# INTERPROFESSIONAL EDUCATION HANDBOOK

Prepared for CAIPE by
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# About the Authors

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Jenny qualified as a speech and language therapist in 1983. After 10 years in practice she moved into Higher Education at De Montfort University. She worked on the preregistration speech and language therapy degree, including 7 years as programme leader. She also set up an interprofessional Service User and Carer Advisory Group. From 2003 she was a member of the Regional Interprofessional Education (IPE) Steering Group contributed to the development of IPE at De Montfort University and jointly with the University of Leicester working with colleagues in education, pharmacy, audiology, social work, policing, medicine, nursing and other disciplines. Her IPE leadership role included developing and delivering facilitator training and working on project which enabled service users and carers to take on leading roles in IPE. Jenny was a Board member of CAIPE for 9 years; during this time, she worked with the student membership and helped to develop membership and Board roles for service users and carers. She is now retired from full-time employment but continues to work with CAIPE.

# Foreword

Effecting strategies to ensure safe, integrated, patient centred care depends on the readiness of the professionals to review their practice critically in anticipation of changes in their relationships and responsibilities. Many are already rising to that challenge, learning with, from and about each other as they explore how to combine their expertise effectively, efficiently and expeditiously.

HEE appreciates the contribution being made by CAIPE to distil best practice by its members in devising, testing and reporting ways to achieve those ends in diverse services and settings. The outcome, distilled by Jenny Ford and Richard Gray in this Handbook, is a practical guide to work-based interprofessional education building on pre-qualifying interprofessional education along a continuum of mutual learning. Part one puts interprofessional education in context, sorting out the semantics, clarifying the meaning, and securing the evidence base and the theoretical undergirding. Part two adds a wealth of advice for teachers and practitioners especially those assigned to the key role of facilitator.

This handbook has been informed by work commissioned by HEE in 2017 to understand and evaluate the best ways to educate for and promote integrated working across the health and care sectors. The report, produced by Coventry University (June 2017), has been well received by stakeholders and is now part of HEE's toolkit of resources to support integrated care. The findings and recommendations have been disseminated and were the subject of a workshop, held in October 2017, for HEIs in the West Midlands.

Following the positive outcome of pilots of the Handbook, completed with CAIPE, in which staff from trusts, universities and others across the South and Midlands & East regions, shared their experiences at workshops, HEE welcomes this final version of the Handbook to be distributed more widely.

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# Introduction

Most Interprofessional working has traditionally taken place internally within health care including the integration of professionals working within primary, secondary and tertiary care. However, currently with increasing pressures of demand, particularly due to an aging population There is renewed emphasis on the need for external integration across sectors involving adult social care and third sector organisations (Clouder et al., 2017).

The Centre for the Advancement of Interprofessional Education (CAIPE) is a UK based charity which is a national and global leader in promoting and developing interprofessional education and learning with the purpose of improving collaborative practice, patient safety and quality of care. CAIPE understands interprofessional and collaborative practice to mean professionals from different disciplines working jointly across health and social care and beyond. IPE is one approach to achieve this, designed to equip professionals with the relevant knowledge skills and values required to enable this to happen (Lindqvist et al., 2017).

This Handbook has been developed by CAIPE as a resource to support educators and practitioners from any profession, who are interested in developing and delivering education interprofessionally. It should be read alongside the CAIPE interprofessional Guidelines (CAIPE, 2017).

To effectively implement an interprofessional education intervention it is necessary to ensure a common understanding of the principles of IPE, involve all relevant stakeholders in the curriculum design and consider the preparation and support of facilitators.

In the UK IPE is part of the curriculum for over two thirds of pre-registration professional courses in health and social care (Barr et al., 2014) and is extending into continuing professional development (CAIPE, 2017). The principles of IPE align closely to current priorities in health and social care, including safe care, integrated person-centred care, values-based practice, continued improvement in quality care, collective leadership in the workforce and the need for transformative thinking to challenge traditional boundaries.

Part one of the Handbook defines IPE and provides background evidence of effectiveness and theory. For more information, see CAIPE (2017) and Barr et al., (2014). Part Two is the main focus of the handbook and provides practical guidance for those planning and implementing IPE, either as part of, or as a freestanding, academic event for groups of professionals who will need to work collaboratively in integrated health and social care

services. This section includes considerations related to planning, educational aims, learning activities, interprofessional engagement, venues and timings, promotion, evaluation and IPE facilitation. An example of an IPE workshop and evaluation form is provided. Finally, readers are signposted to further reading and resources.

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# Part One: Explaining IPE

## 1. What is meant by IPE?

It is important to define what is meant by IPE as clearly as possible. The definition generally accepted both nationally and internationally is that produced by CAIPE:

*Interprofessional Education (IPE) occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care (*CAIPE, 2002)

There is much confusion in the literature regarding the definition and meaning of IPE (Leathard, 1994; Finch, 2000; Barr, 2002; Chattergee, 2002). Examples of different terminologies found in the IPE literature include: "inter-disciplinary", "multi-disciplinary", "trans-disciplinary", "inter-professional", "multi-professional"," trans-professional", "shared learning", "common learning", "collaboration", "common studies", "joint training", "joint learning", and "joint studies". The situation is complicated further using different terminologies by different professions and by authors using such terms interchangeably even within the same publication.

In this context CAIPE uses the term "interprofessional education" (IPE) to include all such learning in academic and work-based settings both before and after qualification. The term professional is used in its widest sense to include all those in health and social care involved with looking after service users[1], including paid carers. The service user or patient and unpaid carers are members of the interprofessional team and will learn alongside professionals in their care journey. This definition of IPE contrasts with the concept "multiprofessional education", which is synonymous with common learning, and can be defined as:

*Occasions when two or more professions learn side by side for whatever reason* (Barr, 2002).

Effective IPE improves collaborative practice which should be planned, purposeful, concerted and sustained (CAIPE, 2016). It should be for the benefit of people who use services, and be defined as:

*Collaborative practice occurs when multiple professionals work together towards a mutually agreed vision of how to receive high quality, safe and compassionate care*

[1] T*he term "Service User" refers to patients and people who use health and social care services and is inclusive of Carers; we recognise that some prefer other terms such as "Expert by Experience"*

*which is truly integrated and person centred. The collaborative process is underpinned by a culture where everyone's contribution is valued. Collaborative practice empowers staff to embrace change and engage with innovation (Lindqvist et al., 2017).*

In contrast the term Integrated care is used as an outcome with a wider context involving professionals across sectors from health, social care and beyond and can be defined as:

*Integrated care is provided by multiple health and social care workers from different professional backgrounds who collaborate interprofessionally across settings in a way that has optimal outcomes for each person in need of care and for those who provide it (Lindqvist et al., 2017).*

Formulating capability or competency-based outcomes can help teachers and students develop relevant IPE (Barr, 1998; Reeves, 2012). Barr (1998) described three different types of competence of relevance to IPE: common competencies (held by all professions), complementary (important to one profession but complementing competences of others) and collaborative (enabling each profession to work collaboratively and effectively with others).

In the UK, capability based outcomes in IPE were initially led by Sheffield Combined Universities Interprofessional Learning Unit (2010). Further frameworks were developed in Canada (Canadian Interprofessional Health Collaborative, 2010), in the USA (Interprofessional Education Collaborative Expert Panel, 2011) and in Australia (Brewer, 2011). These in turn have influenced IPE planning in the UK but as yet there is no recognised common statement that has been agreed by professional bodies which can be applied across the UK (CAIPE, 2017).

At present, interprofessional requirements and procedures differ between professional regulatory bodies within the UK. This can produce duplication with an emphasis on profession-specific studies to address regulations and missed opportunities for interprofessional developments (CAIPE, 2017). More consistent alignment between different regulatory bodies could produce recognition, co-ordination and commitment to common interprofessional values with the benefit of integrated process and outcomes (CAIPE, 2017; Clouder et al., 2017)

# 2. Evidence for the effectiveness of IPE

IPE in its true sense is a relatively new phenomenon in pre-qualifying education and subsequent learning. Only recently have we started to develop a health and social care workforce prepared through IPE to work collaboratively (WHO, 2010). There is an

emerging evidence base demonstrating the effectiveness of IPE, with more work still to be done. Researchers seeking to assess the impact and outcomes of IPE face a number of challenges. IPE is not a single coherent idea in professional education (Haddara & Lingard, 2013). At least two different discourses exist, each with its own language, truths and objects. A utilitarian discourse requires evidence and validity relating to successful outcomes for those receiving care. An emancipatory discourse relates to relationships, including power and dominance, between practitioners. The extent to which educators and practitioners may tacitly align with one discourse or the other may explain the tensions that have accompanied the planning, implementation and evaluation of IPE. Acknowledgement and attention to these discourses is important to improve coherence and impact.

Evidence from isolated evaluations about IPE is not enough. Systematic reviews are seen as the gold standard needed to provide a baseline for future policy. Barr and his team in 2005 conducted a systematic review which considered a range of qualitative and quantitative methodologies and outcomes. This was reported in 2005 and 2007 and included 107 evaluations. The conclusions were that evaluations of pre-qualifying IPE report positive changes in attitudes and for the acquisition of knowledge and skills relevant to collaborative practice (backed up by Lapkin et al., 2013). In contrast, evaluations of post qualifying IPE report changes in individual and organisational behaviour and benefits to practice. The implications are that well planned pre-qualifying IPE meets intermediate objectives, but this is not enough. Foundations laid in pre-registration education must be built upon and developed in the post qualifying arena. This suggests that pre-qualifying and post-qualifying IPE should be seen as a continuum rather than two separate entities (CAIPE, 2017).

Several Cochrane reviews on IPE have been conducted. Findings from these are sometimes cited to support the argument that evidence for the effectiveness of IPE is limited. However, the Cochrane methodology was originally intended to conduct meta-analyses of research into medical interventions and is ill suited for educational evaluations. As Olson and Bialocerkowski (2014) state, there is a struggle between the assumptions underpinning biomedical and health science and those underpinning education studies.

A replication of the 2005 review has recently been published (Reeves et al., 2016.) This and other recent papers are starting to demonstrate increasingly positive outcomes particularly in the pre-qualifying learners' responses to IPE, including improvements in their attitudes toward one another and a gain in the knowledge and skills required for collaborative practice.

In contrast, the same review describes in post qualifying education increasingly positive changes reported for behaviour, organisational practice and delivery of patient/client care.

# 3. Why do we need IPE?

# Integrated Care

Current UK policy aims to achieve full integration of health and social care, meaning that services will deliver a person-centred whole system approach to care across sector boundaries. An "agile" and flexible workforce will be required to adapt to new roles, shifting role boundaries and provide new models of care. Professionals will need to think beyond their own role, their own profession and their own sector (Clouder et al., 2017). The priority is to integrate health and social care but many care pathways, for instance for mental health and safeguarding, span other sectors such as education, police and the voluntary sector. Integration may take place at several levels involving the strategic or policy level, the organisational culture, structures and procedures, administrative functions and clinical (Shaw, Rosen & Rumbold, 2011).

At the heart of such a transformation are interpersonal and interprofessional relationships and interactions. These require interprofessional capabilities such as understanding of others' roles, respect for differences, the ability to communicate with professions with different philosophical and value systems and the ability to negotiate differences to plan person-centred care collaboratively. Interprofessional education equips professionals at any stage of their career with these capabilities enabling them to deliver integrated care. This is reflected in the recommendations of Clouder et al. (2017) for how education can prepare the workforce for Integrated Care (Appendix 3).

## Failures in health and social care policy

In the 20th century there were a number of high profile enquires into failures in health and social care that led to shifts in policy (DHSS, 1974; Butler-Sloss, 1988; Kennedy, 2001; Laming, 2013; Smith, 2004). All these reports highlighted problems with communication between different professionals and ineffective collaborative practice resulting in poor outcomes for the patient or client. The Laming and Kennedy reports went further, recommending that for different professionals to work together they should learn together.

The Keogh report (2013) emphasised the need for communication and openness throughout the NHS; 'no hospital should be an island unto itself'. Professional, academic

and managerial isolation should become a thing of the past. The Berwick Report (2013) similarly emphasised the importance of initial preparation and lifelong education for all health and social care professionals and that this should be firmly linked to quality of patient care and patient safety.

### Safe Care

It is acknowledged in health that IPE has a critical role in shaping the approach to managing patient safety (WHO, 2011). In both the patient is placed at the centre of all learning and different professions are actively and positively involved in an interactive learning process, with the focus on improving the experience of the patient in a learning environment rather than a blame culture. Patient safety depends upon a clear understanding of the role and task of each team member involved in an episode of patient care. In order to address this process and to develop a culture of patient safety within an organisation, IPE is required (Anderson et al., 2017). This enables a supportive working culture which can improve the patient experience of health and social care and help facilitate staff resilience. Although these principles of safe care are recognised in heath they apply equally to social care (Laming, 2003).

## 4. The theory behind IPE

Interprofessional Education is underpinned by theory drawn from various domains especially psychology, sociology and pedagogy (Hean et al., 2012). Theory anchors IPE in logic and explains and predicts the behaviour of learners and practitioners individually and as members of professional groups. Use of theory therefore informs the understanding, design and implementation of IPE. Theory is informative at two levels. First, those designing and leading IPE can draw on theory to develop solutions to the challenges posed by IPE. Second, the underpinning theory can be shared with the learners to inform their developing interprofessional values, knowledge and skills.

### Explaining Individual Behaviour

Psychological theories help to explain and predict the behaviour of individuals, for instance the Myers-Briggs personality inventory, drawing on Jungian psychology, proposes that human personalities can be divided into 16 types based on individual preferences for how the world is perceived and decisions made (Myers, 1980). Experience suggests that individual preferences for perceiving and responding to the world may align to particular working practices and professions. Familiarity with such theory helps us to understand our own behaviour and that of others. Psychological

theories also help to shed light on what happens when individuals interact. Theoretical frameworks can help to unravel the role of "softer" human skills and qualities when individuals work together. Such frameworks include the five components of emotional intelligence described by Goleman (1995) and the Johari window (Luft & Ingham, 1961), which illustrates how "space" is known or unknown and shared or otherwise in interpersonal relationships through feedback and reflection.

## Explaining Group behaviour

Some theories are relevant to all group interactions, interprofessional or otherwise. Tuckman (1965) describes the stages by which teams form, helping us to anticipate and recognise the bumpiness often present when individuals first work together. Belbin (1993) looks in more detail at how individuals contribute to team performance by identifying the nine roles which typically exist within a team, such as "plant", "specialist" and "completer finisher". Knowledge of such theory helps IPE leaders to plan appropriate learning activities and informs facilitators of the need to support learners who may experience the challenges of learning within a newly formed team.

Other theories deal with issues directly relevant to interprofessional practice and interprofessional learning. Professions have often been likened to cultures and the existence of different professional cultures seen as a barrier to collaboration (Hall, 2005). Novice members of a profession are moulded to fit the profession until the language and customs of their profession become automatic and invisible (Wackerhausen, 2009).

The internal cohesion of each profession is cemented by shared social capital (Coleman, 1990) from which members of the professional community benefit. This sense of "belonging" is an important part of an individual's self-concept, according to social identity theory (Tajfel & Turner, 1986) and commonly defines who that individual considers to be part of the "in-group" (typically other members of the profession) and who is part of the "out-group" (typically members of other professions). It is well-established that human beings tend to identify with the values and norms of the in-group and to make sometimes stereotypical assumptions about members of other groups (Turner, 1975). This is particularly the case when professionals work in different sectors as exemplified by the traditionally different cultures in acute medicine compared to social care.

Contact theory has been used as a framework for exploring how such barriers and stereotypical attitudes between professions can be broken down through positive IPE experiences. Hewstone (2003) identifies facilitating conditions for successful contact

between members of different groups; the participants should come together on an equal footing, they should have time to get to know one another, they should believe that the people they meet are typical of their group and the activity (for instance a shared goal) should facilitate equality and the participation of all.

## Learning Theories

Successful interprofessional education draws on learning theories to inform curriculum design and delivery (Hean et al., 2009). Traditionally professional education has followed a didactic model in which theory was delivered prior to practical application and learners were perceived as relatively passive in the educational process. Modern educational theories recognise adult learning as a process in which learners play an active role in seeking meaning and need to align new knowledge with existing knowledge (Driver & Oldham, 1986). Moreover, it is now recognised that there are a variety of different learning styles meaning that learning opportunities should be designed to acknowledge and exploit this variety (Kolb at al., 2000).

IPE curricula and learning activities are therefore commonly designed with these theoretical principles in mind. Learning activities often draw on learner-centred approaches such as problem-based learning or enquiry-based learning in which learners are provided with "triggers" following which they set their own learning goals and identify the means to meet these (Savery, 2006). Successful IPE activities are frequently constructed to follow the reflective learning cycle. The initial "concrete experience" takes the form of trigger material such as a case study or professional interview; the interprofessional learners discuss and interrogate this experience (taking them through the next two stages of "reflective observation" followed by "abstract conceptualisation") and then jointly determine how the learning will impact on future practice, "active experimentation" (Kolb, 1984). The interprofessional nature of such discussions enables each individual professional to go beyond the learning they are likely to achieve from their uniprofessional perspective, taking them from "first order" to deeper "second order" reflection, facilitating the development from a self-affirming to a transformative process (Wackerhausen, 2009).

In summary, IPE underpinned by educational theory is likely to produce the most effective learning for participants. Indeed, it can be helpful for planners to develop their own individual theories, based on their own background and professional experiences, relevant to and underpinning their proposed IPE programme (CAIPE, 2017).

# Part Two: A guide to implementing IPE

See Figure 1 for a summary of the considerations involved in organising an IPE event.

# 1. Collaborative planning

## Create interprofessional planning teams and involve service users

In keeping with the principles of IPE discussed earlier, the planning and delivery of any IPE event should be a collaborative process. Ideally there will be collaboration from the outset in the form of a planning team which can represent the needs and the perspectives of the relevant professions (CAIPE, 2017). For a truly interprofessional approach the members of the planning team should have equal status and involvement in the planning process (Hewstone & Brown, 1986). Those involved initially might challenge themselves as to whether there are other professions who could be involved but have been overlooked. IPE aims to improve the quality and outcome of health and social care (CAIPE, 2002; WHO, 2010) and planners should consider how service users will contribute (Barr & Low, 2013; CAIPE, 2017). An ideal planning partnership will include properly supported service users at all stages: planning, delivery and evaluation (Anderson et al., 2011). However, challenging this ideal might be to achieve, IPE planners must be creative to work towards full service user and carer involvement over time.

# 2. Educational aims

## Develop interprofessional aims; balance the uniprofessional and interprofessional needs of participants

The planning team will need to set aims and objectives for the learning and again these should reflect the needs and perspectives of all professions who will be involved. This can be challenging as different professionals, especially those from different sectors, work from very different underpinning philosophies, use different language and have different priorities (Wackerhausen, 2009). At the heart of successful IPE is the process by which the planning team engages with these differences. In setting aims the planners will need to consider how the three essential components of IPE, "learning with, from and about" will be addressed. The tension between uniprofessional needs and the intended gains from interprofessional learning, needs careful consideration. Simply bringing different professions together to learn something they all need is not IPE. Planners should consider what different uniprofessional knowledge and skills the participants will bring, what they can learn from each other through balanced interaction and what they can learn about one another and how to work with one another (Morison

et al., 2010; Thistlethwaite & Moran, 2010; Barr, 1998)  Models such as Kirkpatrick (1967) can be useful to help define the kind of learning to be achieved, for instance changes to attitudes, knowledge or behaviour. The competency frameworks cited in Part One might also be used as a guide to formulating aims and learning outcomes (see Appendix 1). Ultimately, of course, the goal is to improve the experience of and outcomes for people who use services (Cox et al., 2016)

# 3. Learning activities

## Plan interactive learning activities to ensure interprofessional engagement; meet the needs of participants with different learning styles by using varied activities

Decisions must be made about how the IPE is to be delivered.  IPE is, by definition, interactive and should encompass a variety of learning activities (Barr & Low, 2013).  In order to learn "with, from and about" one another, participants will be organised into small interprofessional groups and given opportunities to interact.  Evidence shows that some key factors help to counteract any barriers which may exist between members of different professions.  It is important that activities are structured so that all participants have an authentic role and can contribute using their professional expertise (Hammick et al., 2007), participants must interact as equals, differences must be acknowledged and respected and there must be a sense of a shared goal towards which each group is working (Carpenter & Dickinson, 2011).  Many established IPE programmes use teaching and learning approaches which draw on the principles of "problem-based learning" in which learners work together to identify and achieve learning points derived from problems posed for them (Wood, 2003).

# 4. Ensuring interprofessional engagement

## Employ "social engineering" to ensure that participants from different professions work together on an equal footing.

Some "social engineering" will be required. Group identity is strong; on arrival course participants will usually gravitate towards members of their own profession.  The IPE leaders will need a strategy for allocating participants into small interprofessional groups which will function as interprofessional teams.  Reasonably balanced numbers of the different professions attending will facilitate this. Experience shows that it is best if the group stays together during the event (Anderson & Lennox, 2009). The organisers should aim to ensure that all groups contain representatives of all professions present and that the numbers are as balanced as possible. The challenges of team formation and

functioning are well-known (Tuckman, 1965); structured time should be allowed for participants to get to know one another and to agree on how they will work together. Throughout the learning the role of the leaders or tutors will be that of facilitator, setting the scene, managing logistics and supporting small groups to facilitate the learners' progression through the "reflective observation" and "abstract conceptualisation" stages of the reflective cycle (Kolb et al., 2000).

# 5. Venues and timings

## Ensure that all participants are equally comfortable

Decisions must be made about the underpinning practicalities such as venue and timings. The impact and importance of "space and place" to interprofessional relationships is frequently overlooked (Kitto et al., 2013). All participants should feel equally at home and included wherever the learning takes place; "neutral territory" is often preferable where possible. Whatever the venue, the physical set up is important. There may be a plenary introduction and scene-setting but, for most of the time, the participants will work in small, interprofessional groups, so the venue should accommodate tables for groups of approximately five to eight people with adequate space between for discussions to take place comfortably. Facilitators should be able to circulate to ensure that all groups understand the task and process and to facilitate group discussions when invited. It is usually advisable to take brief plenary feedback after small group activities and to end the day with a plenary review of the outcomes.

# 6. Facilitating the learning

## Skilled facilitation is essential; facilitators support reflective learning rather than delivering information; they must be sensitive to professional differences

Facilitation is critical for the success of IPE events. Ideally facilitators will be from more than one profession and will model interprofessional working in the way the day is run. Trained service users can act as facilitators and this will model person-centred partnership working. The facilitators will support the participants' learning rather than deliver information. Facilitators should take care to be as inclusive as possible by ensuring they speak to all professions rather than only to their own, acknowledging differences in terminology and approach and using inclusive language as far as possible. The role of IPE facilitators and the skills needed will be discussed in more detail in Section 9.

# 7. Promoting the IPE

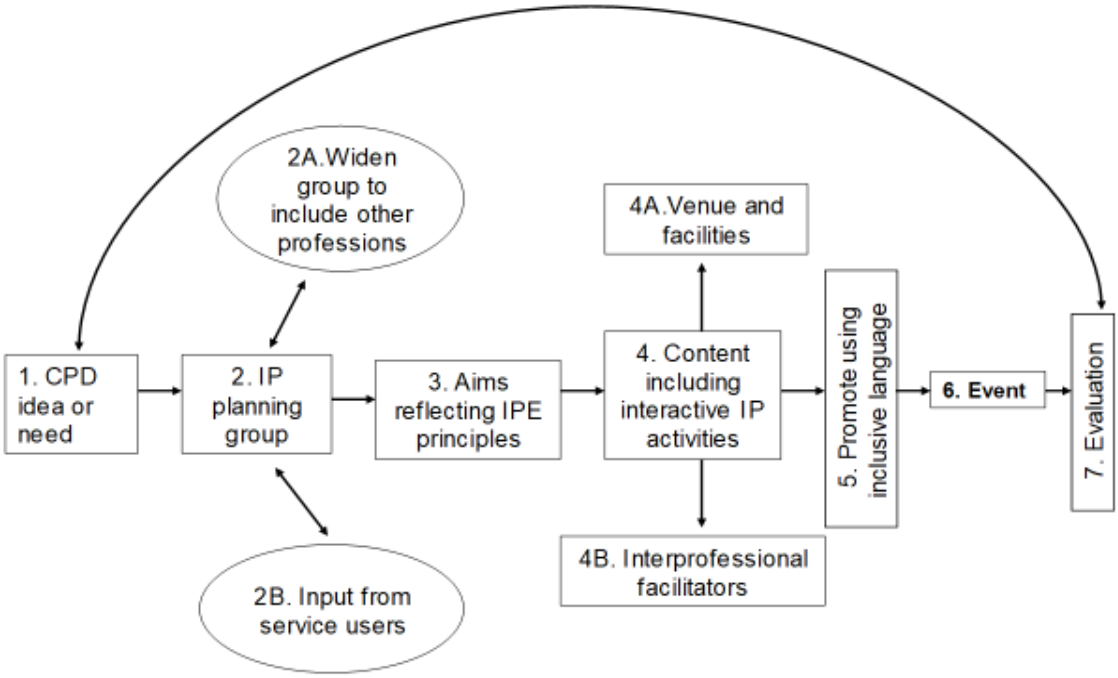
## Follow inclusive principles; avoid profession specific language and attitudes

Promotion of IPE should also follow inclusive and interprofessional principles. Care should be taken to promote the activity equally to all relevant professions rather than implying that it is primarily for certain professions but that others are invited to join in. The promotional literature should avoid, as far as possible, language and assumptions that imply bias towards certain professions, for example if the publicity is aimed at attendees from social care then the terms such as "client" or "service user" as well as "patient" should be used.

# 8. Evaluation

As with any educational activity there should be an opportunity for participants, facilitators and participating service users to evaluate. This should focus clearly on the aims and learning outcomes, on the interprofessional content and engagement and on the potential to change behaviour and impact on future outcomes for people who use services. (See Appendix 2 for an example of an evaluation form).

## Figure 1: IPE Planning Flowchart



## Illustrative example

The following example of an undergraduate IPE workshop illustrates the stages of the flowchart. The workshop is described in more detail in Appendix 1which should be read in conjunction with this example and flowchart to provide background information.

1. CPD Idea or need: colleagues from health and education discussed the fact that speech and language therapists and teachers will work together but do not train together.
2. IP Planning group: Colleagues from health and education worked together to plan the first pilots. Later, social work colleagues joined the planning team (2A). The views of service users were sought through a consultation meeting and by inviting parents to teach during the workshops (2B).
3. Aims reflecting IPE principles: The workshop aims and learning outcomes were set by the planning group and identify knowledge, attitudes and skills needed for interprofessional collaborative practice to support children with communication needs in education.
4. Content including interactive IP activities: The workshop content was developed collaboratively by the planning group. All activities take place in small interprofessional groups. Each group has a chance to share their profession specific knowledge and skills. The day ends with an interprofessional case study exercise. The workshops take place in a neutral venue with space for students to work in small interprofessional groups (4A). Tutors from all three professions act as facilitators; they are prepared with a facilitator guide and a briefing session (4B).
5. Promote using inclusive language: Students are prepared for the event in their uniprofessional courses and given access to materials. All materials are agreed by the interprofessional planning team and are designed to avoid bias towards any one profession.
6. Event: The event is "student-led". The small interprofessional groups of students work through a set of activities using their workbook and uniprofessional preparation. They are supported by facilitators who monitor, advise and encourage and may listen to student discussions by invitation.
7. Evaluation: Written feedback (see Appendix 2) is collected from all students and verbal feedback is collected from facilitators and service users. All feedback informs future planning.

# 9. IPE Facilitators

## The role of the facilitator

IPE facilitators should model interprofessional working and collaboration; a facilitator needs credibility drawn from expertise, teaching skills and an "interprofessional stance".

As described above, those who lead IPE take on the role of facilitator rather than teacher. The way in which facilitators, including service user facilitators, work together should provide a model of collaborative interprofessional working for the learners. This means working as equals, showing awareness of and respect for each other's professional cultures and expertise and demonstrating how the professions complement each other.

An IPE facilitator supports and enables course participants to learn "with from and about" one another through positive and open interaction and dialogue. The facilitator sets the scene and helps create an environment in which this learning can happen. Key to this is the ability to step outside one's own profession and become a "generic professional" who can address all professions inclusively. IPE facilitators must be sensitive to the differences between professions, professional cultures and professional terminology. They must be aware of and alert to potential barriers and tensions especially related to status, hierarchy and contrasting underpinning professional philosophies (Howkins & Bray, 2008). They must be able to listen, support and encourage participants to think beyond their own professional perspectives to enable them to overcome such challenges. The attributes of IPE facilitators are described in more detail in the following section.

## Attributes of IPE facilitators

### Able to recognise reflective learning; understand adult learning; manage group dynamics

As professionals become expert in their own field they will usually become involved with mono-professional teaching. At this stage teachers often become involved with IPE, but many have not yet had an opportunity to develop their interprofessional values and beliefs. This can produce significant tension and anger towards interprofessional issues which can be communicated unintentionally to IPE students. What is not generally recognised is that to become an effective IPE teacher, individuals need preparation and support that includes time to develop an interprofessional identity with related culture, values and beliefs. If this step is omitted then unanticipated difficulties can occur which

by blocking development can be a recipe for disaster (Gray, 2009). In these situations, service users can provide invaluable insights as often they have experienced not just a single profession's values and beliefs but those of an interprofessional team.

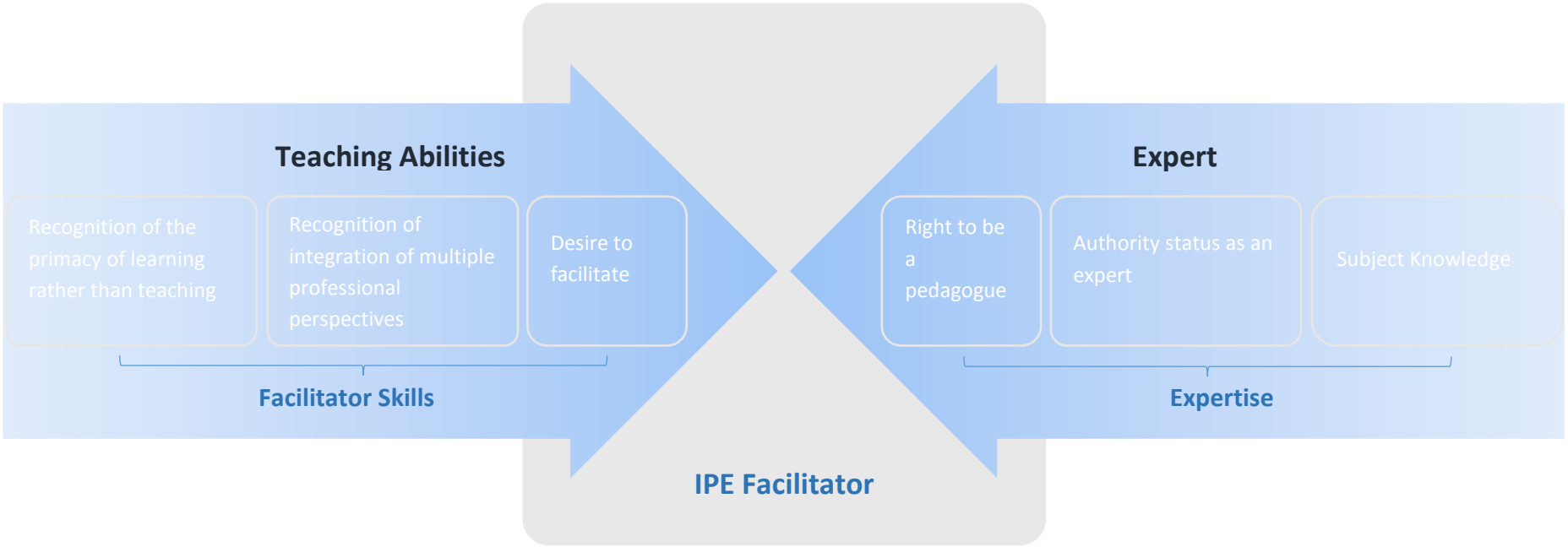
The characteristics of successful IPE facilitators, including knowledge, skills, values and personal qualities, have been described. Of particular importance, is the ability to recognise the value of learning rather than teaching and a sound understanding of theories of adult learning (Anderson et al., 2009). Relevant skills include active listening skills, the ability to manage group dynamics and skills for dealing constructively with differences and supporting others to learn (Freeman et al., 2010). In most instances those new to IPE facilitation will require preparation and support before taking on the role (Anderson et al., 2009).

Anderson (2016) has summarised the relationship between professional expertise, teaching expertise and IPE facilitation skills in the model shown in Figure 2. A skilful IPE facilitator brings together credibility based on professional expertise or lived experience with knowledge and skills related to teaching (including an understanding of adult learning theories, an appreciation of different perspectives and skills for supporting group learning) and the motivation to apply these to IPE. These attributes combine to create a facilitator who can step outside his or her own profession and support interactive interprofessional learning.

# Conclusion

The purpose of this handbook is to provide a summary of the background and theory behind IPE and to offer practical advice by illuminating the considerations that need to be addressed when planning, organising and implementing an IPE event. The following areas need to be included in this context: interprofessional planning including service users, educational aims, learning activities, interprofessional engagement, venues and timings, facilitating the learning, promoting IPE, evaluation and the preparation and support of teachers. It is intended that this handbook is used as an adjunct to additional reading and resources, examples of which are included in Appendix 4.

**Figure 2: Components of IPE facilitation**




Reproduced with kind permission from Professor ES Anderson. See, Anderson. ES., Hean. S., O'Halloran. C., Pitt. R. & Hammick, M. (2014). *Faculty Development for Interprofessional Education and Practice*. Chapter 14, 287-310. In: Steinert, Y. (Eds) *Faculty Development in the Health Professions: A focus on Research and Practice'*. New York: Springer

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https://www.caipe.org/resources/publications/clouder-l-daly-g-adefila-jackson-furlong-j-bluteau-p-2017-investigation-understand-evaluate-best-ways-educate-promote-integrated-working-across

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## Appendix 1: Example of IPE Workshop

Numbers in brackets refer to the stages in the IPE Planning Flowchart (Figure 1, page 16).

Title: IPE in Education

Type: Classroom-based pre-registration IPE, one-day workshop

Students: Third year speech and language therapy students, first year masters social work students, student primary school teachers on a one-year PGCE

Facilitators: Tutors from all three courses

Overall workshop aim (3): To enable students to develop the knowledge, attitudes and skills needed to support children with communication needs in mainstream education and their parents.

Workshop development: The workshop arose from a casual conversation between colleagues in schools of education and health. They reflected that, although speech and language therapists and teachers need to work together they rarely, if ever meet during their professional courses (1). The workshop was subsequently planned by tutors from these two schools and run for these two professions (2). Student evaluations after early pilots indicated that students felt social work students should be included (2A). The workshop is now managed by a team of tutors from all three courses (2). A consultation event with parents of children with complex needs informed the design (2B). After each iteration feedback from students, tutors and participating parents feeds into the planning of the next cycle (7). A workbook for students was developed by the planning team with input from parents (5). This is also reviewed and refined each time the workshop runs (7).

Student preparation (5): Students have a uniprofessional introduction and relevant profession-specific teaching. They receive the workbook with some uniprofessional preparatory work to complete in advance. The workbook and introductory sessions are carefully prepared to reflect all three professions equally and to avoid language specific to any one profession.

Facilitator preparation (4B): The workshop is facilitated by tutors from all three professional courses. The planning team up-date facilitator guides each time the workshop runs. All facilitators receive this guide in advance. The facilitators meet for a final briefing early on the morning of the workshop.

Service user involvement (2B): Each year parents of children with complex needs are invited to participate by giving a talk during the workshop. Before the workshop day all participating parents meet for lunch with tutors and share views about what to include.

On the workshop day, the parents have coffee with tutors before speaking to the students, after their talk they de-brief over lunch. They are sent a summary of student feedback and are invited to give their own feedback after the event.

Learning outcomes based on the workshop aim (3): At the end of the day you will be able to:

**Knowledge**

- Appreciate more fully why collaborative working between Speech and Language Therapists (SLTs), social workers and teachers is important
- Identify the different professional roles and perspectives of SLTs, social workers and teachers

**Skills**

- Use additional skills for collaborative work between SLTs, social workers and teachers to support children with communication needs

**Attitudes**

- Value the contribution of each professional group towards delivering services collaboratively
- Value the contribution of children and families to children's education and care

Workshop format (4):

The workshop takes place in a "neutral" venue where none of the three professions usually study. The venue provides rooms which can be laid out "cabaret style" accommodating students working in small interprofessional groups (4A). The students are divided into small mixed groups before the workshop day and notified of the venue. The student workbook explains the format of the day and includes prompt questions and space for notes. Students undertake peer-teaching tasks, planned in advance, to share knowledge and skills. Each profession has profession-specific information about a small set of case studies including some conflicts and discrepancies between the information to promote discussion. The case studies were developed with the assistance of parents of children with communication needs. At the workshop, each small student group works through the programme of activities with support from the facilitator only when needed.

Schedule (6):

The activities are student-led, each interprofessional groups works together for the whole workshop day. Students come having prepared some materials in advance and use the schedule in their workbook to guide them through the activities. Each room is allocated a facilitator who monitors, advises and encourages and may listen to student discussions by invitation.

| | |
|---|---|
| 9.30 | Welcome by facilitator |
| 9.45 | Group introductions and getting started |
| | Morning activities in which students' share their professional perspectives using prompt questions and peer –teach topics (prepared beforehand) |
| 11.30 | Coffee break |
| 11.45 | Talk by a parent of a child with Speech, Language and Communication Needs |
| 12.45 | Lunch and case study selection |
| 1.30 | Key points from the morning led by Tutor |
| 1.45 | Songs and rhymes – demonstration led by student teacher followed by discussion of professional uses of songs and rhymes |
| 2.00 | Explanation and discussion of the Social Model of Disability led by student social workers |
| 2.15 | Demonstration/explanation of a teaching activity led by student teacher |
| 2.30 | Demonstration/explanation of a therapy activity led by SLT students |
| 2.45 | Joint planning activity using a case study |
| 3.45 | Plenary feedback led by facilitator |
| 4.00 | Close |

## Appendix 2: Sample Evaluation Form (7)

Profession.……

Name (optional) ……..…

| What were the best aspects of this workshop? |
|---|

| What do you think could be improved? |
|---|

| State your key learning and/or benefits from today (knowledge, skills, attitudes/values) |
|---|

| What did you gain from the interprofessional aspects of the workshop? |
|---|

| How will this workshop change your practice? |
|---|

| Do you have any other comments? |
|---|

Thank you for your time

## Appendix 3: "Coventry Report" Recommendations

Clouder, L., Daly, G., Dr Adefila, A., Jackson, A., Furlong, J. and Bluteau, P. (2017) *An investigation to understand and evaluate the best ways to educate for and promote integrated*

*working across the health and care sector: Final Report*, Coventry University & Health Education England (p 88-92)

**Recommendations for Integrated Care Services**

- Co-location allows for informal learning and exchange of ideas, as well as appearing to be an effective, timely and efficient way of problem solving. Therefore, efforts to provide a base or at least a common location for breaks etc. would be beneficial.
- Where an agile working approach is adopted ensure regular meetings for contact between team members occurs and importantly available rooms for this to take place.
- Train the whole team together where possible, as this is more likely to result in change and to cement relationships.
- The focus for training needs to be of common concern to all to encourage full engagement. The impact of training may be greater where it has immediate application in meeting the needs of a specific client.
- Cross training results in a more efficient and effective service but also means that staff have greater insight into the role and responsibilities of others.
- Cascade training where possible.
- Support staff in maintaining profession-specific expertise to ensure that they do not feel deskilled – this may be crucial in keeping good staff.
- Offering placement for students and badging them specifically as integrated care placements could energise teams and provide a means of identifying future recruits.
- Continue to foster clinical supervision and team supervision as part of CPD and as a means of promoting change.
- Rotate staff into integrated care teams to promote the integrated care approach.
- Explore potential links for integrated working with third sector organisations.
- Work with HEIs to identify placements with a specific integrated care focus.
- Consider offering interprofessional placements that involve interprofessional supervision and placing students from different professions to work together. Understanding different professional roles, skills and responsibilities was identified by teams as an important element of integrated care.
- Explore potential to work more closely with HEIs to swap training opportunities between service and students in a mutually beneficial exchange.
- Consider the importance of adequate funding and the impact that the lack of long term funding for training has on project development and implementation, and more importantly staff morale and motivation.

**Recommendations for HEIs**

- Based on good practice identified from the survey of all HEIs in the West Midlands, several recommendations are proposed to facilitate the embedding of integrated care as a desirable outcome of interprofessional education:
- The language of integrated care has yet to filter into undergraduate curricula, although it is evident in a minority of postgraduate programmes. Revalidation could be used as an opportunity to update curricula so that students can readily identify continuities in discourse between their university modules and placement experience. A subtle shift in the use of language could move students' perceptions of IPE concerning their own development, to a means of shifting focus to integrated care. Simultaneous revalidation of programmes, if it can be achieved, provides a prime opportunity to align professional programmes and negotiate space for shared learning.
- A strategic approach is necessary to embed IPE that leads to enhanced integrated working. Formal and integrated structures, such as IPE steering groups and frameworks provide a structured approach to interprofessional education that potentially gives it greater formal recognition and provides a focus for aligning activities.
- The relative pros and cons for integrating IPE into individual modules or developing a bespoke IPE/collaborative curriculum must be judged according to situation. Independent curricula can feel 'bolted on' and reduce the imperative to embed IPE across the whole curricula, but give scope for innovation. Embedding IPE in modules make it part of the norm but it may also become less visible.
- Incorporating IPE into the curriculum at stages throughout the programme allows it to be revisited and acknowledges that not all students are ready to engage with it in their early professional programme. This iterative approach also allows the IPE activities to be interspersed with integrated care placement experience that may help to enhance recognition of its importance for effective patient-centred care. IPE interventions can vary dramatically in length – combining sustained input with short bursts of interaction may enliven IPE.
- Where IPE is a mandatory part of the curriculum it should be assessed on the basis that this sends messages to students about its importance.
- Authenticity is crucial to optimising student engagement in IPL activities. A strong focus for activities around broad common interests is required to make interprofessional learning a positive by-product rather than the focus of activities. Service improvement projects may provide a real-life focus.
- Complex health and social care issues that demand an integrated approach require a suitable pedagogical approach such as case-based, problem-based or scenario-based learning that encourages students to think about the issues holistically.
- Encourage as broad face-to-face interaction with other professional groups as possible. Even brief contact is positive and can be followed up with online activity. Bilateral interaction may prove most beneficial in terms of gaining buy-in for some groups but one-off major IPE events have potential for significant learning and can possibly be more innovative. Explore the potential for inter-university initiatives to enrich IPE especially where on-site interaction is limited and use technology where contact is problematic.
- Actively promote links with social work colleagues with whom links tend to be more tenuous. Be aware of structural barriers and ensure that social work is included in IPE committees, steering groups, revalidation working groups etc.

- Encourage students to form their own IPE groups, to become involved in designing events and evaluating initiatives.
- Finding and naming integrated care placements as such is essential to help students to translate their learning into practice. Ideas of what constitutes a satisfactory placement need to be revisited and updated. Openness to non-traditional, role-emerging placements can offer contemporary experience of integrated working and whilst these should be balanced with traditional placements they offer students a wider perspective on where they might fit into practice.
- Training of practice educators/mentors should incorporate emphasis on exposing students to integrated working where feasible and interprofessional supervision.
- Explore potential to work more closely with service to swap training opportunities between service and students in a mutually beneficial exchange.
- Explore opportunities for cross-university IPE.
- Explore the training requirements of mentors in order to enable them to optimise exposure, experience and learning of students and qualified staff around the integrated care agenda.
- Explore potential learning opportunities available with Community Education Provider Networks. For example, Aston University had arranged professional experience sessions in primary care through links with their local Community Education Provider Network (CEPN) which provided access to GP surgeries and primary care emergency services including virtual pharmacy and virtual doctor services.
- It is not uncommon for staff to be allocated to IPE teaching and this can be problematic if they do not understand the need for 'learning with from and about' (CAIPE 2002) other professionals. Facilitators and teachers who are initially students' main point of professional reference can be highly influential in encouraging positive interprofessional attitudes and values which should result in a focus on the value of integrated care.
- There is wide recognition that integrated care must feature in future provision. Physicians' Associate programmes, such as those offered by the University of Warwick, University of Worcester and University of Wolverhampton, are seen as, offering a means of promoting new roles within integrated care, and are arguably suited to professionals wishing to expand their scope of practice. The learning from delivering these programmes could be used to inform how integration could be fostered in other programmes.
- Promote the development and use of integrated care placements via the targeted use of nursing, midwifery and allied health professional placement tariff.
- Based on the literature there is a need for more longitudinal studies on integrated care.

**Recommendations for Professional and Statutory Regulatory Bodies**

- Continue to reinforce IPE as well as updating the language to reflect contemporary practice and to highlight the association between IPE and working within integrated care teams.
- Ensure that revalidation processes pay sufficient attention to the place of IPE and integrated care in the curricula and that this is also reflected in placement provision.
- Review professional regulations with regards to mentorship arrangements to allow for interprofessional mentorship.
- Work with other bodies to ensure consistency of approach to facilitating integrated care, including 'Social Work England', the intended independent body for the regulation of the Social Work profession, from 2018.
- Ensure professional education standards reinforce the importance of IPE within curricula.

**Recommendations for Health Education England in the West Midlands**

- Continue to promote the need for integrated care as an efficient, effective and when managed well, a satisfying mode of delivering care to both service user and professional.
- Encourage statutory and professional bodies to work across boundaries making greater effort to integrate social work.
- Promote the provision of integrated care placements to ensure that the new workforce is fit for practice.
- Ensure involvement of front-line workers in the design of integrated care projects.
- Encourage mentorship across professions – to align with the recommendation that PSB review professional regulations with regards to mentorship arrangements to allow for interprofessional mentorship.
- Based on the literature there is a need for more longitudinal studies on integrated care

## Appendix 4: Additional reading and resources

### Reading

Barr, H., & Low, H. (2013). *Introducing Interprofessional Education*. Fareham: CAIPE.

Barr, H., & Gray, R. (2013). *"Interprofessional Education: learning together in health and social care".* In Walsh K (ed.) "Oxford Textbook of Medical Education" Oxford University Press.

CAIPE. (2017). *Interprofessional Education Guidelines.* (Barr, H., Ford, J., Gray, R., Helme, M., Hutchings, M., Low, H., Machin, A. and Reeves, S.). *London: 2017,* CAIPE. Available at:www.caipe.org.

Howkins, E., & Bray, J. (2008). Preparing for *interprofessional teaching: theory and practice* Oxford: Radcliffe

Thistlethwaite, J. (2012). *Values-Based Interprofessional Collaborative Practice: Working Together in Health Care.* Cambridge University Press

### Competency and capability frameworks

Brewer, M., & Jones, S. (2013). Interprofessional Capability Framework available https://healthsciences.curtin.edu.au/local/docs/Interprofessional_Capability_Assessment_Tool_2014.pdf

Canadian Interprofessional Health Collaborative. (2010). *National Interprofessional Competency Framework* Vancouver: CIHC available http://www.cihc.ca/resources/publications

CUILU. (2006). *Combined Universities Interprofessional Learning Unit Final Report* University of Sheffield and Sheffield Hallam University available http://caipe.org.uk/silo/files/cuilupdf.pdf

Thistlethwaite, J., Dallest, K., Bainbridge, B., Bogossian, F., Boud, D., Dunston, R.Drynan, D. Eley, D., Forman, D., Fyfe., S, Moran., M, Roberts., C, Strong., J &Dickie, R. (2013*). Work-Based Assessment of Teamwork: An Interprofessional Approach.* University of Queensland available http://www.olt.gov.au/resource-work-based-assessment-teamwork

### Online open resources

Clouder, L., Daly, G., Adefila, A., Jackson, A., Furlong, J. and Bluteau, P (2017) *An investigation to understand and evaluate the best ways to educate for and promote*

*integrated working across the health and care sectors. A final report*. Coventry University and Health Education England West Midlands. Available at:https://www.caipe.org/resources/publications/clouder-l-daly-g-adefila-jackson-furlong-j-bluteau-p-2017-investigation-understand-evaluate-best-ways-educate-promote-integrated-working-across

Clouder, L., Daly, G., Adefila, A., Jackson, A., Furlong, J. and Bluteau, P (2017) *An investigation to understand and evaluate the best ways to educate for and promote integrated working across the health and care sectors. Executive Summary.* Coventry University and Health Education England West Midlands. Available at: https://www.caipe.org/resources/publications/clouder-l-daly-g-adefila-jackson-furlong-j-bluteau-p-2017-investigation-understand-evaluate-best-ways-educate-promote-integrated-working-across-2

TIGER Library. http://tiger.library.dmu.ac.uk/ includes examples of materials, for learning, facilitator preparation and evaluation


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