Using a meta-ethnographic approach to explore the role of interprofessional education in Inclusion Health for health and care staff.

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Abstract

Purpose: To present a systematic review and synthesis of evidence on the experiences, role and use of IPE in IH fields, using a meta-ethnographic approach including key concepts, reciprocal and refutational translation and lines of argument.

Inclusion health (IH) practice suggest the needs of excluded groups are more effectively addressed through collaborative working. Interprofessional education (IPE) occurs when two or more professions engage in shared practice and learning, resulting in improved collaboration and quality of care. Studies on IPE to train staff in fields relating to IH exist, but without a settled consensus on the best approaches/activities to foster inclusive practice.

Methods: This synthesis is underpinned by a meta-ethnographic approach. It provides explicit stages of data collection and interpretation, while providing space to engage with emerging themes and concepts iteratively (reflecting on author experiences) and inductively (reasoning and interpretation). We searched electronic databases and journals for English language peer reviewed articles between 2000-2020. Of the 2217, 19 papers were included. The lead author and reviewer completed the review process and a second reviewer reviewed 10 percent at each stage. The quality was assessed using a modified CASP checklist. Iterative analysis involved PPI and staff stakeholders.

Findings:16 concepts embedded in 19 papers provide insight into the nature of IPE in IH (IH) for staff. We found that IPE in IH covers a broad group of practitioners and is a complex activity involving individual and organisation readiness, practical and pedagogical factors, influenced by setting, method, curriculum, lived experience, reflection and a learner driven approach. Barriers to design, implementation and translation into practice were also found to exist.

Practical Implications Most studies used a combination of core learning and group work. Educational modes include mentoring or coaching, reflective practice, immersive learning, and people lived experience of exclusion involved in or facilitation thematically centred in trauma-informed informed care, cultural competence, communities of practice and service

learning. The aim of these methods was to promote collaboration through identifying shared experiences, problems and tensions, and critical reflection of services and organisations.

Such transformative learning is reported to challenge stigma, discrimination, and misinformation and promote collective empowerment to address social injustice through human connection. Effective models of IPE re-instated the therapeutic relationship and alliances between patients and staff.

Social Implications This review also calls for the development of health and care workers' professionalism in relation to their own reflexivity, establishing anti-racist curricula, challenge stigma and ensuring clinicians are aware of and able to negotiate tension and difference identified within the consultation and between themselves. As well as developing generalist skills, our analysis suggests that IPE in IH may be able to challenge stigma and discrimination towards IH groups by destabilising existing norms and siloed working with the aim of achieving robust interprofessional practice.

Originality and Value: IPE in IH is a complex activity affected by individual and organisation readiness, setting, experiential, practical and pedagogical factors. Models of teaching are focused on re-instating the therapeutic relationship. There are no systematic reviews in this field and previously there was no settled consensus on the best approaches and learning activities to foster inclusive and collaborative practice.

Introduction

Inclusion health (IH) is a relatively new term and an evolving form of integrated practice. Born out of an international grassroots movement in primary and community healthcare teams (Khan *et al.*, 2019), Inclusion Health seeks to prevent and address the health and social inequalities experienced by groups of people at risk of or living with extremely poor health as a result of poverty, marginalisation, multi-morbidity and social exclusion, through holistic, person-centred, multi-professional integrated care (Khan *et al.*, 2019).

Inclusion Health Groups (IHGs) include populations experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery, people with enduring mental illness and those experiencing learning disabilities (NHSEngland, Aldridge *et al.*, 2018). These groups often experience multiple complex needs (Stringfellow *et al.*, 2015) but due to stigma, discrimination, trauma and barriers to accessing services, their care is frequently unplanned and disjointed (Bramley *et al.*, 2020). These systemic problems exacerbate pre-existing health inequalities resulting in some of the worst health outcomes in society (Fitzpatrick *et al.*, 2013, Aldridge *et al.*, 2018).

IH in practice is characterised by complexity and uncertainty, situated within a challenging socio-economic backdrop, a lack of directing policies, fragmented services, and little training to effectively support patients. To address health inequalities and high acute health attendance, systems are now mandated to work collaboratively and in an integrated way across health, housing, social care and voluntary services (KingsFund, 2021, Cornes *et al.*, 2021, Clouder and Adefila, 2017). To facilitate integrated care, interprofessional working

has been described as a priority to deliver safe and integrated person-centred care (Gray and Ford, 2021).

'Educational interventions' are often recommended to improve healthcare delivery, but can range from one-off, asynchronous on-line learning, through to embedded, longitudinal learning. Evaluations of effectiveness rarely explore how and why an intervention was 'successful' or achieved change in practice beyond references to knowledge, skills, attitudes and behaviours. Other theorists (Mezirow, 1997, Taylor and Mezirow, 2009) emphasise transformational learning approaches which can shift the learner's outlook and attitudes about a particular topic or approach.

Previous research identified that IH education is needed to address inequalities and manage the multiple needs of IH groups, (Clark *et al.*, 2022, Davis and Lovegrove, 2015). However, there has been little progress or research to understand what educational interventions should look like or how they can promote interprofessional care. A key issue is how to incorporate the shared "normative narrative"; relationship building to reinforce a shared mission, between services, people and organisations in the care of IH groups (Davis and Lovegrove, 2015). Educational ambitions are also frequently stifled by lack of resources resulting in didactic education that is frequently online and rarely informed by evidence, curricula, or pedogeological theory (Khan *et al.*, 2021).

Interprofessional education (IPE) occurs when two or more professions learn about, from and with each other to promote collaborative practice and improve quality of care (Barr, 2002, Lindqvist *et al.*, 2017). Systematic reviews in IPE indicate that it can promote interprofessional collaboration (Hammick *et al.*, 2007, Reeves *et al.*, 2016a) including in fields closely aligned to IH such as mental health (Pauzé and Reeves, 2010, Curran *et al.*, 2012) and domestic violence management (Reeves *et al.*, 2013). This evidence relates mainly to undergraduates, and there is a research gap in assessing the contrasting clinical effectiveness and impact of IPE interventions with respect to attitudes and empathy towards complex needs (Reeves *et al.*, 2013, Reeves *et al.*, 2016a, Simpson *et al.*, 2020, Brandt *et al.*, 2014, Lawlis *et al.*, 2014, Sunguya *et al.*, 2014).

Education needs to do more than impart skills: it can role model, change attitudes, destigmatise, empower and enable. These transformative learning journeys are often captured through qualitative or sociological methods. Although reported outcomes in papers tend to focus on the short-term, some might examine longer-term change in practice or patient care.

Given the potential importance of IPE in nurturing collaborative and interprofessional practice and with a lack of attention to evidence synthesis in this field, the aim of this review was to understand the experiences, role and use of IPE in IH for staff learners. We present findings from a meta-ethnography that synthesised available research for the staff learner in Health and Care.

Methodology

There are many approaches used to synthesise evidence (Sandelowski *et al.*, 2013, Gough *et al.*, 2017). Meta-ethnography is a methodology increasingly used in the clinical education

community and can be applied when published research is limited. The method was agreed to be the best fit for the subject, because it allows inclusion of a broad range of research but uses a qualitative synthesis methodology, to glean the full richness. Meta-ethnography also provides explicit stages of data collection and interpretation, while providing space to engage with emerging themes and concepts iteratively (reflecting on author experiences) and inductively (reasoning and interpretation). This synthesis is underpinned by a meta-ethnographic approach (Noblit and Hare, 1988) adapted and applied in a recent protocol in IPE research (Reeves *et al.*, 2016b). The recent eMERGe guidance was also reflected on. (Improving reporting of meta-ethnography: the eMERGe reporting guidance | BMC Medical Research Methodology | Full Text (biomedcentral.com).

The following objectives directed the synthesis:

1. To co-construct the review with involvement of stakeholders including staff and people with lived experience of homelessness and exclusion.
2. To synthesise the available research related to interprofessional education in IH for health and care staff.
3. Investigate the aims and use of IPE models including key characteristics and components, learning approaches, and wider organisational factors.
4. To identify gaps in the IPE evidence and inform further research agenda.

Co-construction approach

The lead reviewer ZK is a woman of colour, an academic General Practitioner and worked with excluded groups and led specialist homeless and IH services for 10 years. She has training in qualitative methodologies. In 2018, lead author, ZK, explored the experiences of health care staff in caring for IHG's including the experiences of those with lived experience of exclusion through public involvement meetings. Staff articulated that they felt poorly prepared to care for IH groups and believed a model of cross-disciplinary learning including health, social care and voluntary sector workers would be more successful. They recognised that the care of IHGs requires knowledge in combination with collaborative working to address the range of needs experienced by these groups. As part of this review, ZK regularly met with interprofessional Staff Stakeholders and separately, a PPI group made up of people with lived experience of exclusion. They advised on each stage of the review, including the research question and aims, inclusion and exclusion criteria, reviewing included studies and feedback on the findings. Ethical approval was explored with the ethics department, but it was not needed for the purpose of seeking feedback and advice from stakeholders or PPI.

Inclusion Criteria

The inclusion and exclusion criteria were informed by the PPI and staff stakeholders. For this study, IPE is defined as "when members of two of more profession learning about, from and with each other to improve collaboration and quality of care" (Barr, 2002).

The stakeholders and PPI posited the view that IH is an emerging speciality, and that IPE is less established for staff compared to students. We, therefore, agreed to include studies

where IPE was defined or clearly implied as per the definition and include studies where staff and students learn together. The stakeholders and PPI felt this was particularly relevant for nurses and allied health professionals where student-staff joint learning more commonly occurs. Specifically, this review focused on studies reporting on the delivery of IPE to interprofessional learners. Supervisors advised that contemporary applications of meta-ethnography can and do include a range of research. Given the limited field, no study was excluding based on method. Studies which met the following criteria were included:

1. IH topics or about IH groups
2. Interprofessional education defined or implied within the study
3. Health, allied health or social care staff or staff learning with students (must include staff)
4. Studies were qualitative, quantitative, or mixed methods.

Search Criteria

As IH is an emerging term, the description is unlikely to be found in the existing literature on education. Therefore, search and inclusion terms were intentionally broad to maximise inclusion of relevant papers.

Eight electronic databases and 3 journals were systematically searched for relevant peer-reviewed papers. The databases included: Applied Social Science Index and Abstracts (ASSIA), British Education Index (BEI), CINAHL, ERIC, Healthcare Management Information Consortium (HMIC), MEDLINE, PsychINFO and SCOPUS. A MEDLINE search strategy was developed with an experienced librarian at the South London and Maudsley (SLaM) Trust, to address the review objectives and inclusion criteria. Where needed, this strategy was adjusted and applied to other databases. Search results were limited to the period 2000-2020 and to papers written in English. This is because of limited researcher time and the need to draw on contemporary research situated within to current education and clinical practices.

Additional papers were obtained by screening the reference lists of included studies and searching the last 20 years. We also reviewed databases of 3 journals known to publish much of the IPE research, namely Journal of Interprofessional Education and Practice, Journal of Research in Interprofessional Education and Practice and Journal of Interprofessional Care.

Study selection

The screening process took three stages including removal of duplicates, title and abstract review then full text screening. Due to limited resources the lead researcher (ZK) screened all titles and abstracts from the combined searches and a second reviewer (JD) independently screened 10 percent. Discrepancies were resolved through discussion with JD and the wider research team, guided by the inclusion criteria to ensure consistency and agreement. JD, members of the PPI and Stakeholder group each reviewed 10 percent of full text papers and their feedback incorporated. The included studies were discussed with the PPI and stakeholders to ensure they aligned with the agreed aim and breadth of the study.

Studies were not included for further screening if the abstract or title (when the abstract was unavailable) clearly showed that:

1. the study did not cover IH topics or IH groups;
2. the focus was not IPE;
3. the focus was not staff; or
4. the study was a commentary, a book, a systematic review or not subject to peer review.

Full- text articles selected from titles/abstracts were retrieved and screened against the same exclusion criteria. No additional papers were found from screening reference lists. No pure quantitative research met the inclusion criteria.

Study selection and reason for exclusion is summarised in **Figure 1**. At full text review, a total of twenty-two papers were excluded. Reason for exclusion were; they did not focus on interprofessional education or taught participants in profession specific groups (n=10), the study was not about IH or IH groups (n=6), the study focused on students rather than staff (n=5) and not available in English (n=1). At the final stage (data extraction and quality assessment) one paper was excluded because it evaluated perceptions of interprofessional collaboration (n=1) and one did not detail the mode of IPE intervention (n=1). Nineteen studies met the inclusion criteria and were included in the evidence synthesis.

Data abstraction and synthesis

Lead researcher (ZK) read and re-read all the included studies to gain a detailed appreciation of each study including content, themes, conclusions, and author recommendations. ZK extracted the data from all studies but analysis was discussed with the research team at monthly meetings, stakeholders and PPI. The following data was extracted:

- Study characteristics: mode of learning, aim, study design, data collection method, professional groups, country, setting/context and year ***(Table 1)***
- Findings:
    - ***First order*** - themes and concepts extracted from the papers;
    - ***Second order*** – reported interpretations within the papers;
    - ***third order*** – research team interpretations through translating identified themes and concepts between the studies and constructing an interpretation or ***line of argument***
- Quality assessment ***(Table 2)***: the quality assessment criteria used to assess the quality of included studies is based on an adapted version of the Critical Appraisal Skills Programme (CASP, 2002) quality assessment used by Atkins et al. in an earlier meta ethnography (Atkins *et al.*, 2008)

A meta-ethnography approach includes four analytical processes (Noblit and Hare, 1988, Gough *et al.*, 2017):

1. Identifying key concepts and themes in the primary studies
2. Reciprocal translation: identifying concepts in the studies that agree with each other

3. Refutational translation: identifying differences, disagreement, or conflicts between the study concepts *and*
4. Developing lines of argument which explore concepts, translations, and reviewer's interpretations.

Noblit and Hare (1988) highlight how particular refutational or line of argument analyses might be relevant to sets of data. This study treated refutational translation as useful contrasting information and perspectives. By exploring these tensions, the analysis is refined and clarified, while offering explanation and perspectives on applying the findings into practice.

Second order interpretations are drawn from the author and reviewers' concepts and theory identified in included studies (Noblit and Hare, 1988). Second order interpretations were compared, reordered, and synthesised into third order interpretations (lines of argument). These are communicated as key points, recommendations, and insights for practice.

Findings

Summary and context of included papers

The characteristics of the 19 studies are summarised in ***Table 1***. The setting of the studies included five studies from the UK, ten studies from the USA, three studies from Canada and one study with participants from Malawi and Zambia. IPE was named in twelve studies and clearly implied in seven studies. Implied means synonyms or descriptions of IPE activities for example, "interprofessional knowledge exchange" (Guirguis-Younger *et al.*, 2009), transdisciplinary (Seybold *et al.*, 2014) and multidisciplinary (Sher and Gralton, 2014)

Most studies used a combination of learning methods which often included a combination of core learning and group work. Methods sometimes included mentoring or coaching, reflective practice, facilitators, or people with lived experience of exclusion involved in learning. The learner participants were from a range of backgrounds including medical/psychiatric (thirteen studies) nursing (thirteen studies), allied health (five studies), psychology (nine studies), social care (eight studies), pharmacy (five studies), management (two studies), administration (three studies), community workers (four studies) and peer workers (one study), housing (one study), criminal justice (two studies), police (one study), addictions workers (two studies) and teachers (one study).

Studies were situated in a range of rural and urban settings including homeless night shelter, community services, mental health (community and hospital), primary health care, secondary health care, criminal justice, substance misuse services and prisons.

Quality appraisal

Most papers in this review were case studies. Eleven are single case studies, six multiple case studies, one a qualitative study and one was unclear.

Studies used qualitative methods (six), quantitative methods (five) and mixed methods (eight) to capture data, with most studies opting to use multiple evaluation methods. Evaluation surveys (ten) validated questionnaires (six) and individual interviews (six) were

the most common. Other methods include patient outcomes (three), service or individual narratives (two), focus groups (two), knowledge test (three), observations (four) and action plans or reports (three). Validated questionnaires used included Tool for Assessing Cultural Competence (TACCT), Readiness for Interprofessional Learning Questionnaire (RIPLS), Personality Disorder – Knowledge and Skills Questionnaire (PD-KASQ) and Interdisciplinary education perception scale (IEPS).

Training mainly occurred within the organisation or service, except one study that opted to host training outside of a specified service (Cornes *et al.*, 2014).

The modified quality assessment tool was in a previous meta-ethnographic synthesis of interprofessional facilitation methods (Reeves *et al.*, 2016b). The criteria included the appropriateness of research aims, relevance to the research question, study design, data collection and ethical considerations.

Overall, methodological quality varied between studies ***(Table 2)***. All studies clearly stated the aims of the research and used appropriate methods to address the aim. Most studies did not clearly articulate the relationship between researcher and participant and less than half considered ethical issues. Most of the studies were evaluating interventions so may not have needed ethical approval, however, it remains best practice to document this. As the field of IH education is burgeoning, as with many evidence syntheses which seek to examine a broad range of reported approaches and conceptual underpinnings, we did not want to exclude identified papers, based on our quality assessment (Atkins *et al.*, 2008). The quality process did, however, enable us to identify some key, relevant papers with in-depth data for analysis. While these quality scores informed our analysis, no papers were excluded, and the richness came both from the higher quality papers and breadth.

Data analysis and synthesis (Table 3)

The synthesis generated 16 key concepts from the nineteen included studies. These concepts were further synthesised into 15 third order interpretations. We found that the critical mechanism of IPE in IH were:

1. Curriculum design/development
    - The role of lived experience in patients and learners in shaping the curriculum, delivering education, integrating storytelling and mentoring
    - Pragmatic approaches to curriculum development
    - The role of trauma and violence-informed approaches, psychologically informed approaches, cultural competence, anti-racist approaches, and community of practice.
2. Learning approach
    - The value of immersive, critical, and experiential interprofessional service learning
    - How reflection, support and supervision influence staff learning, care and wellbeing
    - Engaging the individual, the patient, the team, and the organisation in interprofessional IH education
    - Using a range of learning approaches for core knowledge and transformative change
    - The role of IPE in development of integrative thinking
    - How the design and time given to training shaped the learning experience
    - Impact of a learner-driven approach in IPE in IH
3. Outcomes or benefits to staff and IH groups

- How IPE models influence staff attitudes and identity towards IH groups
- How IPE can influence staff coping mechanisms and resilience
- IPE in IH as a mechanism for developing generalist skills in IH

4. Wider social benefits
    - The effect of individual, team, organisation, and structural barriers that impact education of staff
    - IPE as a mechanism for addressing injustice through collective action
    - Tackling barriers to IPE in IH through systems leadership

1. Curriculum design/development

The role of lived experience in IH education, shaping the curriculum, delivering education, integrating storytelling and mentoring: *Learning from storytelling and promoting a holistic and social justice approach.*

The extent to which papers incorporate patient lived experiences and stories varies, but they agree that this can have a positive and powerful impact on learning and care. Studies describe this occurs through engagement to address both the health and emotional needs of patients, “critical listening” of concerns, promoting respect for holistic and person-centred approaches, and increasing self-awareness of cultural, ethnic and gender bias (Chrisman-Khawam *et al.*, 2017, Ebrahim *et al.*, 2016, Kools *et al.*, 2015, Guirguis-Younger *et al.*, 2009, Seybold *et al.*, 2014, Mahoney *et al.*, 2017, Tobias *et al.*, 2005).

Pragmatic approaches to curriculum development. *Making a curriculum relevant for IP staff and the role of research-informed curriculum*

The synthesis highlights a wider debate on how to create and deliver a relevant interprofessional curriculum in IH. Three studies report the potential value of a competency-based curriculum to enhance holistic care through key interventions (Leventhal *et al.*, 2004, Mahoney *et al.*, 2017, Khenti *et al.*, 2017). Other studies feel it would be difficult make such curricula relevant to staff or patient needs in a local context and challenging to deliver to diverse professional groups (Khenti *et al.*, 2017, van Eeghen *et al.*, 2019).

It remains unclear whether it is more effective to deliver standalone IPE curriculum in IH or incorporate IPE into existing educational programmes (Madden *et al.*, 2006). One study reported a pragmatic to enhance existing training curricula or CPD programmes with IPE to realise the potential benefits within limited resources (Leventhal *et al.*, 2004).

2. Learning approach

The effect of immersive, critical, and experiential service learning:

One of the learning concepts identified in the review was "Critical service learning". It is reported as transformative and aims to develop human connection, trust and altruism through an immersive learning experience, by applying reflective approaching involving

interprofessional colleagues and people with lived experience of exclusion. (Chrisman-Khawam *et al.*, 2017).

Similarly, structured learning and reflection was used in the Community of Practice (Cornes *et al.*, 2014), Knowledge and Understanding Framework (Ebrahim *et al.*, 2016) and Knowledge Exchange approaches (Guirguis-Younger *et al.*, 2009). The aim of these methods was to promote collaboration through identifying shared experiences, problems and tensions, and critical reflection of services and organisations.

Such transformative learning is reported to challenge stigma, discrimination, and misinformation and promote collective empowerment to address social injustice through human connection (Chrisman-Khawam *et al.*, 2017, Cornes *et al.*, 2014, Kools *et al.*, 2015, Guirguis-Younger *et al.*, 2009).

Other methods including trauma and violence-informed care (Levine et al. 2020) and cultural consulting (Owiti *et al.*, 2014) reported to challenge the traditional biomedical approach by encouraging learners to recognise and incorporate psychosocial factors and culture in person-centred care planning.

How reflection, support and supervision influence learning, care and wellbeing.

Authors interchangeably use terms including reflection, supervision, facilitation, support, mentoring and coaching but the synthesis identified two main reflective processes used in relation to IPE (Chrisman-Khawam *et al.*, 2017, Ebrahim *et al.*, 2016, Guirguis-Younger *et al.*, 2009, Mahoney *et al.*, 2017, Tobias *et al.*, 2005, Cornes *et al.*, 2014, Khenti *et al.*, 2017, Kools *et al.*, 2015, Madden *et al.*, 2006):

- Support, coaching, modelling, and mentoring **relates to the service or professional role.** This was reported to embed new learning into practice and provide skills to manage challenging behaviour.

- Structured reflection **relates to the self, or the individual.** This was used to maintain learning gains, promote healthy responses to challenges and normalise feelings.

Support, coaching, mentoring and role modelling is used in several IPE/IH models including the personality disorder training (Ebrahim *et al.*, 2016), homeless health (Guirguis-Younger *et al.*, 2009) mental health and addictions (Khenti *et al.*, 2017), substance misuse (Madden *et al.*, 2006), cultural consulting, care of women with substance misuse (Owiti *et al.*, 2014, Seybold *et al.*, 2014), coaching-based approach in substance misuse and brief intervention (Stanton *et al.*, 2012).

Reflection is applied in immersive learning in homelessness (Chrisman-Khawam *et al.*, 2017) , Community of Practice (COP) in homelessness (Cornes *et al.*, 2014), personality disorder training (Ebrahim *et al.*, 2016), homeless health (Guirguis-Younger *et al.*, 2009), trauma and violence approaches (Mahoney *et al.*, 2017) and managing substance misuse (Tobias *et al.*, 2005).

These approaches were applied to a range of professional groups, contexts (specialist and general settings), and professional stages. We were unable to identify differences in terms of longevity of outcomes or 'depth' of transformative learning between these approaches. Staff stakeholders also noted the role of supervision, which is a form of peer support routine to nursing, mental health and allied health staff, is less visible in the included studies.

Most papers describe interprofessional reflective processes as "structured" or "critically reflective" which relates to a formatted, planned or facilitated encounter. These encounters aim to address issues without designing interventions and include facilitated meetings, discussion or written debrief. The included studies align in the view that facilitator involvement along with reflective frameworks or structures can maximise the benefits of such reflective process.

Benefits of facilitation and structure described include developing or enhancing empathy in interactions with IH groups, exploring emotional experiences of caring for vulnerable groups, challenging negative attitudes, promoting confidence and collective motivation to tackle complex problems and the impact of social determinants, the role of the interprofessional team and preventing the Inverse Care Law (Chrisman-Khawam *et al.*, 2017, Cornes *et al.*, 2014, Ebrahim *et al.*, 2016, Khenti *et al.*, 2017, Guirguis-Younger *et al.*, 2009, Tobias *et al.*, 2005).

Using a range of learning methods for core knowledge transformative change.

Included papers reported a range of educational delivery modes. These included lectures, role play/simulation, case studies, patient narratives/storytelling and service learning ***(Table 1)***. Many studies used multi-mode training to address different learning needs such as lectures to dispel myths (Chrisman-Khawam *et al.*, 2017), or group work to explore emotional impact challenging issues or understanding roles (Khenti *et al.*, 2017, Levine *et al.*, 2020, Guirguis-Younger *et al.*, 2009). Combining interprofessional educational approaches and practical experience was found to enrich the learning experience and to sensitise staff to the context of the social determinants and holistic health (Owiti *et al.*, 2014, Seybold *et al.*, 2014, Sher and Gralton, 2014, Tobias *et al.*, 2005).

Our analysis highlights that IPE should be combined with learning that meets individual needs. This was applied by combining IPE with uniprofessional (discipline-specific) training or interagency learning (Hean *et al.*, 2015, Khenti *et al.*, 2017, Madden *et al.*, 2006). We also identified that subject experts and users of IPE should be involved in the design and delivery of education (Stanton *et al.*, 2012, Tobias *et al.*, 2005, Mahoney *et al.*, 2017). These points were also identified as important by the study's staff stakeholders and PPI.

Engaging the individual, the patient, the team, and the organisation in interprofessional IH education.

The studies describe a range of experiential approaches to promote engagement and integration of staff working, deeper understanding, and rapport with patients. These include listening and touch, hearing the patient narrative, role modelling and trauma walk through to experience how services contribute to trauma (Chrisman-Khawam *et al.*, 2017, Kools *et al.*, 2015, Levine *et al.*, 2020, Seybold *et al.*, 2014).

Logistical considerations in engagement identified in the synthesis include locally tailored teaching that draws attention to the prevalence of IH groups, training all team members regardless of role and involving local experts (Owiti *et al.*, 2014, Stanton *et al.*, 2012).

Developing integrative thinking.

Key studies identified underpinning theory and models of learning including trauma and violence-informed approaches, cultural competence, and psychologically-informed approaches (Cornes *et al.*, 2014, Ebrahim *et al.*, 2016, Levine *et al.*, 2020, Mahoney *et al.*, 2017, Owiti *et al.*, 2014, Washington *et al.*, 2017).

These studies highlight integrative thinking as an important learning objective of IPE in inclusion health. This is explored in a humanistic approach, trauma and biopsychosocial lived experience influences on disease and promoting a holistic and interprofessional care through reflexive learning about oneself and others (Mahoney *et al.*, 2017, Owiti *et al.*, 2014). Methods including cultural narrative assessments that explore the cultural influence on illness experience and recovery and training that critically explores compassion, vulnerability and health needs were used (Owiti *et al.*, 2014, Seybold *et al.*, 2014).

How the setting and design of the learning environment influences the learning experience.

The setting of the learning environment were found to influence the learning experience. In the Community of Practice and trauma and violence-informed care models, learning was outside of service structures in small groups to promote equity to discuss challenging issues (Cornes *et al.*, 2014, Levine *et al.*, 2020). Other studies exploring person-centred care and substance misuse support the use of IPE in compulsory but small, facilitated sessions to improve motivation and attendance (Mahoney *et al.*, 2017, Hean *et al.*, 2015).

Two studies highlight risks associated with undermining the value and need for IPE learning including minimising learning gains and worsening practice by increasing stereotypes, “othering” and reinforcing uniprofessional focus (Owiti *et al.*, 2014, Hean *et al.*, 2015).

Some studies collected data about learner demographics, personali characteristics and educational needs. Some studies considered these influenced engagement with learning and motivation for IPE in IH (Kools *et al.*, 2015, Leventhal *et al.*, 2004, Levine *et al.*, 2020, Mahoney *et al.*, 2017).

Others felt it an unhelpful to use personal characteristics to identify learners, as this reinforces power imbalance, perspectives of any IH IPE and may reinforce concerns about sharing challenges (Hean *et al.*, 2015, Leventhal *et al.*, 2004, Levine *et al.*, 2020). One study suggested that an inclusive approach engage all staff in training, even those not directly involved in patient care (Stanton *et al.*, 2012).

Our analysis shows that it is more helpful to explore differences in learner experiences by considering why IPE in IH may not be a positive experience for all staff (Hean *et al.*, 2015). Broader problems that might impact learner experience include professional isolation, lack of core professional training, and that IPE may not change practice while acute health needs and the dominating biomedical view take priority over tackling social determinants (Ebrahim

et al., 2016, Levine *et al.*, 2020). Within any IPE in IH excessive evaluation may not clarify the impact of learning on the learner and changes in attitudes and practice are likely to take longer to achieve than changes in knowledge and skills (Cornes *et al.*, 2014, Khenti *et al.*, 2017).

Using a learner-driven approach in facilitating IPE in IH.

Some studies considered a learner-driven approach (Stanton *et al.*, 2012) as critical to successful IPE, where educators consider staff needs and potential barriers in the design and delivery of IPE in inclusion. We identified the importance of capturing learning needs, tailoring learning through feedback to be relevant to staff and impact on services (Owiti *et al.*, 2014, Stanton *et al.*, 2012, Hean *et al.*, 2015, Levine *et al.*, 2020).

Organisational readiness including understanding of the problems facing IH groups, adequate resourcing, familiarity with the learning intervention and time to attend training were key to implementation of IPE (Madden *et al.*, 2006, Tobias *et al.*, 2005, Seybold *et al.*, 2014, Sher and Gralton, 2014).

Furthermore, aligning IPE with the needs of the professionals involved, seeking staff input into training and implementation, incorporating local evidence, and aligning training with existing professional development and CPD addressed barriers to implementation (Levine *et al.*, 2020, Sher and Gralton, 2014, Stanton *et al.*, 2012). One study suggests that where IPE is not possible, discipline-specific training can facilitate learning oportunities (Stanton *et al.*, 2012).

Less well-developed, but still important concepts include the use of technology and facilitator preparation. Two studies described the role of technology in reducing barriers to accessing IPE and facilitating IPE in practice (Hean *et al.*, 2015, Puskar *et al.*, 2016) and one highlighted increased relevance of IPE when delivered by interprofessional trainers (Khenti *et al.*, 2017).

3. Outcomes/benefits to staff and IH groups

Altering staff attitudes and identity towards IH groups:

Several papers argue problematic perspectives on professionalism which values productivity over than therapeutic relationships, but that IPE in IH has a role in altering staff perception of professionalism and professional identity. It was found that health systems are dominated by the need to manage urgent health issues rather than trust and time to address the emotional needs of patients (Levine *et al.*, 2020, Chrisman-Khawam *et al.*, 2017).

One key study reported that learners changed relationship from an “expected expert” to experiencing the patient story and a caring role (Chrisman-Khawam *et al.*, 2017). Another reported outcome was enabling staff to address inequity through person and family-centred care. This is achieved by IPE that focuses on eliciting the hidden history, recognising one’s own bias and challenging the biomedical view (Hean *et al.*, 2015, Mahoney *et al.*, 2017, Owiti *et al.*, 2014, Kools *et al.*, 2015, Levine *et al.*, 2020).

The same studies warn of potential pitfalls if IPE is not thoughtfully developed and delivered including 'cultural othering' which can reinforce stereotypes (Kools *et al.*, 2015) and failure of training to prepare staff to recognise and care for clients impacted by trauma and violence (Levine *et al.*, 2020).

There is interchangeable use of the term interprofessional working and relationships in many studies, but the synthesis identifies differences that IPE can:

- strengthen interprofessional **working** (day to day care) through clarifying roles, improving communication, facilitating referrals and case discussion of the most complex patients
- Improve interprofessional **relationships** (strategic) to improve approach to inclusive care and networking (Khenti *et al.*, 2017).

Although this approach to IPE can activate collective agency (staff acting together) and collective capability to tackle a range of problems, there still may be a lack of service user gains (Cornes *et al.*, 2014).

Influencing staff coping mechanisms and resilience.

The synthesis found that participation in IPE in IH can be an opportunity to explore challenges of interprofessional working and relationships. This includes emotional experience, managing expectations, and identifying and addressing factors that inhibit integrated care including higher policy issues (Chrisman-Khawam *et al.*, 2017, Cornes *et al.*, 2014, Levine *et al.*, 2020, van Eeghen *et al.*, 2019).

This is achieved through promoting understanding between staff, case exploration, support to contain anxiety and "structural competency" to challenge pre-existing norms, tensions and inequalities (Levine *et al.*, 2020). Staff can share ideas and use "active learning groups" to explore strategies (Cornes *et al.*, 2014, Levine *et al.*, 2020, Tobias *et al.*, 2005, van Eeghen *et al.*, 2019). Training was more beneficial where expert trainers help learners explore interprofessional working as part of any IPE in IH (Hean *et al.*, 2015, Stanton *et al.*, 2012).

Our analysis identified that staff are emotionally and psychologically impacted by working with vulnerable groups (Chrisman-Khawam *et al.*, 2017, Ebrahim *et al.*, 2016, Guirguis-Younger *et al.*, 2009). Although the analysis finds that IPE can have a positive effect on wellbeing, motivation, "elastic tolerance", and may prevent burnout (Cornes *et al.*, 2014, Khenti *et al.*, 2017), one study also warns against learning through wicked issues alone as it risks worsening staff fatigue (Cornes *et al.*, 2014).

Unfortunately, the opportunity of training to improve integrated care is hampered by political, policy and contractual issues that inhibit staff from working effectively. Key issues included failure to recognise the value of long-term case work over short term results, service contracts limiting flexibility to work across interfaces (Cornes *et al.*, 2014, Leventhal *et al.*, 2004, Madden *et al.*, 2006).

Developing generalist skills in IH.

Our analysis identified that modelling, coaching, and mentoring can help integrate learning into practice in IH (Owiti *et al.*, 2014). Models include shadowing and placements to maintain interagency relationships, expert coaching and role modelling to embed skills into practice and address challenging scenarios. One study utilised mentor with lived experience to embed a person-centred approach in patients with mental health and substance misuse (Kools *et al.*, 2015, Hean *et al.*, 2015, Mahoney *et al.*, 2017, Owiti *et al.*, 2014, Stanton *et al.*, 2012).

4. Wider social benefits

The effect of individual, team, organisation and structural factors that impact education of staff.

Studies described barriers to IPE in IH for staff including high workload, lack of time, competing training demands, lack of perceived value and priority by staff. Organisational and structural barriers included insecure service funding, limited training resources, service restructures and restrictive contracts which fail to appreciate working challenges and staff training needs. Where IPE is implemented, lack of organisational readiness to change can limit the impact such learning (Cornes *et al.*, 2014, Hean *et al.*, 2015, Kools *et al.*, 2015, Chrisman-Khawam *et al.*, 2017, Levine *et al.*, 2020, Madden *et al.*, 2006, Mahoney *et al.*, 2017, Owiti *et al.*, 2014).

Addressing injustice through collective action.

The synthesis indicates that IPE has a role in professional networking to address inequalities. This includes, oportunities to activate social capital, understanding of roles, service cultures and challenges and gaining confidence to communicate and collaborate across services and agencies (Chrisman-Khawam *et al.*, 2017, Cornes *et al.*, 2014, Guirguis-Younger *et al.*, 2009, Hean *et al.*, 2015, Tobias *et al.*, 2005, van Eeghen *et al.*, 2019).

Tackling barrier to IPE in IH through systems leadership.

The analysis revealed that systems and structures frequently fail to recognise the social reality of many people in society. Care is focused on delivering contractual agreements and targets which often fails to recognise the value of maintaining stability and identifying and treating the psychological and emotional needs of patients (Cornes et al. 2014). Beyond that, leadership is essential to recognise the value of interprofessional or other education in IH, implementing this and supporting gains from any learning. This includes organisational recognition that interprofessional working for IHGs is an ongoing challenge, requiring adequate resources for training, and offering ongoing learning and support to maintain learning gains and collaborative practice (Cornes *et al.*, 2014, Ebrahim *et al.*, 2016, Khenti *et al.*, 2017, Hean *et al.*, 2015). In one study the lack of leadership and staff supervision were identified as a key cause of attrition of learning gains (Ebrahim *et al.*, 2016).

The synthesis also identified approaches to sustaining learning gains from IPE including accessible information available online, shadowing, and demonstrating impact through local examples of practice change and data (Khenti *et al.*, 2017, Leventhal *et al.*, 2004, Levine *et al.*, 2020).

Underpinning theory

It is suggested that theory is not routinely utilised in implementation research (Kislov *et al.*, 2011). In this synthesis, studies focused on understanding complexity and influencing human behaviour through dialogue, social interaction, and an ethical exploration of hierarchies to reflect upon underpinning theory. In a paper exploring Communities of Practice for people experiencing multiple exclusion homelessness (Cornes *et al.*, 2014), the authors draw on theory of collective capability in enhancing performance through a community that is founded on trust and respect to improve outcomes. They also draw on psychosocial theory which considers self-understanding and the mental processes in practice. This theory informs psychologically informed practice which describes the way staff manage complex trauma in their clients, and their own emotions often in the context of the social-political drivers that can conflict with practitioner roles. A study exploring trauma and violence-informed approaches (Levine *et al.*, 2020) applied critical social theory, feminist intersectionality, and complexity theories to draw attention to power dynamics, including gendered power dynamics in healthcare. A further study exploring trauma and violence approaches in mental health, utilised a narrative ethics approach including storytelling and life events as a basis for ethical reflection and learning (Mahoney *et al.*, 2017). Finally, a study exploring cultural consulting (Owiti *et al.*, 2014) utilised social learning theory which emphasises the importance of observing and modelling behaviours and attitudes, and integrating the illness experience within the social, cultural, and political context.

Discussion

Summary of findings

The aim of this review was to understand the experiences, role, and use of IPE in IH for health and care staff.

The meta-ethnographic approach enabled a reflexive synthesis of 19 included studies. We identified 4 overarching themes including curriculum design, learning approach, benefits to staff and IHGs and wider social benefits. We found IPE in IH:

- can be a transformative learning experience if it includes learning from difficulty, using reflection and integrates previous experience. It also fostered positive interprofessional relationships and helped learners challenge the biomedical view.
- uses different reflective processes including facilitation, mentoring and modelling helps learners explore emotions, challenge negative attitudes and develop and apply skills to tackle complex problems.
- includes different learning approaches including practical experience and involvement people with lived experience and learners, sensitised learners to the impact of exclusion.
- applies a carefully designed curriculum and incorporates experiential learning approaches to help staff engage in learning and with each other in more productive ways.
- embedded Integrative thinking and practice. It can promote holistic care and generalist skills in the care of those with complex needs.
- needs preparation, situating in an environment that is inclusive for a range of staff learners and must be a safe space to explore experiences and attitudes.

- helps staff be patient centred by challenging the existing norms of professionalism and altering focus on the expected expert to one of holistic practitioner.
- Needs to be well facilitated can help staff develop elastic tolerance, manage anxiety and frustration and solve higher IH policy issues through integrated working.
- Fosters understanding about roles, services and culture and can create collective agency to address a range of issues through collaborative and co-ordinated care.

For IPE in inclusion health to be successful, it needs organisational readiness to change and for education and practice leads to place value on collaborative learning and care. They need to support and resource such training including facilitation and align IPE in IH to professional development or regular CPD opportunities.

This synthesis showed that co-construction of research with involvement from staff and people with lived experience is both practical to apply and highly beneficial to study relevance.

Relevance to existing literature

In accordance with reviews in other settings, our findings reinforce the evidence for IPE as part of an effective learning environment for interprofessional collaboration and improvement (Pauzé and Reeves, 2010). The findings of this review provide a comprehensive account of the use of IPE in IH in a range of settings and contexts, particularly as part of the canon of established approaches, such as Trauma-and Violence-Informed Care and psychologically informed approaches. Based on the findings the use of different approaches including Cultural Consulting and Communities of Practice could also be used to help staff and systems in this particularly complex area.

This review also calls for the development of healthcare workers' professionalism in relation to their own reflexivity, establishing anti-racist curricula, challenging stigma and ensuring clinicians are aware of and able to negotiate tension and difference identified within the consultation and between colleagues. As well as developing generalist skills, our analysis suggests that IPE in IH may be able to challenge stigma and discrimination towards IH groups by destabilising existing norms and promoting understanding. The challenge of applying IPE in IH is limited by resources, learning time, system and learner engagement and training of facilitators (or educators). These issues have identified in other meta-ethnographic reviews in IPE (Reeves *et.al*., 2016b) and a lack of clear support would jeopardise the viability of IPE and such transformative learning (Reeves *et.al*., 2016a).

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Most included studies (n=15) were authored in the last 10 years, a period including a global economic crisis, UK-wide austerity measures and populist governments, which are recognised as drivers of social injustice. This suggests that research into IPE has arisen to

challenge the biomedical approach, return focus to therapeutic relationships and alliances and address unmet care needs (Cocksedge *et al.*, 2020).

Implications for practice

The interest in health equity and inclusion health is growing and strengthened by the recent publication of NICE guidelines on integrated health and social care in the field (Overview | Integrated health and social care for people experiencing homelessness | Guidance | NICE). Although our analysis supports the role of IPE and other IH education as a disruptive force for overcoming health inequalities, target focused approaches are commonplace and seldom work to deliver holistic care that meets the needs of IHGs or simply diverse communities.

The breadth of the synthesis and included studies suggests that the findings are transferable beyond IH groups/complex needs, to the care of all diverse communities. The use of structured reflective approaches as both an experiential learning experience and a supportive mechanism for staff can also be broadly applied.

In times of economic and social challenge, those designing and delivering education must allocate time and resource to interrogate and incorporate IH education as a mechanism to improve approaches to managing complexity.

Further research

The search did not identify studies specifically covering psychologically informed approaches and IPE, which is core to IH practice. A further search by ZK revealed one study set in the probation service that met the inclusion criteria, but this was published after our search (Bruce *et al.*, 2020). We did not find data that explored the role of clinical or other supervision. The stakeholder group viewed supervision as important because it is peer led support involving both pastoral and professional development.

Further research, into the role of supervision, reverse supervision, and the impact of the therapeutic relationship in consultations with IHGs would benefit the field.

Strengths and limitations

The study is registered with PROSPERO and applied an established and contemporary approach to meta-ethnographic synthesis. We used a broad search covering electronic databases, journals and hand searching reference lists, included papers from the last 20 years and involved stakeholders at every stage. The tool used to assess methodological quality was the modified CASP tool (Atkins *et al.*, 2008, CASP, 2002). This showed that included studies were generally rigorous but lacked consistent ethnical consideration. The synthesis found that IPE occurred in a range of settings relevant to IH groups and used a range of different modes, often in combination with reflection, coaching and mentoring as a tool to elicit the hidden curriculum. This synthesis identified ways in which the study context, underpinning theory and educational practice converge (are similar) and ways they diverge (are different). In doing so, this work provides robust evidence of what “good IH education for staff” looks like and ways it can be pragmatically, practically, and sensitively delivered. The educational mechanisms are outlined as well as barriers to implementation and risks of devaluing the need or undermining models of effective training.

This PPI and Staff Stakeholders reported that involvement was a positive experience, they felt heard, were able to share ideas and learnt about research methods. From the perspective of the lead researcher, involvement was readily facilitated through networks and had a positive impact on the synthesis findings and its relevance to real world settings.

There are some limitations of this synthesis. The search excluded grey literature and only included papers in English which may have missed a small number of studies. The included studies tend to report positive results of IPE in IH, but about half of studies also identify important barriers, challenges, and negative findings, helping us understand both the value of IPE and its limitations.

Conclusions

In undertaking this synthesis, we welcome those responsible for designing and delivering education, including professional bodies, education providers and health and care providers to use the findings to review the needs of their staff and patients, critique existing education provision and identify ways of incorporating models of IH IPE and other learning to empower staff and improve care for IHGs. In addition, this study provides useful signposting and direction on areas of professional development and CPD for staff across sectors.

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