

## **Interprofessional Education: A UK Perspective**

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### **Abstract**

To review the development of interprofessional education (IPE) in the United Kingdom (UK) it is necessary to appreciate that the UK is made up of four countries: Scotland, Wales, Northern Ireland and England each with its own health and education policy although health professions are currently regulated at the UK level. For all four countries, meeting future health and social care needs is a critical need that will require the development and introduction of new roles in and across health and social care, new ways of working and as a consequence changes to the kind, content and delivery of education and training. The development and implementation of IPE in the UK therefore requires not only strategic cross-profession agreements but also understanding of the differing labour market challenges and realities within and between the four UK countries.

It is evident that some progress has been made across the UK at a pre-qualifying level with the development of common learning for students from a range of health and social care professions. Programmes for qualified staff often aim to attract participants from a range of disciplines. However despite concerted efforts IPE appears still be somewhat on the margins and evidence of impact is difficult to find at scale.

Rather than promoting IPE or not, maybe the questions for the next decade should be: what are the health and social care needs, what are the skills required to do this work, what therefore should the workforce look like and how should it be prepared. As Wanless (2002) noted "although the number of health care professionals is important for the capacity of the system, arguably the way the workforce is used is even more important".

### **Introduction**

To review the development of interprofessional education (IPE) in the United Kingdom (UK) it is necessary first to understand that the UK is made up of four countries: Scotland, Wales, Northern Ireland and England each with its own health and education policy although health professions are currently regulated at the UK level. The professional regulators such as the General Medical Council, the Nursing & Midwifery Council and the Health Professions Council set the standard, kind and content of educational preparation for entry onto the professional register. The UK is also part of the European Union which itself also has a role in defining the scope and content of education programmes for health professionals in order to enable freedom of movement within Europe.

How IPE has developed in the UK, and the pace of that change, have also been influenced by how and where health and social care professionals are educated, how that education is funded, trends in the numbers trained in response to evolving workforce needs, as well as high profile threats to patient safety.

## Background

Since political devolution in the late 1990s in the UK, there has been a transfer of power and authority for a range of political functions including health from the UK Government to political authorities in Wales, Scotland and Northern Ireland. The four countries of the UK have the freedom to develop and pursue their own health policy. Consequently, there are now some distinct differences between the national health services of the four countries, particularly in their organisation and management. Similarly in terms of education each country has its own credit and qualifications frameworks and different approaches to regulation have been established for some elements of the health and social care workforce. The success of the NHS in all four countries depends on an appropriately skilled workforce to meet local needs. In Scotland, N. Ireland and Wales the health workforce is commissioned nationally. In England nurses and allied health professions (AHPs) are currently commissioned at a Regional level and it is proposed to devolve this further to a local level by enabling employers to have more direct influence. The number of places for initial medical education remains firmly controlled centrally.

Understanding the health and social care needs across the UK is also fundamental to drivers for workforce change. In 2000 the incoming New Labour government commissioned a long-term assessment of the trends affecting expenditure on health services in the UK. This review was undertaken by Derek Wanless, former Group Chief Executive of Nat West Bank. Wanless (1) concluded that the UK would need to devote a substantially larger share of national income to health care in the future. By 2009 health spending had risen and accounted for 9.8% of GDP in the UK, slightly more than the OECD average of 9.5% (2). Across the UK, an ageing population, and the associated increase in chronic long term conditions and health challenges like dementia and obesity are creating ever increasing demands on health and social care services. There is interest in all four UK countries in encouraging self-care and promoting greater co-production of desired health outcomes. Common health policy themes include an emphasis on:

- Health education and promotion
- New clinical pathways
- Integrated service delivery across health and social care
- Making the most of the skills of the whole clinical team.

In this context the Wanless Report (1) made some important recommendations regarding the health and social care workforce. It is notable that that Wanless adopted such an integrated view of the workforce, prior to this much of the rhetoric and policy about transforming the workforce had focused on single professions, usually doctors and nurses. He noted that the strong demarcation of roles and responsibilities between different staff groups, often reinforced by legislation or regulation, was getting in the way of the skill mix changes likely to be required. He also urged that patients should be viewed as 'co-workers' in their care and that for overall continuity of care the workforce should learn to work together. Wanless (1) also suggested radical workforce transformation into 'health care practitioners' who he envisaged as 'registered health care professionals able to span a number of current professional boundaries', and 'care co-ordinators' who would be 'health or social care workers supporting patients with chronic and major conditions, across institutional boundaries'.

Many of the changes recommended by Wanless had been signalled a year earlier with the publication by the Department of Health in England of 'Working Together, Learning Together' (3), a framework for lifelong learning to support the human resource changes in the NHS Plan (4). This policy of transformation included the education and training of the health care workforce, with a clear commitment that 'all health professionals should expect their education and training to include common learning (IPE)'.

By 2009 the UK had 2.7 practising physicians per 1000 population, a big increase from 2 per 1000 in 2000 but still below the OECD average of 3.1. There were 9.7 nurses per 1000 in 2009, up from 8.7 in 2000 and higher than the OECD average of 8.4. The numbers of training places for the health professions remains tightly controlled and ostensibly related to predicted workforce demand although demand is notoriously difficult to predict in part because of changes in service delivery models, retirement patterns and the need for part-time working to support individuals' caring responsibilities. That said, the policy direction in all four countries encourages a move towards increasing flexibility and diversity within the workforce (3;5;6). It also acknowledges that as yet insufficient use is being made of the non-professionalised workforce and that in order to meet future policy and service requirements career pathways will need to span the currently registered and non-registered workforce and the long established health and social care boundaries(7-9). Regardless of the setting there is a growing emphasis in all services on team competency to deliver services rather than restricting particular activities to particular professions.

Higher Education Institutions are also working with the regulatory bodies to modify existing professional education both pre- and post-qualification to support service re-design. For example 'A Force for Improvement; the workforce response to better health, better care' set out the Scottish Government's ambitions for the NHS workforce (6). NHS Education for Scotland (NES) is charged with developing education and training packages to support new role development, based on workforce plans, developing multi-professional postgraduate education and training to meet ongoing and future service needs and developing a structured educational approach to career development for nurses and AHPs.

There are also important country specific challenges which have implications for IPE too. For example, in Scotland there is very low density of population in the Highlands and Islands (only 8 people per sq km compared to Glasgow with 3,540 people per sq km) and most of the remote populations are in Island communities consequently there have long been hybrid nursing roles in these remote communities.

For all four of the UK countries, meeting future health and social care needs is seen to require the development and introduction of new roles in health and social care, new ways of working and as a consequence changes to the kind, content and delivery of education and training. The development and implementation of IPE in the UK therefore requires not only strategic cross-profession agreements but also understanding of the differing labour market challenges and realities within and between the four UK countries.

### **Current situation**

No matter when the first IPE initiatives were launched in the UK it is clear that IPE for health professionals in particular moved from being a marginal activity engaged in by committed

enthusiasts to mainstream policy across the health and social care sector in the last decade of the 20th century. This shift was closely associated with the 1997 New Labour Government and their modernisation agenda, which included an explicit intention to break down the boundaries between professional groups for the benefit of the patient(4).

Dealing with crises, most often related to high profile concerns about patient safety has also been an important driver for IPE historically. For example the inquiry into the poor quality of children's heart surgery at Bristol Royal Infirmary between 1984 and 1995, chaired by Sir Ian Kennedy, recommended shared education and training for health professionals(10). The Government's response included a strong commitment to health professional learning and working together (11).

In 2003 the report by Lord Laming following the inquiry into the death of a child Victoria Climbié recommended that *'each of the training bodies covering the services provided by doctors, nurses, teachers, police officers, officers working in housing departments, and social workers [are] to demonstrate that effective joint working between each of these professional groups features in their national training programmes'* (12).

Less dramatically, but no less importantly, successful service reform across health and social care has also been believed to rely upon professionals learning together at a pre and post qualifying levels in health and social care(3).

### **IPE as implemented**

In the UK Health and social care professionals are all educated in universities, although few universities provide education for the full range of health and social care professions. Typically, even in the same city medicine, pharmacy and dentistry are taught in different universities from nursing, midwifery, physiotherapy, occupational therapy and so on. All health and social care professionals will now exit their professional programmes with an undergraduate degree (this will be implemented with nursing in England for programmes beginning in 2011). The length of the programmes for individual professions varies from 3-5 years as does the way students are funded and places are commissioned – medicine and dentistry being treated differently from the rest. All of which has consequences for the logistical as well as philosophical implementation of IPE.

Despite these challenges there have been undergraduate and postgraduate IPE initiatives in all four countries of the UK. In this section an example from each country is highlighted to show both the commonalities in and range of IPE developments.

In England, in 2001/2 the Department of Health made funding available via a national bidding process to support the development of its policy commitment to see the introduction of IPE within all pre-registration programmes by 2003. Four 'leading edge' sites were selected, Newcastle, South London, Sheffield, and the largest, The New Generation Project (NGP) that involved a partnership between the University of Southampton and University of Portsmouth and local health and social care providers. The underlying principles of the NGP reflect a commitment to expose all health and social care professional students to significant interprofessional learning opportunities throughout their undergraduate studies. The New Generation Project comprises three interprofessional learning units (IPLUs), which are mandatory and assessed and embedded within all pre-qualifying health and social care programmes. The curriculum changes were launched in 2003 and remain in place today.

In Aberdeen in Scotland, the foundations of IPE are embedded in the curricula of ten undergraduate professional courses across two universities – diagnostic radiography, dietetics, medicine, midwifery, nursing, nutrition, occupational therapy, pharmacy, physiotherapy and nursing - in years 1 and 2 (years 2 and 3 for nursing). Students are divided into small groups of 10-12 students with facilitators from the different professions. The aim is to generate an appreciation of professional identities; interprofessional team working and communication, and to engage in patient centred discussions in practice however the total amount of curriculum time devoted to this is minimal: a workshop in year 1, some patient centred activities in term 1 year 2, some mentor-led activity in practice year 3 and a module in year 4. Basic life support skills are also taught interprofessionally.

The Higher Education Academy invited Higher Education Institutions in Wales in 2008-2009 to submit case studies of IPE. The 13 submissions received covered students and staff from health and social care disciplines, with one case also including magistrates and early years practitioners. Three of the case studies are 'extra-curricular' and demonstrate how continuing professional development, involvement in networks and groups, and less formal settings can promote interprofessional learning. Five postgraduate case studies reflect changing practices and new or extended practice roles. One of the case studies describes the development of a trans-national interprofessional programme. The remaining five case studies explore IPE opportunities at the undergraduate, pre-registration level.

The School of Medicine, Dentistry and Biomedical Sciences at Queen's University Belfast run a postgraduate programme for qualified health and social care professionals in Interprofessional Health and Social Care Management. The programme aims to provide students from different health and social care professions an opportunity to harness the diversity of their experience to develop a holistic, interprofessional view of care; foster learning from and about other healthcare professions and provide an environment where students can develop skills for effective interpersonal and interprofessional working.

It is evident that some progress has been made across the UK at a pre-qualifying level with the development of common learning for students from a range of health and social care professions. Programmes for qualified staff whether provided in the workplace or in university often aim to attract participants from a range of disciplines. However despite concerted efforts IPE appears still be somewhat on the margins and evidence of impact is difficult to find.

### **Impact and Effect**

Some of this lack of evidence of impact and/or effectiveness may be because the level of intervention has been insufficient and/or at the wrong level or stage in practitioners development. There remains a lack of clarity in definition and debate as to whether or not the focus of IPE must be on collaborative working between professionals or merely involve learning together about topics of common interest such as anatomy and physiology, safety, quality improvement and so on. There are also differences of opinion about when such learning should take place, whether or not it should be the foundation of each practitioners professional training or whether it works better at post-qualification level once practitioners have already developed a confidence in their own particular profession's traditions and gaze. Where IPE should take place to have most impact ie in the classroom, practice and/or both is also currently unclear. Some IPE initiatives are part of the formal assessment process, others are not and whether or not ensuring participation in IPE should

contribute to degree classification for it to be valued and taken seriously by staff and students is also open to debate.

Even in areas where there has been considerable passion for change and significant investment in IPE fundamentally the training of health and social care professionals hasn't really changed that much rather a module or two on IPE has been added into an otherwise traditional programme.

The role of the IPE facilitator in the classroom and in the practice setting also seems to be crucial. Interprofessional education places staff in a situation which is different from the uni-professional norm and which may be uncomfortable for some(13)

The nature of the evidence of the impact of IPE indicates a lack of investment in research to evaluate the impact of policy in practice, in particular the paucity of longitudinal research and more rigorous practice based studies (14). The University of Southampton and Leicester have invested in their own internal longitudinal evaluation (15-17) however this appears to be rare. The challenges associated with evaluating educational interventions have been well rehearsed (18). For example how to disentangle the elements to identify which actually make the difference e.g. the particular mix of participants, the course design, the quality of the teaching or the content of the programme itself. The IPE literature still lacks detail of the types of educational programme design and learning activities likely to deliver the required outcomes.

Developments to encourage IPE have coincided with an unprecedented growth in the level of health and social care spending. Over the next five years in all four countries of the UK the NHS will be moving from a position of growth to one of consolidation and reduction in spending. To meet increased demand within existing resources is likely to require further fundamental change in the way that services are delivered and innovation to improve productivity and quality outcomes. This will require increasing patient engagement, reducing inappropriate clinical variation and supporting the development of evidence based and cost effective care. It will also necessitate care pathway re-design and the movement of more care into the community. Many of the challenges driving the need to transform the education of the future workforce for the needs of society were captured by the Lancet Commission (19), *'Our vision is global rather than parochial, multiprofessional and not confined to one group, committed to building sound evidence, encompassing of both individual and population-based approaches, and focused on instructional and institutional innovations'* (pp 1951)

An analysis of a selection of Strategic Health Authority commissioning intentions across England undertaken as part of the process of generating this paper highlighted the intention to reduce or steady state commissions across nursing and the Allied Health Professions and to increase the number of associate/assistant practitioner commissions. None made any mention of investing in IPE although Learning and Development Agreements make mention of the value of interprofessional learning and an expectation that providers should facilitate this.

### **Enhancing and hindering factors**

As Humphris and Hean (17) note the complexity of the change should not be underestimated intertwined as it is with operational realities, the politics of higher education, professional prejudice and the powerful processes of occupational socialisation. In addition, sadly in many ways, the

enhancing and hindering factors for IPE appear well known. For example the importance of putting the patient at the centre, having senior champions, a positive culture that supports IPE, and investment in an appropriate infrastructure to support IPE are well accepted. Many of the hindering factors identified in the 1990s namely; differences in history and culture; historical interprofessional and intraprofessional rivalries; differences in language and jargon; differences in schedules and professional routines; varying levels of preparation, qualifications, and status; differences in requirements, regulations, and norms of professional education; fears of diluted professional identity; differences in accountability, payment, and rewards and concerns regarding clinical responsibility remain. Yet despite this knowledge and even with sustained pressure from government in state run health and education systems and the financial incentives available (in England in particular) to support IPE development, these hindering factors remain persistent. IPE is still seen as a marginal issue in many of the professions and as involving minor adjustments at the 'edges' rather than wholesale workforce transformation.

### **What the contemporary IPE discourse precludes**

It is clear that the UK discourse related to IPE is still very much driven by the professions and affected by the dominance of medicine both nationally and locally whether positively as a champion or negatively as a less than willing partner in developments. There is limited patient voice and patient engagement both in the debates and in the process yet success depends on putting the patient at the centre of both.

The term 'inter-professional education' is in itself problematic. It assumes the continued existence of professions, that we can define the professions and who therefore can and should be included in such initiatives. To an extent this ensures IPE remains a marginal activity. Professions are defined by their boundaries and professional status involves mastery over a particular body of knowledge. Consequently shared learning can only ever be a minority of the educational experience otherwise the whole notion of a profession starts to look tenuous.

### **Conclusions**

Current health trends in the UK and beyond require a different sort of workforce from the one we currently have which is still grounded in 19th century understandings of health need (19). Indeed a focus on health alone is too narrow. To truly address the 'carequake' more than the sticking plaster approach of IPE is required. In some of the contemporary debate regarding IPE it appears that the essential purpose of IPE may sometimes have become lost. IPE is a means not an end and the point of promoting it is to prepare practitioners who are able to better meet changing health and social care needs, improve the patient experience and increase safety and quality.

Rather than promoting IPE or not, the questions for the next decade should be: what is the health and social care work to be done, what are the skills needed to do this work, what therefore should the workforce look like and how should it be prepared. As Wanless (1) noted "although the number of health care professionals is important for the capacity of the system, arguably the way the workforce is used is even more important".

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