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Review of Interprofessional Education in the United Kingdom, 1997–2013

IN BRIEF

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CAIPE

CENTRE FOR THE ADVANCEMENT OF INTERPROFESSIONAL EDUCATION

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CAIPE

Founded in 1987, CAIPE is a charity and company limited by guarantee which promotes and develops interprofessional education with and through its members. It works with like minded organisations in the UK and overseas to improve collaborative practice, patient safety and quality of care by professions learning and working together. CAIPE's contributions to IPE include publications, development workshops, consultancy, commissioned studies and international partnerships, projects and networks.

CAIPE not only offers expertise and experience, but also provides an independent perspective which can facilitate collaboration across the boundaries between education and health, health and social care, and beyond.

Membership of CAIPE is open to individuals, students and organisations such as academic institutions, independent and public service providers in the UK and overseas.

CAIPE offers its members:

- a network to exchange ideas and experiences;
- special rates for conferences, workshops and consultancies;
- current information about interprofessional learning and working through its E-Bulletin and website;
- access to the Journal of Interprofessional Care at special rates.

The annual CAIPE Chair's Event is designed primarily for individual members, providing an opportunity for them to come together and share ideas, experiences and expertise.

The students' own lively network enables them to take part in CAIPE events, share experiences, link with students in other countries and apply for CAIPE scholarships.

Corporate membership confers access to the Forum through which members:

- work closely with CAIPE and each other;
- collaborate in research and development;
- relate to interprofessionally committed organisations in other countries including exchange visits and joint projects;
- raise the profile of their interprofessional activities nationally and internationally.

For further information about CAIPE and other benefits of membership go to **www.caipe.org.uk**

CAIPE'S RESPONSE

Publication of the Review coincides with determined efforts to remedy longstanding concerns regarding lapses in quality of care and patient safety, which have been exposed in successive inquiry reports. It coincides too with renewed efforts to deploy the workforce more flexibly and to integrate health and social care services more effectively in response to the needs of individuals, families and communities. New policies demand new ways of working and learning that transcend boundaries between agencies and between professions. Teachers are rising to that challenge as they weave interprofessional into professional education – sometimes with difficulty as the Review found.

Against that backdrop, CAIPE commends the Review to each of the many organisations variously responsible locally and nationally for health professions' education throughout the United Kingdom:

- government departments and their agents promoting and commissioning the education including NHS Education Scotland, Health Education England and the Higher Education Funding Councils
- bodies regulating the education, including the Health and Care Professions Council, the General Medical Council, the General Pharmacy Council, the Nursing and Midwifery Council and others, with the Professional Standards Authority and the Quality Assurance Agency;
- universities developing, providing and evaluating the education;
- service organisations contributing to its planning, practice learning and ongoing study opportunities.

Closely involved as it has been throughout the years under review, CAIPE responded readily to the request from the authors – Hugh Barr, Marion Helme and Lynda D'Avray – to publish and promote their paper, to steer the consultative process and to report progress. With them, Board members will respond readily to requests to advise and assist in considering the review, its recommendations and their implementation.

CAIPE is asking for meetings, as a first step, with the national organisations to which the recommendations are addressed in England, Scotland, Wales and Northern Ireland. It will welcome requests for meetings with other interested parties including employers' associations, trade unions and professional associations. The review will be discussed with representatives from universities and service agencies during regular meetings of the CAIPE Forum and visits to universities. Invitations to take part in meetings beyond the CAIPE membership will be much appreciated. Discussion within and between so many parties will necessarily take time. We aim to report progress a year hence, marking up issues for ongoing attention.

The review in full (Barr, Helme & D'Avray, 2014) can be found on the CAIPE website – www.caipe.org.uk – with the interim report (Barr, Helme & D'Avray, 2011) which drew on the literature sources more fully. The following summary is also on the CAIPE website. Evidence from the review underscores CAIPE's guide to education commissioners and regulators (Barr & Low, 2012).

Richard Gray
for the CAIPE Board
June 2014

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The Review in Brief

Introduction

We reviewed the development of pre-qualifying interprofessional education (IPE) in the United Kingdom (UK) from 1997 to 2013 drawing on three sources: the literature, an online survey and reflective accounts by invited teachers with follow-up interviews. Our aim was to understand how prequalifying IPE had developed, celebrate the significant achievements and identify what needed to be done to improve its efficiency and effectiveness set against a changing and complex policy landscape in education, health and social care, and government.

First, we explored significant themes and progress in IPE during the research period from UK documentary sources (Barr, Helme & D'Avray, 2011). Second, we conducted an online survey of all UK universities known to provide pre-qualifying health and social care courses. Third, we invited teachers from selected universities[1] to contribute reflective accounts of their experience in initiating and sustaining IPE. Two of the research team then interviewed the authors sometimes with colleagues. We compared and contrasted findings from the three stages of the research.

We acknowledge the limitations of the review within the constraints of the resources on which we had call: its emphases on pre- to the relative exclusion of post-qualifying IPE; on operations rather than outcomes; and on English more than Scottish, Welsh and Northern Irish developments without reference to those in Europe and internationally of which they are part.

Getting started

Many of the forces driving the implementation of IPE were external, including government policies, central funding and findings from inquiries into errors and failures in care. Universities had benefitted from First Wave funding (DH, 2000a), from DH funding to promote common learning (DH, 2000b & 2001), from earmarked funds from the Scottish Executive and large scale initiatives recognising excellence in teaching and learning. Smaller sums enabled research, evaluation and publication. IPE was also driven from within universities, where teachers and managers saw merit in students learning the same topics across health and social care courses optimising the use of specialist teaching expertise, gaining from economies of scale and furthering collaborative practice.

Internal and external context influenced the way in which IPE took shape in each university. Some had prior experience on which to build. Some had pre-qualifying courses for many of the relevant professions; others had courses for as few as one or two of those professions, restricting scope for IPE unless and until partnerships were forged with other universities. Some were relatively isolated in rural areas; others were in close proximity to other urban universities with professional courses suitable for inclusion in IPE.

1 Canterbury Christ Church, Coventry with Warwick Medical School, Hull with Hull York Medical School, Leicester with De Montfort and Northampton, Nottingham, Robert Gordon with Aberdeen, Sheffield Hallam and the West of England.

Introducing IPE was easier across the allied health professions and nursing when independent profession-specific schools were relocated into polytechnics (later to become universities). These might well include social work but almost always excluded medicine, dentistry and pharmacy.

One university started IPE by introducing shared learning to large numbers of students from many professions. Others selected smaller groups from fewer professions. Yet others combined these approaches, opting for larger and more diverse interprofessional cohorts in the early years of study followed by smaller tailored opportunities for more senior students in later years. The spread of professions included was wide, but instances came to our attention where one or more opted out of all or some of the interprofessional learning even though it was required by the regulatory bodies.

Implanting interprofessional curricula

Universities and service providers were joined in common purpose enshrined in competency-based outcome frameworks for IPE, but achieved in diverse ways. Curriculum design, content, educational approaches, learner interaction and assessment all differed. Diversity, in our view, was a necessary response to context but made for difficulties when comparing IPE process and content. Not all universities provided clear information, especially for prospective and current students, about how they proposed to teach interprofessional learning.

We recommend to universities, their service organisation partners and commissioners of professional education and training that they publish the interprofessional learning pathways in course descriptions.

Ambiguity between the terms 'common learning' and 'interprofessional learning' was largely resolved. Contributors were clear that interprofessional learning outcomes should be common across different professions, also that 'real interaction' was required between students from different professions. IPE was integrated into the curriculum for many professional courses, at least in the classroom, and 'one off' interprofessional events towards the end of training tended to give way to staged, cumulative, progressive and assessed learning for all the professions involved.

We noted a 'turn to practice' as an addition to classroom learning in recognition of the need for IPE to be authentic and to engage students. Teachers saw IPE in practice as fitting the person centred agenda, which they were trying to accomplish through partnerships and orientation towards workforce needs. Promising though examples cited were, the underlying problems regarding the development of effective interprofessional practice learning (especially training wards) remained. These could not be resolved piecemeal.

We recommend to universities, their service organisation partners and commissioners of professional education and training that they forge partnerships to develop IPE in the practice environment.

Developing teaching and learning

Competency-based frameworks served to identify common ground in the formulation of learning outcomes responsive to current public and policy concerns. The preferred mode of learning was interactive in facilitated groups, using case studies and practice oriented material. E-learning was almost ubiquitous. Most of the materials were developed in house with less sharing than we had expected, given the many UK conferences and funded projects focusing on use of technology in IPE. E-learning seemed at first a relatively easy option for implanting IPE with minimal disruption and low running costs, once the initial outlay had been met, while putting the onus on students to manage their own interprofessional learning outside class contact time. However, indications were that it fell short unless complemented by face-to-face learning.

We recommend to universities that they combine and align e-learning in IPE with face-to-face learning.

There was a strong sense for interprofessional teachers of 'growing with the job'. What began as a sideline for many became a major part of their role with clear benefits in getting to know colleagues in other professions, learning new teaching methods and cultivating cohesion between faculties and schools.

Many of the universities provided some preparation of staff for IPE teaching, although this was not necessarily recognised in terms of professional development. Some assumptions made in the early years were that IPE facilitation was something any teacher could do, that they just needed to be familiar with the IPL exercise, but experience demonstrated that particular knowledge, skills and approaches were required for effective facilitation of interprofessional learning.

We recommend to the regulatory bodies that they require universities to demonstrate how all teachers (including practice teachers) will be prepared for interprofessional teaching.

We recommend to the Higher Education Academy that its requirements for teaching in higher education include the rationale and teaching of IPE in certificated courses for new entrants to professional and vocational teaching in universities and in accreditation schemes.

We recommend to universities that they:

- **include a critical appreciation of IPE in certificated/accredited courses for all new entrants to health and social care professional teaching;**
- **provide and require professional development in IPE for all existing teaching staff in health and social care.**

We recommend to universities, their service organisation partners and commissioners of professional education and training that they foster competence in interprofessional teaching, including it in appraisal and review processes.

Involving service users

About half the universities in the survey sample involved service users in the interprofessional curriculum in some way. This may be expected to develop further with encouragement from professional bodies.

We recommend to universities and their service organisation partners that they optimise opportunities to involve service users in the planning, teaching, mentoring, assessing and reviewing of IPE.

Managing the interprofessional learning

Support from universities was generally positive if occasionally passive. It seemed in some to rest more on achieving economies of scale through shared learning than on the benefits of IPE. Implementing IPE often relied on goodwill between teachers of different professions, between university and practice, and between facilitators and students. Although the accounts and survey provided clear evidence of thriving IPE, interviewees questioned whether 'good will' was sufficient to project IPE into a permanent, integrated and valued position within curricula. There was still a sense of IPE as a movement or campaign to be won rather than as an institutional imperative or requirement.

Where developments were large scale they were typically guided by a committee of heads of schools and other senior personnel espousing a mission with stated goals. Advantageous though that was in raising the profile of IPE, top-down management did not translate into quality teaching unless the people responsible for implementation were effectively involved in the decision-making.

IPE coordinators were not line managers in departments and faculties. Getting buy-in from colleagues across all academic courses could be a sticking point. Resolving that problem depended on the establishment of good working relationships with managers who could then ensure their staff were actively committed.

Only one of the universities providing the reflective accounts had a staff member wholly employed in coordinating IPE; the others had posts in which profession-specific teaching made up at least 40% of the time. In most cases, provision of facilitators for IPE was arranged year on year on a pro rata basis depending on student numbers. This seemed to work well enough with occasional temporary reluctant 'conscripts'. Trying to ride two horses at once remained a source of continual tension.

Forging partnerships

Earlier arrangements for joint planning and management commended by government (DH, 2000b & 2001) fell into abeyance. Partnerships between universities became less formal and promoting IPE more entrepreneurial in the climate of the times. Partnerships were more likely to survive where: universities were close by; relations between senior personnel were well established and positive; institutional agreements predated IPE; courses offered were complementary not competitive; and technology was compatible.

The prevailing culture influencing IPE differed depending on its location in an old or new university with their different traditions and in a medical school or a health sciences faculty. The less numerous professions felt more included where the culture was 'health' rather than 'medicine' or 'nursing'. Either way, social work could feel marginalised.

Findings from our survey, cross-checked against informed sources, exposed a residue of universities with courses for three or fewer health and/or social care professions, seemingly without formal IPE provision. Discussions between personnel in adjacent universities might suggest how they could work together to mutually enhance interprofessional learning opportunities. Future solutions may depend upon the location and relocation of new and existing courses.

We recommend to the Funding Councils for England, Scotland, Wales and Northern Ireland that they take into account the need for shared learning across professions, including IPE, when the location of professional courses is under consideration.

Provision of IPE required partnerships not only within and between universities but also with service agencies to inform curricula and provide practice learning. One of the surprises from the survey was the apparent lack of formal partnership arrangements with those providers, although respondents may have omitted to include the established educational ties necessary for the prescribed hours of placement learning. Partnership with agencies came through more strongly during the interviews.

Aligning curricula

Alignment problems dogged pre-qualifying IPE from the beginning. Patterns in different professional study typically did not align, curtailing opportunities to introduce IPE in the

classroom or on placement. The significant developments, led by committed, innovative, thoughtful and capable teachers were often against the odds. Misalignment between programmes, timetables, placements, faculties, regulators, validation and periodic review cycles and other factors meant that introducing and sustaining prequalifying IPE was complex, subject to year on year adjustments requiring considerable negotiation skills and time from IPE leaders. In some cases managing alignment problems involved 'letting go' of well thought of IPE programmes as well as adapting others.

We recommend to the regulatory bodies that they require universities to demonstrate in validation and review documentation how the constituent professional courses are being realigned to optimise IPE, with particular reference to timetabling and placement patterns.

IPE was 'shoehorned' into professional courses with few if any concessions made in their requirements, structure and prescribed outcomes. Dovetailing the same interprofessional learning into two or more professional courses meant surmounting numerous difficulties. Professions often held different assumptions about IPE with implications for ways in which it could be accommodated within their systems, structures, requirements and habitual ways of working. While espousing an 'interprofessional philosophy', some universities allowed professions to opt in or out of IPE at the discretion of their programme leaders, so that that a large group such as medicine or nursing might not participate at all.

We recommend to the regulatory bodies that they consider, during the review of such courses, whether all relevant professions are participating fully in the IPE and how obstacles may be overcome

Readiness to re-jig timetables, vacations and validation and review cycles to accommodate IPE was needed. Problems were exacerbated where the personnel charged with planning, coordinating and teaching IPE did not have authority and position to negotiate changes in the uniprofessional education systems and lacked active endorsement from senior management. Lack of alignment, for example different modular structures or e-learning platforms, also inhibited IPE developments between universities.

Problems were not confined to universities: service providers routinely supported students on placement from a number of courses with the potential for interprofessional practice learning only to find that it was constrained by inflexible interpretation of requirements, for example assessment by a designated person from the said profession. At least one university justified its decision not to build in interprofessional practice learning in the absence of an interprofessionally sympathetic culture and mentorship.

We recommend to universities, their service organisation partners and commissioners of professional education and training that they realign the constituent professional courses to optimise interprofessional learning, with particular reference to timetabling and placement patterns.

Alignment was most problematic regarding formal assessment of interprofessional learning, including equitable allocation of academic credits. There was still some way to go in achieving consistency and parity in assessment requirements for all the professions learning together. Some universities were working towards summative assessment for all the student groups; others left responsibility for assessment solely in the hands of course leaders for the student's respective professions.

We recommend to the regulatory bodies that they require consistent procedures and criteria for the assessment of IPE across professions and courses.

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Harmonising regulation

Despite understandings between regulatory bodies, IPE remained subject to validation profession by profession. The interprofessional learning was either scrutinised by different panels working to different requirements, or set aside as being too hard to handle. The latter response gained credence where regulatory bodies specified outcomes leaving teachers to determine how their students were to achieve them. Whatever the expected benefits for uniprofessional learning of this approach, it was less than satisfactory for interprofessional learning in contested territory. The more professional groups, faculties and universities included in IPE, the more complex and costly parallel validation became. Hidden costs incurred across outmoded regulatory systems cannot be discounted.

We recommend to the regulatory bodies that they:

- **synchronise procedures for the validation and review of courses where two or more contain the same IPE;**
- **ensure members of validating committees and visiting panels are briefed about IPE;**
- **ensure panels always include at least one member with first-hand IPE experience.**

Arguments floated down the years to introduce 'kite marking' for IPE are seductive. We would, however, resist, any move to hive off IPE validation from the professional education of which it is part. A more constructive way forward would be to build on the experience that regulatory bodies have already gained, complemented by the growing evidence base for IPE and the experience of CAIPE members, to clarify and codify requirements for interprofessional within professional education.

We recommend to the regulatory bodies that they agree and publish a joint statement regarding the outcomes they require from students on completion of pre-qualifying IPE in health and social care.

We recommend to the Quality Assurance Agency that it reactivate its involvement in IPE by revising composite benchmarking statements and publishing reviews, reports and analyses.

Leading the way

A recurrent message was the imagination, industry and ingenuity with which the IPE coordinators strove time and again to create interprofessional learning opportunities compatible with requirements for each of the constituent professional education systems. Their role had become more sophisticated and more complex as the scale and diversity of IPE activities extended and evidence was brought to bear.

The very substantial teaching and managerial experience that most coordinators brought with them to the role, was less than sufficient to prepare them to work within and between institutional and professional traditions and cultures; systems and structures; expectations and requirement; policies and priorities; and budgets and resources.

Many of the universities created new IPE posts, especially to coordinate some of the larger programmes in the early stages. Others assumed that IPE coordination could simply be added to the remit of one or more existing teaching posts. Both approaches failed to recognize that introducing or maintaining IPE in a culture of uniprofessionalism required more than merely organising exercises for students. IPE leads found themselves challenged by cultures that valued professional above interprofessional priorities and that protected established patterns of education with curricula that had no room for IPE.

Our contributors were candid in sharing the joys and sorrows associated with the role. While some were enthused and energised by their experience, others were stressed and pressured. While some succeeded in engaging colleagues in sustained and concerted action, others were not able to do so. Coordinating IPE could be lonely when assigned to a single person. Parallel appointments spread the load, countered isolation and built in mutual support. Growing up together in IPE, as many of the first generation of IPE coordinators did, strengthened collegiality and interdependence as they travelled the same road.

It became increasingly clear that the grading accorded to the IPE coordinating posts not only failed to reflect the responsibilities carried by the post holders but also status necessary vis à vis course leaders.

We recommend to universities that they relate the grade of the IPE coordinators to that of course leaders.

Strengthening national support

Endorsement for IPE from commissioning and regulatory bodies has built up over the years though responsibility remains divided in pluralist systems for each of the four countries. The need for coordinated support for IPE from relevant national and UK bodies is now pressing to promote and sustain IPE, addressing problems that cannot be resolved at local or regional level.

We recommend to the HEE, the HEFCE, the HEA, the Professional Standards Authority, the QAA and the DH that they convene a periodic forum (administered by CAIPE) to review progress in promoting and developing IPE in England and to facilitate national collaboration in support.

We recommend that comparable bodies in Scotland, Wales and Northern Ireland convene meetings for the same purpose.

Assembling the evidence

We present findings from our review as part of the growing evidence base for IPE. Their distinctive contribution lies in enabling teachers themselves to tell their stories. Such subjective evidence must be set alongside objective evidence as independent evaluations become more numerous, more systematic and more rigorous worldwide. Less has, however, been done in recent years, nationally and internationally, to digest and disseminate findings than in earlier years (Barr et al., 2000; Barr et al., 2005; Hammick et al., 2007). Replication of reviews subject to narrowly defined criteria under the auspices of Cochrane (see, for example, Reeves et al., 2008) was not enough, excluding as they did the wider range of methodologies and outcomes in many IPE evaluations. A further broad based review is overdue.

We recommend to CAIPE that it instigate discussions with researchers at home and abroad with a view to establishing a group to conduct an up-to-date, broad-based worldwide systematic review of qualitative and quantitative evidence for pre-qualifying IPE in health and social care.

Conclusion

Weaving IPE into the fabric of teaching and learning within and between pre-qualifying health and social care courses proceeded steadily throughout the UK during the period under review. Competing claims were largely resolved, outcomes agreed and foundations

laid for continuing interprofessional development. One size did not fit all. Implementation differed in context and progress was impeded by misalignment. Institutions teaching single professions faced particular problems in introducing IPE which collaboration with other universities may yet resolve. Strengthening partnerships between universities, and with service providers, called for top-level agreements underscored by commissioning and regulating bodies to harmonise policies and procedures. Reconciling course structures and professional requirements needed action at every level to implant IPE more expeditiously, efficiently and effectively. We framed our recommendations accordingly in order to strengthen local and national infrastructures for IPE. We highlighted the preparation of teachers, the recognition of their specific roles and skills in IPE, and the need for universities to empower coordinators to instigate change. Sustaining the progress made will depend on concerted support from governmental, commissioning, regulatory and professional bodies in partnership with providers emphasising better cultures and safer practice.

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