Interprofessional Education in the United Kingdom

Some Historical Perspectives 1966 - 1996

A supplement to:
Creating an Interprofessional Workforce: An Education and Training Framework for Health and Social Care

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Contents

Background

There is room for argument about when, where and why the first interprofessional education (IPE) 'initiatives' were launched in the United Kingdom (UK), but this much is clear. Parallel developments gathered momentum from the late 1960s in community care, primary care, learning disabilities, mental health, elder care, palliative care and other fields in employment and educational settings, converging into a single movement from the late 1980s and paving the way to establish IPE nationwide from the late 1990s.

Initiatives are grouped in this paper into three mutually reinforcing subsidiary movements:

- Work-based
- Pre-qualifying
- Qualifying

Work-based Initiatives

The earliest initiatives were typically isolated, small-scale, post-experience, work-based workshops, seminars or short courses as their pioneers tested first one way and then another to cultivate understanding, trust and collaboration between professions. Kuenssberg is credited with convening the first, a two-day symposium in London in 1966 on "Family Health Care: the Team" to explore working relations between general practitioners, district nurses and health visitors, sponsored by the Royal Colleges for general practice, midwifery and nursing with the Queen's Institute of District Nursing, the Health Visitors' Association and the Society of Medical Officers of Health. The significance of the occasion was reinforced by having Kenneth Robinson, the then Minister of Health, as the keynote speaker (Kuenssberg, 1967). Many similar workshops followed locally and regionally, some encouraged by regulatory and professional bodies centrally, who also convened national conferences to support these developments and weigh progress (see, for example, England, 1979).

The report from a series of workshops in Manchester is graphic:

> *The health visitors and GPs found district nurses reticent and defensive – doers rather than talkers. Social workers said that GPs did not easily recognise all the social needs of their 'clients'. Health visitors said that teams worked better when nurses and health visitors were diplomatic in their approach towards GPs, although difficulties could arise when male social workers were unwilling to be deferential. The health visitors saw themselves as buffers between dissatisfied GPs and the new social services departments. But some social workers seemed to have deep-*

> *seated prejudices toward health visitors who wanted, they said, to be all things to the patient. The GPs position at the top of the status tree was accepted reluctantly by the nurses, resented by the health visitors and rejected by the social workers. Such difficulties were, however, said to be capable of resolution by personal contact* (Thwaites et al, 1977).

Seminars and workshops also began to be convened for newly qualified workers on first appointment in the same neighbourhoods to explore doubts and misunderstanding about each other's ways of working (see for example, Samuel and Dodge, 1981; Jones, 1986). Learning together was also taking root in the workplace, notably in Liverpool where facilitators worked with GPs and nurses to break down isolation between practices, to promote the employment of practice nurses and to encourage a reorientation from one-off treatment of disease towards health promotion (Thomas, 1994). One project offered daffodils in exchange for cigarettes!

Many initiatives remained 'one-off', but planned and sustained series were mounted during the 1980s, notably by the Health Education Authority (HEA) which capitalised on the growing interest in shared learning to launch a traveling 'circus' of workshops throughout England and Wales designed to enlist primary health care teams in health education. Each team was invited to send three participants from different professions to the same workshop. Each threesome then selected an aspect of health education to be promoted in its centre and developed an action plan during the workshop. Groups were targeted, campaigns conceived, services outlined, obstacles identified and ways devised to overcome them. Introducing cervical screening, and tackling alcohol, drug and tobacco abuse were the most common (Spratley, 1990a).

Regional workshops followed to train members of Local Organising Teams responsible for mounting rolling programmes of workshops which tackled almost every topic of the day from multidisciplinary audit to GP fundholding (Spratley, 1990b). Barriers came down between professions and between centres, as workshops became more widespread and a cadre of skilled and experienced facilitators was established (Fullard et al., 1984 & 1987). Other organizations including CONCAH (Continuing Care at Home) and LOTUS (Learning Opportunities for Teams) followed the lead given by the HEA, mounting rolling programmes nationally and regionally (CONCAH, 1989; Pirie and Basford, 1998). Initiatives became less pre-occupied with interprofessional relationships, more committed to service improvement and health promotion.

Many of these early initiatives covered both primary health and community care, but separate developments followed as policies for 'care in the community' were implemented from the mid-1960s onward with the closure of long-stay mental handicap and psychiatric hospitals. Progress was faster in Scotland than in England. There, the Social Work Service Group and the NHS Management Executive commissioned the University of Dundee to facilitate workshops, offer

consultancies and develop training networks to help implement community care policies that extended beyond teamwork to include also collaboration between agencies and between management and practice. Issues tackled ranged from user involvement to hospital discharge arrangements and from care management to local needs analysis (Rowley, 1993).

Concerned that primary and community care had drifted apart, some health and social services managers convened joint meetings for their respective staff to discuss implications of the 1989 NHS and Community Care Act. Describing strategic planning for "interagency training" between statutory and voluntary sectors in health and social services in a London borough, William Horder (1996) regretted that priority was being given to measurable short-term change at the expense of long-term goals. Topics covered by the training included updating, needs-led assessment and care planning, meeting the needs of service users and carers, working in partnership, cross-cultural communication, welfare benefits, discharge planning and after-care, protecting vulnerable adults and the role of the key worker.

The NHS Training Directorate and the Social Services Inspectorate set up the *Caring for People* Joint Training Project to ensure that an integrated approach to care was supported by appropriate training and organisational development. Reviewing that project, Carpenter et al. (1991) found widely different developments of shared learning in seven English areas following the implementation of the NHS and Community Care Act. Authorities, it seemed, were making a fresh start, even though there was a wealth of experience upon which they might have called.

Work-based IPE for child care was developing separately under the guidance of Area Child Protection Committees (ACPCs), driven by harrowing reports from all too frequent inquiries into the abuse and sometimes death of children (see, for example, Department of Health & Social Security, 1972). The Michael Sieff Foundation fostered development and innovation in the care of abused and neglected children, while the Training Advisory Group on the Sexual Abuse of Children (1988) made the case for “multidisciplinary agency training” (TAGSAC, 1988) following the Butler Sloss report (1988) into multiple allegations of such abuse in Cleveland. The National Children's Bureau, the National Society for the Prevention of Cruelty to Children and the University of Nottingham (Charles and Stevenson, 1990 a&b) combined their expertise to support local initiatives and sponsored the first joint conference where participants identified a number challenges:

- Variable support for joint agency training amongst service managers
- The need to develop training strategies owned by ACPCs
- How to engage professional groups who play key roles in child protection, but seldom participated in inter-agency training

(Hendry, 1995)

They were not alone in voicing concern. Despite the arguments advanced for 'joint training' in successive reports, Birchall and Hallett (1995) found that little or no training about child abuse was being provided for experienced practitioners. Furthermore, some of the events described as interprofessional as reported did little more than bring together a mixed audience in one room, without opportunity to enhance mutual understanding (Stevenson, 1995).

CAIPE, launched in 1987 with Dr John Horder as its first Chair, grew out of these work-based initiatives, although its subsequent remit also included university-led developments. Its remit was to support, co-ordinate and represent the emerging interprofessional movement. In the same year, Professor Kenneth Calman (as he then was at the School of Medicine at the University of Glasgow) launched Interact which convened a rolling programme of meetings throughout Scotland to promote and support IPE initiatives. The World Health Organization also held its seminal workshop (WHO, 1988) although its impact on UK developments was limited.

Post-Qualifying Initiatives

Meanwhile, universities were responding to the need for continuing education by launching postgraduate courses, many of which were multiprofessional. Exeter claimed to be the first university in the UK to launch a multiprofessional masters course in health and social care in 1986 to enable nurses, physiotherapists, occupational therapists, social workers and others to compensate for limitations in their earlier pre-qualifying education; and to complement practice experience with a grounding in the social sciences and research skills. As reported, however, it did not include interprofessional learning (Pereira Gray et al, 1993). A second masters course at Exeter – an MSc course in professional education – plus doctoral research opportunities were also multiprofessional, drawing upon experience gained from more modest multiprofessional initiatives dating back to 1973 including week-long residential courses for GPs and nurse trainers.

Storrie (1992) canvassed 15 universities in England and Scotland for information about such courses which they were known to be running at masters level.

Twelve responded with information about 21 courses focusing on:

- a client group, e.g. elderly, mentally ill, learning difficulties, child protection
- care delivery, e.g. community care, primary care and counseling
- planning, organisation and management of services
- interprofessional learning and working
- other, e.g. medical social anthropology

Despite commitment to interprofessional understanding and co-operation, most of these courses were based in traditional single discipline academic

departments. Exceptions were noteworthy, for example at the University of Southampton, where courses in psychiatric medicine and palliative medicine were the joint responsibility of medical and social work departments. Similarly, at the University of Hull two such courses were run jointly by nursing and social sciences departments (in one case also including the psychology department).

Most had started recently, only one before 1990 although all but one was based in an established academic department with a track record in health and social care studies. Several enjoyed external support. The Scottish Office, for example, had funded the Centre for Child Protection at the University of Dundee, which ran one such course, whilst Age Concern had funded the MSc in gerontology at King's College London.

Only one course, at South Bank University, gave interprofessional learning and working as its primary focus, although two others launched soon after also did so, one at the Marylebone Centre Trust in association with the University of Westminster and the other at the University of Central England in Birmingham (Gorman, 1995). The remaining masters courses found by Storrie, albeit not established primarily to focus on the promotion of interprofessional understanding and collaboration, had developed such teaching and learning as an extension of their original objectives. Between them, they were recruiting from the allied health professions, clergy, housing, pharmacy, planning, police, medicine, nursing, social work, and youth and community work. With few exceptions, doctors were only recruited to courses based in medical departments.

Storrie's enquiries did not pick up courses in public health and health education, some of which were at post-graduate certificate or diploma level. Courses in public health medicine were being extended to include students from other professions, while the HEA was promoting multiprofessional postgraduate diploma courses in health education for primary care professionals in polytechnics, in parallel with its traveling circus of workshops (see above). Diploma courses were providing generic studies for students from a range of professions to prepare to become health education officers complemented by masters degrees in health education in medical schools to enable professionals to transfer into that field (Beattie, 1994a&b).

One post-qualifying programme merits particular mention - the Joint Practice Teachers Initiative launched in 1989 by CCETSW[1], the ENB[2] and the College of Occupational Therapists and comprising 13 projects funded by the Department of Health throughout England. The programme prepared practice teachers for interprofessional qualifying studies to which we now turn our attention (Bartholomew, 1996).

[1] The Central Council for Education and Training in Social Work
[2] The English National Board for Nursing, Midwifery and Health Visiting

Qualifying Initiatives

Conventional wisdom long held that IPE was better left until after qualification when practitioners had found their respective identities and had experience under their belts to share. Steps were, however, being taken as early as the 1960s to enable related professions to share pre-qualifying studies in the belief that core values, knowledge and skills were transferable between them and that each would gain strength by association with the others. Four 'collective movements' gathered momentum – for social work, nursing, professions allied to medicine and the complementary therapies, in that order. A fifth and very different movement cut across nursing and social work. All five would be more accurately described as multiprofessional than interprofessional education. Each did, however, set a precedent for shared qualifying studies between a broader spectrum of health and social care professions within which interprofessional education could take root.

The introduction of 'generic' studies for social work, and soon after combined studies for branches of nursing with midwifery and health visiting, can be seen with hindsight to have been a transitional phase between separate qualifying education for each sub-profession towards integrated provision for a group of professions. That process began for social work in the 1960s and for nursing and midwifery in the 1980s, later for the professions allied to medicine and most recently for the complementary therapies. Of these, only social work led to complete integration (although courses for probation officers were later withdrawn). Nursing continues to have its branches, with midwifery remaining a separate profession, but within a single regulatory, education and organisational structure. Both the allied health professions and the complementary therapies remain looser alliances, albeit drawn closer as they share some of their learning.

Each of these collective movements consumed time and energy at the expense of wider exploration of scope for shared learning with professions beyond the immediate 'family'. That social work, nursing and the allied health professions have become engaged with other professions in more broad-based interprofessional learning may be seen as a mark of maturity, as integration of each of their families has reached the point when it was ready to look outwards. A parallel movement remained for some time between the allied health professions intent on finding common curricula as the basis for shared studies, but it has now been absorbed into the mainstream of qualifying interprofessional education. The complementary therapies may still need more time before they reach that stage. Medicine, dentistry and pharmacy each enjoyed a relatively secure and established status with no need for comparable educational movements, although lack of them may be one reason for their relative isolation from subsequent developments in IPE.

The fifth of these movements was quite different from the other four and its out-workings more fraught, but, with benefit of hindsight, perhaps more significant in

breaking the mould of qualifying education and paving the way for broader-based developments later. It grew out of recommendations by the Jay Committee (Jay, 1979) to substitute a social model, deemed more appropriate as patients and staff relocated from hospital to community, for the existing medical model in mental handicap, transferring responsibility from the four General Nursing Councils to CCETSW. Nurses, parents and pressure groups were vehemently opposed. Psychologists attacked social care for being too passive and, forming an alliance with mental handicap nurses, advancing alternative arguments for a new profession to include `teachers` of mentally handicapped adults as well as specialist nurses based upon an educational model. Faced with an impasse, Ministers rejected Jay's recommendation and called upon the GNCs and CCETSW to establish a joint working group in the expectation that it would make recommendations for "joint training". Obligingly it did so. Recommendations were made for such training at pre-qualifying level between students preparing for the Certificate in Social Service and the specialised mental handicap nursing register (GNCs/CCETSW, 1982) and at the post qualifying stage (GNCs/CCETSW, 1983).

Only two pre-qualifying courses got off the ground (Brown, 1994). Neither survived major reforms in nurse and social work education, but two similar courses were later established linking the new qualifying systems (Project 2000 for nursing and the Diploma in Social Work). What seemed to some of us who were involved at the time as an aberration may be seen, with hindsight, to have been a portent of arguments later for ‘common learning’ designed to create a more permeable and more flexible workforce throughout health and social care. Indeed, the Audit Commission (1986) was already arguing for such learning for a new community care profession.

Where then were the explicit examples of IPE? “Piecemeal endeavours" in shared undergraduate studies had been reported in Southampton, Liverpool, Newcastle, Manchester, Canterbury and Keele (Mortimer; 1979), although data were lacking to clarify whether these fell within the collective movements reported above or were primarily interprofessional. Subsequent initiatives (none of them listed by Mortimer) were, however, clearly interprofessional. In Salford, multiprofessional education was introduced into qualifying courses for occupational therapists, physiotherapists, radiographers and chiropodists (Lucas, 1990) based on common skills, methods and learning needs (NHS Training Management, 1986) employing problem based learning (Hughes and Lucas, 1995) and weaving in IPE. In Thamesmead, lunchtime meetings, half day seminars, joint home visits and a residential weekend were organised where students in general practice, nursing and social work on placement compared perspectives and explored ways to surmount barriers in their practice (Jacques, 1986). In London, medical, nursing and physiotherapy students at the Middlesex Hospital were required to spend two and half weeks doing practice learning together in the geriatric department (Hutt, 1980; Beynon et al, 1978). In Edinburgh, teachers at Moray House College of Education were devising ways to

enable each profession to get to know the others personally and professionally during a series of workshops that included exercises in self-disclosure, games, role-play and debates (McMichael and Gilloran, 1984, McMichael et al. 1984a, McMichael et al. 1984b). In Bristol, there were similar initiatives between doctors and nurses (Carpenter, 1995), and between doctors and social workers (Carpenter and Hewstone, 1996) where participants learned as equals in pairs and small groups focusing on differences as well as similarities between their professions, while respecting each other's identities.

In 1996 Ross and Southgate (2000) mapped 'shared learning' between medical and nursing students at the qualifying stage, drawing on their respective professional and academic networks in preparation for two CAIPE workshops. They found only three examples of such shared learning, two lapsed "pilots", but "advanced plans" in four institutions and "plans" in a further eleven. More were to be reported later in the lead up to government policies introduced from 2000 onwards, but after the cut-off date for this review.

Commissioning reviews

The growing significance being accorded to IPE prompted government departments, the ENB, CAIPE and the Committee of Vice Chancellors and Principals to commission reviews.

The Department of Health commissioned the Scottish Council for Research in Education, with the universities of Dundee and East Anglia, to ascertain the extent of "multidisciplinary education" throughout the UK. Pirrie et al. (1997, 1998 a&b) found that neither teachers nor students universally welcomed moves to break down barriers between professional education programmes, although many of the course organisers interviewed saw a direct correlation between a satisfactory experience of learning with other professions and working together effectively in teams.

The Welsh Office commissioned CAIPE and City University (Freeth et al, 1998; Tope, 1998) to identify the way forward for IPE in Wales based upon a review of current IPE activity and an analysis of factors that promoted or impeded effectiveness. The reports cover the identification of plans for IPE in the Principality, an analysis of the perceived effectiveness of interprofessional courses, issues affecting students and staff and testing options for future development.

Miller et al (1999 & 2001) reviewed nurses' collaboration in practice and implications for IPE for the ENB based on case studies, a survey of educational institutions and interviews with NHS Trusts managers. They found that very little of the multiprofessional education in universities was addressing interprofessional issues. Common curricula had been established to reduce

duplication, not to utilise and value professional differences.

CAIPE commissioned the Institute of Community Studies to conduct a survey of IPE throughout Great Britain (Northern Ireland being excluded). The researchers (Shakespeare et al, 1989) found 695 examples of interprofessional education. Just 2% were at undergraduate level, 18% during post qualifying studies and 83% during continuing professional development. Most were brief. Over half lasted less than a day with over a quarter between two and four days. Very few were longer. Topics covered included child abuse, teamwork, AIDS, mental health and learning disabilities.

CAIPE conducted its second survey itself during 1994, covering the whole of the UK (Barr and Waterton, 1996). It was designed to replicate the first, but that was frustrated by a markedly lower response rate. The survey nevertheless found 455 examples of IPE. Three quarters of these were at the post-experience stage, most lasting between two to five days, with a third lasting less than two days. Topics covered were life stages from maternity to palliative care, chronic illnesses, collaboration, community care, counseling, disabilities, education and training, ethics, management and mental health.

Coinciding with the end of the period reviewed in this paper, the Committee of Vice Chancellors and Principals (now Universities UK) found that 54 of 77 higher education institutions with courses for health professions offered some “shared learning”, of which 13 were at undergraduate level and 30 at both undergraduate and postgraduate level (CVCP, 1997). Twenty-four institutions had plans to expand shared learning in response to the expectations of NHS purchasers, of which 20 said that they were influenced by the need to prepare students for teamwork. Nine were planning modules in interprofessional skills, including communications. Twenty-five regarded shared learning as more cost effective than uniprofessional learning. These data suggested a higher incidence of IPE at the qualifying stage than found three years previously by the second CAIPE survey, but differences in methodology precluded strict comparison, while the term “shared learning” was more inclusive than “interprofessional education”.

The scene was set for the more ambitious developments that were to follow.

References:

Audit Commission (1986) *Making a Reality of Community Care.* London: HMSO.

Barr, H. and Waterton, S. (1996) *Interprofessional Education in Health and Social Care: the Report of a United Kingdom Survey.* London: CAIPE

Bartholomew, A. Davis, J. and Weinstein, J. (1996) *Interprofessional Education and Training: Developing New Models.* London: CCETSW.

Beattie, A. (1994a) *War and Peace among the Health Tribes.* In K. Soothill, L. Mackay and C. Webb, Interprofessional relations in health care. London: Edward Arnold

Beattie, A. (1994b) *Healthy Alliances or Dangerous Liaisons? The Challenge of Working Together in Health Promotion.* In: L. Leathard (ed) op. cit.

Beynon, C. Wedgewood, J. and Hutt A. (1978) Multidisciplinary Education in Geriatrics: an Experimental Course at Middlesex Hospital. *Age and Ageing,* 7 193-200

Birchall, E. and Hallett, C. (1995) *Working together in child protection.* London: HMSO

Butler Sloss. E. (1988) *Report of the Inquiry into Child Abuse in Cleveland 1987.* Cmnd 413 London: HMSO

Carpenter, J. (1995) Interprofessional Education for Medical and Nursing Students: Evaluation of a Programme. *Medical Education* 29.

Brown, J, (1994) *The Hybrid Worker.* Department of Social Work. University of York.

Carpenter, J. and Hewstone, M. (1996) Shared Learning for Doctors and Social Workers. *British Journal of Social Work,* 26, 239-257

Carpenter, J., Onyett, S., Smith, H., Williams, J. and Peck, E. (1991) *Caring for People Joint Training Project Report*. Bristol: NHS Training Directorate

Charles, M and Stevenson, O. (1990a) *Multidisciplinary is Different. Child Protection: Working Together, Part I. The Process of Learning and Training.* Nottingham: University of Nottingham

Charles, M. & Stevenson, O. (1990b) *Multidisciplinary is Different. Child Protection: Working Together, Part II. Sharing Perspectives.* Nottingham: University of Nottingham

CONCAH (1989) *Multi-Disciplinary Learning.* Oxford: Continuing Care at Home, Report 4.

CVCP (1997) CVCP *Survey of Interprofessional Education and Training.* London: Committee of Vice Chancellors and Principles

Department of Health and Social Security (1974) *Report of the Committee of Inquiry into the Care and Supervision provided in the relation to Maria Colwell.* London: HMSO.

England, H. (ed) (1979) *Education for Co-operation in Health and Social Work: Papers from the Symposium in Interprofessional Learning, University of Nottingham, July 1979.* London: Royal College of General Practitioners

Freeth, D. Meyer, J. Reeves, S. and Spilsbury. K. (1998) *Interprofessional Education and Training in Wales: Stages 2 & 3 of the CAIPE Consultation.* London: City University, Internal Research Report Number 8

Fullard, E., Fowler, G. and Gray, M. (1984) Facilitating prevention in primary care. *British Medical Journal,* 289, 1585-1587

Fullard, E., Fowler, G. and Gray, M. (1987) Promoting prevention in primary care: controlled trial of low technology, low cost approach. *British Medical Journal* 294, 1080-1082

GNCs/CCETSW (1982) *Co-operation in Training. Part 1. Qualifying Training.* London: GNCs/CCETSW

GNCs/CCETSW (1983) *Co-operation in Training. Part 2. In-Service Training.* London: GNCs/CCETSW

Gorman, H. (1995) Postqualification/Postgraduate Education in Community Care: Learning from Experience. *CAIPE Bulletin* No. 9. Spring.

Lucas, J. (1990) *Towards Shared Learning.* Salford: Salford College of Technology

Hendry, E. (1995) Training Together for Tomorrow: a Report on the First National Child Protection Trainers' Symposium. *CAIPE Bulletin* No. 9 Summer, 11-12

Horder, W. (1996) Structures, Cultures and Undertows: Inter-Agency training for Community Care. *Journal of Interprofessional Care* 10 (3) 121-132

Hughes, L. and Lucas, J. (1997) An Evaluation of Problem Based Learning in the Multiprofessional Education Curriculum for Health Professions. *Journal of Interprofessional Care* 11 (1) 77-88

Hutt, A. (1980) Shared learning for shared care. *Journal of Advanced Nursing* 5 389-396

Jacques, D. (1986) *Training for Teamwork: the Report of the Thamesmead Interdisciplinary Project.* Oxford: Educational Methods Unit, Oxford Polytechnic.

Jay P. (1979) *Report of the Committee of Enquiry into Mental Handicap Nursing and Care.* London: HMSO

Jones, R.V.H. (1986) *Working Together-Learning Together.* Occasional Paper 33. London: Royal College of General Practitioners.

Keunssberg, E. (1967) *Conference Report, Family Health Care: The Team.* London: Royal College of General Practitioners

Lucas, J. (1990) *Towards Shared Learning.* Salford: Salford College of Technology.

McMichael, P. and Gilloran, A. (1984) *Exchanging Views: Courses in Collaboration.* Edinburgh: Moray House College of Education.

McMichael, P. Irvine, R. and Gilloran, A. (1984a) *Pathways to the Professions: Research Report.* Edinburgh: Moray House College of Education.

McMichael, P. Molleson, J. and Gilloran, A. (1984b) *Teaming up to Problem Solve.* Edinburgh: Moray House College of Education.

Miller, C., Ross, N. and Freeman, M. (1999) *Shared Learning and Clinical Teamwork: New Directions in Education for Multiprofessional Practice.* London: English National Board for Nursing, Midwifery and Health Visiting.

Miller, C., Freeman, M. and Ross, N. (2001) *Interprofessional Practice in Health and Social Care: Challenging the Shared Learning Agenda.* London: Arnold

Mortimer E. (1979) Interdisciplinary Learning at the Qualifying and Post-Qualifying stages. In H. England (ed) op. cit.

National Society for the Prevention of Cruelty to Children (1995) *Promoting Quality Standards for Interagency Child Protection Training.* Leicester: NSPCC

NHS Training Management (1986) The Education and Training of Professions Allied to Medicine: a Discussion Paper. London: Department of Health

Pereira Gray, D. Goble, R. Openshaw, S. Bolden, K, Hall, M. Lewis, A. Jones, R. Scott, J. Hall, A. Damant, M. Hunter, L. (1993) Multiprofessional Education at the Postgraduate Medical School, the University of Exeter, United Kingdom. *Annals*

of Community-Oriented Education. 6 181-190

Pirie, Z. and Basford, L. (1998) Lotus delivering CPD to teams. *CAIPE Bulletin* 15 Autumn, 16-17

Pirrie, A., Wilson, V. and Stead, J. (1997) Mapping Multidisciplinary Provision. Journal of Interprofessional Care 11 (20) 228-229

Pirrie, A. Elsegood, J., Hamilton, S., Harden, R., Lee, D., Stead, J. and Wilson, V. (1998a) *Evaluating Multidisciplinary Education in Primary Health Care* (Unpublished)

Pirrie, A., Wilson, V., Harden, R. and Elsegood, J. (1998b) Promoting Cohesive Practice in Health Care. *AMEE Guide No. 12 and Medical Teacher* 20 (5) 409-416

Ross, F. and Southgate, L. (2000) Shared learning in medical and nursing undergraduate education. *Medical Education* 34; 739-743

Rowley, D. (1993) *The Interchange Programme: Executive Report*. Dundee: University of Dundee

Samuel, O. and Dodge, D. (1981) A Course in Collaboration for Social Workers and General Practitioners. *Journal of the Royal College of General Practitioners, 31 172-175*

SCOPME (1997) *Multiprofessional Learning and Working: Sharing the Educational Challenge.* London: Standing Conference in Postgraduate Medical Education

Shakespeare, H. Tucker, W. and Northover, J. (1989) *Report of a National Survey on Inter-professional Education in Primary Health Care.* London: Institute of Community Studies for CAIPE.

Spratley, J. (1990a) *Disease Prevention and health Promotion in Primary Health.* London: Health Education Council.

Spratley, J. (1990b) *Joint Planning for the Development and Management of Disease Prevention and Health Promotion Strategies in Primary Health Care.* London: Health Education Council.

Stevenson, O. (1995) *Child Protection: Where now in Inter-professional work?* In: A. Leathard (ed) Going Interprofessional. London: Routledge

Storrie, J. (1992) Mastering Interprofessionalism. *Journal of Interprofessional Care.* 6 (3) 253-259

Training Advisory Group on the Sexual Abuse of Children (1988) *Post Cleveland: The Implications for Training.* London: National Children's Bureau

Thomas, P. (1994) *The Liverpool Primary Health Care Facilitation Project, 1989-1994.* Liverpool FHSA

Thwaites, M., Green, J., Borland, M. and Lloyd, G. (1977) *Interdisciplinary Workshops:* Manchester. Personal communication

Tope, R. (1998) *Interprofessional Education in Wales: a Report submitted by CAIPE to the Clinical Effectiveness Support Unit Wales.* London: CAIPE (unpublished)

World Health Organization (1988) *Learning Together to Work Together for Health*. Geneva: WHO