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Mainstreaming Interprofessional Education in the United Kingdom: A Position Paper

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Summary
Interprofessional education (IPE) is being built into the mainstream of professional education for all health and social care professions throughout the United Kingdom (UK) driven by the Labour Government elected in 1997, coincidentally the year that this Journal hosted the first *All Together Better Health* conference in London. The incoming government prioritized pre-qualifying IPE to be provided in partnership by universities and service agencies supported regionally by workforce development confederations, later absorbed into strategic health authorities (SHAs), and centrally by educational, professional and regulatory bodies. Ambitious agenda for pre-qualifying IPE set by government are being tempered by realistic assessment of current outcomes borne of experience and corroborated by evidence. This paper suggests some ways to ease constraints and improve outcomes, but emphasizes the need to generate continuing interprofessional learning opportunities that build on the basics. It argues that accumulating experience and evidence must be brought to bear in formulating criteria for the approval and review of IPE within regulatory systems for professional education. Can IPE be sustained within mainstream professional education once initial enthusiasm ebbs and earmarked funds run dry? That is the issue.

Keywords: *Mainstreaming, regulation, sustainability, interprofessional education*

Facilitating critical comparison between countries

Our focus is the distinctive qualities of IPE in the UK in their political context, our purpose to inform critical comparison with developments in other countries. Please add your perspectives from home and abroad via the Editors' "post bag". We shall be happy to collate responses with a view to publishing a collation in a future issue. The UK is learning more and more from other countries as the "interprofessional movement" gathers momentum worldwide, as this paper amply illustrates, but stands ready to share its accumulating experience. We, with fellow editorial team and board members of this journal, have been privileged to promote and develop it as a vehicle for international exchange on matters interprofessional as its readership and coverage has spread ever wider during the years under review. We look forward to developing that role further in partnership with the International Association for Interprofessional Education and Collaborative Practice (InterEd).

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Reconciling competing agenda

"Mainstreaming" is a convenient catchword (or catchall) to capture diverse meanings and motives driving the promotion of IPE, rehearsed many times in the literature (see, for example, WHO, 1988; Department of Health, 1998; Barr, 2002, 2003). It refers most obviously in the UK to steps being taken to integrate IPE – in organizational, financial, regulatory and theoretical terms – into professional education with which its relationship had previously been tenuous and marginal. Integration, so the argument runs, will secure its future, enhance its credibility and make IPE more effective as a means to improve collaborative practice and thereby the quality of care. Viewed thus, mainstreaming is the means to bring IPE as developed and understood during the three preceding decades in from the cold.

That agenda has, however, been overlaid by a more radical one to modernize the health and social care workforce by "educational engineering" with IPE as the chief agent. Practising professionals, say the policy makers, need to be educated to be more responsive to consumer expectation and to changes in the organization and delivery of services. IPE should not only contribute to the modernization of service, but also to the modernization of professional education systems by the back door. The veiled threat to the integrity of the professions and to their educational systems did not pass unnoticed and accounted, in our experience, for much of the early resistance towards "mainstreaming".

Progress depended upon unravelling the confusion surrounding the purpose and meaning of IPE whilst acknowledging and reconciling competing agenda. It has been largely at local level between stakeholders promoting and developing pre-qualifying IPE, gravitating upwards as educational, professional and regulatory bodies centrally have taken stock of developments on the ground and reviewed their national policies and requirements.

Responding to Government's lead

Early IPE initiatives in the UK were invariably isolated, small-scale and short-lived in response to local needs and opportunities (Ross & Southgate, 2000; Barr, 2002), although some enjoyed support and encouragement nationally from regulatory and professional institutions. Since 1997, however, central government has taken the lead (Secretary of State for Health, 1997; Department of Health, 1998; Pitillo & Ross, 1998; Barr, 2000). The Department of Health expects, and may soon require, that pre-qualifying courses for all entrants to health and social care include interprofessional learning (Department of Health, 2000a). The drive for more and more effective IPE comes therefore from above and below. Neither national edict nor local initiative alone could have generated the commitment to IPE now manifest throughout the UK.

Entering the mainstream

SHAs are promoting IPE as part of their responsibility for professional education, advised in England by "Creating an Interprofessional Workforce", a three-year project initiated by the Department of Health "to mainstream interprofessional learning and development in health and social care".[1] Most regulatory, educational and professional institutions, including those professional associations enjoying the prestigious status of "royal college", have enshrined IPE in their policies, guidelines and requirements. The contribution of the Higher Education Academy is noteworthy, through three of its subject centres,[2] which convene interprofessional conferences and workshops and publish interprofessional papers. The UK

Centre for the Advancement of Interprofessional Education (CAIPE) continues to support and represent its members, run workshops, contribute to conferences and publish on matters interprofessional through its website[3] and books in association with Blackwell (Meads et al., 2005; Barr et al., 2005; Freeth et al., 2005a).

IPE is being woven into the fabric of uniprofessional education at the pre-qualifying stage and multiprofessional education at the post-qualifying stage.

Promoting pre-qualifying IPE

Conventional wisdom that IPE is better left until after qualification has been swept aside as the case for collaborative practice has become ever more compelling. Pre-qualifying IPE partnerships have been established throughout much of the UK, including four pilot sites in England funded by the Department of Health.[4] Many comprise two or more universities (often in different towns) between them providing pre-qualifying programmes for most if not all of the regulated health and social care professions, in partnership with NHS Trusts, local authorities and agencies from the independent sector. The number of students registered for IPE is growing rapidly (the largest number at one site being 7,000), although time spent in IPE is typically a small part of their pre-qualifying professional studies.

Ways in which IPE is being introduced differ. Some sites "implant" it as one or more module or sequence into university-based curricula, the test being whether it "takes" in the host body. Others include it in practice placements, yet others as e-learning in parallel with professional studies. The New Generation Project in Southampton and Portsmouth[5] is more ambitious. It has remodelled much of the uniprofessional into multiprofessional learning in the form of common curricula across professions, but mostly taught separately for logistical reasons. Relatively short periods of time are protected for intensive, interactive, face-to-face, small group, interprofessional learning (O'Halloran et al., 2006).

The Department of Health for some time preferred the term "common learning" to "interprofessional education" with the inference that health and social care students, regardless of their professions, should follow common curricula. Persuasive though the case made for common studies was (Department of Health, 2000b), it detracted from the differential application of knowledge and for comparative curricula about respective roles and responsibilities. The trend towards the reinstatement of the term "interprofessional education" is providing much needed reassurance that cultivating relations between professions lies at the heart of learning together, whatever else it may seek to achieve.

Data from the pre-qualifying IPE sites have yet to be collated and analysed, but evaluations are beginning to be published from some sites (Parsell et al., 1998; Tunstall-Pedoe et al., 2003; Cooper et al., 2005), which provide early clues about the relative effects of different models and learning methods. None of the four designated pilot sites has so far reported, but a composite monograph is in preparation while the overall evaluation of those sites by Carolyn Miller and her team for the Department of Health is keenly awaited.

Evaluations so far of pre-qualifying IPE tend to be more revealing about process and outcomes for interprofessional interventions than to the overall programmes of which they are part. At issue is whether outcomes from short periods of IPE, however positively reported on immediate completion, have lasting benefit by the end of the professional programmes and subsequently in practice. If so, well-planned implants may suffice. If not, renewed efforts will be needed to develop longitudinal and incremental IPE sequences that permeate professional programmes with an interprofessional ethos. Learning from those sites that have made progress along these lines is critical.

Setting realistic objectives

Expectations of IPE have multiplied (see above), but interprofessional educators are cautious. They are alive to the potential pitfalls in expecting more of IPE than it can realistically deliver at the pre-qualifying stage or their students can master so early in their careers. They understand well their duty to prepare students for their primary roles in each profession, mounting pressure on uniprofessional curricula and constraints of profession-specific regulations. Encouraged though they are by national and international evidence that pre-qualifying IPE can, under favourable conditions, modify attitudes and perceptions, and provide knowledge and skills, to pave the way for collaborative practice (Barr et al., 2000, 2005), they are reluctant to make claims that go further. Their experience teaches them that lasting benefit depends upon opportunities to consolidate learning after qualification in a working environment that supports collaborative practice, with continuing opportunities for interprofessional learning in the workplace and in university.

But they are not complacent. Work is in hand to introduce interprofessional learning methods that may prove to be more effective and more efficient, including e-based learning (Hughes, 2004) and innovative practice learning models (Lennox & Anderson, in preparation) that may extend outcomes. Developing competency or capability-based models may move beyond modifying attitudes to changing individual behaviour; improving preparation for teamwork may move beyond changing individual behaviour towards changing organizational behaviour (Barr et al., 2005).

Building on the basics

Outcomes will nevertheless always be constrained at the pre-qualifying stage, which points to the need to build on the basics. Interprofessional learning is being introduced into multiprofessional conferences, workshops and short courses. But the number of students released for longer university-based post qualifying IPE remains small in marked contrast to the "battalions" soon to emerge who have benefited from at least some interprofessional learning during their pre-qualifying courses.

IPE is nevertheless being built into post-qualifying multiprofessional education[6] including systems that offer a choice of modules to be built into sequences of study leading to a range of awards. At best, they take into account the preferences of students and their employers, while building in flexibility in response to the vicissitudes of fashion in the educational market place and maintaining viability as numbers wax or wane for any one course or module. Viability depends on devising user-friendly patterns of study in consultation with service agencies and those staff whom they are contemplating releasing, at the same time making provision for relatively small numbers of full-time students often enrolling at their own expense. Experience suggests that university-led post-qualifying systems stand a better chance when they meet service agencies' preference halfway for less costly in-house continuing education. This obviates the need to take staff away from their regular duties and responds to priorities for organizational development and improvements in service delivery.

Some universities are exercising imagination and ingenuity to retain their stake in post-qualifying uniprofessional, multiprofessional and interprofessional education, but the main thrust in continuing learning is now work-based. Attention is turning to ways in which interprofessional learning occurs (or fails to occur) during everyday work. Continuous quality improvement projects are proving to be especially productive in generating learning opportunities where colleagues from different professions own the same problems and work together to effect improvement (Annandale et al., 2000; Wilcock et al., 2003).

Lead responsibility for uniprofessional and interprofessional education in the UK is polarizing between universities at the pre-qualifying stage (as they assume the lead albeit in partnerships with employing agencies) and service agencies at the post-qualifying stage. This makes it harder to formulate a coherent and unifying rationale for career-long continuing professional education that interweaves uniprofessional, multiprofessional and interprofessional strands in university and workplace. The key may lie in understanding and exploiting work-based learning better so that uniprofessional, multiprofessional and interprofessional education can be developed in service agencies and universities, separately and together. Expectations of pre-qualifying interprofessional education may then be cast in a fresh light.

Reinforcing regulation

IPE is necessarily becoming subject to regulation as it enters the mainstream of professional education and makes greater claims on the public purse. Many UK universities now take it into account during internal approval or review of their professional programmes and ensure that it features in documentation presented for external validation or review. Requirements for IPE in the UK have been written into regulations for professional education by professional institutions and regulatory bodies, service agencies and central government.

Groundbreaking work has all but been completed by the Quality Assurance Agency for Higher Education in England (QAA).[7] It invited representatives for nursing and for each of the allied health professions to prepare benchmarking statements as standards for pre-qualifying professional education for health care programmes (QAA, 2001) complementing earlier work for social care (QAA, 2000). It invited the same representatives from health care to work together to draw up common benchmarking statements applicable to all the health professions. More recently, the QAA has formulated (but at the time of writing not yet published) benchmarking statements for collaborative practice between these professions.

The QAA statements are as remarkable for the process by which they have been prepared as for the consensus generated between professions within a framework of mutual respect. Albeit long and detailed, the statements have already been widely adopted to inform the design of uniprofessional, multiprofessional interprofessional education, and its approval and review by universities and by the QAA itself.

They have also been taken as first base for ongoing reforms in the validation and review of health professions' educational programmes. These are being led by Skills for Health[8] on behalf of the Department of Health in consultation with the Health Professions Council (HPC) (responsible for the allied health professions), the Nursing and Midwifery Council (NMC) and others. The "Partnerships Quality Assurance Framework for Health Care Education in England" (PQAF) will take into account benchmarking and quality standards and the "shared evidence base" (Department of Health, 2003).

It remains to be seen how the role of the QAA may be redefined with regard to the regulation of the health and social care professions. It remains to be seen too how the anticipated reduction in the number of regulatory bodies will affect the HPC and the NMC and possibly the General Medical Council, the General Dental Council and the Royal Pharmaceutical Society under the umbrella of the Council for Healthcare Regulatory Excellence (CHRE). The General Social Care Council (GSCC) has not so far been brought under that umbrella and may remain outside health-centred reforms. Arguments for inclusion gain ground as health and social care services for adults and older people are integrated, but the integration of education and social care services for children brings together a different configuration of professions with different implications for regulation.

Interprofessional educators may be watchful that future regulatory systems and criteria do not inhibit IPE from making expeditious, innovative and imaginative responses to unforeseen and unforeseeable developments in policy and practice. They will be following closely how the PQAF reconciles benchmarking statements and occupational standards[9] in the context of National Service Frameworks (NSFs).[10] They may be anxious to see how guidelines for IPE expected in 2007 from the Department of Health will relate to the PQAF and whether they will take into account principles and guidelines commended by CAIPE (CAIPE, 2001; Barr, 2003) and advice to IPE programme on development, delivery and evaluation (Freeth et al., 2005a, b).

Consultation between policy makers and interprofessional educators about the future development and regulation of IPE will be more focused and more intelligent if it is informed by an agreed evidence base that includes findings from systematic reviews to which we now turn attention.

Assembling the evidence base

Sustained efforts have been made during the past eight years by a UK team to assemble the evidence base for IPE from national and international sources. Its first review was under the auspices of the Cochrane Collaboration and subject to criteria agreed with it. These were that an eligible evaluation comprised a randomized controlled trial, controlled before and after study or an interrupted time series study *and* that outcomes reported referred to patient experience and/or the improvement of services. Exhaustive searches of Medline and CINAHL found no evaluations that met *both* these criteria (Zwarenstein et al., 2001) feeding ammunition to sceptics at home and abroad all too eager to seize on evidence that IPE does not "work".

Members of the Team had, however, become aware of many evaluations of IPE that, albeit not meeting the tight criteria agreed with Cochrane, were relevant to their quest. They therefore reconstituted themselves as the Interprofessional Education Joint Evaluation Team (JET) to conduct further reviews within equally rigorous but less constrained criteria. Its second review was a qualitative critique of 19 UK evaluations (Barr et al., 2000). Its third, based upon a realistic theory, revisited the same databases as the first, plus others, and found 353 evaluations that met its revised criteria (Barr et al., 2005). Of these, 107 were judged to be sufficiently robust to include in the analysis. Its fourth review for BEME (Best Evidence Medical Education) is in preparation, updating and augmenting data from third, and setting a higher threshold of study quality for inclusion.

Findings from the second and third of these reviews render redundant debates about whether IPE "works", pointing instead to the need to focus on the efficacy of different types of interprofessional education and their outcomes.

It remains to be seen whether protestation that there is no evidence of the benefits of IPE will be laid to rest in the light of these reviews. Four issues are at stake. The first is whether the efficacy of IPE should be judged against the RCT "gold standard" for evaluating clinical interventions or against well-tried evaluative methods more often employed in education. The second is the value to be accorded to intermediate outcomes that equate with objectives typically set for pre-qualifying IPE, e.g., establishing knowledge base for collaborative practice and modifying negative stereotypes, thought to pave the way for collaborative practice, service improvement and benefit to patients and clients. The third is the credence to be accorded to the findings to inform UK policy when two-thirds of the evaluations reported were from other countries, notably from the United States with its markedly different health care system (Barr et al., 2005). The fourth is the weight to be accorded to

evidence from research, including that reported in systematic reviews, relative to evidence born of experience and from programme review.

We question the relevance of hierarchies of evidence in this context, preferring to treat the relationship between these three sources of evidence as iterative, each corroborating, modifying or challenging the other. We anticipate that IPE policy and practice will be reappraised in the UK weighing findings from QAA reviews, the evaluation of programmes commissioned by the Department of Health, other comparable UK evaluations, comparable evaluation in other countries and, hopefully, the experience of the individuals and organizations directly involved.

IPE, like the professional education of which it is part, merits more research than it has so far received, but the number of studies reporting from the UK and other countries is rising steadily and their quality is improving. Policy makers and programme planners alike can therefore expect to have more and better evidence at their disposal, but judgement will still need to be exercised, informed by a variety of sources of evidence.

Introducing theory

Theoretical perspectives (see, for example, Colyer et al., 2005; Barr et al., 2005; Hean & Dickinson, 2005) are helping to establish the credibility of IPE in academe and to explain it in terms with which teachers, especially from contributory disciplines, can engage. Those perspectives draw on a spectrum of the educational, organizational, behavioural and social science disciplines, calling on sources from Russia to the United States. Some illuminate the interprofessional practice for which programmes are preparing their students, others the means by which they learn together, yet others processes of service improvement within which work-based interprofessional learning can be cultivated. A digest of these developments would be premature until the first round of publications has been subjected to critical review, further contributions prompted and connections made taking into account papers in the pipeline from other countries.

Sustaining IPE

IPE, once it is embedded in the mainstream, will be relatively secure and sustainable. So says conventional wisdom. We have warned against the danger when implants fail, although we doubt whether this worst case scenario occurs often in IPE.

The dangers are more insidious, for example, when:

- competing claims on teachers, including pressure to conduct research and publish, constrain time and opportunity to reflect and innovate in teaching and learning,
- their interprofessional commitment wanes,
- high turnover of teachers is compounded by lack of preparation in IPE for new appointees,
- cuts in resources undermine small group teaching on which effective IPE depends,
- managers and regulators fail to understand and protect its distinctive features,
- top level support is withdrawn following changes in senior management, and
- IPE is marginalized, boxed in or isolated from uniprofessional learning.

Securing mainstream educational funding, locally, regionally and nationally, is critical to sustain both the quality and quantity of IPE and to carry forward its development. Successful bids for support from the Higher Education Funding Council for England to

establish Centres for Excellence in Teaching and Learning (CETLs) not only provide much needed resources for IPE development but also tangible evidence that IPE is gaining acceptance. The terms of reference for many of the CETLs bear on IPE directly or indirectly.[11]

If "mainstreaming" is to be more than mere rhetoric IPE must pervade the culture of professional education, supported unequivocally by top management, backed by the spectrum of stakeholders, benefiting from core educational funding, owned equally by each of the constituent professional programmes, permeating uniprofessional and multiprofessional teaching and learning throughout. Easily said, less easily done!

Notes

1. www.cipw.org.uk.
2. Medicine, Dentistry and Veterinary Science, Health Sciences and Practice, and Social Policy and Social Work.
3. www.caipe.org.uk.
4. King's College London with Greenwich and London South Bank universities, Newcastle and Northumbria Universities, Sheffield and Sheffield Hall universities, and Southampton and Portsmouth universities, all in partnership with Health Trusts, Local Authorities and other employing agencies, working with Strategic Health Authorities.
5. www.commonlearning.net.
6. Throughout this paper we use "multiprofessional education", as defined by CAIPE to refer to occasions when professions learn side by side for whatever purpose and reserve "interprofessional education" for those occasions when they learn with from and about each to improve collaboration and quality of care.
7. www.qaa.ac.uk.
8. www.skillsforhealth.org.uk.
9. www.lg-employers.gov.uk/skills/nos/index.html, www.lg-employers.gov.uk/skills/nos/index.html.
10. www.dh.gov.uk.NationalServiceFrameworks.
11. They include:

    - interprofessional education in Southampton – d.humpris@soton.ac.uk
    - interprofessional e-learning in Coventry and Sheffield – p.blateau@coventry.ac.uk
    - interdisciplinary teaching in mental health in Birmingham – a.davis@bham.ac.uk
    - assessment of learning in practice settings in Leeds – t.e.roberts@leeds.ac.uk
    - curriculum and assessment development in interprofessional education in Belfast – s.morison@qub.ac.uk
    - placement learning in health and social care in Plymouth – susan.lea@plymouth.ac.uk
    - interprofessional clinical and communications skills – m.j.nicol@city.ac.uk
    - health care professional education in Newcastle – g.r.hammond@ncl.ac.uk

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