, PAMs, Social Work
4	A school of health care in a university	Post-qualifying or continuing professional development	Local Multidisciplinary Facilitation Team Course	22-60 days	1994	General Practice, Nursing, Practice Management, Reception
5	An institute of health and community services	Post-qualifying or continuing professional development	BSc Health & Social Studies	3 years	1994	General Practice, Management in Health Social Work, Nursing, Social Work
6	A social services training department	Basic professional education/ training	Joint Foundation for Community Care	6-21 days	1994	Health, Housing, Medicine, Social Service
7	A school of cultural and community studies	Basic professional education/ training and post-qualifying or continuing professional development	Helping Professions Workshop	2-5 days	1980	Health Visiting, General Practice, Social Work

UK CENTRE FOR THE ADVANCEMENT OF INTERPROFESSIONAL EDUCATION

Survey of Interprofessional Education and Training
In 1988 CAIPE commissioned the Institute for Community Studies to undertake a survey of interprofessional education in primary health care in Great Britain. The report proved invaluable as a guide to future action. However, much has happened since then, which makes the need for an up-to-date picture pressing. That has been made possible by a grant from the Department of Health.

The Survey
While the present survey builds on the earlier one, it goes further. It covers all initiatives where community based health and social care professionals learn together throughout all parts of the United Kingdom. It has taken advantage of findings from a `Review of Shared Learning' undertaken by the School of Social Studies at the University of Nottingham on behalf of CAIPE.

Aims
The survey has been designed to:

- provide an up-to-date overview of interprofessional education and training
- facilitate networking
- provide a database accessible to CAIPE's members and interested others
- inform CAIPE's future policies and priorities
- enable CAIPE to target its services

Boundaries and Definition
This survey covers "initiatives" that are primarily educational e.g.conferences, courses, seminars, workshops, open and distance learning, and guided work-based learning completed between **1/10/93 and 30/9/94:**

- where two or more health and/or social care professions learn together;
- during basic or continuing education and training;
- whether in the workplace, college or university, or elsewhere;
- whatever the duration;
- in any part of the United Kingdom;
- in respect of any service based in the community;
- without restriction in terms of types of service user

Locating Initiatives
Help in locating such initiatives is being sought from directors of nurse education, teachers of midwifery, course organisers for nursing, health visiting and social work, training officers in social services/social work departments, undergraduate deans in medical schools, regional advisers, course organisers and tutors in general practice, UK readers of the Journal of Interprofessional Care and CAIPE members. Other offers of help in locating initiatives will be much appreciated.

Methods
A copy of a short postal questionnaire is being sent to all known and identified initiatives. A questionnaire should be filled out for each initiative run. Please ensure that it is given to the person responsible for each initiative. Further copies of this questionnaire will be provided on request.

Where an initiative lasted two days or longer we shall be sending a supplementary questionnaire.

In return for their help, all respondents can choose to receive a summary of the main findings and to purchase the report at a discount.

Uses of Data
Basic information regarding topic, location, duration, participant groups and organisations responsible will be recorded on CAIPE's operational database to assist in response to enquiries. All other information will be analysed exclusively for the published report without reference to the initiative by name.

Personnel
The survey is being directed by Hugh Barr (working one day per week) and administered by Sarah Waterton in the CAIPE office. The Steering Group comprises Dr John Horder, Margaret Thwaites, Lonica Vanclay (CAIPE's Director) and Jenny Weinstein.

Please address any queries to Professor Hugh Barr, Survey Director, at CAIPE, 344 Gray's Inn Road, London WC1X 8BP or telephone Sarah Waterton, Research Assistant on 071 278 1083.

INTERPROFESSIONAL EDUCATION AND TRAINING IN PRIMARY HEALTH AND COMMUNITY CARE

A NATIONAL SURVEY

Code No:.....

This aim of this survey is to find out about the extent and nature of interprofessional education and training for primary health and community care professionals that took place between **1st OCTOBER 1993 AND 30th SEPTEMBER 1994**.

It is financed by the Department of Health and conducted by CAIPE (the UK Centre for the Advancement of Interprofessional Education). It will serve as a general information resource and will help inform CAIPE's work in encouraging and supporting those involved in interprofessional education.

Note - throughout the questionnaire we use the words:

participants to mean *workers/students;*
teachers/trainers also to mean *tutors, consultants, facilitators* and *mentors;*
service users to mean *patients and/or clients*

Please fill in one copy of this questionnaire for each initiative organised. In the case of modular initiatives it would clearly be asking too much of you to fill in separate questionnaires for each module; therefore please complete only one questionnaire for each modularised scheme of study.

Your name.....

Position.....

Organisation (abbrev.& in full).....

.....

Address.....

.....

Postcode.....Telephone.....

---

1. **Title or topic of the initiative:**.....

.....

2. **Was the initiative during**
(please tick one only)

Basic professional education/training? ☐

Post-qualifying studies or continuing professional development? ☐

Other (*please specify*)..... ☐

.....

3. **Which organisation(s) <u>instigated</u> the initiative?**

.....

.....

4. **Which organisation(s) <u>ran</u> the initiative?**

.....

.....

5. **In what town/city etc.was the initiative held?**

.....

6. **Was it held:**
(please tick one or more)

in the workplace? ☐

in an employer`s training centre? ☐

in a college or university? ☐

in a hotel or conference centre? ☐

elsewhere? (*please specify*)..... ☐

.....

7. **How long, in total, did the initiative last?**

(If sessional, please estimate the total in whole day equivalents, based upon 6 hours per day)

Less than one day ☐

One day ☐

2-5 days ☐

6-21 days ☐

22-60 days ☐

More than 60 days ☐

(Please specify).....

8. **In what year did essentially the same initiative first take place?**

(write in year) 19.....

9. **Did the initiative's participants include more than one profession?**

Yes ☐

No ☐

If so, which?.....

.....

.....

10. **Please help us to find other examples of interprofessional education and training by giving us details of as many as are known to you.**

Title/Topic.....

Organisation.....

Contact person's name and address

.....

.....

.....Tel.....

(please continue on a separate sheet with any other initiatives)

11. If you would like to receive a free summary of the main findings of the survey please tick here ☐

THE TROUBLE YOU HAVE TAKEN IN COMPLETING THIS QUESTIONNAIRE IS MUCH APPRECIATED

Please return in the stamped addressed envelope provided to: Sarah Waterton, Research Assistant,CAIPE, 344-354 Gray's Inn Road, London WC1X 8BP

Copies of prospectuses, papers and reports which refer to the above initiative would be much appreciated, both to inform the survey and for CAIPE to retain for future reference.

INTERPROFESSIONAL EDUCATION AND TRAINING IN PRIMARY HEALTH AND COMMUNITY CARE

A NATIONAL SURVEY:SUPPLEMENTARY QUESTIONNAIRE

Code No:.....

Your name:
.....

1. **Title or topic of the initiative:**

   .....

   .....

2. **Did the initiative constitute the complete learning for the participants?**

   Yes ☐
   No ☐

3. **Did the inititiative constitute part of the learning for the participants (within their separate professional courses)?**

   Yes ☐
   No ☐

   If you replied yes to 3 please name each course from which participants came.

   Course
   .....

   .....

   .....

   .....

   .....

4. **Please mark the following from 1 to 10 in rank order indicating the extent to which they influenced the decision to launch this initiative?** *(Marking the most important 1 and the least important 10)*

Enlarging markets/ensuring viable numbers ☐

Meeting common learning needs across professions ☐

Enabling professions to learn from and about each other ☐

Widening choice of studies available to each profession ☐

Integrating and coordinating services to users ☐

Promoting teamwork ☐

Responding to new/changing health/social problems ☐

Creating a flexible and/or transferable workforce ☐

Implementing health/and or social policies ☐

Implementing educational policies ☐

Other (*please specify*) ☐

.....

.....

Please add any comments

.....

.....

5. **Was the initiative:**
(please tick one)

- a single block of study? ☐
- intermittent study spread over a period of time? ☐
- modular? ☐

6. **Was the initiative:**
(please tick one)

- residential? ☐
- non-residential? ☐
- both? ☐

7. **How many times between 1/10/93 and 30/9/94 did it run?**

- Once ☐
- Twice ☐
- Three times ☐
- Four or more times ☐
- More times ☐
  (please indicate).....

8. **How many teachers/trainers were there?**
(*Please include sessional contributors*) .....

9. **Between the teacher/trainer(s) which of the following professions/disciplines were represented?** (*Please tick all that apply and write alongside the particular branch of that profession/discipline*)

PROFESSION/DISCIPLINE	BRANCH	
Medicine	.....	☐
	.....	
Nursing Groups	.....	☐
	.....	
Social Work	.....	☐
	.....	
Professions Allied to Medicine*	.....	☐
	.....	
Management	.....	☐
	.....	
Education	.....	☐
Psychology	.....	☐
Health Sciences	.....	☐
Sociology/Social Policy	.....	☐
Other (*please write in*)	.....	☐
.....	.....	

*Includes physiotherapy, occupational therapy, radiography, podiatry, chiropody, etc.

10. **How many participants were there?** .....

11. **Between the participants which of the following professions were represented?** *(please tick all that apply and write alongside the particular branch of that profession and the number of students from each)*

PROFESSION	BRANCH	NUMBER
Medicine	.....	☐
	.....	
Nursing Groups	.....	☐
	.....	
Social Work	.....	☐
	.....	
Professions Allied to Medicine*	.....	☐
	.....	
Management	.....	☐
	.....	
Education	.....	☐
Psychology	.....	☐
Other(*please write in*)	.....	☐

*Includes physiotherapy, occupational therapy, radiography, podiatry, chiropody,etc.

12. To what extent did the content of the initiative:

	a lot	a little	not at all
Provide a common value/ knowledge/ practice base for the professions represented?			
Address differences in value/ knowledge/ practice bases between the professions represented?			

Any comments?.....

13. To what extent did methods used during the initiative include:

	a lot	a little	not at all
didactic teaching?			
interactive learning between the professions represented?			
practice based learning?			

Any comments?.....

14. Was participants' learning formally assessed?

Yes ☐

No ☐

15. By what means?

	Individually	**In groups**
examinations	☐	☐
essays	☐	☐
dissertations/theses portfolios	☐	☐
observed practice	☐	☐
assignments	☐	☐
oral presentations	☐	☐

other (please write in).....

16. **Did participants' learning lead to, or carry credit towards, a qualification or an award?**

Yes ☐

No ☐

If yes, which qualification(s) or award(s)?

.....

.....

17. **Was the initiative validated or approved?**

Yes ☐

No ☐

18. **If yes, by which body or bodies?**

.....

.....

.....

19. **Was the initiative evaluated?**

Yes ☐

No ☐

20. **If yes, by whom?**

	Yes	No
The organiser(s) or teachers/trainers?	☐	☐
Independent person(s) or organisation?	☐	☐

21. Which of the following did the evaluation cover:

	Yes	No
- the planning, organising and/or running of the initiative?	☐	☐
- before and after measurement of change in participants' attitudes, perceptions or behaviour?	☐	☐
- observed impact of learning on collaborative practice?	☐	☐
- participants' expressed benefits from/satisfaction with the initiative?	☐	☐
- views of others about the merits of the initiative?	☐	☐

please specify.....

.....

22. Has the evaluation been written up?

Yes ☐

No ☐

23. If yes, please give details below

Author .....

Title.....

Date.....

Publisher or source.....

.....

24. Does your organisation have plans to:

(please answer each question)

	Yes	No
...repeat the same initiative?	☐	☐
...run a modified initiative or initiatives?	☐	☐
...run (an)other interprofessional initiative(s)	☐	☐

If you have answered "yes" to one or more of these questions please give further details below.....

.....

.....

.....

.....

.....

25. What further points would you like to add about the initiative?

.....

.....

.....

.....

.....

26. What for you are the salient issues in interprofessional education with which CAIPE should be concerned?

.....

.....

.....

.....

.....

.....

THE TROUBLE YOU HAVE TAKEN TO COMPLETE THIS ADDITIONAL QUESTIONNAIRE IS MUCH APPRECIATED

Please return this questionnaire in the stamped addressed envelope provided to:

Sarah Waterton
Research Assistant
CAIPE
344-354 Gray's Inn Road
London WC1X 8BP Tel: 071 278 1083

Copies of prospectuses, papers and reports which refer to the above initiative would be much appreciated, both to inform the survey and for CAIPE to retain for future reference.