Walk the Talk

Sustainable Change in post 2000
Interprofessional Learning and Development

Third Supplement to Creating an Interprofessional Workforce: An Education and Training Framework for Health and Social Care in England

Author:
Professor Geoffrey Meads
University of Warwick and University of Winchester

Supported by the Department of Health

Contents

Background	**3**
What is the Question?	**3**
3-D Approach	**4**
False Starts and False Dawns	**5**
The Tortoise and the Hare	**6**
Much Ado About Nothing	**7**
Medical Opposition – or What?	**8**
The Ideal Type	**10**
Crisis, What Crisis?	**11**
An Acute Dilemma	**13**
Will it Last?	**14**
Sustainable Change	**15**
Transferable Learning	**16**
Creating an interprofessional Workforce – Indirectly	**18**
Friend or Foe?	**19**
Walk the Talk	**20**
References	**21**

Background

This supplement to *Creating an interprofessional Workforce: a Framework for the Practice of Interprofessional Learning and Development in Health and Social Care* covering the 2003-2006 period, is lighter weight and more journalistic in style. It represents an ethnographic study of the state of interprofessional learning and development in the NHS during the lifetime of the Creating an Interprofessional Workforce Programme. It takes the implementation of the NHS Plan and its associated human resources policies and its starting points and includes a wealth of quotations derived from a cascade of interviews with many of the most prominent Directors of IPE Programmes and Deans of Medical Schools and Health and Social Studies in England today. This data is enriched by the evidence of three case study sites and the findings of relevant research articles during the period under review.

In addition, Professor Hugh Barr, President of CAIPE, has authored a further supplement to the CIPW Framework entitled *Interprofessional Education in the United Kingdom, 1967 – 2000*. Together these three reports will supply a unique sense of IPE over time: its Past, Present and Future.

What is the Question?

Questions produce more questions, especially in research. Honing in on the right question for the objectives set is the first art of the researcher. But just as important is revising the question in the light of the answers received and data available. The pursuit of knowledge is a process of peeling back the layers.

This CAIPE research project thus began with the following question in February 2005:

- How has the Creating an Interprofessional Workforce programme contributed to effective interprofessional practice and development?

Two months later the initial protocol had broadened this to:

- Which modern NHS policies have been effective in promoting interprofessional practice and development? And why?

By October 2005, when the research commenced, the initial literative review, along with subsequent pilot interviews and discussions with project sponsors meant further modifications. Already it was becoming clear that the principal focus on the formulation of policy was mistaken. The obstacles to and opportunities for the implementation of policy were more significant and, in this context, the timescales for the research questions needed to be extended.

Accordingly by January 2006, when the data collection really got under way, the research question had once more deepened:

- What are the factors that may promote sustainable cultural change in relation to interprofessional practice and development?

Gone were the earlier references to the NHS, to policies and even to the CIPW Programme itself.

And, of course, as issues raised by Deans of Medical Schools were cascaded down to local Directors of IPE Programmes, the new question produced, by August 2006 from these respondents, further real questions of their own:

- How does IPE move from ad hoc to systematic development?
- How does IPE relate to a health system based on patient not professional choices and partnerships?
- What do we mean by 'We' now in health care: the team, the profession, the culture or even a movement?

The last of these captures the difficulty of locating IPE not just in contemporary research but also in the contemporary health system, particularly given the scale and speed of continuous change. All findings are contingent as a result.

3-D Approach

Triangulation is a term that many non-medical 'modern' researchers covet. Particularly if they belong to those emerging academic disciplines that champion the cause of qualitative research. The notion that a subject of study can be encapsulated and contained by three sides of a triangle intersecting on fixed points of new knowledge is seductive. Not least if one of the sides of the triangle represents robust statistical data and can be made to join with the other two. Other 'evidence' drawn from observation and experience acquires a fresh legitimacy as a result. And in health care, as elsewhere, new forms of nursing, psychology and semi-professional practice are born as a consequence. The science of medicine can then be placed increasingly under siege.

It is this science that gave birth to the clinical specialisms that historically have been the biggest obstacle to interprofessional education in health care. The barriers between different branches of medicine have, of themselves, produced a two-century legacy of separate and defensive protectionism, often still reflected in the titles of both Royal Colleges and university departments. For an authentic culture of interprofessional learning and practice to take root the new sciences and their mixed data sources do need to hold sway.

Accordingly, addressing the subject of sustainable change in interprofessional education has meant adopting the new three-dimensional perspective. The 3D approach has, this time augmented the solid facts of NHS policy statements and contract documents, with the author's participant observation in three regional case-study sites, and the findings from 16 semi-structured interviews with a purposive nationwide sample of Deans of Medical Schools and Directors of accredited IPE programmes.

The timescale was 2004-2006. This was the period immediately following the launch of the improvement strategy for delivering the 2000 NHS Plan, on which so many hopes for a real quantum leap in the status of IPE rested. The 3-D approach adopted allowed us to take a rounded view of what has actually taken

place, balancing important political rhetoric with interpersonal encounters and individual insights into those imperatives for change in relation to IPE that actually sometimes seem to directly contradict this rhetoric.

False Starts and False Dawns

Prior to 2000 most UK initiatives on interprofessional education were, in Hugh Barr's pithy phrase, 'brief, work-based and short-lived' (Barr 2005, p138). Few were recorded. So while the trend over time was upwards, the troughs that occurred, for example in the early NHS market years of the 1990s, went unchallenged by effective evaluations or evidence. For forty years IPE was characterised by false starts and false dawns.

The fear now is of a similar experience, especially in the aftermath of the hopes raised by the millennium NHS Plan. This boldly proclaimed that 'the increasingly unhelpful split between public health functions, the NHS, and social services will be overcome' with a new Modernisation Agency accountable for achieving profound cultural change through a comprehensive range of Primary and Emergency Care, Cancer, Older Peoples and other 'Collaboration Programmes'. The Plan was accompanied by the most upbeat policy statement - in interprofessional terms - ever issued by the Department of Health. Building on the 'Working Together' Human Resources Guidance of the previous year this declaration for 'a workforce of all the talents' set out to:

"Look at the workforce in a different way, as teams of people rather than as different professional tribes. For too long we have planned and trained staff in a uni-professional / uni-disciplinary way". (DH, April 2000, 1.3)

Recommendations for fundamental reform were forthrightly presented and early moves were made to both unify the regulatory requirements of different professions and to combine their separate commissioning arrangements. There was a new Strategy for Allied Health Professions to 'Meet the Challenge' of 'joining up health and social care' by becoming 'supporting (not separate) professions working alongside doctors, nurses and scientists'. (DH, November 2000, 1.1-1.3). And a year later, in 2001, 'Shifting the Balance' sought to keep up the momentum promising much greater devolution to all frontline staff so that 'the whole system of health and social care works in an integrated way' (DH, 2001, 5.43).

But in 2006 many of the research respondents are not only disappointed, they are also disillusioned. They see the post 2000 agenda being driven by other, at the time, less obvious elements in the NHS Plan and its subsequent three-yearly Planning Guidance (DH, 2003). The interprofessional agenda, especially for those designing curricula that exploit the business opportunities open to newer universities is secondary to that of new providers, extended practice and patient choice. They point to the 2003 NHS Knowledge and Skills Framework (KSF) as their source policy document and see new skills mix, substitution and semi-professional roles as the way forward. They note that the KSF does not apply to Medicine, which releases them from the academic power struggles that would inevitably arise from their inclusion.

And these respondents list the IPE failures of the past five years:

- The rise and fall of the NHS University and its School of Interprofessional Education.

- The minimal recruitment of integrated Care Trusts and the collapse of Intermediate Care strategies.

- The passing of the Modernisation Agency, many of the 'Collaboratives' and Zonal Partnerships and the explicit exclusion of IPE from the new National Institute for Learning, Skills and Innovation.

- The loss of Workforce Consortia, and then more seriously, the forced merger and perceived 'takeover' of interprofessional Workforce Development Confederations, with strong lay and external representation, by performance managing, politically oriented Strategic Health Authorities - 'just as they were beginning to make a difference'.

And so to 2006 with its new White Paper, Our Health, Our Care, Our Say (DH, 2006) and a new strategy for Best Research (DH, 2006b). In neither is there a direct reference to IPE. In such a context the Creating an Interprofessional Workforce Programme itself is seen by some as 'tokenistic' or even 'out of date'. In 2006 the Department of Health has its designated 'Champions' for 'Knowledge Management' and 'Action Plans' for Communications Technology rollouts and even 'Sustainable Development'; but not for an Interprofessional Workforce. Not yet, at least.

The Tortoise and the Hare

A widely held underlying assumption of many CIPW research respondents and participants is that interprofessional education is the Higher Education Institution (HEI) tortoise to the hare of NHS organisational change. The competitive imagery of a race is commonly used: "universities have not caught up with the 'modernised' NHS", "IPE is lagging behind PBL (Practice Based Learning)" and "is not going anywhere. We (in the NHS) need to force the pace through micro case management". These are typical quotes encapsulated in a simple statement by one Dean of a new university: "NHS Agenda for Change policies have replaced the interprofessional agenda".

These policies are seen to emanate from the continuing development of the NHS as a managed market. As such it is felt to increasingly encroach upon the higher education sector - adopting and funding those local universities with little hope of high Research Assessment Exercise ratings to produce more short term 'task centred training', 'foundation degrees for (various) new health care technicians' and 'extra learning in the workplace'. Instant on-line support is especially valued and the NHS language is of 'Added Value', 'Unique Selling Points (USPs)' and 'Collaborative advantage for competitive edge'.

Limited resources for longer-term, postgraduate and post-qualifying programmes are frequently referred to as a significant factor and one new local NHS Director of Learning dismissed the traditional notion of higher education as a vehicle for

individual development and independent critical enquiry as “hopelessly old fashioned and out of date”. In his view education had to be incorporated into the daily roles of jobholders through IT led feedback processes of task oriented improvement. This is what the NHS understands now by life long learning. IPE does not apply unless it can fit in with this.

The tortoise and the hare simile applies within higher education as well as with the NHS. HEIs view themselves now as competing with each other: for international high fee paying students; for research ratings and recruits; for commercial opportunities and lucrative consultancies. Their marketplace has become highly stratified. At one end, in one location, a struggling local university complained of the impact of low cost entrepreneurial evangelical conference agencies in ‘poaching’ from higher education precious academic audits and evaluations of multi agency developments. For both HEIs and the NHS the race is not just within and between each other, it is also with a burgeoning ‘Third Sector’.

At the other, more stratospheric end of the scale, a Dean of a large Medical School dismissed IPE as ‘irrelevant’ in terms of the ‘high ground’ of the super-specialist training for future doctors whose status depends upon being ‘beyond the internet’. For him, IPE belonged unequivocally to ‘low level’ NHS facilities. There is a real risk of IPE now lagging back, left behind in the pack of the plethora of new more expedient and less expensive development enterprises.

Much Ado About Nothing?

Nobody can doubt that levels of IPE activity have substantially increased over the 2004-2006 period. People have been extremely busy. Attendance at those conferences in which CAIPE has been a partner have tripled in number and size. A less than three figure attendance is now the exception not the rule. Such journals as ‘Learning in Health and Social Care’ have sprung up to meet the new need. The CAIPE website can easily total a thousand hits per month and the Creating an Interprofessional Workforce websites has achieved over 500,000 hits in its first 10 months. There has been a surge in demand for IPE facilitator training especially, and IPE now crops up at every stage of a health services career from a Further Education Access course to the specifications for new Medical Schools foundation years’ placements.

This is very encouraging. It is also, in many research participants’ views not quite what it seems. Most of the IPE activity in 2004-2006 is regarded as being about processes of exploration and engagement. Only in one or two areas covered by this research project is it characterised as genuinely ‘outcomes driven education’. For many we are still at the ‘Fight / Flight’ stage. In the words of one senior interviewee from higher education: “you can still count those really interested here in IPE on the fingers of one thumb!”

The illusion of activity is attributed to four main factors:

- The re-badging’ of existing programmes, particularly for the purposes of meeting external audit and accreditation requirements

- The ‘New Generations’ phenomena which led to new competition and growth in IPE and then a trailing off as Workforce Development Confederations and dedicated resources declined

- The strengthening of subject benchmarks (e.g. in Nursing) and student-staff ratios (e.g. in Psychology) by individual and separate professional bodies to prevent a further blurring of boundaries between different health professionals

- The CIPW programme itself with its extensive planning processes, leading to large numbers involved in consultations about IPE, although not necessarily in its actual commissioning or delivery.

The ‘illusion’ of increased IPE activity, or at least its changing profile, is indicated further by evidence from our three case study sites. In each, postgraduate interprofessional programmes were abandoned for lack of numbers. At two locations the degree courses were left with just one student. It is a sad story. IPE of itself will ‘still not put bums on seats’.

Because of this in universities and at the Centres for Excellence in Teaching and Learning, in particular, there now is what is sometimes termed ‘The Second Job Syndrome’. IPE leaders in the Higher Education Academy’s Centres of Excellence in Teaching and Learning (CETLs) are successful and impressive in their accounts of progress achieved. Their diaries are also booked up for months ahead; in conducting this research it was much easier to get to see an NHS executive or Dean of a Medical School than a Director of an IPE Programme. Their terms of employment can be tied to the duration of the IPE development project; and at interview there is often a sense of the ‘real job’ being either on hold or still waiting in the wings.

“A period doing IPE definitely now counts towards career advancement (in a way that it never used to); and this is at a more senior management level than before”, suggested one experienced Medical Dean. But it is still not a career in itself for high flyers. The guidance or curricula development for IPE supplied by the Higher Education Academy is widely regarded as helpful, and increasingly so. But it was a senior member of the HEA itself who commented that higher education would not really change until “the Faculty itself is shaped by IPE”. This prospect still seems some way off.

Medical Opposition - Or What?

Classic models of interprofessional education begin with the dangers of stereotyping and the importance of addressing usually simplistic and sometimes blind prejudice. One Dean of a Medical School described past relationships, especially with Nursing Schools as “territorial warfare”, and sardonically referred to a tradition amongst doctors of “relegating IPE to the domain of rural teamwork”. The resistance of doctors’ remains for other professionals we found, the most often cited reason for delays in IPE developments. And, of course, internationally as well as in the UK there is a literature to support this stance.

But this is not the position we found in 2006. All eight Deans of Medical Schools we interviewed were ready to be interviewed. Each cited specific areas of progress in IPE curricula. None relied on a colleague to provide more detailed information; there was no need for delegation. IPE has risen managerially to the top of the academic pecking order in Medical Schools that ranged, in our communications, from those newly formed in partnership with an existing faculty to those aligned with the largest acute sector hospitals in our largest cities.

And the leadership of Medical Schools in England is clear about why they are changing. A factor analysis of the interview data produced a two-tier explanation of the reasons for conversion to IPE. The five primary causes seem to be:

- New regulatory requirements, particularly those arising from the translation of 'Tomorrow's Doctors' into the General Medical Council's accreditation arrangements and annual reviews

- Multidisciplinary research requirements, in terms of areas of knowledge and personnel, emanating from, in particular, the Medical and Economic and Social Science Research Councils.

- Financial reforms which have led to significant sums for IPE through the 'New Generations' cluster of pilots, the shift from SIFT to MPET funding especially for University Teaching Hospitals and, prospectively, the further devolution of funds for commissioning IPE to practice based consortia and teaching primary care trusts.

- Workplace developments that focus on integration of service inputs locally within national frameworks for multiprofessional contributions, such as the practical guidance provided by the National Institute for Clinical Excellence and NHS performance management measures.

- Personal leadership from individuals at or aspiring to second tier executive levels in both the NHS and higher education (HE) through records of successful innovation and achievement in IPE. The personal leadership provided by the Creating an Interprofessional Workforce Programme was seen positively by a number of research participants to fall into this category.

Each of the above is a driver for change in its own right. In addition, however, the Dean of Medical Schools identified secondary influences which taken together constitute a favourable background for the longer-term progress of IPE developments. These included the direction of NHS policies and organisational re-engineering, especially following the impetus given by new Strategic Health Authorities overseeing whole-systems approaches; the inevitable continuing pursuit of new skills mixes and substitution and the resultant moves towards interdependence of professional groups and associations; and finally the joint HE/NHS focus on 'Participation'. For some Medical Schools this actually means discovering the neighbourhood Further Education Colleges for the first time. Together this second set of five factors is seen as supplying the incentives for the idea of medical opposition to IPE to move from the present to the past.

The Ideal Type

By definition 'the' ideal type does not exist. Nevertheless for policymakers at least, it has long been seen as an important tool and point of reference[1]. From the data collected in this project it is possible to put together an ideal type for interprofessional education. That is, all of the following elements are actual and possible to reference: they simply never exist together in one place. And sadly in all probability nor could they or will they.

So, from our findings in 2004-2006, the ideal type has ten features:

1. A Strategic Health Authority with leadership at Chair/Chief Executive level that assumes responsibility for systems wide collaborative working practices. This translates into annual reviews of NHS policy developments and performance priorities in relation to their IPE (and other) requirements with education providers and due processes for joint planning and delivery.
2. A sympathetic Vice Chancellor who sets the tone for IPE throughout the University, from standard requirements for joint courses in Lecturers' job descriptions to interdisciplinary membership for Quality Assurance Agency (QAA) and Subject Review Teams; from the format of degree awards ceremonies and honorary doctorates to the Senate's or Council's model of community governance and lay and local authority representation.

3. Learning contracts between HE Schools of Health and Social Studies with individual teams and collaborative units, tailored to the latter's peculiar needs and requirements with online support, commissioned through purchasing NHS primary care trusts with delegated management to clusters and consortia of practice based commissioning agencies.

4. A shared and systematically updated database across the local health and social care system of IP learning and developments categorised by shared interagency performance priorities and policies. Linked to relevant national websites and a dedicated IPE academic library section.

5. Leadership at Pro-Vice Chancellor (Learning and Teaching) or equivalent level that regards NHS and its rapid organisational developments as 'a dynamic source of learning and a laboratory for applied research', with flexible and supportive procedures for grant funding, approvals and reports that ensure effective feedback loops with local NHS.

6. Further Education and Foundation Degree courses use of locally designed and approved client case studies and Patient Pathways for study purposes by multidisciplinary course entrants. Course tutors to include wide-ranging mix of health and social care practitioners to both mirror and make best use of this material.

7. Joint IPE Curricula Development Boards encompassing, as a minimum, (different) HE host organisations for Medicine, Nursing, Health Management and Social Policy, and Allied Health Professions; with senior NHS, Local Authority and Third Sector membership. Board role to include timetabling and

alignment of Subject and Professional Accreditation Reviews for award bearing courses and Continuing Professional Development programmes.

8. Inclusion of requirements for interprofessional awareness and knowledge - including basic understanding of up to 10 key health and social care professionals' roles, responsibilities and relationships - in formal pre-qualifying student assessments (examined) by end of Year 3. Process to be explained as part of initial recruitment and selection of students involving cross-agency staffing from HE and NHS.

9. Tripartite educational exchanges between local services and HE organisations with at least two international counterparts with relevant and comparable contexts: from economically developed and developing countries.

10. Inclusion in terms and conditions for Private Finance Initiatives and parallel external tenders to ensure appropriate space and facilities for IPE, including with independent and voluntary agencies.

All of the above are happening or are planned to happen now, somewhere in England. Each comes direct from the research data of this project gained through interview, observation or documentation. Accordingly, taken together - although they may seem like Mission Impossible - they are a practical proposition not just a perfect counsel for sustainable IPE.

Crisis, What Crisis?

Crisis prevention has historically been the principal UK policy driver for improvements in interprofessional collaboration.[2] For at least one Dean of an English Medical School it still is. The changes to working practices arising from the Bristol Royal Infirmary and Shipman Inquiries are, in his view, predominantly still about reducing risk and retaining reputation. Elsewhere, in other countries, collaboration is identified more with a wider development agenda and its processes: what one Oxford academic referred to at interview as 'the ideal of fellowship as the catalyst of creativity'.

In the UK, IPE may not quite have moved its locus from crisis prevention to development in the 2004-2006 period but it is now clearly viewed as an important element of performance. Several respondents referred to 'teamwork', 'clinical (and care) networks' and to 'working together' as just 'being the way we are expected to do things now'.

In the context of these changes, crisis prevention in the traditional sense has paradoxically lost some of its power to drive forward IPE. Moreover, modern approaches to crisis prevention have then actually gone further in creating new obstacles to IPE development. On both counts modern IPE loses out.

These two assessments are reached through the data analysis in this research project that highlighted the following:

- The diminishing impact of policies for children on the commissioning of professional education. Historically child abuse and protection have

constituted the single most significant set of client group pressures for IPE. The loss of Social Services Department representation on Workforce Development Confederation Boards by 2005 seemed to accelerate the decline at the locations we visited.

- The absence of other single patient or client group categories from the agendas of management decision-making forums in relation to IPE, other than what are perceived as the relatively marginal areas of community mental health and drugs and addictions teams. Agendas are dominated by corporate performance requirements arising from the NHS Plan in terms of increases in individual professional numbers, new practitioners and arrangements for service re-engineering and workforce redesign.

- The continuing real or perceived resource restraints that invariably during 2004-2006 led to IPE being seen as either a surplus or supplementary subject. Rather than being part of a positive response to financial pressures in terms of offering cost benefits and effectiveness, it is typically described as 'The Eleventh (additional) Profession'. This phrase came at interview from an NHS Director of Commissioning who said she feared that IPE would lead to a whole new set of teaching staff in universities, additional expensive student induction programmes and yet another emergent discipline campaigning for scarce NHS research funds.

- The consistent view amongst research respondents that interprofessional issues are secondary to those of inter-agency organisational developments. The impact of the 2001 Health and Social Care Act flexibilities in terms of shared resources with social care, and the expanding role and contribution of private and voluntary organisations are the main reasons for this argument. The consequence is that the focal point for a 'Patient-led NHS' is not the professional (or even the interprofessional) but the identity of the chosen provider agency.

Together these four factors have shifted the spotlight away from professional interfaces. High profile NHS incidents require 'modernising' organisational changes - rather than just better professional contacts and communication as in the past. Privately run diagnostic and treatment centres; privately financed general hospital developments; community hospital partnerships with voluntary agencies and the franchising of general medical and dental practices are illustrations of such changes arising from service shortfalls that have demanded government attention during the period of our study.

The specific practical consequences become clear from the evidence of our case study sites. At one, a £200,000 NHS teambuilding programme had no applicants in its first year from any hospital-based professionals. At another, by mid 2005, the Workforce Development Confederation formally concluded that while 'important' it was 'not in a position to support the common learning programme' initiated by one local university for its pre-registration health and social care students. The university would 'have to look for support elsewhere' and see 'if national monies' might be available. At the third, a new proposal for a 'Centre' to facilitate IPE simply had 'Inter Agency Partnerships' inserted at the beginning of

its nameplate. The allocation for ‘hotspots’ (training interventions) by the Strategic Health Authority was three times that for IPE.

An Acute Dilemma

It has been axiomatic that hospitals and interprofessional education in the NHS do not go together. The lateral peer-based relationships of the latter are seemingly incompatible with the vertical accountability structures of the former. Over the 2004-2006 period our research respondents continued to identify the absence of incentives for hospital based professionals and practitioners to learn and work together as a major drag on IPE progress.

The Journal of Interprofessional Care remains still the authoritative voice of IPE. Its contents mirror the state of the subject and in its twelve editions between May 2004 and March 2006 hospital developments still barely figure. Eight articles each are devoted to community mental health and primary care developments: double the number for any other health sector or patient group. By December 2005 only one covered an acute care setting; the same total as the subject of Intermediate Care which came and went midway through 2004.[3] This contrasts, for example, with a steadily growing number of sound research based IPE developments in palliative care and the management of chronic conditions; as evidenced by Hermgen’s and Arievian’s articles in 2005.[4,5]

The need to further incentivise the powerful pairing of the large specialist teaching and general hospitals and their allied medical schools, was a persistent and recurring theme in interviews. Without such incentives the oft-expressed fear was of interprofessional learning and development remaining ‘sidelined’ in community settings, identified with rural not urban developments; and ‘dependent on the new universities and allied health professionals for leadership’.

But the same interviewees also pointed to some signs of improvement, signalling hope for the future. Relatively random in nature they do not really yet constitute a pattern. The rise of the Journal of Integrated Care; the growing extended membership of the NHS Alliance; the impact of the National Service Framework for the Care of Older People in particular; and above all, the coalescence of health professional regulatory requirements: each of these were referred to as ‘opportunities’. The role of the Creating an Interprofessional Workforce Programme in focussing attention on the need to harmonise and strengthen educational standards and ethics is especially welcomed.

And the tide may be turning. In 2006, the present year, some of the United Kingdom’s most respected IPE leaders have been published in the Journal of Interprofessional Care for their work in the acute sector.[6] By the middle of the year no fewer than three articles in the Journal of Interprofessional Care had already been drawn from NHS hospital developments with one actually addressing with patients and users the needs of Cancer Services.[7] The underlying current seems to be positive with the prospect of new NHS Foundation Trusts even indicating that, unlike in November 2004, when the Journal of Interprofessional Care devoted an edition to community governance

and participation, it may not have to be reliant exclusively on examples from developing countries overseas.

Will it Last?

It should not come as a surprise that the UK Department of Health has its own Sustainable Development Action Plan. Published early in 2006 this concentrates on physical issues of the environment: waste, energy, water, procurements and transport (DH, 2006). For IPE sustainable change is seen now to require a rather different framework. For today's NHS the point of reference suggested by our research data is not drawn from estates management but rather from models of community participation.

The reasons are straightforward. First the growth of interprofessional learning and development has led to 'communities of practice', often responsible for care pathways that cross conventional service sector and separate professional boundaries. Secondly, interprofessional learning and developments are, as a wealth of parallel international evidence also indicates, often at their strongest where accountabilities are predominantly local and community based rather than top down. And finally, the process of IPE, when effective, is regarded as essentially participative.

The thematic analysis of interview data validated this finding. A trawl of the Community Participation literature identified one theoretical model, tested and successfully applied in the Canadian health system that is particularly relevant to the CIPW programme today in the NHS. This Abelson model of 'Contextual influences on healthcare decision-making'[8] divides the factors that together contribute to sustainable change into three categories. In summary these are:

A. Pre-disposing influences: the structural and social associates of sustainable change, which include favourable policies and organisations, demography and residential profiles and educational curricula.

B. Precipitating influences: specific and short term triggers for change that include crises, media communications, issue based coalitions, interest groups and individual executive actions.

C. Enabling influences: the cultural components of historic and geographic factors, local government, institutional relationships and public relations, and local community action and development.

As we aggregated the factors mentioned by the participants in this programme it became clear that the majority were in the last category. Enabling cultural characteristics are seen as more powerful than any structural policy development. While the role of a precipitating crisis, such as a widely publicised clinical negligence case or child protection report, on which so many past interprofessional initiatives have been based, is now regarded as negligible in terms of achieving genuine sustainable change for IPE.

And, as a footnote, the interview data also validated the findings of another piece of research into sustainability in primary care development: that the presence of an independent non-governmental organisation identified with the cause is vital (Sarriot et al, 2004).[9] For IPE this has to mean the UK Centre for the Advancement of Interprofessional Education. A vote of confidence for the role and rights of CAIPE in 2006-2007, and an indicator, perhaps, of where the legacy of the Creating an Interprofessional Workforce Programme should lie.

Sustainable Change

Sustainable change comes down to culture. And culture comes down to lots of things, none of them seemingly indefinable. History and geography, however, do clearly have large parts to play. The levels of interprofessional education over 2004-2006 were perceived by research participants as at their highest in those areas where first there was a long term record of collaborative working practices and secondly where there was a distinct local identity based on communities seeing themselves (and being physically) separate and different from others. East Africa, Tyneside and the South West Peninsula all fit this description.

In such places the post-NHS Plan plethora of new 'Partnership' HR policies are 'absorbed' into existing conventions. They are seen affirmatively as assets rather than requirements for innovation. Unlike elsewhere, they are not a threat. Drawing on Abelson's classification of 'Pre-disposing' influences for sustainable change[10] it is possible from the project data to identify four consistent cultural factors that create the pre-conditions for IPE - almost regardless of national policy initiatives. These are:

1. A strong infrastructure of numerous service developments largely sponsored by the main local authority, usually with funded logistical and personnel support by this body, and always including not just NHS agencies but also local universities and colleges and a broad spectrum of Third Sector representatives. This infrastructure is characterised by enduring over time regardless of organisational turnover in individual member agencies and, in particular, the NHS.

2. A positive and proactive media in terms of commitment usually to a Regional level of economic growth and social cohesion - which leads to an accumulated narrative of 'good news' stories by the 'lead' local newspaper and radio station regarding successful joint developments, each with a named village, neighbourhood, family or patient as the beneficiary. The effect of this to strengthen not just local accountability and responsiveness, but the capacity of higher education and NHS to 'counterbalance' standardised central policies that 'do not fit' local circumstances. This media support can even produce a local language of collaboration evidenced in, for example, the titles of university development centres and projects.

3. The personal leadership of highly committed individuals often with charismatic characteristics, but more significantly with formal arrangements for both their succession and their responsibilities across individual agency and professional boundaries. Interprofessional education here is not dependent

on a single product champion, although the person in this position has the authority to exemplify its qualities through, for example, the management of joint service and subject reviews. The IPE leaders are seen as creative and progressive: in the words of one interviewee:

"It comes down to getting a shared vision from key individuals
keeping in touch as risk takers together".

4. 'Socialising mechanisms' that prevent, in the words of one academic Dean "life-long capture by the professions own societies" and all the 'resistance' this then brings. This socialisation consists of a web of events and exchanges, many of which are informal and interpersonal. A recurring characteristic in this research project has been the links between socialisation and a local 'product' in terms of an idea or principle that is regarded as transcending not only professional but also political priorities. Offering together 'Servant Leadership', 'International Best Practice as our Unique Selling Point' and 'Breaking down the Barriers as a Movement' are three examples drawn direct from interviewees. Multidisciplinary Professional Doctorates, statements of shared ethics and joint fundraising 'for freedom from regulation' are three outputs of such socialisation.

Of course, alongside and sometimes beneath positive cultures for sustainable change in IPE go sub-cultures and even alternative cultures hostile to such collaborative developments. The union of the University Teaching Hospital with the Medical School is the most frequently cited source of cultural opposition with one Dean, for example, describing IPE as "a low level function" needed to make sure MRI scanners (and the like) are used efficiently. For another, reflecting on the next Research Assessment Exercise "Medicine is literally thirty five times the value of the next profession (Nursing) in terms of its status and financial returns".

So, nationwide, despite favourable climate for IPE in some parts of England, there is still a long way to go. The lessons from these parts of the country, moreover, is that these policies that promote IPE most are often not those that directly address HR issues. Indeed the post-2000 national policies seem actually to have produced the effect of 'a common enemy' to fight against through, for example, the undermining of the NHS University, in many cities with long established university medical schools and teaching hospitals. For IPE it is local and regional levels of policy making that generally seem to be most productive, with the actions of national government best reserved selectively for such exceptional opportunities as that provided by the chance to create and combine new medical and nursing schools. This is a tough political lesson to learn.

Transferable Learning

The notion of reciprocal exchange between developing and more economically developed countries underpinned the international research programme from which the present project on Sustainable Change in Interprofessional Education emanates[11]. This 'transferable learning' is an unusual idea. Normally the NHS relies on its more affluent allies for new ideas and practices to adapt and apply. Australia, Canada and New Zealand, in particular, through colonial links; parts of Europe increasingly, but always with the United States as the chief source of

intelligence. Research respondents in this project saw it as both a strength and a weakness of contemporary IPE that its principal points of reference are outside this sphere of influence. The strength lies in the richness and range of curricula developments now accessible to UK innovators. The weakness is in their detachment from the Managed Care 'Club' of countries that the NHS and Department of Health still feels it belongs to in terms of shaping overall system change and market oriented organisational developments.

Nevertheless there is widespread agreement that the period 2004-2006 has 'internationalised' IPE. Almost 400 delegates attended the multi-national All Together Better Health III three-day conference at Imperial College, London in April 2006. UK members have played increasingly prominent roles - twice as Chair - during this period in the Interprofessional Taskforce of the WHO sponsored 'NETWORK / Towards Unity for Health movement; and international academic partnerships have flourished. The result is that IPE is no longer in the UK merely a model of behaviour modification, which could conveniently offer the prospect of political compliance.

Past IPE pedagogy in HEIs and the NHS has emphasised the importance of interactive learning 'with, through and by other health and social care professions'. Onto this, the Dutch 'Problem Based' approach has grafted the 'Shared Learning' style of pooled professional perceptions and expertise. These models still start and finish with control in the hands of the professionals. The IPE approaches of developing countries place the power elsewhere. With local neighbourhoods, lay representatives and Civil Society forums in the 'Community Based Education' models of Venezuela, Peru, Kenya, Sudan and Uganda for example. Or with the customs and rituals of the cultures and sub-cultures that are now themselves coming together in new contemporary combinations of health care partnerships and provision.

In the UK this means a nurse from the Philippines with a General Practitioner from India negotiating with indigenous white English patients of Anglo Saxon origins the alternative meanings of their diagnosis and disease, and appropriate options for, let us say, physical therapies that can stretch from Thai massages to Chinese acupuncture practised by immigrant East Europeans. And indeed at formal international IPE planning levels the last group are now increasingly prominent in, for example, CAIPE's collaboration on the European IPE Network (EIPEN) with the Higher Education Academy. These new models of Values and Community Based Education offer anything but compliance to the central political will.

As such these forms of IPE internationally are part of the 'transferable learning' taking place between countries keen to decentralise their health care systems. For the likes of Chile, Colombia, Costa Rica and even Greece and Italy, IPE belongs to national strategies for rooting responsibilities for health and health care in collaborative local relationships. These strategies are profound and far-reaching, sometimes involving the virtual extinction of the 'native' NHS, (as in Colombia, for instance). Multiple forms of finance, cross-sectoral provision and partnerships, social organisations in primary care, community custodianship of public health and large-scale increases in popular participation mechanisms are the other main components of these strategies.[12] The research participants in

this project would see them as sitting uneasily with their experience of the contemporary NHS and its management. The ‘transferable learning’ on IPE from abroad, accordingly, is often felt to supply a developmental stimulus to which the political environment cannot respond.

Creating an Interprofessional Workforce – Indirectly

While by no means all our research participants had heard of the Creating an Interprofessional Workforce Programme, those that were aware of it made positive and encouraging references. At its minimum it is seen as important symbolically; plus it has an informative website. At its optimum it is perceived as the vehicle for achieving a wider level of individual and organisational interest in interprofessional education (IPE) then ever before. Attendance and participation in its consultation events seem to testify to this, with both impressive numbers and diversity over a sustained period. The CIPW programme has made a difference. CAIPE itself has no longer felt isolated as the sole advocate and representative nationally for interprofessional learning and development.

Two specific commendations of the CIPW programme mentioned at local sites have been its attempts to engage effectively with regulatory bodies and with the third sector of voluntary agencies and private enterprises. Both are viewed as tough nuts to crack, but essential if IPE is to flourish as a cultural norm. As the CIPW programme has grown so too has the recognition that linear models of project management which ‘drill down’ as a single task are not only outdated and inappropriate, but also actually counterproductive effective indirect interventions are everything.

Recent international research points in the same direction. Collaborative practice allied to supportive interprofessional education can be counter cultural in those countries where the dominant themes are reductionist managed care and aggressively expansionist new health technologies developments.[13] If this applies mostly to the United States and its associates (including, it can be argues, the United Kingdom), even in developing countries IPE requires complex strategies for its effective establishment

The adoption of an interprofessional model of primary care across a range of states that include Croatia, Cyprus, Zimbabwe, Jordan and Estonia, for example, has required the combined inputs of a major Scandinavian university, an American sponsored charity, multinational donors and the use of Moldova as a pilot demonstration site.[14] Above all, because of the IPE imperative of contextual fit with regional culture and local frameworks for organisational partnership, in countries as far apart as Zambia[15] and Canada[16] the critical factor in effectual IPE programmes has been the conscientious management of decentralisation through, for example, training in integrated health service delivery models which emphasise unified assessments, shared budgets, common reviews and information technology and single points of access to the interprofessional resource.

This international perspective and the ‘toughness’ of the challenge posed to the CIPW programme by engagement with regulatory bodies and the third sector,

suggest that there will be much left still to do beyond 2007. Establishing interprofessional education is an endless priority and process to which individual projects are seen only as one ‘contribution along the way’. This contribution is the more effective and enduring when its influences are indirect, in effect laying long-term siege to the fortresses of resistance that can so easily still rebuff a heads-on assault.

Friend or Foe?

‘Change has been forced. There are too many initiatives in quick succession’.

‘Professional resistance has got worse. It is like they are all back in their own societies again – on the defensive’.

‘The Strategic Health Authority lacks any vision of its own government can try to create the climate; that’s all. Locally there are no resources for IPE – it’s at the margins’.

‘The biggest obstacle is standardising policies. One size does not fit all in IPE. The logistics are always different. National initiatives are a distraction’.

There are many mental models of policymaking, particularly of policies formulated at central government levels. The quotes above are from interviews across the length and breadth of England. They reflect a vertical model of policy development and implementation. Top-down, lacking ownership at intermediate levels and often experienced as oppressive. Moreover, together they capture a feeling of loss for a model of converting policy into practice usually described as ‘incremental’.[17] This previously gave scope to individual professionals, and others, to negotiate and adapt government statements at different stages in the dissemination now, for these interviewees, there is a sense of being ‘done to’ with the vertical policy model being augmented by what he called ‘the big Bang approach’.

However, not all the interviewees shared this perspective. For some, contemporary policies were more friend than foe. The following responses from both directors of interprofessional programmes and university Deans illustrate an alternative mindset.

‘We feel we have had sympathetic support from both the government and the strategic health authority for our combined pre-registration programmes’.

‘Here the Chief Executive of the SHA has helped to trigger everything, rolling out interprofessional collaboration to all the trusts the key policy criteria for everybody has been safe clinical outcomes’.

‘We try to turn everything we’re given into bite sized chunks in the workplace. Act – reflect – generalise – plan together: without any extra monies, that’s our model’.

‘We have to stay close to government policy and projects all the time it’s almost the only way a new university in health care can get any funds and its vital now if we are to be part of local commissioning’.

Here the mental model of policy making, if not bottom up, certainly understands the relationships required as not simply hierarchic but as lateral and reciprocal. The results seem to be more creative stance in relation to pedagogy. E-learning and Problem Based Learning courses which ‘balance the contact between working professional’ are more prominent and these interviewees made greater reference to risk sharing and contingency planning.

In theoretical terms the models of policy formulation and implementation had become ‘selective’ and ‘processual’.[18] In the past such a model has been associated with such powerful elites as civil servants or even civil society champions. For the promotion of ‘inteprofessionality’, however, it now requires engagement at lower levels in the local and regional health systems. In the words of one research respondent:

‘We need to all learn together for policy as much as from policy. It’s a resource itself (for IPE) and we learn by working it through, by making it effective’.
In the words of another such an enlightened ‘policy agenda is very challenging’. It certainly is.

Walk the Talk

Walk the talk. Ultimately, this is the take home message. Turn words into action. IPE as a daily way of life, and not just activity but authentic action: with purpose and direction.

And there is a lot of just talk. The research project has highlighted the new rhetoric of ‘inteprofessionality’ and the volume of novel presentations and publications. The consultation of the Creating an Interprofessional Workforce Programme has contributed significantly to both. The result is a raised profile and increased expectations.

But the walk remains the same. The paths to ‘inteprofessionality’ are strewn with policies and propaganda, with obstacle and debris from past crisis driven interventions. The way ahead seems still to lie in cultures of collaboration in which health is a community issue at the heart of which are relationship values. When IPE complies with this culture and is one of its key constituents it is sustainable; if locally it does not go against the grain it lasts. If not, it will not and any amount of national policy, however well intentioned and articulated, cannot in the end turn the tide.

References

1. Light D. (1997) Community health care: the limits of countervailing powers to meet the health care needs of the twenty first century. Journal of Health Politics, Policy and Law; 22: 106-145.

2. Ashcroft J. (2005) Crisis Prevention. In Meads G., Ashcroft J. et al. The case for interprofessional collaboration in health and social care. Blackwell Publishing, Oxford. Chapter 7.

3. Nancarrow S. (2004) Dynamic role boundaries in intermediate care services. Journal of Interprofessional Care; 18(2): 141-152.

4. Hermsen M.A., Ten Have H.A. (2005) Palliative care teams: effective through moral reflection. Journal of Interprofessional Care; 19(6): 561-568.

5. Arevian M. (2005) The significance of collaborative practice model in delivering care to chronically ill patients: a case study for managing diabetes mellitus in a primary health care centre. Journal of Interprofessional Care; 19(5): 444-451.

6. Anderson E., Manek N., Davidson A. (2006) Evaluation of a model for maximising interprofessional education in an acute hospital. Journal of Interprofessional Care; 20(2): 182-194.

7. Sitzia J., Cotterell P., Richardson A. (2006) Interprofessional collaboration with service users in the development of Cancer Services: The Cancer Partnership Project. Journal of Interprofessional Care; 20(1): 60-74.

8. Abelson J. (2001) Understanding the role of contextual influences on local health-care decision making: case study results from Ontario, Canada. Social Science and Medicine; 53: 777-793.

9. Sarriot E.G., Winch P.J., Ryan L.J. et al (2004) Qualitative research to make practical sense of sustainability in primary health care projects implemented by non-governmental organisations. International Journal of Health Planning and Management; 19: 3-22.

10. Abelson J. (2001) Understanding the role of contextual influences on local health-care decision making: case study results from Ontario, Canada. Social Science and Medicine; 53: 777-793.

11. Meads G. (2006) Primary care in the twenty first century. An international perspective. Radcliffe Publishing, Oxford.

12. (Social Seguridad)

13. mechanic D. socio-cultural implications of changing organizational technologies in the provision of care. Social Science and Medicine. 2002; 54(4): 59-467.

14. Bivol G., Corocichin G, Sitnuck A et al. development if Family Medicine Education in Moldova with Carelift International Education for Health 2002; 15(2): 202-214

15. Miller Franco L., Bennett S. and Kanfer R. Health sector reform and public sector health worker motivation: a conceptual framework. Social Science and Medicine. 2002; 54: 1255-1266

16. Hebert R., Durand P., Dubuc N. et al. PRISMA: a new model of Integrated Service Delivery for the frail older people in Canada. International Journal of Integrated Care. 2003, 18 March.

17. Lindblom C. the policy-making process. New jersey: prentice-Hall, Englewood Cliffs; 1968.

18. John P. Analysing Public Policy. Continuum, London, 1998.