



*Centre for the Advancement of
Interprofessional Education*

INTERPROFESSIONAL EDUCATION GUIDELINES 2017

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PREFACE

These guidelines are addressed to organisations responsible for commissioning, developing, delivering, evaluating, regulating and overseeing interprofessional education (IPE) during prequalifying and continuing professional education for health, social care and related fields in the United Kingdom (UK) and beyond. CAIPE commends them to inform consistent policies, practices and procedures within and between those organisations to ensure efficient, effective, economic and expeditious planning and implementation of IPE interventions and strategies.

Grounded in CAIPE's Statement of Principles (2011) (see Appendix A), they build on:

- the experience of CAIPE's members and the interprofessional movement nationally and internationally;
- findings from the UK IPE review (Barr, Helme & D'Avray, 2011 & 2014);
- evidence from systematic and scoping reviews;
- consultations with UK commissioning, regulatory and other standard setting organisations.

Publication of the UK IPE Review prompted two additional studies. Health Education England Thames Valley followed up responses by universities and service agencies (unpublished) to recommendations in the Review addressed to Health Education England probing further selected policies and practices. Discussions followed with CAIPE regarding on-going work to promote collaboration in Thames Valley and throughout England leading to the production of a handbook to assist in planning IPE interventions (Ford & Gray, forthcoming). The Health and Care Professions Council (HCPC) commissioned an unpublished review of IPE from Keele University.

CAIPE has lodged on its website a summary of its consultations throughout the UK following the Review (CAIPE, 2016).

We draw attention to findings from systematic and scoping reviews recording evidence regarding the effects of IPE on collaborative practice. They include the updated Best Evidence Medical Education review (Reeves, Fletcher, Barr et al., 2016) as well as other publications which have synthesised the evidence for IPE (e.g. Abu-Rish, Kim, Choe et al., 2012; Brandt, Lutfiyya King et al., 2014; O'Carroll, McSwiggan & Campbell, 2016; Reeves, Palaganas & Zeirler, 2017). We urge universities and others to delve into that literature when planning their IPE. Securing the foundations must not, however, inhibit innovation which, by definition, reaches beyond the tried and tested. It is here that evaluation needs to be most rigorous to add robust findings to the growing evidence base as the boundaries for IPE extend wider.

Consistent with national and international usage, we employ the term interprofessional education (IPE) to embrace a repertoire of learning methods within a rationale comprising values, objectives and theory grounded in evidence. We employ interprofessional learning (IPL) when one or more of those methods is embedded within professional education whilst respecting alternative usage by others. We distinguish between IPL interventions, i.e. discrete elements of such learning, and IPL strategies, i.e. planned progressions of such elements. Other terms employed accord with the *Journal of Interprofessional Care* glossary reprinted selectively as Appendix B.

These guidelines replace those published previously by CAIPE for prequalifying IPE (Barr & Low, 2012) and augment its 2016 Guidelines by incorporating additional material on practice learning and continuing interprofessional development. Work remains to be done to review formulations of outcomes from IPE, student assessment and the evaluation of interprofessional interventions and strategies to be incorporated in a later edition.

PART ONE: UNDERSTANDING INTERPROFESSIONAL EDUCATION

Improving collaboration

IPE enables two or more professions to learn with, from and about each other to improve collaborative practice and quality of care (CAIPE, 2002). Well planned and conducted, it can promote flexible, coordinated, complementary, person centred and cost effective collaboration in interprofessional teams within a policy-aware understanding of organisational relationships. IPE recognises and respects profession-specific requirements and safeguards the identity of each profession. Dealing in difference, it works towards meeting competency-based outcomes within a common framework.

CAIPE's (2011) statement of principles for IPE enshrines and extends those for adult learning. Responsibility for managing the learning rests not only on the individual but also on the group - a peer group from different professions with discrete and differing roles, perceptions and expectations. Within a given set of learning outcomes, members explore how each of them can contribute to a process of cooperative, cyclical, iterative, reflective and socially constructed learning, towards the resolution of conflicts, and the development of insight, understanding and skills. The learners become a community of practice. They negotiate the meaning of phenomena and problems engaged in a process which relies for its success upon their willingness and ability to enter into new experiences, to reflect on them from different perspectives, to align their values, to create concepts that integrate their observations into logical theories and to use them to make decisions and solve problems. Interprofessional students call on a shared repertoire of communal learning resources, facilitating change where the meaning of the activities that occur is a constantly negotiated and renegotiated interpretation of those held by all the participants (Kolb, 1984; Lave & Wenger, 1991; Wenger, 1998; Barr & Gray, 2013).

Prequalifying IPE can heighten students' appreciation of safe and good practice. It can create opportunities for them to explore ways in which their professions can work more closely together to respond more fully, more effectively and more economically to multiple and complex needs associated, amongst other factors, with ageing populations, urbanisation, migration and multiculturalism. It may respond, inter alia, to public and political concern to engage more effectively together in care, including end of life care, for people coping with chronic illnesses and disabilities, not least dementia, beyond the capacity of any one profession or service alone.

Learning together can cultivate mutual awareness, trust and respect, countering ignorance, prejudice and rivalry in readiness for collaborative practice. Interdependence in learning can pave the way for interdependence in practice helping workers to withstand occupational stress and mitigating defensive behaviour impeding innovation and collaboration (Hinshelwood & Skogstad, 2000; Menzies, 1970; Obholzer, 1994).

Educators structure opportunities in the classroom, on placement and in virtual learning environments where students can compare and contrast their professions' roles, responsibilities and relationships. University based educators usually approach such learning from psychological, social psychological or sociological perspectives to explore relationships within and between groups (Barr, 2013), challenging 'groupthink', i.e. allegiance to one group at the price of invidious, prejudiced and stereotypical perceptions of others (Janis, 1972 & 1982). Practice based educators enable students to apply that learning as they observe and evaluate good and not so good relationships between agencies and between professions.

In developed countries, prequalifying IPE typically prioritises work with disabled and older adults, less often with children and their families, still less in public health; priorities that

may well be reordered in developing countries. Accommodating all three within the same IPE strategy can be over complex. IPE may more effectively be organised separately for each within a unifying rationale.

Improving care

The collaboration for which IPE prepares is more than cooperation. It is a planned, purposeful, concerted and sustained endeavour within a defined legal and policy context to ensure comprehensive provision of quality care which transcends demarcations between professions, between practice settings, and between organisations. Teamwork can drive collaborative practice. Students can learn how members empower each other in a nurturing and mutually supportive environment to collaborate flexibly, economically, expeditiously and effectively across predetermined professional demarcations; not only teamwork but also more diffuse, more ephemeral and less structured ways of working together such as networking.

Appraising policy and practice critically from interprofessional perspectives can alert students to the need for closer collaboration to improve care and services as they explore how each professional group complements the others. Projects and assignments on placement and in the classroom enable learners to explore roles, responsibilities and relationships between their respective professions (see strengthening interprofessional practice learning below).

Learners may discover that integrating services is not enough to ensure collaborative practice and deliver better care unless and until the professions are actively, positively and collectively engaged, mediating the application of policies to practice, countering unintended consequences, resolving rivalries and conflicts, pulling together for the good of those whom together they serve. They can embed that learning within a working knowledge of relevant health and social care policies; policies that may redraw boundaries, reassign responsibilities or redistribute power facilitating or frustrating collaboration as they learn how to hold the tension between competition and collaboration.

The interprofessional movement is one of several driving change in health and healthcare delivery.

Others include:

- integrated care;
- collaborative practice;
- quality improvement;
- health education;
- health improvement;
- patient safety;
- clinical communications;
- workforce planning.

Each relies for its success on professions joining in common purpose which IPE promotes.

PART TWO: IMPLEMENTING AN INTERPROFESSIONAL LEARNING STRATEGY

Planning together

IPL is best planned jointly at every level closely involving educators from all the relevant professions with representatives of practice and employing agencies, professional associations, trade unions, students, service users, carers and other stakeholders. Some will have interprofessional experience on which to call. Others may be hoping to learn from those already travelling the interprofessional road. Much can be learnt by comparing and contrasting IPL interventions and strategies, but no two situations are the same. One size does not fit all. Each group has to devise its own strategy allowing time and opportunity to reconcile differing expectations.

Devising a strategy

Agreeing when, where and how to introduce IPL between two or more professional courses is a complex process. Courses differ in length, structure and timetabling. Educators differ in their practice backgrounds, their theoretical orientation and their preferred learning methods. Introducing IPL interventions ad hoc may seem the realistic way to begin, but can make it difficult later to knit them together into coherent and progressive sequences. Formulating and agreeing an IPL strategy at the outset saves time in the long run.

Underpinning with theory

IPL is more coherently planned, consistently delivered, rigorously evaluated and effectively reported when it is explicitly underpinned with theory. Educators need to reconcile and harmonise theoretical perspectives from education and practice from their respective professions. Psychodynamic perspectives informed some early IPL initiatives, giving way to psycho-social and, more recently, sociological perspectives (Barr, Koppel, Reeves et al., 2005). The onus rests on the planners to construct their own, synthesising anthropological, educational, organisational, psychological and/or sociological perspectives into a coherent and theoretical rationale underpinning the IPE programme (Barr, 2013; Reeves and Hean, 2013; Hutchings, Scammell & Quinney, 2013).

Formulating outcomes

Composite benchmarks, as agreed between UK associations for the health professions (QAA, 2006), set overall standards before formulating competency-based outcomes. The most authoritative frameworks come from Canada (Canadian Interprofessional Health Collaborative, 2010) and the United States (Interprofessional Education Collaborative Expert Panel, 2011). Both refer to a UK framework (Combined Universities Interprofessional Learning Unit, 2010) in which educators formulated capabilities rather than competencies to convey an on-going learning process. Outcome led curricula encourage educators and students to develop teaching and learning responsively and flexibly (Barr, 1998; Reeves, 2012).

Adapting teaching and learning methods

A range of learning methods, from which educators choose, have been adopted and adapted from professional for interprofessional education. These include: case-based learning; problem based learning; collaborative inquiry; appreciative inquiry; observation-based learning; experiential learning; reflective learning; simulated learning; continuous quality improvement; and others (Barr, 2002; Barr, Koppel, Reeves et al., 2005).

Experienced educators may well change the learning methods as students' needs evolve and to hold their interest. No one method suffices. Whichever are selected they should be active, interactive, reflective and person-centred, service user/carer-focused, creating opportunities to compare and contrast roles and responsibilities, power and authority, ethics and codes of practice, knowledge and skills in order to build effective relationships between the professions and to develop and reinforce skills for collaborative practice.

Strengthening interprofessional practice learning

Interprofessional practice learning (IPPL) is more robust when universities and practice agencies enter into mutually beneficial agreements ensuring, on the one hand, that IPE placement experiences are available in the necessary numbers to the required standard and, on the other hand, that practice educators are prepared, supported and valued. Teaching and learning in the classroom and on placements can then be two sides of the same coin.

Responsibility for planning and implementing IPPL rests jointly with universities and practice placement providers. Partnership working between them is essential to ensure that students have high quality professional and interprofessional experiences, optimising satisfaction and achieving theory and practice related learning outcomes. Developed thus, IPPL becomes an integral part of incremental curricula. It ensures that students acquire knowledge and skills for interprofessional practice delivered in the classroom and on placement in response to their evolving needs throughout their qualifying courses. It provides access to a multiplicity of resources including simulated and technology enhanced learning and facilitated by skilled, enthusiastic practitioners assigned responsibility for the students' learning.

Relying on students to identify the IPPL opportunities for themselves falls short. Practice based educators may assemble those opportunities with university-based educators. Together, they can generate collaborative and team-based opportunities for co-located students (Barr & Brewer, 2012).

A well planned sequence of placements progresses from observation to hands-on, team-based practice. There is a compelling case for every student to have at least one placement in an interprofessional team during their course, for example, on a training ward or in a community setting (Brewer & Stewart-Wynne, 2013; Jacobsen, 2016; Thomas & Reeves, 2015). It is there that they have opportunities to reflect on their working relationships and respective performance as they sharpen their awareness of conditions favourable to effective teamwork.

All prequalifying courses approved by regulatory bodies integrate theoretical and practice based learning to prepare students for safe, evidence based practice in their chosen profession. Practice learning does not only take place in a practice placement environment. Classroom based learning often focuses on learning about and preparing students for practice. IPPL is no exception. To be effective, it needs to provide opportunities for students to engage actively, holistically and collaboratively in a variety of immersive experiences anticipating the kinds of encounters they will experience in their professional practice (Hutchings & Loftus, 2012).

Cultivating the context for IPPL

Some practice learning settings lend themselves more readily than others to the introduction of IPPL. Derbyshire (2017) found that participation in interprofessional teamwork to meet patients' complex needs contributed to the students' interprofessional knowledge and skills development. Other factors, she found, that supported IPPL included a well-developed collaborative culture within the host department; a values-based

approach to shared working practices; and clear professional roles and responsibilities. She devised a tool to pre-assess readiness for IPPL in a practice learning setting comprising three sections around the themes of culture, structure and human agency each with five statements and Likert scales about what to expect in an environment where a positive IPPL experience could be facilitated. Placements could then be better planned in advance to optimise student's interprofessional learning.

Differences in educational background, professional cultures, power, status, hierarchy, language and professional perspectives in practice settings present barriers that can detract from students' learning. IPPL opportunities need therefore to be planned and structured (Howkins & Low, 2014). Comprehensive mapping, identification and negotiation of placement allocations are prerequisite to identify IPPL opportunities for sustainable well planned interprofessional student experiences (Joseph, Diack, Garton et al., 2014). IPPL partnerships affirm the need for a strong collaborative alignment between the role of the university IPE educator and the crucial role of the practice educator in identifying and facilitating IPPL for achieving effectiveness in student learning (Howkins & Low, 2014).

Howkins and Low (2014) note a propensity for learning in the workplace to be informal, incidental, non-intentional, learner-centred and embedded in work activities, but highlight the challenges. Rich though such a learning environment may be, such IPPL opportunities may not be recognised and fully exploited. This emphasises the importance of having a well-informed cadre of practice educators, trained and confident in recognising IPPL opportunities and facilitating mixed interprofessional groups. Exposure to observational placements of interprofessional team working and role modelling by practice education facilitators can bring learning benefits for students. These may, however, be less than adequate without opportunities for critical dialogue, questioning and reflection by students on the experiences they have observed working in, not just sitting alongside, interprofessional teams.

Grounding IPPL in evidence and learning theory

Whether the locus for IPPL is in the classroom or on placement, it will benefit from grounding in educational and sociological theory to provide an evidence-based rationale and coherence in the practice learning strategies, methods and models that providers, working in busy practice environments, can adopt and adapt to suit their different workplace settings (Barr, 2013; Hutchings, Scammell & Quinney, 2013; Kitto, Thistlethwaite, Chesters et al., 2011; Reeves & Hean, 2013). Key guiding principles for achieving high quality IPPL can be drawn from experiential, social-constructivist and situated learning theories (Dewey, 1933; Kolb, 1984; Lave & Wenger, 1991; Wenger, 1998). Constituents for learning and working together include opportunities for collaborative group work; engaging in authentic activities that have real-world relevance; using loosely-defined person-centred, service user/carer-focused issues as catalysts for learning; encouraging participants to think constructively and creatively and to become active shapers of their own learning; drawing on different forms of evidence and ways of knowing; and providing opportunities for focused reflection, application and development, with feedback and feed-forward (Boud & Feletti, 1997; Clark, 2006; D'Eon, 2005; Hutchings & Loftus, 2012; Hutchings, Scammell & Quinney, 2013).

While adopting the principles of good learning design can support high quality IPPL, the anticipated benefits may not be readily achieved. Hutchings, Scammell and Quinney (2013) identified three distinct zones of praxis for consideration when developing IPE; professional differences and identity positioned in the zone of professional practice development, learning approaches positioned in the zone of pedagogic strategies, and digital literacy positioned in the zone of technology enhanced learning. Where students and practitioners' knowledge and understanding of these three zones of praxis varies, this can act to enable or constrain the processes of engaging with IPPL. Factoring in an

appreciation of differential positions in these interconnected zones of praxis can help improve the outcomes for IPL.

In the classroom

The advantage of introducing IPPL in the classroom is that it offers opportunities to prepare students for the realities of practice by learning and working together in small groups through planned activities in a safe and supported learning environment. Strategies in the classroom for IPPL fall broadly within the field of experiential learning. They range from inviting service users, carers, actors and practitioners to share experiences to more structured simulations and role plays, and case-based and problem-based learning which can be delivered both inside and outside the classroom using technology enabled learning and virtual learning environments. IPPL enables students to learn a range of both technical and soft skills in communication, reasoning, decision-making, team-working and leadership underpinned by evidence and technical knowledge.

IPPL in the classroom is complemented by such learning on placement and in virtual learning environments. Learning and working together in small groups, students build relationships with each other and with their teachers in anticipation of teamwork in practice. Educators bring practice into the classroom inviting service users, carers and practitioners to contribute to teaching, devising assignments and assessment methods and selecting case studies that not only drive home the need for collaborative practice but also the means by which it can be delivered. They discuss with students the practice learning opportunities available during preparation for successive placements anticipating opportunities to observe and experience collaborative practice and demonstrating how learning in the classroom carries forward on placement and during virtual learning, debriefing on their return critically comparing and contrasting experiences.

On placement

Qualifying courses for the health and social care professions in the UK almost invariably include practice placements, typically as much as 50% of the time, during which students encounter situations that demand responses beyond the responsibilities and resources of their own profession. They may be invited to attend team meetings with other professions or case conferences. They may enjoy the company of co-located students from other professions creating opportunities to compare experiences. Illuminating though such serendipitous encounters can be, value is added when IPPL opportunities are planned with the practice educators beforehand and reviewed afterwards.

Barr & Brewer (2012) distinguish between three IPPL placement models.

In the first model students are expected to find IPPL opportunities for themselves, for example, when completing assignments. This is not enough in the absence of other IPPL models. Practice educators may intervene, advising, assisting, anticipating, negotiating and exploiting IPPL opportunities for students individually but preferably in interprofessional teams. Responsibility for coordination may be assigned to a designated practice educator where students from two or more professions are co-located. Partnership working between University teachers and practice educators can assist in developing a bank of curriculum relevant, structured IPPL activities for use in the placement setting; adaptable to fit the IPPL context.

The second model brings together co-located students from a range of professions for additional group activities introducing IPPL with minimal disruption to placement routines and making marginal additional claims on resources. Viability depends on there being enough students in the same place at the same time. The classic example was between 1976 and 1979 in Thamesmead - then a new dormitory town on the south east edge of

London - where practice educators invited students there on placement concurrently to meet once a week for lunch. Following ice breakers, they introduced each other in pairs, played games, discussed cases, role played, formed topic groups and made joint home visits to patients backed up by joint supervision sessions. Activities over time included day workshops and a weekend retreat (Jaques & Higgins, 1986).

The third model is more ambitious. It entails establishing "a team-based interprofessional practice placement" (TIPP) as "a dedicated and prearranged opportunity for a number of students from health, social care and/or related professions to learn together for a period of time in the same setting as they perform typical activities of their profession as a team focused on a client-centred approach" (Brewer & Barr, 2016 p. 747).

Creating a TIPP calls for careful planning and sometimes protracted negotiation between the host practice agency and the university before a mutually beneficial agreement is reached. Scheduling of placements and preparation of students needs to be synchronised, and practice educators recruited with skills already well developed in interprofessional learning. TIPPs are resource intensive calling for careful consideration of feasibility from the outset. The greatest on-going cost is the employment of the TIPPs' facilitator who needs to be onsite for much, if not all, of the time with students; facilitating their learning and overseeing the quality of care and safety of their practice. This facilitator is supernumerary given the lack of time others may have to dedicate to practice learning.

Experience suggests that a TIPP should not be less than the equivalent of two weeks fulltime, and best during the latter stages in students' courses when they have had earlier IPPL experiences and developed their professional identities, confidence and practice capabilities. Exacting though these requirements are, this model occupies the high ground in client-centred interprofessional team-based practice. It is most often found in student units on hospital wards, notably in Scandinavia (e.g. Hylén, Nyholm, Mattiason & Ponzer, 2007; Jacobsen, Fink, Marcussen et al., 2009; Ponzer, Hylén, Kusoffsky et al., 2004; Wilhelmsson, Pelling, Ludvigsen et al., 2009) less often in the UK (but see Reeves & Freeth 2002) and more recently in Australia (Brewer & Stewart-Wynne, 2013).

Brewer and Barr (2016) also cite examples in primary schools, residential aged care, international service learning, primary care and others that come close to their definition of a TIPP including pre-arranged mixed professional groups of students following patients through their pre- and peri-operative journeys (Joseph, Diack, Haxton et al., 2012) and joint visits by students to patients' homes learning about their life and health (Anderson & Lennox, 2009). Depending on the setting, a TIPP may include assessment and intervention, planning and implementation, case conferences, ward rounds, patient handovers, team meetings, clinical teaching and professional development.

Evaluations cited by Brewer and Barr (2016) show how TIPPs can alter students' attitudes towards other professions; increase insight into their own and other professions' roles and competence; increase confidence in sharing their professional expertise in an interprofessional team; strengthen collaboration with other professions in subsequent practice; improve students' decision making; and enhance their attitude toward person-centred care and collaborative practice. Patients on student run wards reported a higher quality of care delivered by students than on staff run wards. We refer readers especially to Jacobsen's (2016) review of 20 training wards in Sweden and Denmark where he found that the TIPP model enabled students to achieve both professional and interprofessional learning outcomes whilst strengthening the formation of their professional identities.

Through simulations and technology enhanced learning

Interprofessional educators and practice educators in the UK almost invariably introduce simulated and technologically enhanced learning into prequalifying health and social care courses (Barr, Helme & D'Avray, 2014). Some of these resources are 'tailor-made' devised by the educators to use with their own students. Others are 'off-the-peg' brought or bought in from manuals and catalogues. They may range from low tech and low cost to the latest state of the art advances in educational technology to augmented reality.

Technologically enhanced learning has been widely adopted in IPPL, encompassing a wide diversity of resources ranging from e-learning modules on developing collaborative practice to reusable learning objects on real-life cases and patient journeys (Edelbring, 2010). It also includes virtual and augmented reality learning environments where the technology can be used to connect and mediate communications between participants in practitioner-focused learning spaces (Edelbring, 2010), and citizen-focused virtual communities where case scenarios, of service user and carer stories, can be used as triggers for interprofessional problem-based learning, placing the service user at the heart of the learning to provide more authentic learning experiences (Quinney, Hutchings & Scammell, 2008; Pulman, Galvin, Hutchings et al., 2012) and support positive attitudinal change (Clouder, 2008). Many UK universities have developed reusable 'learning objects' accessible on-line (Gordon, Booth & Bywater, 2010; Bromage, Clouder, Thistlethwaite et al., 2010), others 'virtual communities' which support and strengthen an authentic person-centred approach (e.g. Quinney, Hutchings & Scammell, 2008).

Simulation techniques range from small scale low-tech practice and role play to advanced patient simulators to teach communication, team working and clinical skills (Fung, Boet, Bould et al., 2014). The degree of realism and authenticity afforded by high-fidelity patient simulators does not necessarily equate with high quality learning (Alinier, Hunt & Gordon, 2004; Bligh & Bleakley, 2006; Thomas & Reeves, 2015). The curation of the learning environment, the atmosphere, the pedagogy, and social interactions are crucial here.

Simulation is being widely adopted as patient safety comes to the fore, including opportunity for students comprising an interprofessional team to practice their respective interventions together around a manikin (Boet, Bould, Burns et al., 2014; Thomas & Reeves 2015). More investment in the technology and provision of clinical skills laboratories is critical before every IPE student will have that opportunity. But simulation must not replace practice-based learning, however hard it may be to find enough suitable placements. It is more effective when 'blended' with face-to-face learning. Each complements the other (Reeves & van Schaik, 2012).

The same resources may be differentially applied in the classroom or on placement. The key considerations in both settings lie in selecting appropriate simulation scenarios and technology for purpose, achieving realism and authenticity, and ensuring conditions to transfer simulation to practice. For example, Reime Johnsgaard, Kvam et al. (2017) identified that observing simulation training can be a valuable learning experience, but students preferred hands-on participation and learning by doing. Debriefing following simulated learning sessions is arguably where the opportunity for IPPL can be maximised. In a planned debrief setting a skilled IPPL facilitator can deepen the students' learning with, from and about each other through encouraging focused reflection on the interprofessional working processes, barriers and enablers inherent in the situation they have enacted.

Assessing learning

Assessment of students' IPL should be based on demonstrated competencies for collaborative practice. It may be formative, but students and educators are more likely to value assessment that is summative towards professional qualifications. Reflective diaries, learning logs, portfolios and objective structured clinical examinations (OSCEs) are some of the assessment methods used. Some students may be required to demonstrate interprofessional outcomes when completing profession-specific assessments. Procedures, criteria and credits should be consistent across professions and across courses (Wagner & Reeves, 2015).

PART THREE: ENGAGING THE PARTIES

Involving students

There is growing evidence for providing IPE for all health and social care students during their pre-qualifying courses (Hammick, Freeth, Koppel et al., 2007; Abu-Rish, Kim, Choe et al., 2012; Reeves, Fletcher, Barr et al., 2016). Pressure can build to include an open-ended list of professions as IPE gains popularity. Depending upon the configuration of professions engaged in collaborative practice, some universities are extending IPE beyond health and social care to include, for example, students from sports and leisure, school teaching, law, probation and police. Choices may, however, be constrained by the range of professions studying in the same location, eased sometimes by assembling the preferred mix across sites, schools or universities.

Students often respond more positively, and more readily see relevance, when they are learning with professions with whom they anticipate working after qualifying. That can be difficult to arrange where those professions are taught in different universities or at different levels, i.e. pre-qualifying and post-qualifying. The absence of one or more professions whose role is pivotal in collaborative practice, e.g. management, medicine or social work, may make the IPL seem less relevant, however carefully educators may try to compensate. The participating professions may be drawn closer together neglecting the absent one at its expense.

Limits must be set operationally taking into account not only local needs, priorities and opportunities, but also how operational boundaries are drawn around occupations deemed to be 'professions'. A narrowly elitist definition, restricted to the established professions, excludes many whose engagement in collaborative practice is essential, with much to give and gain during IPE. Conversely, an egalitarian definition which blurs the boundary between professions and other occupational groups may optimise student mix for collaborative practice, but detract from the search for shared professional values, dissuade more established professions from participating and limit learning opportunities.

Educators engage students as adult learners. That may run counter to students' prior experience at school or university. They may need help in letting go of deferential and hierarchical styles of learning where the teacher was the unchallenged authority, before being ready to embrace egalitarian, democratic and socially constructed learning. They may need help also in relinquishing assumptions about professional relationships and hierarchies colouring reciprocal perceptions in the student group. Preparation is essential for students to understand the IPL process and their educators' expectations.

Confidence in self-directed and peer-group learning builds up over time. Some final year students, prepared and supported by their educators, facilitate groups and mentor first year students. Others contribute to IPE promotion, planning, development and evaluation.

Prospective students may well expect to find information about IPE in course prospectuses tracking one or more interprofessional pathways that they might follow to the outcome competencies.

Involving service users and their carers

Consistent with its definition, service users and carers should invariably be at the centre of IPE. There are several models, frameworks and taxonomies which inform and explain the ways in which patients can contribute to healthcare education (Spencer, Godolphin, Karpenko et al., 2011). In the UK, the most frequently cited framework is the ladder of involvement from mental health (Tew, Gell & Foster, 2004). At the lower levels of involvement, service users may simply be the person with whom a group of students work. At the higher levels, service users and carers may work alongside educators to design learning and may support other service users and lead teaching (McKeown, Malihi-Shoja & Downe, 2010). Service users and carers can also be involved in student selection, mentoring and assessment, as well as the planning and reviewing of IPL interventions and strategies (e.g. Cooper & Spencer-Dawe, 2006; Anderson & Lennox, 2009; Furness, Armitage & Pitt, 2011).

Considerations that need to be borne in mind include: the relevance of service users' and carers' experience to students' learning needs; their readiness to share personal matters; and their vulnerability. Service users are more effective in their teaching roles, more confident and more at ease when they have preparation and on-going support from the educators. Planning their induction, preparation and support is essential. Some have high dependency needs calling for additional support and sensitivity from students, educators and each other as part of the mutual learning. The nature of their involvement will determine their relationship with the university. Where, as in many instances, this is an employment relationship, universities carry an obligation as good employers to support, sustain and remunerate the service users and carers whom they engage. Some retain panels who contribute to teaching and learning across a range of professional and interprofessional programmes (McKeown, Malihi-Shoja & Downe, 2010).

Learning how to facilitate

Teaching has its place in IPE, but the role of the educator is essentially to facilitate student learning rather than to deliver information didactically. Facilitating professional learning is challenging; facilitating interprofessional learning is more so. Even the most experienced educators find it challenging to be confronted with students from diverse backgrounds with different perspectives, expectations, assumptions and styles of learning (Egan-Lee, Baker, Tobin et al., 2011; Evans, Knight, Sønderslund et al., 2014).

Educators enable students from different professions to enrich and enhance each other's learning in supportive small group settings. They need to be able to discern and address with sensitivity, diversity and differences between the student groups in educational, professional and cultural background, power, status and hierarchy, language and practice perspectives across professional and organisational barriers to effect group development equitably and effectively. Mindful that students will perceive them as interprofessional role models, they must maintain their professional neutrality, listen actively, understand and respond to the dynamics of the group diplomatically and flexibly as they motivate, encourage and support the IPL process (Anderson, Cox & Thorpe, 2009; Barr & Coyle, 2012; Egan-Lee, Baker, Tobin et al., 2011; Freeman, Wright & Lindqvist, 2010).

Preparation is essential. It differs depending on the roles to which the educators are assigned. All engaged in IPE need preparation to understand its ethos, principles and methods and to be aware of its implications for their habitual styles of teaching. Those who are already well versed in the application of principles of adult learning in professional

education may need less help than those accustomed to more didactic methods, but will nevertheless still have much to learn. Workshops for educators enable them to enter into interprofessional experiences learning from positive and negative encounters in the group. Team teaching, or working with a 'buddy', can help them gain confidence in teaching outside their 'comfort zone' (Hanna, Soren, Telner et al., 2013).

Hall and Zierler (2015) advise on interprofessional faculty development in the first of a series of practice guides in the *Journal of Interprofessional Care* based on the experience of pilot programmes in US universities and academic health centres comprising a combination of didactic presentations, small group activities and immersion experiences including direct involvement in IPE facilitation with coaching and peer support. The faculty development needs to fit the context, focus on problems learning from failures as well as successes, compare experience between institutions, measure and monitor outcomes relating education and training robustly.

Practice educators, in common with many of their university colleagues, may well be accustomed to facilitating professional learning. If so, that provides a foundation on which to build, but interprofessional facilitation demands a repertoire of specific skills. Effective interprofessional facilitation enables students from different professions to enrich and enhance each other's learning in a supportive small group setting; sensitive to the perspectives, perceptions and particular needs of each individual and profession; able to turn conflict into constructive learning; and aware of ways in which their own attitudes, values and behaviour can impact positively or negatively on students' experience (Freeman, Wright, & Lindqvist, 2010). It assists the student group to optimise its learning by calling on resources within its membership while resisting pressure to assume the teaching role, unless and until the group has expended its own learning capacity (Howkins & Bray, 2008). Research suggests that IPL facilitation requires skills and qualities comparable to those required for transformational leadership (Derbyshire, Machin & Crozier, 2015); for example, the ability to dynamically engage a diverse group in a shared sense of purpose, fostering a group commitment to act collectively for the mutual benefit of all involved. With patience and practice, these leadership skills can be invested in the participants as they become more adept as active shapers of their own learning.

Over time, having engaged in IPL and IPPL as students themselves, there will be a critical mass of practice educators who have more understanding and more confidence in facilitating IPPL. However, at the time of writing there is a gap in IPPL experience, understanding and skills. Some practice educators feel underprepared and undervalued for that role. They find it daunting to be confronted by students from diverse backgrounds with different perspectives, expectations, assumptions and styles of learning. Interprofessional practice based education does indeed entail working with students and teachers from other professions in fields of practice beyond the familiar milieu of the practice educator's own profession. Some practice educators may already be attuned to the dynamics of small groups. If so, they will be on their way towards understanding how students may behave in an interprofessional group, the roles which they may play in leading or obstructing its work, assisting or impeding the learning of others, and the conflicts and rivalries which may intrude, for example, where differences are played out in power and status which mirror those between the students' professions. The facilitator can encourage the members of the group to view the learning experience as a microcosm of collaboration in working life, a test bed under safe and controlled conditions to develop their collaborative capabilities, an opportunity to review what can get in the way and to explore more productive ways of working together.

Facilitation enables students from different professions to enhance each other's learning; sensitive to their differing perspectives and perceptions, above all enabling them to translate problems into opportunities as they focus on the client and ways to improve

health and social outcomes. Co-facilitating can be an especially helpful way to learn, enabling you and a colleague from another profession to compare your evaluations of the group's progress, complement each other's insights and interventions, and offer mutual feedback. Candid feedback from the students on this process will be a bonus.

The challenge in the context of busy practice environments is having enough skilled facilitators, with a specific IPPL remit, or who are willing to take time out from their profession specific educator role to support students from other professional groups. Preparation for the facilitating role is essential, preferably in a group including practice educators (and sometimes university teachers) from the range of relevant professional backgrounds, building on, but extending beyond, the range of knowledge, skills and attitudes required for professional practice teaching. Anderson, Cox and Thorpe's (2009) evaluation of the impact of a masters level two day course designed to prepare teachers for their facilitating role supported their hypothesis that participants needed tailored professional development opportunities. Another model of preparation might be interprofessional collaborative learning groups in practice as part of existing professional development or supervision processes. In such a setting, interprofessional role development focuses on interprofessional leadership and involves a facilitated analysis of authentic IPPL experiences - positive and negative - encountered by other practice educator colleagues. Taking an action learning approach the group decides on a focus for their learning and identified actions to take back to their practice educator role to enhance the student IPPL experience. Facilitating this type of group requires a coaching approach to ensure relevance to each individual practice educator in the group who may have different levels of knowledge and skills for IPPL facilitation.

Leading the way

IPE coordinators need industry and ingenuity to create interprofessional learning opportunities that complement requirements for each of the constituent professional programmes. Prior teaching experience, however substantial, is less than sufficient to prepare them to work within and between institutional and professional traditions and cultures; systems and structures; expectations and requirement; policies and priorities; and budgets and resources.

PART FOUR: MINDING RESOURCES

Accommodating teaching and learning

Small group teaching, on which effective IPE relies, needs an ample supply of comfortably appointed syndicate rooms ensuring privacy to discuss confidences including those in case based material. A large lecture theatre may also be needed for interprofessional groups to come together for shared didactic teaching. Access to clinical skills laboratories is critical to enable all the students to engage in simulated IPL with particular reference to patient safety. Libraries need to stock interprofessional texts, journals and learning materials for the benefit of students and teachers (Nordquist, Kitto & Reeves, 2013).

Being cost effective

Investment needed to plan an IPE strategy is repaid when cost effective educational systems result and returned with interest when it drives collaborative practice leading to more efficient and more economic delivery of care (Berwick, Nolan & Whittington, 2008; Barr & Beunza, 2014; Brandt, Luftiyya, King et al., 2014; Walsh, Reeves & Maloney, 2014). Small group learning, on which IPE relies, carries a price tag offset where agreement is reached and logistics resolved to combine lectures for core subjects across professional programmes. Technologically enhanced learning can also result in savings once the initial outlay has been met. IPE strategies that reinforce community-based care

result in savings where they reduce or delay hospital admissions and expedite discharge planning.

PART FIVE: ALIGNING LEARNING

Misalignment between the professional courses can frustrate best made plans to weave the interprofessional teaching and learning sequentially, logically and progressively into each. Coordination and commitment is needed within and sometimes between universities to synchronise systems and structures to accommodate not only timetabling and placement patterns but also assessment procedures and criteria.

Misalignment between classroom, placement and virtual environments can result in disjointed learning leaving the students to make connections with difficulty; compounded when more than one university sends students to more than one practice agency. Universities and agencies need to agree plans that reconcile requirements and structures for placements (Anderson, Cox & Thorpe 2009; Long, Dann, Wolff et al., 2014).

PART SIX: ALIGNING REGULATION

Misalignment between regulatory systems can result in costly duplication of effort in the preparation of review material in response to different requirements at different times resulting in conflicting advice and decisions, and missed opportunities for comparative critique.

IPE is typically subject to internal and external validation, modification and review within the professional courses in which it is embedded. Requirements and procedures differ between universities internally and between regulatory bodies externally rendering it difficult to ensure that procedures and criteria are consistent, coherent and comparable. Efforts have been made between regulatory bodies to conduct reviews concurrently for those professional courses including the same IPE strategy thereby facilitating comparative critique of process and outcomes. The dividends outweigh the difficulties.

Comparison can be further assisted by explicit, consistent and systematic recording of IPL found during reviews in each course in a common template carried forward into periodic subject reports. That practice is assisted where visiting panels include at least one member with first-hand IPE experience and all members have had an interprofessional orientation. Transparently and consistently conducted reviews generate data meriting inclusion in the IPE evidence base.

PART SEVEN: EVALUATING INTERPROFESSIONAL INTERVENTIONS AND STRATEGIES

Universities expect educators to monitor and report IPE interventions. Some educators go further, engaging in systematic investigation sometimes included in research leading to higher degrees. A *Journal of Interprofessional Care Practice Guide* (Reeves, Boet, Zierler et al., 2015) helps by formulating the evaluation questions. Consider, the authors advise evaluation as early as possible; involve as many stakeholders as practicable; be clear about the purpose of the evaluation; consider learning outcomes; think about theoretical perspectives; employ an evaluation model; select an evaluation design; think about ethical approval; understand that there is an evaluation effect; manage the evaluation; and diversify dissemination methods. Relatively few IPE interventions are subject to independent and external research. Available funds may best be protected to evaluate innovative pilot approaches that may merit wider adoption (Freeth, Reeves, Koppel et al., 2005).

PART EIGHT: CONTINUING INTERPROFESSIONAL DEVELOPMENT

Much that we have included above carries forward from pre-qualifying IPE into postqualifying learning. Ideally, pre-qualifying IPE is the first step from induction and orientation into advanced or specialist practice, and educational, managerial or research roles along a continuum of interprofessional development (CIPD) woven into the continuum of professional development (CPD). Realistically much remains to be done to achieve that goal. Educators can and do help students to acquire the habit of self and group-directed learning anticipating how each may apply and progress that learning as career preferences take shape. Workers on first appointment need encouragement, support and guidance to recognise, exploit and access work-based IPL opportunities helped by designated line managers, mentors and training personnel supported in their learning by more experienced team members. They may be steered towards courses and study programmes that complement their work-based learning and promise to further their interprofessional development (Kitto, Goldman, Schmitt et al., 2014).

We respond finally to the need to assist qualified health, social care and related workers to:

1. Heighten their interprofessional awareness as they progress in their respective professions following qualification;
2. Reinforce, augment and apply in successive roles and responsibilities collaborative competencies learnt during their prequalifying studies.

We focus on continuing learning for workers whose qualifying courses included interprofessional education (IPE) compatible with guidelines from CAIPE (2012 and current).

CAIPE defines CIPD as:

"The means by which members of two or more professions learn with from and about each other to extend and reinforce collaborative competence to improve quality and safety in practice."

Applying this definition, CAIPE subscribes to the view that each practitioner is responsible for their CIPD as part of their continuing professional development (CPD). As defined by the Health and Care Professions Council (2017), CPD comprises "a range of learning activities through which health and care professionals maintain and develop throughout their career to ensure that they retain their capacity to practice safely and effectively within their evolving scope of practice."

Effective CIPD is dependent on employing agencies, professional and educational institutions to make available many of the opportunities. Planning CIPD progressively and productively is challenging and complex for all parties, especially for the workers themselves, helped where mentoring is offered by colleagues alive to the opportunities and the pitfalls.

Work-located and work-related learning

Work-located CIPD is derived directly from experience in the work place, work-related from courses, conferences and workshops in a college, training centre or virtual learning environment (Barr, 2003). The work-located opportunities may be implicit (Eraut, 2000), but more lasting, more transferable and more generalisable when made explicit (Reeves, Lewin, Espin et al., 2010). They may be seized or missed in practice as colleagues discuss cases and overlapping responsibilities, compare perspectives, challenge cherished assumptions, reconcile differing values and test alternative approaches. It is in the work setting above all where practitioners learn directly from service users and their carers by

listening to their stories (Launer, 2002) and hearing about their experiences in the hands of professions, teams and organisations. Work-related opportunities can be found where objectives for courses, conferences and workshops are vocationally and practice oriented as distinct from academic. They may well include visits of observation, placements or assignments. Practice located and practice related learning complement each other.

The more pertinent work-located interprofessional learning becomes, the greater may be the temptation to rely on it rather than work-related interprofessional learning. Workers, however, benefit from opportunities to reflect on their practice (Kolb, 1984). They need to stand back from their everyday work, moving beyond the constraints of their professional perspectives achieving deeper, transformative “second order reflection” (Wackerhausen, 2009: 466). They can then learn with and from colleagues in other settings and organisations, taking a broader, longer-term and sometimes more critical view reflecting not only in but also on their practice (Schön, 1983 & 1987).

Learning together

Responsible though each practitioner is for their CIPD, it depends upon collaboration between professions. Broadly similar learning methods apply as in pre-qualifying IPE. Experienced workers can, however, reasonably be expected to take more responsibility for organising and facilitating their interprofessional learning, investigating and critiquing practice employing approaches such as collaborative inquiry (Reason, 1999) or continuous quality improvement (CQI) (Wilcock, Campion-Smith & Elston, 2003). We draw a broad distinction between such learning for students on courses and for practitioners in teams.

---- in an interprofessional student group

Post-qualifying courses in the UK in fields, for example, such as counselling, education, management, research methods and specialist practice typically recruit students from a range of professions, services and settings. Many are designated as multiprofessional.¹ Most are part-time enabling students not only to relate their learning and practice but also to compare and contrast practice in their respective fields (Barr, 2007). Part-time courses may include work based assignments conducted preferably in interprofessional pairs or groups and assessed towards their qualifications. Practice placements are the exception. If and when included, we refer readers to the above discussion with particular reference to the development of team-based interprofessional placements (Brewer & Barr, 2016). Given the will on the part of students and educators, such interprofessional learning opportunities may be introduced into multiprofessional courses without major modification (Barr, Koppel, Reeves et al., 2005). More far reaching reforms may be possible when courses become due for periodic review.

Owen and Schmitt (2013) outline a step-by-step process (which we amend as follows) to ‘interprofessionalise’ a multiprofessional course in whole or part:

- Reviewing and revising aims and objectives to contribute to CIPD outcomes;
- Testing against evidence based education and practice;
- Surmounting barriers;
- Projecting a continuum of interprofessional teaching and learning;
- Evaluating changes made.

We commend this approach to commissioning, regulatory, employing and professional bodies to exploit the interprofessional potential in multiprofessional education. It may

¹ We define a multiprofessional course when members (or students) of two or more professions learn alongside one another: in other words, parallel rather than interactive learning.

often be a more effective, economic and expeditious means to promote CIPD than designing freestanding interprofessional courses from scratch.

----- in an interprofessional practice team

CIPD can be woven into employment-led CPD wherever interprofessional teamwork is well established applying principles of 'Practice Professional Development Planning' (PPDP):

- reconciling and integrating individual, team and organisational learning needs and priorities;
- harmonising uniprofessional, multiprofessional and interprofessional learning;
- accessing best value learning opportunities;
- mobilising, optimising and deploying available learning resources;
- developing incremental learning pathways.

(Department of Health, 1998)

PPDP was introduced into primary care in England and Wales as a process of lifelong learning for individuals and teams which enables professionals to expand and fulfil their potential whilst also meeting the needs of service users and delivering the health and healthcare priorities of the NHS. Its purpose is to generate mutually reinforcing opportunities for learning in groups.

PPDP develops the concept of the community of practice (Wenger, 1998) as a human resource for health and social care based on its service development plan taking into account local and national objectives as it introduces innovative ways of learning. It generates mutually reinforcing opportunities for learning in groups reconciling the needs of the individual, the team and the organisation. It is purposeful, motivating, person-centred, change oriented and educationally effective taking into account professional and interprofessional learning needs. There is a case for appraising its utility wherever health, social care and other professions learn together in work-based interprofessional teams.

PPDP is applicable in team-based practice beyond primary healthcare for which it was conceived. Every learning team holds the potential to become part of a learning organisation "where people continually explore their capacity to create the results they truly desire, where new and expansive learning patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning to see the whole together" (Senge, 1990: 3).

--- in other learning environments

We have focused on the contexts in which CIPD is most frequently developed. There are others where, for example, workers, often of their own volition in their own time, convene special interest groups, learning sets, quality circles or reading clubs and respond to aspirations which may go beyond the horizons of their present employment. Value is added when learning materials intended for individual study are shared in an interprofessional group.

The Continuum

Against that backdrop, we trace progression in CIPD step-by-step from induction and orientation on first appointment to responding to changes in policy and practice, to preparation for specialist practice, educational, research and managerial roles (Barr, 2009; Reeves, 2009; Reeves & Kitto, 2017).

The point of departure is to establish a baseline of interprofessional learning and collaborative competence on which to build a CIPD system. Doing so is relatively easy where the CIPD is being planned primarily for former students from the local university where information regarding interprofessional learning during prequalifying courses and their outcomes should be readily available; more difficult where it is being planned to cater for workers from a range of universities including those further afield.

Induction, Orientation and Transition

Induction as commonly understood is the process by which newly appointed workers are introduced to their roles and responsibilities with reference to the policies, practices, structures and resources of the organisation, made interprofessional when it relates to the roles and responsibilities of others. Orientation as commonly understood, contextualises that learning in practice, collaborative practice when it includes encounters not only with other professions but also with the community including service users, carers, voluntary groups and community leaders.

Induction and orientation on first appointment is a time of transition from student to worker, relinquishing one identity for another, applying precept to practice. Experience differs from profession to profession, from organisation to organisation and from individual to individual. Some newly appointed workers are seemingly thrown in at the deep end to sink or swim. Resultant stress can drive them to adopt defensive coping mechanisms (Hinshelwood & Skogstad, 2000) at variance with their best intentions. Others enjoy sustained support with protected caseloads. Interprofessional engagement at this early stage is critical to provide recently qualified workers with mutual support and learning (Institute of Medicine, 2015).

Effecting change

The case for combining professions in CIPD in response to changes in policy and practice is more than economic. CIPD can build in opportunities for the participant professions to compare the implications for their respective roles, relationships, powers and duties, anticipating and dissipating tensions and lessening the risk that change will be debilitating or resisted. This becomes even more necessary when implementation redraws boundaries, redeploys responsibilities and sometimes introduces new occupational groups. Time is well spent devising and debating grassroots strategies, laterally between the practising professions and vertically with management and policy makers, relating proposed policies to the particulars of practice. CIPD is, however, more than a means to accommodate top-down change; it is also a proactive agent for change bottom-up dedicated to improving quality, driving innovation and ensuring safe practice (Donansky & Luebbbers, 2017).

Progression into specialist practice, education, research and management roles

Additional responsibilities invariably demand additional learning. That learning acquires an interprofessional dimension when account is taken of joining a team comprising a different configuration of professions and specialties, where the definition of boundaries and the distribution of power may be unfamiliar and fellow team members may have role expectations that add or subtract from those that the worker assumes. These implications are many and varied when practitioners progress into consultancy, research and

managerial roles. They are especially pertinent in the context of these guidelines when that progression is into educational roles – mentoring, supervising, facilitating and teaching – replete with opportunities to promote and champion interprofessional learning in every way at every stage.

PART NINE: TRANSFORMING PROFESSIONAL EDUCATION FROM WITHIN

From the outset, the World Health Organization (WHO, 1973 & 1978) invoked IPE as the means to reform professional education to become more responsive to population healthcare needs and community based developments reinforced over the years (see WHO, 2010). Returning to that theme in its first education and training guidelines, the WHO (2013) envisaged that a transformative and interdependent professional educational system for health professionals could be achieved by activating the case championed by the Lancet Commission (Frenk, Chen & Bhutta et al., 2010) for the reform of health professionals' education through IPE.

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APPENDICES

Appendix A

CAIPE Statement of Principles of Interprofessional Education

CAIPE commends the following principles, drawn from the experience of its members and the interprofessional literature, for the consideration of all who are engaged in commissioning, designing, delivering and evaluating interprofessional education.

Values

Interprofessional education:

- Focuses on the needs of individuals, families and communities to improve their quality of care, health outcomes and wellbeing;
- Applies equal opportunities within and between the professions and all with whom they learn and work;
- Respects individuality, difference and diversity within and between the professions and all with whom they learn and work;
- Sustains the identity and expertise of each profession;
- Promotes parity between professions in the learning environment;
- Instils interprofessional values and perspectives throughout uniprofessional and multiprofessional learning.

Process

Interprofessional education:

- Comprises a continuum of learning for education, health, managerial, medical, social care and other professions;
- Encourages student participation in planning, progressing and evaluating their learning;
- Reviewing policy and practice critically from different perspectives;
- Enables the professions to learn with, from and about each other to optimise exchange of experience and expertise;
- Deals in difference as it searches for common ground;
- Integrates learning in college and the work place;
- Synthesises theory and practice;
- Grounds teaching and learning in evidence;
- Includes discrete and dedicated interprofessional sequences and placements;
- Applies consistent assessment criteria and processes for all the participant professions;
- Carries credit towards professional qualifications;
- Involves service users and carers in teaching and learning;

Outcomes

Interprofessional education:

- Engenders interprofessional capability;
- Enhances practice within each profession;
- Informs joint action to improve services and instigate change;
- Improves outcomes for individuals, families and communities;
- Disseminates its experience;
- Subjects developments to systematic evaluation and research.

Hugh Barr

Helena Low

January 2011

Appendix B

GLOSSARY

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For the full original with references see:

www.interprofessionalprofessionalism.org/.../glossary_ipc_terms

Accountability: Active acceptance for the responsibility for the diverse roles, obligations, actions, including self-regulations, and other behaviours that positively influence patient and client outcomes, the profession, and the health needs of society.

Altruism: Overt behaviour that reflects concern for the welfare and well-being of others and assumes the responsibility of placing the needs of the patients or clients ahead of the professionals' interest.

Care/Caring: Behaviour that reflects concern, empathy and consideration for the needs and values of others and a level of responsibility for someone's well-being.

Collaboration: The act of working together cooperatively, especially in the case management of a patient or client; including sharing responsibilities for solving problems and making decisions to formulate and carry out plans for patient care.

Communication: Imparting or interchange of thoughts, opinions or information by speech, writing or signs which are the means through which professional behaviour is enacted.

Ethical Behaviour: Reflects the values and guidelines governing decisions in health care practice.

Excellence: Behaviour that adheres to, exceeds, or adapts best practices to provide the highest quality care; including engagement in continuous professional development.

Interdisciplinary Health Care occurs when health care professionals representing expertise from various health care disciplines participate in the support of clients and their families in health care delivery.

Interprofessional Health Care occurs when various professions learn from and about each other to improve collaboration and the quality of care. Their interactions are characterised by integration and modification reflecting participants understanding of the core principles and concepts of each contributing discipline and familiarity with the basic language and mind sets of the various disciplines.

Interprofessional Education occurs when students from various professions learn from and about each other to improve collaboration and the quality of care. Their interactions are characterized by integration and modification reflecting participants understanding of the core principles and concepts of each contributing discipline and familiarity with the basic language and mind sets of the various disciplines.

Interprofessional Practice occurs when practitioners from two or more professions work together with a common purpose, commitment and mutual respect.

Interprofessional Professionalism is the consistent demonstration of core values evidenced by professionals working together, aspiring to and wisely applying principles of, altruism, excellence, caring, ethics, respect, communication, accountability to achieve optimal health and wellness in individuals and communities.

Multidisciplinary is an adjective used to describe, for example, types of teams or education and indicates that people from different disciplines are involved in the given activity. In other words, individuals from two or more disciplines working in parallel, coming together only for specific issues and problems.

Profession refers to a vocation with a body of knowledge and skills put into service for the good of others which has led to an autonomous, self-regulated profession.

Professionalism includes a distinct set of professional responsibilities and actions composed of seven basic elements: excellence, humanism, accountability, altruism, duty, honour and integrity, and respect of others.

Respect: Behaviour that shows regard for another person with esteem, deference and dignity. It is a personal commitment to honour other peoples' choices and rights regarding themselves and includes a sensitivity and responsiveness to a person's culture, gender, age and disabilities.

Teamwork: Cooperative effort by the members of a group to achieve a common goal.

Transdisciplinary is used to describe teams in which members' share roles and systematically cross discipline boundaries to pool and integrate their expertise so that more efficient and comprehensive assessment and intervention services may be provided.

Appendix C

CAIPE

Centre for the Advancement of Interprofessional Education

Founded in 1987 CAIPE is a UK-based charity and company limited by guarantee which is a global leader in promoting and developing interprofessional education and learning. CAIPE is a community of committed individuals and organisations dedicated to a collaborative future, working with like-minded organisations in the UK and overseas to improve collaborative practice, patient safety and quality of care by professions learning and working together. We offer expertise and experience and an independent perspective to facilitate collaboration across the boundaries between education and health, health and social care, and beyond. We support students, academics, practitioners, researchers and people who use health and social care services through sharing information and enabling networking opportunities.

Our contributions include publications, development workshops, consultancy, commissioned studies and international partnerships, projects and networks. Membership of CAIPE is open to individuals, students, service users and organisations including academic institutions, independent and public service providers in the UK and overseas.

Benefits of membership include access to:

- The global interprofessional community of practice
- A programme of events
- Developmental workshops
- On-line resources
- Individual and group expertise
- Funding opportunities and bursaries
- Research and opportunities for research collaborations
- The Journal of Interprofessional of Care

For further information about CAIPE including the benefits of membership for organisations, individuals, students and service users and how to join go to www.caipe.org or email: admin@caipe.org

