Centre for the Advancement of Interprofessional Education

CAIPE

Continuing Interprofessional Development: Guidelines 2017

Prepared for CAIPE by Barr, H., Ford, J., Gray, R., Helme, M.& Reeves, S.

Introduction

These guidelines respond 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.

They focus on continuing learning for workers whose qualifying courses included interprofessional education (IPE) compatible with successive guidelines from CAIPE (2012, 2016). They are addressed to all who are responsible for commissioning, developing, delivering, evaluating and overseeing continuing interprofessional development (CIPD) to be read in conjunction with CAIPE's current IPE guidelines (CAIPE, 2016). Like them they apply primarily to practice in the United Kingdom (UK), but, allowing for differences in context, may also be applicable in other countries. CAIPE will be publishing guidance later for workers and mentors.

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 (Schon, 1983 & 1987).

Learning together

Responsible though each practitioner is for their CIPD, it depends by definition upon collaboration between professions. Broadly similar learning methods apply as in pre-qualifying IPE (CAIPE, 2016: 7). 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 relevant CAIPE guidelines (Barr,

[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.

Hutchings, Machin et al. in preparation) 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.

Owens 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 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 of interprofessional development

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.

Some universities have formulated or adopted capability or competency based outcomes, in the UK notably Sheffield Hallam and Sheffield universities (Combined Universities Interprofessional Learning Unit, 2010) adopted in all or part by others. Formulations in Canada (Canadian Interprofessional Health Collaborative, 2010), the United States (Interprofessional Education Collaborative Expert Panel, 2016) and Australia (Brewer & Jones, 2014) have influenced UK programme planning. There is, however, no one authoritative and dependable statement of interprofessional outcomes applied UK-wide.

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 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 & Skodstat, 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 & Luebbers, 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.

Conclusion and next steps

We have shared our understanding of the essential qualities of CIPD within CPD. CAIPE welcomes opportunities to work with stakeholders to build effective CIPD strategies and systems from transition from student to practitioner onwards.

May 2017

References

Barr, H. (2003) Interprofessional issues in work based learning. In: J. Burton & N. Jackson (eds) *Work based learning in primary care.* Abingdon: Radcliffe Medical Press, 73-86.

Barr, H. (2007) *Interprofessional education in the United Kingdom, 1966 - 1997* Health Education Authority: Health Sciences & Practice.

Barr, H. (2009) An anatomy of continuing interprofessional education. *Journal Continuing Education in then Health Professions* 29, 147-151.

Barr, H., Koppel, I., Reeves, S., Hammick, M. & Freeth, D. (2005) *Effective interprofessional education: argument, assumption & evidence.* Oxford: Blackwell.

Barr, H., Helme, M. & D'Avray, L. (2014) *Review of interprofessional education in the United Kingdom, 1977-2013.* Fareham: CAIPE.

Barr, H., Hutchings, M. & Machin, A. et al. (in preparation) *Interprofessional Practice Learning during Prequalifying Courses: Guidelines.* Fareham: CAIPE.

Brewer M. & Barr, H. (2016) Interprofessional education and practice guide number 8: Team-based interprofessional practice placements. *Journal of Interprofessional Care* 30 (6) 739-746.

Brewer, M. & Jones, S. (2013). *An interprofessional practice capability framework focusing on safe, high quality client centred health service. Journal of Allied Health* 42 e45-e49.

Canadian Interprofessional Health Collaborative (2010). *A national competency framework for interprofessional collaboration.* Available at: www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf

Combined Universities Interprofessional Learning Unit (2010) *Interprofessional Capability Framework 2010 Mini-Guide*- London: The Higher Education Academy Subject Centre for Health Sciences and Practice.

CAIPE (2012) *Interprofessional education in pre-registration courses: A CAIPE guide for commissioners and regulators of education.* Fareham: CAIPE.

CAIPE (2016) *Interprofessional education guidelines 2016.* Fareham: CAIPE

Donansky, M. & Luebbers, E. (2017) Overcoming challenges to interprofessional education in the workplace. In W. Rayburn, M. Turco & D. Davis (eds) *Continuing professional development in medicine and health care.* Philadelphia: Wolters Kluwer, 271-285.

Department of Health (1998) *A review of continuing professional development in practice: a report of the Chief Medical Officer*. London: HMSO

Eraut, M. (2000) Non-formal learning and tacit knowledge in professional work. *British Journal of Educational Psychology:* 70, 113–136

Health and Care Professions Council (2017) *Continuing professional development.* Available at: http://www.hcpc-uk.org/registrants/cpd/

Hinshelwood, R.D. & Skogstad, W. (eds) (2000) *Observing organisations: anxiety, defence and culture in health care.* London: Routledge.

Institute of Medicine (2015) *Measuring the impact of interprofessional education on collaborative practice and patient outcomes.* Washington DC, IOM.

Interprofessional Education Collaborative Expert Panel (2016) *Core competencies for interprofessional collaborative practice: 2016 update.* Washington DC: Interprofessional collaborative.

Kolb, D. A. (1984). *Experiential learning: Experience as the source of learning and development* (Vol. 1). Englewood Cliffs, NJ: Prentice-Hall.

Launer, J. (2002) *Narrative-based primary care: A practice guide.* Oxford: Radcliffe Medical Press.

Owen, J.A, & Schmitt, M.H (2013) Integrating Interprofessional Education into Continuing Education: A planning process for implementing continuing interprofessional education programs. *Journal of Continuing Education in the Health Professions* 33(2):109-17.

Reason P. (1999) Integrating education and reflection through cooperative inquiry. *Management Learning,* 30: 207-26.

Reeves, S. (2009) An overview of continuing interprofessional education. *The Journal of Continuing Education in the Health Professions* 29 (3) 142-46.

Reeves, S. & Kitto, S. (2017) Collaborating interprofessionally for team-based care. In W. Rayburn, M. Turco & D. Davis (eds) *Continuing professional development in medicine and health care.* Philadelphia: Wolters Kluwer, 121-133.

Reeves, S., Lewin, S., Espin, S. & Zwarenstein, M. (2010) *Interprofessional teamwork for health and social care.* Oxford: Wiley-Blackwell.

Schön, D. (1983) *The Reflective Practitioner. How professionals think in action*, London: Temple Smith.

Schön, D. (1987) *Educating the Reflective Practitioner*, San Francisco: Jossey-Bass.

Senge P. (1990) *The Fifth Organization: The art and practice of organizational learning.* New York: Currency Doubleday.

Wackerhausen, S (2009) Collaboration, professional identity and reflection across boundaries. *Journal of Interprofessional Care* 23 (5) 455-473.

Wenger, E. (1998). *Communities of practice: Learning, meaning and identity*. Cambridge, U.K: Cambridge University Press.

Wilcock P. Campion-Smith C. & Elston S. (2003) *Practice professional development planning: A guide for primary care.* Oxford: Radcliffe Medical Press.