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

Supported by the Department of Health

CONTENTS

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GLOSSARY OF TERMS AND ABBREVIATIONS

Across the different communities of stakeholders involved in CIPW there is a huge difference in the terminology adopted and styles of language used. In producing this document, efforts were made to use plain English and keep the use of culturally specific language to a minimum. However, this was not always possible and a glossary of terms and abbreviations is provided below.

GLOSSARY OF TERMS

Appreciative Inquiry
Appreciative Inquiry is an organisational development process or philosophy that engages individuals within an organisational system in its renewal, change and focused performance. (Cooperrider & Srivastva1990)

Commissioning
For the purposes of this Framework, the term commissioning has been used to describe the commissioning of programmes of education.

Common Learning
Common Learning, also know as Multiprofessional Education, where two or more professions learn with, or alongside each other. The term Common Learning is sometimes used incorrectly to be synonymous with interprofessional education.

Community of Practice
The concept of a community of practice refers to the process of social learning that occurs when people who have a common interest in some subject or problem collaborate over an extended period to share ideas, find solutions, and build innovations (Wikipedia).

Interprofessional Education
Interprofessional education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care (Freeth et al, 2005).

Iterative
An iterative process is one of repetition, where each repetition streamlines and improves on the last one.

Mainstreaming
Mainstreaming is the process of making a concept or process the chief trend, or direction of development, in accordance with what is normal or standard.

Outputs and Outcomes
Outcomes are very different to outputs. Outcomes in essence are the benefits that can be demonstrated when central policy and change programmes are implemented into service delivery thus achieving local improvements for

users, staff and the service itself. These benefits need to be demonstrable in a tangible way. Outputs however, are the concrete, immediately measurable products of the workforce in a given service. They are the raw data that need to be translated into outcomes (Tope et al, 2007).

Partnership Quality Assurance Framework (PQAF)
The Department of Health (DH) worked closely with education commissioners; education providers (higher education institutions and placement providers); the Nursing and Midwifery Council; the Health Professions Council; students and service users, to develop one shared framework for healthcare education that is robust and meaningful, and intended to reduce the administrative burden on education providers. Skills for Health are undertaking a review of the quality assurance framework on behalf of the Department of Health. The Consultation on the new QA Framework will start on 28th September 2007and last until 31st December.

Registered Professions
Those members of the health, social care and children's services workforce who are registered with a Statutory Regulatory Body

Service users and Service-Eligible People
A service user is someone who uses health, social care and/or children's services. For reasons of brevity, the term service user has been adopted within this Framework but is redefined to include service eligible people. The term service eligible people may include service users, people who choose not to use service, people who have been rejected by services or people who are invisible to services but have unmet needs (Advocacy in Action).

Uniprofessional Learning
Uniprofessional learning takes place where students or members of one profession learn with others from their own profession.

ABBREVIATIONS

AHP	Allied Health Professional
AI	Appreciative Inquiry
CAIPE	UK Centre for the Advancement of Interprofessional Education
CIPW	Creating an Interprofessional Workforce Programme
DCWDC	Devon and Cornwall Workforce Development Confederation
DH	Department of Health for England
EIPEN	European Interprofessional Education Network
InterEd	International Association for Interprofessional Education and Collaborative Practice
PQAF	Partnership Quality Assurance Framework

FOREWORD

The Creating an Interprofessional Workforce (CIPW) Framework is aimed at those planning, delivering and evaluating interprofessional education (IPE), and will be of particular use to those commissioning and developing programmes of IPE. It is a tool to enable the spreading of good practice in IPE to support effective interprofessional collaboration and improve the quality of care. It also offers guidance to those involved in IPE wishing to develop and enhance their practice.

The CIPW Framework builds on the consultations carried out as part of the Creating an Interprofessional Workforce Programme. It has been informed by evidence from research, systematic review and experiences of IPE with Appendix C linking it to Government policy. It represents the culmination of three years work carried out across the health and social care sector and reflects the views of its wide range of stakeholders.

Chapter 1 describes the origins of the CIPW programme and introduces the concepts and processes undertaken to produce this Framework.

Chapter 2 describes the CIPW consultation process, underpinned by Appreciative Inquiry.

Chapter 3, under different authorship, describes how strong leaders and champions of interprofessional education can play a vital role in sustaining a shift towards a collaborative culture and ways of working. Bryony Lamb and Nick Clutton developed the CIPW Effective Leadership Grids that provide guidance on cultural change for leaders and managers when implementing the CIPW Framework. These grids were a further development of their teamwork development tools and Bryony's concurrent work for the new Interprofessional Institute (South West London Academic Network, SWAN).

Chapter 4 describes the integral processes required to create an interprofessional workforce as identified by the CIPW participants. These are engaging stakeholders, planning, delivering, evaluating and sustaining interprofessional education and collaboration. This chapter discusses the relationship between these processes and their role in the sustainability of an interprofessional workforce.

Chapter 5 contains the recommendations and the outputs of their implementation as well as drawing conclusions. The CIPW Framework encompasses responsibilities for its implementation divided between various organisations; the implications for each are laid out in this chapter.

Acknowledgements

In completing this three-year project, thanks are due to everyone who gave their time, expertise and enthusiasm to the CIPW in the true spirit of collaboration.

Tracey Marsh, the CIPW Programme Coordinator, played a key role in the programme's success, not least by establishing and maintaining the phenomenally successful CIPW website.

I would like to thank my friends and colleagues at CAIPE, especially Bryony Lamb, who authored a chapter in the Framework, Rosie Tope, Hugh Barr, Marilyn Hammick, Isabel Jones, Geoff Meads, John Horder, Helena Lowe and Barbara Clague, as well as Siobhan Ni Mhalrounaigh, Julia Rout, Pat McMorran and Nicky Burns, the CIPW Development Associates, for their integral role in bringing this document together.

Thanks are due to Rosie Tope and Eiddwen Thomas of HERC Associates who produced the first supplement to this Framework regarding the policy agenda and its relationship with IPE, which underpins all aspects of the Framework and has been used across Europe and Canada, Hugh Barr who produced the second supplement giving a history of the development of IPE in the UK and Geoff Meads who produced the third supplement, which proved invaluable in producing the section in the Framework regarding the sustainability of IPE.

Hugh Barr and Rosie Tope have been constructive critical friends, giving their time far beyond the call of duty, for which I am most grateful.

The support and guidance of the Higher Education Academy Health Science and Practice Subject Centre and in particular Margaret Sills and Marion Helme, has been invaluable.

The success of the working groups was due in no small part to Bryony Lamb, Anne O'Connor and Eileen Huish who brought enthusiasm and innovation.

My friends at the Department of Health gave continued support and guidance and showed a real commitment to IPE, thank you Colin Day, John Cowles, Filao Wilson and Frances Harkins.

Finally, I would like to dedicate this Framework to the memory of my friend and colleague Paul Loveland, without whom the CIPW Project would never have taken place.

Lisa Hughes
Director, Creating an Interprofessional Workforce Programme
June 2007

CHAPTER 1: INTRODUCTION

This chapter describes the origins of the Creating an Interprofessional Workforce Programme (CIPW) and introduces the concepts and processes undertaken to produce this Framework.

The proposal for CIPW originated within the Department of Health with a view to mainstreaming the development of interprofessional education across the Strategic Health Authorities in England.

In 2004, as the Common Learning Pilot Site Projects reached their completion and positive outcomes started to emerge (Coster et al, 2007), the need for a national strategic framework for interprofessional education (IPE) was recognised and CIPW was created.

The Devon and Cornwall Workforce Development Confederation (DCWDC) (which became the South West Strategic Health Authority) was asked to take the lead because of their involvement in the interprofessional agenda.

DCWDC entered into a collaborative arrangement with the UK Centre for the Advancement of Interprofessional Education (CAIPE) to take forward this work. CAIPE's status as an independent body that promotes and develops interprofessional education gave the CIPW team access to expertise and networks from across the UK and abroad. The outcomes of the CIPW programme fed back into the continuing work of CAIPE.

One of the first tasks was to identify what 'interprofessional' meant for the purposes of CIPW. CAIPE defines interprofessional education as *"when two or more professions learn with, from and about each other to improve collaboration and the quality of care"* (Freeth et al, 2005). This was reinforced in January 2007 when Steven Hoffman, President of the Canadian National Health Sciences Students' Association, described interprofessional collaboration as *"a patient-centred, team-based approach to health and social care and it is through this synergy that the strengths and skills of each contributing health and social care worker is maximised, thus increasing the quality of patient/service user care* (Hoffman et al, 2007). Steven supported this with reference to research that shows that interprofessional collaboration:

- *"lowers patient mortality*
- *improves patient safety*
- *improves health services*
- *reduces hospitalisation and associated costs*
- *enhances patient satisfaction*
- *improves levels of innovation in patient care and*
- *increases staff motivation, well-being and retention"* (West et al, 2006 & McGrath, 1991)

The term 'interprofessional' could be seen to refer only to registered professions. However, the term was recognised by the CIPW participants to embrace the wider workforce (health, social care and children's services), such as administrators and care assistants, together with patients, service users and carers. In addition, there is value in the term 'professionalism' being used to describe the principles and values held and demonstrated by an individual, regardless of whether they are a member of a registered profession. This Framework is based on the evidence that '*being interprofessional enhances profession specific identity'* (Meads & Ashcroft, 2005).

> *"Interprofessional working is not about fudging the boundaries between the professions and trying to create a generic care worker. It is instead about developing professionals who are confident in their own core skills and expertise, who are fully aware and confident in the skills and expertise of fellow health and care professionals, and who conduct their own practice in a non-hierarchical and collegiate way with other members of the working team, so as to continuously improve the health of their communities and to meet the real care needs of individual patients and clients"*
> (McGrath 1991)

Having reached the conclusion that the remit of the programme needed to be widened to take account of the evolving role of IPE in workforce development, Lisa Hughes, Director of CIPW, worked in collaboration with Barbara Clague and Helena Low from CAIPE to identify four classifications of the outcomes of the programme and derived four strands of work, which are discussed below. A critical appreciation of the education, practice and policy contexts led to the commissioning of a number of Supplements to the CIPW Framework.

Direction
The direction strand involved establishing the relationship between current and emerging government policy and the mainstreaming of IPE through the commissioning of the first Supplement to the CIPW Framework, *Health and Social Care Policy and the Interprofessional Agenda* written by Rosie Tope and Eiddwen Thomas of HERC Associates. This strand also involved describing practice that may contribute to/influence policy change/development in the form of recommendations. This relationship between policy and the recommendations is described in Appendix C.

Information
The information strand involved capturing the learning, the methods and strategies from the outcomes of the Department of Health Common Learning Pilot Sites, Allied Health Professions modernisation sites and other interprofessional learning and development initiatives. This involved the commissioning of the second Supplement to the CIPW Framework, *Interprofessional Education in the UK: Some Historical Perspectives* written by

Hugh Barr. In addition, the CIPW team gathered information about current practice in IPE in a number of ways.

One method of information gathering was the development of the CIPW website and the beginnings of a national IPE activity database. The CIPW website, which went live in January 2006, successfully created an interactive on-line community of practice. The website was developed and maintained by Tracey Marsh, CIPW Programme Coordinator and Captiva Media. The website was extremely successful, receiving over 500,000 visitors from around the world in its first year and over 500 people signed up for its monthly newsletter. The website was pivotal in developing an on-line community of practice in IPE, promoting good interprofessional practice and linking it to policy reform. The website also raised awareness of the programme and therefore contributed to its development and sustainability.

As demonstrated in *Figure 1*, the website was supported by the Department of Health, hosted by South West Peninsula Strategic Health Authority and the content was developed in partnership with CAIPE, the European Interprofessional Education Network (EIPEN) and the International Association for Interprofessional Education and Collaborative practice (InterEd).

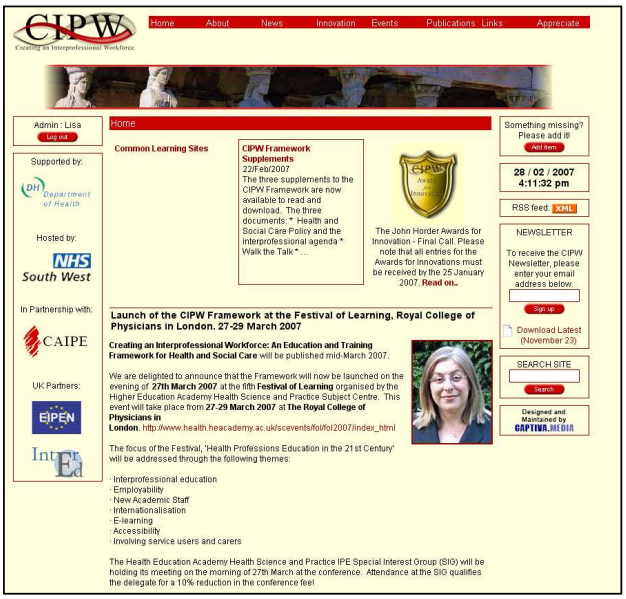


Figure 1 – Screenshot of the CIPW Website

In addition to the website, information was gathered through the consultation process, which is described below, and through the IPE literature, conferences and symposia and through joint working with other projects and programmes in health and social care in the UK and abroad.

Consultation

The consultation strand involved producing and implementing the consultation strategy. This strand of work is key to the success of CIPW and is described in detail in Chapter 2.

Dissemination

The dissemination strand dealt with the dissemination of the programme itself and its outcomes. The dissemination of the programme was successfully achieved through the website, partnership working and through presentations and workshops at conferences in the UK, Europe and Canada. The website

provided the early stages of an IPE activity database through which CIPW was able to recognise and reward innovative practice. This resulted in the presentation of the first CIPW John Horder Award for Innovation to Katie Cuthbert and her colleagues at the University of Derby for their Court Room Experience, which is described in Chapter 4. The outcomes of the programme will be disseminated by the publication of this Framework and through the work that will be undertaken by CAIPE and others, such as the Higher Education Academy.

CHAPTER 2: THE CONSULTATION PROCESS

This chapter describes how Appreciative Inquiry was used to work towards consensus in developing the Creating an Interprofessional Workforce recommendations. All those involved in the evolution of the CIPW programme accepted the outcomes of the consultation process, however contentious they appeared to be, and worked towards consensus.

As discussed in Chapter 1, the consultation aspects of CIPW were fundamental to the evolution of its recommendations.

This Framework is derived from the analysis of the extensive consultations carried out as part of the CIPW Programme. The consultation process was undertaken using Appreciative Inquiry (Cooperider & Srivastva, 1990, Reed, 2006) and, in one instance, the Delphi technique (Keeney et al, 2001).

In implementing the CIPW consultation strategy, the team was looking for a method that would be interactive with, and inclusive of, the stakeholders. The experience of Bryony Lamb, a key member of the CIPW team, brought Appreciative Inquiry to our attention. This conceptual model seemed appropriate to CIPWs requirements.

The following types of stakeholder were consulted:

- Patients/service users
- Carers
- Students
- Educators and educational institutions
- Practitioners
- Employer organisations
- The voluntary and community sectors
- The independent sector
- Government departments
- Strategic Health Authorities
- Sector Skills Councils
- Statutory Regulatory Bodies
- Professional bodies
- Quality assurance agencies

A wide range of professions and disciplines were consulted including social workers, doctors, nurses, midwives, pharmacists, radiographers, occupational therapists, podiatrists, dietitians, physiotherapists, psychologists, social care assistants, healthcare assistants, teachers from universities and further education institutions, researchers, administrators, education coordinators, practice coordinators and placement facilitators.

The CIPW participants were asked to consider the following questions:

What is an interprofessional workforce?
How do we create an interprofessional workforce?
How do we engage all stakeholders in developing the workforce?
How do we ensure quality learning and development experiences?

How do we encourage organisations to embed interprofessional education and collaboration within their strategic plans?
How do we know that an interprofessional workforce has been achieved?
How do we sustain an effective interprofessional workforce?

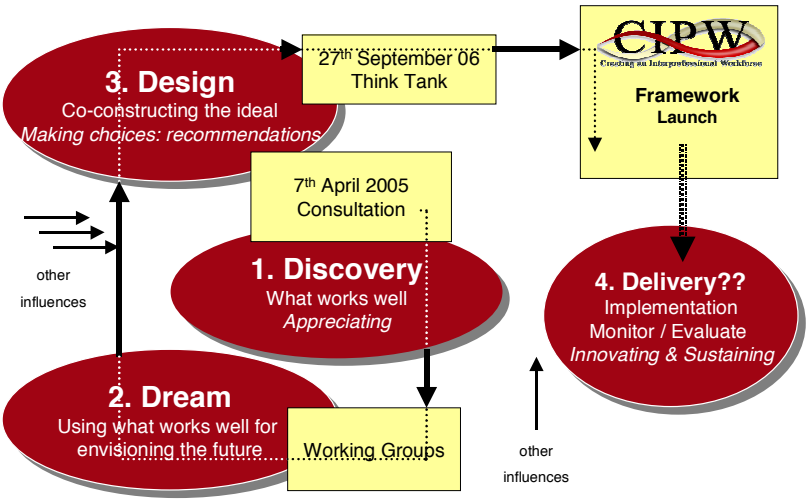
The answers to these questions are embedded within the Framework.

The CIPW consultation process systematically identified the stakeholder perspectives on these questions and used these to generate the recommendations, supported by evidence from published research. The consultations took place in workshops, think tanks, electronically, through commissioned work and working groups as well as informal interviews, and discussions following presentations at conferences and seminars.

The first round of consultations took place in four sites in 2005. As a result of these forums, a formal CIPW consultation strategy was developed and the following describes the implementation of that strategy.

Figure 2 illustrates the CIPW stakeholder consultation process that used an Appreciative Inquiry approach. This identifies the different stages of Appreciative Inquiry and links them to CIPW activity.

Figure 2 - The CIPW Framework Underpinned by Appreciative Inquiry



Stage 1, ***Discovery***, took place at the CIPW Stakeholder Consultation Event in 2005 where the participants worked together to 'discover' what works well and what makes this happen; what has been learned from this and how it can be used to address issues and challenges. From this the CIPW team were able to develop the structure of the CIPW Framework.

Stage 2, ***Dream***, took place in the CIPW Working Groups, where participants worked together to develop their visions of the future relating to each Working

Group: Regulation and Quality Assurance Working Group; Learning in Practice Working Group; Commissioning Interprofessional Education Working Group; Working with the Voluntary Sector Working Group.

The remit of the working groups was to establish clearly CIPWs position on the issues involved in the working group areas by carrying out a mapping process and producing a position paper.

At the initial meeting, members of each group summarised their organisation or stakeholder's position or perspective on IPE. The group then identified any areas of agreement or potential conflict for discussion.

A second meeting involved small group work to produce information grids that took into account key factors identified from the initial meeting. The grids identified:

- What worked well
- What made this happen
- What learning took place
- How this learning may be used to address issues and challenges

Having filled in individual grids, group members worked in pairs to identify key issues relating to their own organisations, taking turns to identify commonalities and differences. Two pairs then worked together to identify key issues across the four organisations and finally fed them back to the large group.

Stage 3, ***Design,*** where participants made choices and recommendations building on what works well and realistic aspirations, took place with the working groups coming together to agree 15 *'Next Steps in Establishing the Creating an Interprofessional Workforce Programme'*. These were then presented and refined at the 2006 Think-Tank. From the outcomes of this event, the CIPW team identified 12 recommendations and developed the CIPW model for sustaining IPE. The recommendations are listed in Section 5.

Finally, Stage 4, ***Delivery***, refers to the plans to take forward the implementation of the CIPW Framework after the completion of the programme.

Although these constitute the stages of the development of the CIPW Framework, *Figure 3* identifies information from consequent consultations, for example at meetings and conferences, which continued to influence and shape the Framework through the remaining development period.

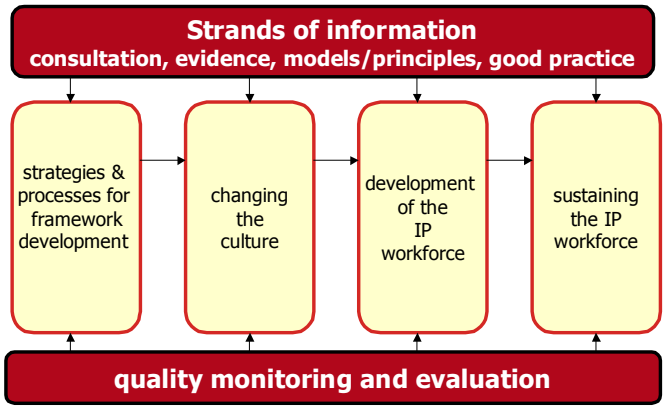
Figure 3 - Information Strand Diagram

The CIPW participants identified that where there is a clash of cultures, both within organisations and between health, social care and education providers in the UK, some fundamental changes would be required to facilitate the development and sustainability of an interprofessional workforce.

To achieve these changes the CIPW participants identified the strategies and processes required to develop the CIPW Framework, as indicated in *Figure 4*.

Figure 4 also highlights that the strands of information necessary to inform the Framework are equally important in terms of sustainability and must be underpinned by quality monitoring and evaluation.

Figure 4 - Using Knowledge to Sustain an IP Workforce



The CIPW team were asked frequently what they thought an interprofessional workforce would look like. At the end of the programme, taking into account all that had been learned, an electronic think-tank considered this question using the Delphi Technique (Keeney et al, 2001) (see Appendix B). In concluding what an interprofessional workforce would look like, the members

of the think-tank were clear that this was just the beginning of an iterative process. The think-tank, however, concluded at that stage that an interprofessional workforce would:

- Explicitly share its values: collaborative patient/service user care is articulated by the team and openly acknowledged as being central to the shared values of all its members
- Be equally accountable for implementing these values in practice
- Be inclusive and supportive of the wider workforce
- Be inclusive of the public, independent sector, voluntary sector and of social enterprises
- Recognise the importance of middle managers contributions towards sustainability
- Place service users at the centre and ensure that they are involved at all levels and in all activities
- Understand the roles and responsibilities of people, organisations and agencies
- Have equity in access to resources and support across the health, social care and children's workforce
- Embrace new roles and new ways of working
- Promote effective leadership and membership skills including team work and collaboration
- Have defined clearly the roles and responsibilities of both individuals and teams with semi-permeable boundaries instead of barriers
- Have education and training embedded throughout practice in lifelong learning and with open access for all
- Recognise, validate and appreciate IPE

A number of documents summarising the outcomes of the CIPW consultations were published during CIPW. Details of how to obtain these documents can be found in Appendix D. In every document, the importance of effective leadership in facilitating cultural change is clear.

CHAPTER 3: EFFECTIVE LEADERSHIP FOR CULTURAL CHANGE

This section, under different authorship, describes how strong leaders and champions of IPE can play a vital role in sustaining a shift to a collaborative culture and ways of working. Bryony Lamb and Nick Clutton developed CIPW Effective Leadership Grids, based on their interprofessional teamwork and leadership tools and Bryony's concurrent work for the new Interprofessional Institute (South West London Academic Network, SWAN) to provide guidance on cultural change for leaders and managers when implementing the Framework.

The CIPW consultations revealed the need for strong leaders and IPE champions to change cultures and ways of working. Effective leadership, teamwork, and management support are the bedrock of collaboration, as identified by quotes from some of the CIPW participants in *Figure 5* below.

In addition, Interprofessional Institute stakeholders considered effective leadership crucial when identifying criteria for the achievement of successful engagement and collaboration for preparing an interprofessional workforce:

- Strong leadership
- Shared values and vision
- Clarity of direction, roles and responsibilities
- Effective feedback processes are established
- Strong relationships are developed and sustained
- Clarity and honesty across partnerships
- All stakeholders are able to voice opportunities and concerns
- There are effective communication strategies
- Management structures which support innovation (Lamb, 2007)

In response to the CIPW consultation outcomes, Lamb and Clutton developed the CIPW Effective Leadership Grids. These provide guidance for implementing the CIPW Framework to leaders and managers within organisations and communities of interprofessional practice. These grids are underpinned by the extensive literature on effective teamwork from both the aviation industry and health and social care (Goleman, 1999, Headrick et al, 1998, Nowacyk et al, 1998, NHS, 2002, NHS, 2003, Poulton et al, 1999), encapsulated by Lamb and Clutton (2005) within their teamwork development tools. These tools have been used within multidisciplinary team develop workshops which they delivered in England and Finland for teams within Nokia.

Figure 5 - CIPW Participants' Vision

The CIPW Effective Leadership Grids are for use by those responsible for developing partnership working and sustainable collaborative strategies for commissioning, managing, developing, delivering and evaluating IPE programmes. To create and sustain an interprofessional workforce, team leaders and managers should assess their current organisational culture and style of leadership. This will enable them to identify what already works well within their teams and organisations and how to manage change by building on this for improvement. The grids can also be used to identify staff development and learning needs. Models of change management that are strength based and focus on transformational change could also be used in conjunction with these grids.

CIPW Effective Leadership Grid 1: How an organisation can develop a collaborative culture: focuses on leadership characteristics and management processes necessary for the organisational change required to develop and sustain a collaborative culture. The grid highlights:

- The importance of leaders being fully aware of the drivers for IPE
- The need to work in collaboration with a wide range of partners
- The professional and local factors that need to be considered and
- The implications of making this happen

Questions have been included within the grid to help leaders plan and manage the changes required within and across teams and organisations. It is essential leaders can envisage the type of culture required to support IPE

effectively, and have the ability to build a shared vision whilst fostering creativity and innovation.

CIPW Effective Leadership Grid 2: How people and teams can be managed to develop a collaborative culture: builds on Grid 1, focusing on leadership characteristics, teamwork processes and social mechanisms required for a systems approach to the development of a collaborative culture. Questions within this grid act as an aid to developing a collaborative culture and supportive infrastructure for the training and development of an interprofessional workforce.

Effective Leadership Grid 1: How an *organisation* can develop a collaborative culture

Leaders are fully aware of the BIG PICTURE

- Awareness and understanding of all the national and local drivers for IPE to enable quality collaborative care and treatment for service users and carers
- Awareness and understanding of quality assurance processes and standards; education commissioning learning, teaching and assessment methods; the student experience and the need for a range of stakeholders to be involved in decision making and delivery
- Ability to integrate information to present the case for change

Leaders have a VISION FOR CHANGE

- Change organisations to reform education and services
- Migrate from a performance requirements focus, to the service user journey and improvement at the heart of management decisions
- Service user focused IPE embedded within all health and social care education programmes - not an 'add-on'
- Inter-agency organisational developments and partnerships, including education, social and health services, with independent and crucially non- government voluntary organisations

Leaders have the ability to BUILD A SHARED VISION whilst fostering creativity and innovation

- Value and build on current good practice to generate shared vision
- Challenge, inspire and motivate all stakeholders, teams and individuals to engage in achieving this vision
- Develop strong positive relationships enabling all stakeholders to work collaboratively and creatively to prepare students for working interprofessionally and across agencies to achieve this vision

Leaders WORK WITH PARTNERS to develop strategies for collaborative working

- Steer / inform local and regional policy making regarding IPE
- Establish, with partners, clear strategic direction which aligns with those of each partner organisation
- Commitment to open and honest communications, valuing equality and diversity
- Responsibilities and accountability established to create new ways of working to achieve quality IPE
- Establish feedback structure and culture of timely two way feedback, underpinned by robust evaluation strategy
- All information required is accessible and managed appropriately
- Sign up to local memorandum of co-operation and partnership
- Local media support to promote and sustain local partnerships in achieving the vision

QUESTIONS FOR LEADERS TO ASK

Vision of the organisation

- Does the organisation demonstrate genuine commitment to working in partnership across sectors to achieve quality IPE?
- Does the organisation accept the probability that working collaboratively will be better for IPE and service improvement?

Collaboration to realise the vision

- Can you identify the professions, organisations and other stakeholders that need to be involved?
- What are the structures, processes, types of relationships and different ways of working involved in the sphere of change? Is collaboration strong and is there a willingness to change?
- Who will be the key players?

Involving people who use the services

- How can you secure genuine and meaningful service user involvement?
- What action needs to be taken to address the challenges of language and communication?

Leadership & resources

- Can leadership be shared across organisations?
- Can you identify and secure resources to support and sustain the change – or is there another way?

Effective Leadership Grid 2: HOW *people and teams* can be managed to develop a collaborative culture

IDENTIFY/DEVELOP highly committed and enthusiastic leaders and champions at all levels across sectors, who

- Can facilitate change sensitively, monitoring the impact of the change on teams and organisations
- Role model collaborative working, their intentions are transparent and reflect a consistent link between their values and actions (their actions back up their words), which supports and helps others to work collaboratively (to work effectively together) and prepare for change and challenges
- Foster transparent decisions and processes which lead to a transparent and positive collaborative culture that reflects a commitment to achieving service user satisfaction and workforce development
- Ensure responsibilities across agencies and professions are clear and agreed. This should include succession planning, to avoid dependence on individuals, account for organisational turnover and the need for sustainability
- Build on what works well within local communities of practice around education and care pathways which cross professions and sectors
- Value service users' experiences and skills, acknowledged in true partnership to provide focused IPE and services

VALUING EXPERTISE AND CONTRIBUTIONS of the entire team, leaders

- Ensure all stakeholders are involved in building a shared vision, creating a sense of ownership, a desire for success and confidence to challenge obstacles
- Encourage individuals to appreciate the roles and responsibilities of other professions and agencies as well as their own and how they can collaborate and contribute to effective team working
- Build on strengths of individuals and teams, encourage innovation, new ways of working together within teams and across agencies
- Hear and listen to all voices, are open to challenge, and differences are regarded as opportunities for development
- Are accessible and approachable, keeping people involved and informed

Social MECHANISMS TO ACHIEVE AND SUSTAIN a collaborative culture

- Organise events across sectors, other than formal meetings and task-oriented activities, e.g. opportunities to share good practice and network, informal and interpersonal exchanges (seminars, conferences, visits to different agencies, brown bag lunches, executive dinners, etc.)

ADDITIONAL QUESTIONS FOR LEADERS TO ASK

Best use of resources

- Can you define the specific roles of those taking an active part in changing the culture and how will these be allocated?
- Do the teams believe that between them, resources for the task have been allocated appropriately?
- Are the processes in place to share these resources?

Engaging & motivating across teams

- How will others be encouraged to take the lead in implementing change in their areas?
- How will dissenters be encouraged to work differently? How can you secure commitment from all partners?

Feedback for evaluation

- How will progress be monitored regarding the impact of change?

Ways of disseminating the culture

- How will the processes involved in the change be disseminated and implemented across teams and organisations?

CHAPTER 4: MAKING IT HAPPEN

This section describes the vision of the CIPW participants, makes recommendations for the creation of an interprofessional workforce and identifies the outputs of implementing them effectively. Case studies are used in this section to illustrate good practice.

The CIPW Framework reflects the perception of the participants that all education and training should be an integrated, life long learning experience across formal and informal learning environments e.g. on campus and in the community, in the classroom and in practice. In order to achieve this, effective coordination and partnership working is essential and should connect service, education, commissioning, quality assurance and evaluation.

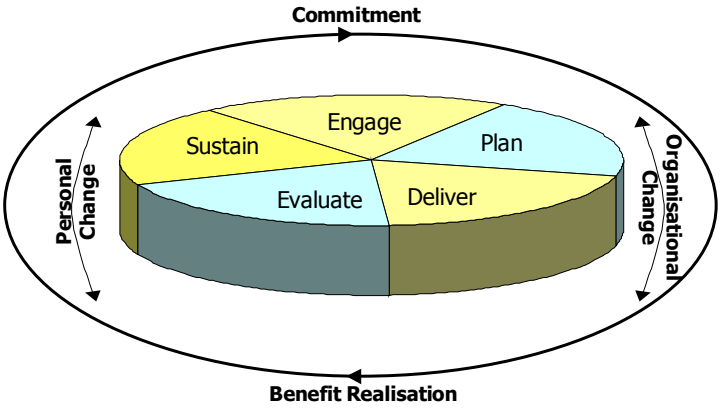
This reflects views expressed by the Chief Executive of an NHS hospital trust in the scoping study undertaken by Lamb (2007), where a *"disconnect"* was perceived between education, commissioning and service.

> "*It's important to stop that disconnect and use sensitive approaches to work with new partners. The opportunity for regular dialogue between universities and commissioners leads to understanding of what can be provided and what can be done differently. There is also the opportunity to look at where training and education fit with practice based commissioning"* (Lamb, 2007).

Nicky Burns, a CIPW Development Associate working in the NHS, identified that *"A failure to reform education and service in partnership risks producing a workforce not fit for purpose and unable to meet the needs of the community."*

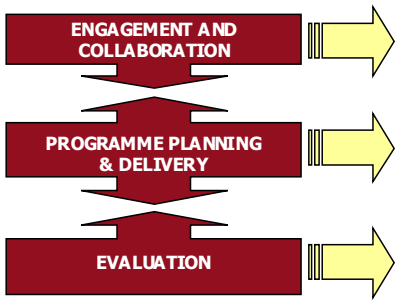
So, what are the integral processes necessary to produce a workforce that is fit for purpose? *Figure 6,* below, taken from the CIPW Key Messages document, demonstrates a way of making this happen. The starting point for collaborative working is engaging stakeholders in this process, enabling participants to gain useful insights into patterns of events that affect outcomes and facilitate personal and organisational change.

Figure 6 – The Processes Integral to Creating an Interprofessional Workforce



Each section of the CIPW Model of IPE Sustainability (shown below in *Figure 7*) is inter-dependent to achieve sustainable change. A **sustainable** interprofessional workforce is dependent upon the development of a collaborative culture, which in turn is dependent upon **engaging** stakeholders, for the effective **planning** and **delivery** of IPE, informed by robust **evaluation**.

Figure 7 - CIPW Model of IPE Sustainability



The following sections describe the CIPW participants' perceptions of the importance of these integral processes and how they may be implemented usefully in practice.

4.1 Engaging stakeholders in interprofessional education

"The experience and skills of the people using health and social care services are valued and acknowledged in true partnership to provide focused interprofessional education and services."
CIPW Participant

This vision, taken from the CIPW document Key Messages from the Consultation Event, is achievable providing the right levers are employed to change cultures.

The CIPW participants identified that successful collaboration involves stakeholders building a shared vision in order to create a sense of ownership, a desire for success and the confidence to challenge obstacles. This perspective is reflected in **Recommendation 1**.

Recommendation 1
Commissioners, education providers and **employers** ensure that the active participation of **patients/service users, carers** and the **voluntary, community and independent sectors** is embedded in every aspect of workforce planning for the health, social care and children's workforce.

Outputs:
- Patients/service users, carers and the voluntary, community and independent sectors perspectives inform every aspect of workforce planning
- Increased quality of care and service user satisfaction
- Increased communication between professions
- Reduced barriers between professionals
- More holistic/integrated care
- Service provision focuses on patients' experiences and knowledge
- Evidence of this is demonstrated in the evaluation of IPE initiatives
- Commissioning is driven by service need

In implementing **Recommendation 1**, inter-agency collaboration and partnerships between education institutions, social care organisations, health services, children's services and with the voluntary, community and independent sectors, are crucial not only within but also between health and social care and beyond.

Effective engagement depends on effective leadership, developing a collaborative culture and different ways of working. Questions for leaders to ask when building a shared vision for collaboration can be found in Chapter 3. Within this chapter, Lamb and Clutton have identified strategies required to establish collaborative partnerships. The benefits of these collaborations are shown in *Figure 8* below:

Figure 8 - Strong collaborative partnerships can:
(Adapted from Effective Leadership Grids)

- Steer/inform local and regional policy making regarding IPE
- Establish clear strategic direction which aligns with those of each partner organisation
- Commit to open and honest communication, valuing equality and diversity
- Establish responsibility and accountability to create new ways of working to achieve quality IPE
- Establish a feedback structure and culture of timely two way feedback, underpinned by a robust evaluation strategy
- Enable all information required to be accessible and managed appropriately
- Enable all partners to sign up to a local memorandum of cooperation and partnership
- Enable the local media to support local partnerships to promote and sustain the local vision

Local partnerships must develop strong positive relationships enabling all participants to work collaboratively and creatively to prepare the current and future workforce to achieve this vision. Developing a collaborative culture is discussed further in section 4.2.

The CIPW Learning in Practice Working Group agreed that interprofessional development of the workforce requires that individuals understand the roles and perspectives of the wider health, social care and children's team (for example, managers and care assistants) and the opportunity to learn as well as work together. New ways of working involves health, social care and children's service teams in learning and working with a wider range of occupations and agencies making participation with and development of the wider workforce in IPE and collaboration crucial. It should not be forgotten that personal experience as a service user can lead members of the workforce to a greater understanding of the needs of others and of the need to connect and integrate services. However, the majority of IPE research and practice published to date relates to health and social care professionals who are studying for or hold a statutory registration. Clearly, there is a need to broaden this scope to embrace other members of the health, social care and children's workforce.

Historically, many members of the wider workforce did not undertake formal post-compulsory education or training. In this instance, learning may have taken place in community or acute care settings through employment and unpaid activities such as informal caring or volunteering. In order to create a fully inclusive interprofessional workforce, all those involved should have access to IPE opportunities that are appropriate to the individual's and teams' current and future role and scope of practice. Additional questions for leaders to ask when managing people and teams to develop a collaborative culture can be found in Chapter 3.

In recognising the importance of learning to work within the wider health, social care and children's team, as highlighted in **Recommendation 2**, it is necessary to identify:

- How the stakeholders within this wider team, including all agencies, professions, occupations, voluntary organisations, carers and family members, can be involved in the patient/service user journey or pathway
- How IPE can involve the whole team
- How different levels of achievement within the workforce can be accommodated within the interprofessional learning of the whole team
- How equity can be achieved within such a diverse workforce

Recommendation 2
Employers and **education providers** provide the **wider health, social care and children's workforce** with access to interprofessional learning and development opportunities that are appropriate to the individual's current and future role and scope of practice.

Outputs:

- A collaborative culture is developed/enhanced
- Employers develop their own interprofessional workforce
- Practitioners develop interprofessional capacity and capability
- The professions and the wider workforce understand each other's roles and perspectives leading to closer collaboration for quality care

This does not, however, detract from the fact that IPE within and between the registered health, social care and children's workforce is vital to the development of a collaborative culture of care. Moreover, the registered professions retain accountability and remain answerable for ensuring that their actions deliver a comprehensive package of care that meets the needs of the patient/service user.

Case Study 1 – Engaging Stakeholders in IPE

The following case study, describing the work of Advocacy in Action, demonstrates how working in partnership with patients, service users and carers can contribute to the development of a collaborative culture.

Learning with and from one another

Service users lead the way to joint solutions

Advocacy in Action is a small community network of service-eligible people who promote partnership and advocate for social justice. It has been involved in higher education and continuing professional development since 1989, supporting health and social care students and workers to reach across organisational and cultural barriers that separate them from one another and from the people they serve. They bring professional, public and personal worlds together within a framework of mutual value and respect to critically reflect on experience and move forward together.

Their award winning and internationally recognised training provides programmes to a large number of British universities. From community presenter's stories, listeners engage with the 'whole person' rather than solely in the narrow confines of professional interests.

Advocacy in Action's 'case study' approach extrapolates from these real-life stories diverse alternative-learning scenarios, facilitated by service-user and citizen educators that consider equity of opportunity and the costs of its denial. There is a proactive focus on celebration of both common humanity and human difference. The training workshops include topics such as:

- People not labels
- Exploring oppression
- Receiving personal experience
- A model for shared learning
- The way forward

In addition, Advocacy in Action has defined a common set of values, understandings and skills required by all who seek to provide honourable public and professional service.

Julie Gosling, Kevin Chettle and Leigh Russell
April 2006

Learning points:

- Learning with and from one another in unity towards joint solutions enables the sharing of knowledge in partnership between practitioners and service users
- Holistic models enable present and future practitioners in the health, social care and children's services to learn from the experiences of the least well served and well heard in society

- Using a 'case-study' approach extrapolated from real-life stories facilitated by service-users and citizen educators enables learners to consider equity of opportunity and the cost of it's denial

4.2 Planning Interprofessional Education

The planning of effective IPE takes place in collaboration with those stakeholders engaged in its delivery and evaluation, as described in *Figure 9* below. Effective planning is key to the success of interprofessional teaching, learning and working. All aspects of IPE need to be grounded in effective interprofessional practice to meet workforce as well as local community needs. Common experiences reported by the CIPW participants revealed that effectively planned and delivered IPE enhances the students' and teachers' confidence in IPE as an effective educational model to improve care.

CAIPE's *Principles for Effective Interprofessional Education* are integral to this planning process, as shown in *Figure 9* below. These principles guide the provision and commissioning of IPE and assist in its development and evaluation. They draw on the IPE literature, evidence base and the experience of CAIPE members, underpinned by values common to all care professionals including a commitment to equal opportunities and a positive regard for difference, diversity and individuality.

Figure 9 - CAIPE Principles of Effective Interprofessional Education
1. Works to improve the quality of care No one profession, working in isolation, has the expertise to respond adequately and effectively to the complexity of many users' needs and so to ensure that care is safe, seamless and holistic to the highest possible standard.
2. Focuses on the needs of service users and carers IPE puts the interests of service users and carers at the centre of learning and practice.
3. Encourages professions to learn with, from and about each other IPE is more than common learning, valuable though that is to introduce shared concepts, skills, language and perspectives that establish common ground for interprofessional practice. It is also comparative, collaborative and interactive, a test-bed for interprofessional practice, taking into account respective roles and responsibilities, skills and knowledge, powers and duties, value systems and codes of conduct, opportunities and constraints. This cultivates mutual trust and respect, acknowledging differences, dispelling prejudice and rivalry and confronting misconceptions and stereotypes.
4. Respects the integrity and contribution of each profession IPE is grounded in mutual respect. Participants, whatever the differences in their status in the workplace, are equal learners. They celebrate and utilise the distinctive experience and expertise that participants bring from their respective professional fields
5. Enhances practice within professions Each profession gains a deeper understanding of its own practice and how it can compliment and reinforce that of others. This is endorsed where the IPE carries credit towards professional awards and counts towards career profession.
6. Increases professional satisfaction IPE cultivates collaborative practice where mutual support eases occupational stress, either

by setting limits on the demands made on any one profession or by ensuring that cross-professional support and guidance are provided if and when added responsibilities are shouldered. CAIPE, 2006

The CIPW participants considered joint working between those responsible for the commissioning and quality assurance of interprofessional education as key to successful planning processes. Providers of health and social education are required to respond to the quality assurance processes of education commissioners, the Quality Assurance Agency and professional institutions. The CIPW participants identified the need for an agreed, coordinated approach to ensure that the quality assurance requirements of education providers are clear and complementary. The CIPW Strategic Health Authority IPE Network was set up as an outcome of the CIPW Stakeholder Consultation Event and became increasingly concerned with the commissioning of IPE programmes. Members of this Network became chairs of the CIPW Commissioning Working Group and the Regulation & Quality Assurance Working Group. These groups identified that commissioning and quality assurance must be integrated if effective programmes of IPE are to be planned and delivered. This perspective is reflected in the responsibilities of stakeholders when implementing **Recommendation 3**.

Recommendation 3
Commissioners, education providers, employers, patients/service users and **carers** work in partnership to strengthen the interprofessional elements within local education and training quality assurance arrangements.

Outputs:
- Quality assurance teams are trained to identify quality interprofessional education as part of the PQAF
- Interprofessional education competences are an essential component of the undergraduate curriculum
- Perspectives of patients/service users and carers are integral to monitoring the quality of interprofessional education
- Uniform interprofessional competences are developed
- The quality of commissioned education is enhanced

The complexity of the relationship between the various stakeholders involved in quality processes for IPE needs careful consideration at a local and national level for the successful implementation of **Recommendation 3.** The Quality Assurance Agency website (QAA), which provides details of the quality reviews of undergraduate programmes in health care, is a useful source of information on the quality assurance of the interprofessional elements of these programmes.

It is the perception of the CIPW Commissioning Working Group that historically, education commissioning has focused on professional needs rather than service needs. The working group supports partnership

commissioning of education linked to workforce development, as reflected in **Recommendation 4**.

Recommendation 4
Commissioners, **education providers, patients/service users, carers** and **employers** work in partnership to integrate the commissioning, planning, delivery and evaluation of interprofessional education for health, social care and children's services.

Outputs:
- Integrated commissioning, planning, delivery and evaluation of interprofessional education takes place
- Partnership relationships are pivotal to integrated interprofessional education
- All partners share the commitment and responsibility to ensure that interprofessional initiatives are sustainable
- Increased quality of care
- All partners are jointly responsible for students and learners
- Development of a collaborative culture

The success of partnership commissioning is dependent, in part, on engaging all partners in contributing to IPE curriculum development.

Curriculum planning

Collaborative curriculum planning is necessary to embed IPE within all programmes, to sustain a collaborative learning culture across campus and practice as required in HR in the NHS Plan (DH, 2004). Interprofessional learning experiences should equip the current and future workforce to meet the diverse needs of both individual patients/service users and the whole community.

The CIPW participants perceived culture clashes between education and practice that act as a barrier to student development and were concerned that *"students frequently have trouble in graduating from student to practitioner."* Communication and interpersonal skills are crucial tools to overcome this barrier and embrace new ways of working with other practitioners as well as with patients/service users (DH et al, 2003). This requires an understanding of the roles and perspectives of the wider team, patients/service users and relevant agencies in order to identify opportunities to learn and work with them. Evidence suggests IPE is a successful method for overcoming cultural clashes rather than professional identity being *'watered down'* by interprofessional learning and working, it actually enhances professional identity and enables the development of a collaborative culture (Meads & Ashcroft, 2005).

The CIPW participants identified the following examples of how this clash of cultures can be overcome by adopting a more collaborative learning model:

- Developing links between pre and post registration education to provide a learning continuum for IPE
- Applying a strength-based approach, such as Appreciative Inquiry, to interprofessional curriculum design, learning strategies, assessment criteria, delivery and evaluation, will build on good practice and encourage students/learners/educators to value and learn from what works well
- Identifying appropriate learning experiences involving patients/service users, their families and carers
- Developing learning experiences focused on both the commonalities between professions/disciplines and comparing professions/disciplines understanding, roles and responsibilities, powers and duties and perspectives and perceptions (Barr, 2005)
- Ensuring that interprofessional learning experiences take place at all stages of the curriculum

The sustainability of this change in culture was perceived by the CIPW participants as being dependent on the adequate funding and preparation of interprofessional teachers and facilitators. Local champions of IPE were seen as essential in overcoming cultural and organisational resistance and developing locally owned IPE strategies. In order to sustain this cultural shift the CIPW participants highlighted the importance of protecting the time commitment of facilitating IPE within job profiles.

Barr (2005) cites Harden's (1999) *11 Steps from Isolated to Integrated Learning Between Professions*, shown in *Figure 10*, suggesting that these steps are *"perhaps better treated as characteristics to be combined and introduced in different orders rather than along a continuum."*

Figure 10 - 11 steps from isolated to integrated learning between professions

1. Each profession organises its own teaching unaware of what is taught by other professions.
2. Teachers are aware of what is covered by professions, but with no formal contract.
3. Consultation about teaching programmes between teachers from different professions.
4. Teaching relating to the work of other professions is included.
5. Time tabling is arranged to permit to schedule the same learning experiences
6. Joint teaching in part of otherwise separate programmes
7. Sessions scheduled for multiprofessional consideration of topics
8. Multiprofessional and uniprofessional teaching runs side by side
9. The programme emphasises multiprofessional learning, each professional looking at themes from its perspective
10. Each profession looks at the subject from its own perspective and that of the other professions
11. Multiprofessional education is based upon experience of the real world

(Harden 1999)

Whilst it is recognised that IPE can never be more than part of an undergraduate programme (Barr, 2005), the CIPW participants supported the view that IPE should not be a *'bolt-on'* to a uniprofessional programme, moreover, IPE should be central to all programmes and be mandatory and assessed.

Case Study 2 – Planning IPE

There are many examples of joint working in the planning of interprofessional education. This case study is an example of the collaborative working taking place between the General Social Care Council, the General Teaching Council for England and the Nursing and Midwifery Council.

Regulatory bodies join forces to promote working together in children's services: A statement of shared values for interprofessional working

The organisations that regulate two million nurses, school teachers and social workers have joined forces to help promote a shared approach to improving services for children and young people. The General Social Care Council (GSCC), the General Teaching Council for England (GTC), and the Nursing and Midwifery Council (NMC) have drafted a statement of values for wider discussion. The goal is to help professionals work together more effectively in the interests of children and young people.

The joint statement was developed in response to discussions with practising nurses, midwives, school teachers and social workers who were keen to work together and felt that this was most effective when there was a shared understanding of each others' professional values, as well as ways of working.

The GTC, NMC and GSCC want the joint statement to be a practical tool that will help practitioners to build services around the needs of the child or young person. It asks social workers, nurses and teachers to commit themselves to upholding children's rights, to involving families in the decisions that affect them and to learn and make use of each other's areas of expertise.

The three organisations are now seeking feedback and support from individual practitioners who work with children and young people, from children and young people themselves and from other organisations representing or regulating professionals who work with them. People are asked to comment on the statement itself and on the ways that it could be used to support joint working. The GSCC, GTC and NMC are keen to explore the potential of the statement to be a resource for all children's practitioners as well as their own.

A joint website – www.nmc-uk.org.uk/interprof - provides an opportunity for feedback, expressions of support and suggestions for taking the joint work forward.

May 2007

Learning points:

- Joint regulation promotes interprofessional collaboration
- Regulation should be based around the needs of stakeholders
- Shared values support quality improvement
- Regulation must be grounded in effective interprofessional practice
- Joint regulation enhances practice within professions

Figure 11 - Statement of inter-professional values underpinning work with children and young people

Key attributes

Children and young people value practitioners who enjoy working with them, who treat them with respect and who are good at communicating with them.

Children's practitioners place the interests of children at the heart of their work. They share responsibility for a range of outcomes for children. They are committed to ensuring all children have the chance to*:* be healthy, stay safe, enjoy and achieve, make a positive contribution, and experience economic well-being[1]. They recognise children's fundamental right to be safe, in order to reach other goals.

Practitioners concern themselves with the whole child, whatever their specialism. Although their own involvement with specific children may be short-term, children's practitioners work to develop the potential and capacities of children for the longer term.

Children's practitioners are committed to equality of opportunity for all children, and actively combat discrimination and its effects through their work. They respond positively and creatively to diversity among children and families, and colleagues.

Practitioners recognise that respect, patience, honesty, reliability, resilience and integrity are valued by children, families and colleagues. By demonstrating these qualities in their work they help to nurture them in others.

Work with children and young people, parents, carers and families

Children's practitioners recognise and uphold children's rights. They involve children in decisions about their lives and take account of their views and preferences. They recognise that childhood and early adulthood are times of change, and that they need to respond to changes in children's views, capabilities and circumstances.

Practitioners recognise the fundamental role played by parents in children's well-being and development, and all this implies for working in partnership with parents in the interests of children.

Practitioners are committed to engaging children and families fully in identifying goals, assessing options, and making decisions. They support children's and families' involvement in issues that matter to them, including through involvement in the development and evaluation of children's services.

Children's practitioners respect the right to confidentiality for children, and for families. They also recognise that their duty to safeguard children comes first.

They acknowledge these commitments sometimes present dilemmas to be resolved.

Inter-professional work with colleagues

Children's practitioners value the contribution that a range of colleagues make to children's lives, and form effective relationships across the children's workforce. Their inter-professional practice is based on a willingness to bring their own expertise to bear on the pursuit of shared goals for children, and a respect for the expertise of others.

Practitioners recognise that children and families, and colleagues, value transparency and reliability, and strive to make sure that processes, roles, goals and resources are clear.

Practitioners involved in inter-professional work recognise the need to be clear about lines of communication, management and accountability as these may be more complex than in their specialist setting.

They uphold the standards, and values of their own professions in their inter-professional work. They understand that sharing responsibility for children's outcomes does not mean acting beyond their competence or responsibilities.

They are committed to taking action if safety or standards are compromised, whether that means alerting their own manager/employer or another appropriate authority.

Children's practitioners understand that the knowledge, understanding and skills for inter-professional work may differ from those in their own specialism and they are committed to professional learning in this area as well as in their own field, through training and engagement with research and other evidence.

They are committed to reflecting on and improving their inter-professional practice, and to applying their inter-professional learning to their specialist work with children.

Work with children can be emotionally demanding, and children's practitioners are sensitive to and supportive of each others' well being.

A note on terms **-** The text uses 'children' for 'children and young people' and 'parents' or 'families' for 'parents, carers and families' for brevity. We have used the terms 'children's practitioner' or 'practitioner' throughout.

[1] In the English context, these goals are set out in the Green Paper (2004), *Every Child Matters*. The parallel framework in Scotland is (2005) *Getting it right for every child: proposals for action*, which states that all children need to be safe, nurtured, healthy, achieving, active, respected and responsible, and included. Similar frameworks for inter-professional work with children are being developed in other parts of the UK.

4.3 Delivering Interprofessional Education

The case has already been made for engaging all partners in planning and developing IPE every step of the way. Equally, the effective delivery of IPE is dependent on the contribution of these partners. The CIPW participants concluded that this should involve the staff delivering the interprofessional learning experience both directly (e.g. practice teacher) and indirectly (e.g. administrator). The delivery of IPE is dependent on the appropriate preparation of those facilitating learning and assessment.

It is the perception of the CIPW participants that every member of the current and future workforce should have access to interprofessional learning opportunities that are appropriate to their current and future roles. These learning experiences should reflect real life and be underpinned by interprofessional values and principles, as highlighted in **Recommendation 5**.

Recommendation 5
Professional Bodies, Sector Skills Councils, quality assurance bodies, commissioners, education providers and **employers** work together to ensure that the quality of the interprofessional elements of health, social care and children's services education programmes is monitored continually.

Outputs:
- Monitoring aligns to service user need
- Focus of education are on learning with, from and about each other
- The process and outcomes of monitoring are jointly owned by the partners
- The results of monitoring feed in to the formal evaluation
- The perspectives of patients/service users and carers are integral to the monitoring process to ensure that IPE mirrors real life
- Recommendations from evaluations are taken into account when planning future interprofessional initiatives

CIPW participants agreed that effective IPE is delivered in both the classroom and in practice. It may be 'on the job' training, undergraduate education, postgraduate education or continual professional development and may take place within the public, independent or voluntary sectors.

The interprofessional learning experiences offered should be underpinned by and be assessed against the CAIPE Principles of Effective Interprofessional Education (*Figure 9)* as highlighted in **Recommendation 6** (DH, 2004).

Recommendation 6

Commissioners, education providers and **employers** ensure that interprofessional education is mandatory and assessed within health and social care education and training programmes resulting in an award.

Outputs:

- Specific performance criteria relating to interprofessional education is embedded within the assessment of student competence
- Students value interprofessional education as a means to develop a professional identity and develop interprofessional competence
- Students are more able to cope with the progression from student to practitioner
- Students achieve interprofessional competences and/or capabilities
- Interprofessional education competences are essential components of all health and social care education and training
- Service users benefit from a workforce capable of working together to provide effective integrated and collaborative services

The CIPW participants considered it important that IPE activity should not be optional or additional to core curriculum. Rather, it should be embedded in all mainstream programmes and continuous personal and professional development.

Freeth et al (2005) state *"Interprofessional education delivery is a continuum ranging from incidences where the interprofessional education is a minority component within uniprofessional curricula and the emphasis on the client, policy and practice dominates; through an equal stress being placed on knowledge and skills for specific client groups and interprofessional collaboration to a focus on interprofessional collaboration to solve problems or improve quality"*.

CIPW participants chose not to identify one IPE model as preferred over another. However, the following characteristics of effective IPE delivery were identified. IPE is enhanced when:

- Interprofessional learning experiences are appropriate to the stage of student development
- Appropriate interprofessional learning experiences are built in to programmes of education at an early stage
- Interprofessional activities that take place whilst on placement or at work are specifically designed for students/learners
- Students from different educational institutions are enabled to work and learn in practice together
- Students/learners are encouraged and supported to make the most of interprofessional opportunities during everyday activities
- Students/learners are placed in other working environments with other professionals/disciplines
- Virtual learning environments such as simulation and e-learning are used

- Students/learners are briefed and debriefed for each interprofessional experience.
- Disciplines/departments are enabled to offer learner exchanges and host learners for interprofessional experiences.

The CAIPE website, the series of CAIPE books (Barr et al 2005, Meads & Ashcroft, 2005, Freeth et al, 2005) and the Journal of Interprofessional Care amongst other journals are useful sources of information about models of IPE on campus and in practice.

The CIPW participants agreed that the role of practitioners and practice educators was crucial to the development of an interprofessional workforce. Both educators and students perceived a lack of equity between campus and practice-based learning. As highlighted in **Recommendation 7**, the CIPW participants want to see partners working together to identify systems and processes that support a shift in culture and practice towards joint ownership of student's learning experiences and outcomes.

Recommendation 7
Employers, commissioners and **educators**, in partnership with **patients/service users and carers**, adopt and sustain a systematic approach to interprofessional practice based learning.

Outputs:
- Campus and practice-based learning is considered equally important to the development of competence and capability
- Partners share responsibility for learning outcomes/students
- The practice-based element of pre-registration education is commissioned jointly with the campus-based element
- Practice and campus based facilitators take joint responsibility for students learning and development

To implement **Recommendation 7**, it will be essential that interprofessional champions/coordinators are in place in campus and in practice, sharing the responsibility for students. A champion, by definition, is a transient role. The CIPW participants would like to see the definition of a champion redefined, as shown in **Recommendation 8**, to reflect someone who is employed and funded to take on this role.

Recommendation 8
Commissioners, employers, education providers and **professional bodies** ensure that interprofessional champions and/or co-ordinator roles are established/sustained within all organisations.

Outputs:
- All education institutions offering health, social care and children's services programmes and their placement partners have interprofessional champions and/or co-ordinators
- The role of interprofessional champions and/or co-ordinators is established formally
- Time and funding for these roles is protected as part of their job descriptions

Once interprofessional champions/coordinators are in post, it is crucial that they work to ensure that those staff working with students on IPE programmes, whether in practice or in campus, are trained appropriately. The CIPW participants were clear that this requires skills additional to those used when facilitating uniprofessional learning, hence **Recommendation 9**.

Recommendation 9
Professional Bodies, commissioners, education providers and **employers** ensure that interprofessional staff development is mandatory and ongoing for all those who facilitate interprofessional learning and assessment in practice and the classroom.

Outputs:
- Those who teach, facilitate and assess interprofessional education on campus and in practice undergo interprofessional training
- The quality of interprofessional education is improved

Case Study 3 – Delivering IPE

This case study is an example of good practice in delivering interprofessional education and as such won the CIPW John Horder Award for Innovation.

All Rise! The University of Derby

Using a staffed "mock" court room at the University of Derby, **social work and radiography students** had first-hand experience of providing expert witness testimony. Acting as their solicitor, **law students** were responsible for collecting statements before the court hearing and 'coaching' their client (i.e. the social work and radiography students) through the court room procedures. Cross-examination took place, during which students experienced the potential impact of their professional duty. After the event, all students engaged in a full debrief discussing the procedures and psychology of the court. Feedback from the students emphasised the need for this style of learning and students felt more prepared for this type of duty when they qualify.

Students were expected to meet on the day of the case prior to their 10-minute court appearance. The staffing of the court room was undertaken by academics wearing robes to aid the simulation and adherence to court etiquette.

Dr Kate Cuthbert, Fran Fuller,
Kevin Bampton, Tony Wragg & Wendy Lowe
June 2006

Learning points:

- The students gained hands-on experience and knowledge about their relative roles within a "real-life" practice setting
- The learning was student-led, students interpretations of role and placement experience led the discussion
- There was considerable exchange of knowledge between professions
- There was reflective time through group debrief where the students left their professional roles and discussed shared issues
- The importance of students engaging in formal and informal activities when developing professional partnerships was recognised
- There was an appreciation of the level of training and future working environments of other professions

4.4 Evaluating Interprofessional Education

The CIPW participants concluded that evaluation should be planned and delivered in partnership with the stakeholders. It is essential to ensure that the requirement to evaluate interprofessional initiatives is built into the commissioning process and that evaluation is streamlined with the quality assurance and assessment aspects of interprofessional initiatives as highlighted in **Recommendation 10**.

Recommendation 10
Commissioners, Professional Bodies, quality assurance bodies and **education providers** ensure that evaluation is embedded within all interprofessional education initiatives.

Outputs:
- Evaluation is embedded in all stages of commissioned programmes of interprofessional education
- Outcomes of evaluations are shared with and jointly owned by all partners and publication is encouraged
- Dissemination and learning from evaluations is evidenced as part of the quality assurance programme
- The quality of interprofessional education is improved
- Recommendations for change from evaluations inform the monitoring process of all interprofessional initiatives
- Evaluation processes are undertaken in partnership

In order to embed the evaluation of IPE effectively, a robust mechanism for assessing outcomes is essential. Freeth et al (2005) provide a useful typology of outcomes of IPE and their measurement.

Figure 12 - Typology for Outcomes of Interprofessional Education

1	Reaction	Learners' views on the learning experience and its interprofessional nature
2a	Modification of attitudes/perceptions	Changes in reciprocal attitudes or perceptions between participant groups. Changes in perception or attitude towards the value and/or use of team approaches to caring for a specific client group
2b	Acquisition of knowledge/skills	Including knowledge and skills linked to interprofessional collaboration
3	Behavioural change	Identifies individuals' transfer of interprofessional learning to their practice setting and changed professional practice
4a	Change in	Wider changes in the organisation and delivery of

	organisational practice	care
4b	Benefits to patients/clients, families and communities	Improvements in health or well-being of patients/clients, families and communities

(Reproduced from Freeth, Hammick, Reeves, Koppel and Barr (2005), Effective Interprofessional Education: Development, Delivery & Evaluation, Blackwell Publishing, Table 2.1 p34 with the permission of Blackwell Publishing).

This typology may be useful to stakeholders when implementing **Recommendation 10**.

In 2005 the Higher Education Academy published their fifth Occasional Paper entitled *Evaluating Interprofessional Education: A Self-Help Guide*, another useful tool for educators and practitioners to evaluate their interprofessional initiatives (Freeth et al, 2005b). The self-help guide, containing ideas and resources on the evaluation of IPE in the context of health and social care, is divided into four sections:

- **Section 1** outlines and discusses the principles of good practice in planning, conducting and disseminating an evaluation of IPE
- **Section 2** offers a critical discussion of a range of approaches employed to evaluate IPE
- **Section 3** discusses a selection of enquiry instruments that can be employed in the evaluation of IPE
- **Section 4** presents a selected bibliography of useful evaluation and research texts, examples of IPE studies and a list of useful websites.

The evaluation of IPE should not be an isolated event, rather it should be seen as part of the continuing quality improvement programme for all education initiatives. The NHS Clinical Governance Support Team recognised that *"we need new enduring frameworks for quality improvement – previous models have emphasised the independent strands of quality as supports, rather than their inter-relationships. Integrated governance recognises the dynamic tension of competing elements: national v local, quality v cost, information sharing v individual rights, lessons from the past and demands of the future, and encourages Trust Board members to be the arbiters of these balancing acts"* (www.cgsupport.nhs.uk). This statement supports the CIPW recommendation that commissioning be integrated with the planning, delivery and evaluation of IPE as highlighted in **Recommendation 1**.

The dissemination of evaluation outcomes is essential for the realisation of the benefits of interprofessional initiatives to patients, service users, carers, educators, practitioners, commissioners and managers.

Case Study 4 – Evaluating IPE

This case study demonstrates how an effective evaluation process, embedded within the development and delivery of interprofessional education, can show benefits to students, teachers, practitioners and patients.

The Leicester model of interprofessional education
A practical guide for implementation in health and social care

The **Leicester Model of Interprofessional Education**, published as *Special Report 9 of the Higher Education Academy Medicine, Dentistry and Veterinary Medicine Subject Centre*, is a guide that invites readers to adopt a carefully developed, robustly tested and evaluated interprofessional learning model of health and social care education.

The guide provides information on the model and details the practical processes required to replicate the experience. Emphasis is given throughout to the importance of creating a learning environment in which quality interprofessional education can occur.

Chapter 5 of the report comprises the evaluation methodology, including ethics and governance, action research and the stages in the evaluation process:

- Defining the aim and objectives of the programme evaluation
- Selecting and designing the methodology, including data collection instruments
- Collections of data
- Analysis and dissemination of the findings

Programme evaluation forms an integral part of the delivery of Leicester Medical School's interprofessional education programmes. Gathering evaluation data is the responsibility of the programme leader(s). The relevant educational steering group receives the evaluation outcomes and recommends education programmes are continually evolving.

Thorough assessment of the education process is required for quality assurance processes to:

- Ensure alignment to the learning and teaching strategies of higher education institutions
- Fulfil rigorous investigation by external examiners and the quality assurance processes
- Monitor student progressions
- Provide evidence for evolving and improving the programme

And for the Leicester Model to:

- Provide feedback to stakeholders, including service organisations and patients, whose unique contributions underpin the learning cycle

Dr Angela Lennox and Dr Elizabeth Anderson
July 2007

Learning points:

- Evaluation studies contribute to the quality assurance process and ensure that the Leicester Model is continually evolving
- Evaluation outcomes identify that the Leicester Model positively impacts on students' learning, professional attitudes and knowledge of team work and prepares students for future practice
- Learning in interprofessional groups enriches all programmes
- Patients enjoy taking part and feel supported
- Health and social care staff and their managers respect the ability of the Leicester Model to inform their practice and reflect on the quality of their collaborative working

4.5 Sustaining Interprofessional Education and Collaboration

"Creating an interprofessional workforce is dependent on partnerships, making appropriate connections between agencies, professions and organisations and with patients and service users. This is the only way forward to develop and improve integrated local services and care. Partnership depends on shared values to build and maintain good relationships and achieve common goals, while interprofessional learning and development is required to develop integrated services, including multi-agency networks and teams. Effective interprofessional/multi-agency working is dependent upon uniprofessional competences."
CIPW Participant

This statement, taken from the report of the CIPW Consultation Event held on 7th April 2005, demonstrates the importance of building positive, collaborative relationships in sustaining an interprofessional workforce.

The building of collaborative relationships underpins the development of a collaborative culture, which the CIPW participants considered necessary to sustain IPE and create an interprofessional workforce. Guidelines for developing a collaborative culture can be found in Chapter 3.

The participants attending the CIPW Think Tank on 27th September 2006 considered the following factors key to the development of a collaborative culture and the creation of an interprofessional workforce:

- Scheduling time to plan, deliver, facilitate and evaluate IPE
- Developing and sustaining of IPE champions
- Implementing mandatory IPE within all education programmes
- Agreeing in partnership criteria for the success/quality of IPE

- Developing a collaborative culture in which health and wellbeing are a community issue
- Focusing IPE is on patients/service users
- Ensuring parity of training and education across the workforce and agencies
- Effectively commissioning IPE
- Embedding interprofessional collaboration in service delivery
- Effectively disseminating evaluations of interprofessional initiatives
- Endorsing IPE as integral to all strategic planning and service delivery to:
    - Respond more fully to the complex needs of patients and service
    - Improve recruitment and retention of staff
    - Permeate the culture to promote wider collaboration

The shared learning that will take place when adopting these key factors is crucial to the mainstreaming of IPE, as highlighted in **Recommendation 11**.

Recommendation 11
Commissioners, education providers, employers and Professional Bodies work with **CAIPE** and the **Higher Education Academy** to identify and encourage interprofessional good practice.

Outputs:
- Interprofessional champions/coordinators are encouraged and enabled to become part of the community of interprofessional practice e.g. CAIPE
- Organisations share examples of good interprofessional practice regionally and nationally

By implementing **Recommendation 11**, interprofessional champions/coordinators will become part of the community of interprofessional practice enabling organisations to share examples of good interprofessional practice.

In the third supplement to the CIPW Framework, Meads (2006b) identified the sharing of good practice as one of the characteristics of successfully sustained interprofessional initiatives. These characteristics are categorised below:

Figure 12 –Characteristics of successfully sustained interprofessional initiatives

1. A strong infrastructure

- Numerous service developments largely sponsored by the main local authority
- Usually with funding for logistical and personnel support
- Always including health and social care agencies, local universities and colleges and a broad spectrum of Third Sector representatives
- Enduring over time regardless of organisational turnover in individual member agencies and, in particular, the NHS

2. Sharing good news

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

3. Leaders and champions

- Personal leadership of highly committed charismatic individuals with authority to exemplify interprofessional qualities through, for example, the management of joint service and subject reviews
- Formal arrangements for both their succession and their responsibilities across individual agency and professional boundaries
- IPE is not dependent on a single champion
- IPE leaders are seen as creative and progressive
- *"It comes down to getting a shared vision from key individuals keeping in touch as risk takers together"*

4. Socialising mechanisms

- Prevent *"life-long capture by the professions own societies"* and all the 'resistance' this then brings
- Consist of a web of events and exchanges, many of which are informal and interpersonal
- Links between socialisation and a local 'product' in terms of an idea or principle that is regarded as transcending not only professional but also political priorities
- Offering together 'servant leadership', 'international best practice as our unique selling point' and 'breaking down the barriers as a movement'
- Outputs of socialising mechanisms include: multidisciplinary professional doctorates, statements of shared ethics and joint fundraising 'for freedom from regulation'

The CIPW Effective Leadership Grids in Chapter 3 were designed in response to these factors and linked to the recommendations to identify how organisations can manage people and teams to develop a sustainable collaborative culture. The Grids highlight the importance of identifying and securing resources to support sustainable change.

There has been a substantial increase in the level of IPE activity over the period of CIPW (2004 – 2007). Meads found that:

- Attendance at conferences in which CAIPE has been a partner have tripled in number and size
- Journals such as Learning in Health and Social Care have been launched in addition to the established Journal of Interprofessional Care to meet the increased need
- The CAIPE website achieves at least a thousand hits per month and the CIPW website achieved over 500,000 hits in its first 10 months.
- There has been a surge in demand for IPE facilitator training
- IPE is now present at every stage from further education Access courses to the specifications for new medical schools' foundation years' placements

However, Meads found that *'most of the IPE activity in 2004-2006 is regarded as being about processes of exploration and engagement. Only in one or two areas covered by this research project is it characterised as genuinely outcomes driven education'*.

Meads identified four main factors that accounted for the increased activity between 2004 and 2006:

- The re-classification of existing programmes, particularly for the purposes of meeting external audit and accreditation requirements
- The Department of Health's funding of the four common learning sites which led to new competition and growth in IPE and then a tailing off as dedicated resources declined
- The strengthening of subject benchmarks and student-staff ratios by individual and separate professional bodies to prevent a further blurring of boundaries between different health professionals
- The CIPW programme itself with its extensive planning processes, leading to large numbers involved in consultations about IPE

The role CAIPE plays in the sustainability of IPE in the UK should not be underestimated. As an independent community with interprofessional expertise, CAIPE can maintain its role as an authority in IPE, in enabling others to develop collaborative cultures, and in influencing policy and decision makers at a local, regional and national level.

Recommendation 12
Stakeholders, together with **CAIPE,** should develop a national mechanism to recognise and reward organisations with a sustainable collaborative culture.

Outputs:
- Interprofessional champions/coordinators are encouraged and enabled to share experiences locally, nationally and internationally
- Stakeholders are encouraged by CAIPE to work together to identify a national process for rewarding organisations achieving a sustainable collaborative culture

The Higher Education Academy Health Science and Practice Subject Centre's IPE Special Interest Group also has an important role to play, together with the Subject Centre for Medicine, Dentistry and Veterinary Medicine (MEDEV) and Social Policy and Social Work (SWAP), the European Interprofessional Education Network (EIPEN) and the International Association for Interprofessional Education and Collaborative Practice (InterEd) in implementing **Recommendation 12** by supporting the development and dissemination of good practice.

"The way ahead seems still to lie in cultures of collaboration in which health is a community issue at the heart of which are relationship values. When interprofessional education complies with this culture and is one of its key constituents, it is sustainable; if locally it does not go against the grain, it will last. If not, it will not last and any amount of national policy, however well intentioned and articulated, cannot in the end turn the tide" (Meads 2006).

Case Study 5 – Sustaining IPE

This case study demonstrates how IPE may be sustained in practice.

Achieving sustainability through commissioning in Surrey and Sussex

In 2005, the Surrey and Sussex SHA Education Quality Assurance Manager took on the responsibility for IPE across the region. This joint role led to integrated quality assurance and commissioning processes to ensure that IPE was embedded within the programmes of AHP and nursing education through the Programme Standards (Schedule 7) of the National Standard Model Contract. This schedule defined the Principles to be applied in the implementation of the local Quality Improvement Framework for the quality assurance and enhancement of health care education.

A regional IPE steering group made up of members from the SHA, local education providers including the medical school, practice educators, practitioners and the national IPE community of experts was set up. The group agreed the following statement that was added to the standard principles within Schedule 7:

"Systems, models and processes are in place to support the demonstration of competence in effective collaborative learning and working with other professionals and agencies"

The interprofessional elements of the programmes were highlighted as being of an extremely high standard and the role of the SHA in this was recognised as crucial both locally and nationally by professional validation bodies and by the Quality Assurance Agency. This good news was disseminated through a regional conference on interprofessional achievements, rewarding innovation and a selection of media tools.

Anne O'Connor
December 2005

Learning points:

- The presence of a dedicated IPE lead integral to the education commissioning process was shown to be necessary to embed IPE in contract arrangements
- IPE integrated into well established processes and standards for quality assurance is more effected than added as a 'bolt-on'
- Celebrations of achievement assist in breaking down professional barriers and strengthen local accountability and responsiveness

CHAPTER 5: CONCLUSIONS & RECOMMENDATIONS

This chapter describes the key factors in sustaining an interprofessional workforce, the responsibilities of stakeholders in making this happen and the CIPW participants' vision for the future.

In this document, we have described why an interprofessional workforce is necessary, what it might look like and how we can make it a reality. Creating an interprofessional workforce will not be easy; the necessary changes in culture and practice will require effective leadership of organisations and of people at a local and a national level. However, the ultimate challenge comes not in creating an interprofessional workforce but in sustaining a collaborative culture that is focused on delivering the services that patients, service users and carers want and need.

Sustaining IPE

The key factor in sustaining IPE, and thus creating an interprofessional workforce, is the development of a collaborative culture that values IPE as the means to develop and enhance health and social care services as well as the health and wellbeing of communities. The CIPW participants considered it important to recognise formally those organisations that have achieved a sustainable collaborative culture and identified the following crucial steps towards sustaining IPE:

- Involve all stakeholders in collaborative partnerships
- Commission IPE effectively
- Centre IPE on patients/service users and carers
- Protect time to plan, deliver, facilitate and evaluate IPE
- Agree criteria for success /quality of IPE in partnership
- Develop and sustain the role of IPE champions and coordinators
- Make IPE mandatory within all education programmes
- Ensure parity of training and education across the workforce and across agencies
- Disseminate evaluations of interprofessional initiatives
- Embed interprofessional collaboration in service delivery

Roles and responsibilities of stakeholders

The CIPW Framework encompasses responsibilities for its implementation divided between various organisations with implications for each:

Commissioners
Eleven of the 12 recommendations in the CIPW Framework relate to commissioners working in partnership with other stakeholders. The responsibilities of commissioners include:

- Ensuring the active participation of patients/service users, carers and the voluntary, community and independent sectors in health, social care and children's services workforce planning
- Integrating the commissioning, planning, delivery and evaluation of interprofessional education for health, social care and children's services
- Ensuring that the quality of the interprofessional elements of health, social care and children's services education programmes is monitored continuously

Education Providers
All 12 recommendations in the CIPW Framework relate to education providers working in partnership with other stakeholders. The responsibilities of education providers include:

- Ensuring that interprofessional education is mandatory and assessed within health, social care and children's services education and training programmes resulting in an award
- Adopting and sustaining a systematic approach to interprofessional practice based learning
- Ensuring that evaluation is embedded within all interprofessional education initiatives
- Identifying and encouraging interprofessional good practice

Employers
Of the 12 recommendations in the CIPW Framework, 11 relate to employers as representatives of practitioners and other staff. The recommendations all involve employers working in partnership with other stakeholders. The responsibilities of employers include:

- Providing the wider health, social care and children's workforce with access to interprofessional learning and development opportunities that are appropriate to the individual's current and future role and scope of practice
- Ensuring that interprofessional champions and/or co-ordinator roles are established/maintained within all health, social care and children's services organisations
- Ensuring that interprofessional staff development is mandatory and ongoing for all those who facilitate interprofessional learning and assessment in practice and the classroom

Professional Bodies
The CIPW Framework makes four recommendations to the professional bodies in their role as representatives of practitioners. These should be implemented in partnership with other stakeholders and include:

- Ensuring that the quality of the interprofessional elements of health, social care and children's services education programmes is monitored continually
- Developing a national mechanism to recognise and reward organisations with a sustainable collaborative culture

The future

It is important to realise that although the CIPW recommendations are the outcome of a three-year programme involving over 250 participants, this is the end of the beginning of the process rather than the end. Although much remains to be done in creating an interprofessional workforce, ensuring its sustainability will present even more of a challenge.

This Sustainability of IPE will require an increase in local, regional and national collaboration; resources, time and effort to embed the CIPW recommendations into organisational cultures; further research; and a national strategic lead, to ensure that the development of IPE supports the implementation of Government policy.

RECOMMENDATIONS

The following recommendations were derived from the views and perspectives of over 250 CIPW participants who worked together to reach consensus.

	Recommendations CIPW recommends that:	Outputs of effective implementation
1	**Commissioners, education providers** and **employers** ensure that the active participation of **patients/service users, carers** and the **voluntary, community and independent sectors** is embedded in every aspect of workforce planning for the health, social care and children's workforce.	• Patients/service users, carers and the voluntary, community and independent sectors perspectives inform every aspect of workforce planning • Increased quality of care and service user satisfaction • Increased communication between professions • Reduced barriers between professionals • More holistic/integrated care • Service provision focuses on patients' experiences and knowledge • Evidence of this is demonstrated in the evaluation of interprofessional education initiatives • Commissioning is driven by service need
2	**Employers** and **education providers** provide the **wider health, social care and children's workforce** with access to interprofessional learning and development opportunities that are appropriate to the individual's current and future role and scope of practice.	• A collaborative culture is developed/enhanced • Employers develop their own interprofessional workforce • Practitioners develop interprofessional capacity and capability • The professions and the wider workforce understand each other's roles and perspectives leading to closer collaboration for quality care
3	**Commissioners, education providers, employers, patients/service users** and **carers**	• Quality assurance teams are trained to identify quality interprofessional education as part of the PQAF

	work in partnership to strengthen the interprofessional elements within local education and training quality assurance arrangements.	• Interprofessional education competences are an essential component of the undergraduate curriculum • Perspectives of patients/service users and carers are integral to monitoring the quality of interprofessional education • Uniform interprofessional competences are developed • The quality of commissioned education are enhanced
4	**Commissioners**, **education providers, patients/service users, carers** and **employers** work in partnership to integrate the commissioning, planning, delivery and evaluation of interprofessional education for health, social care and children's services.	• Integrated commissioning, planning, delivery and evaluation of interprofessional education take place • Partnership relationships are pivotal to integrated interprofessional education • All partners share the commitment and responsibility to ensure that interprofessional initiatives are sustainable • Increased quality of care • All partners are jointly responsible for students and learners • A collaborative culture is developed
5	**Professional Bodies, Sector Skills Councils, quality assurance bodies, commissioners, education providers** and **employers** work together to ensure that the quality of the interprofessional elements of health, social care and children's services education programmes is monitored continually.	• Monitoring aligns to service user need • Focus of education is on learning with, from and about each other • The process and outcomes of monitoring are jointly owned by the partners • The results of monitoring feed in to the formal evaluation • The perspectives of patients/service users and carers are integral to the monitoring process to ensure that IPE mirrors real life • Recommendations from evaluations are taken into account when planning future interprofessional initiatives
6	**Commissioners, education providers** and **employers** ensure that interprofessional education is mandatory and assessed within health, social care and children's services and training	• Specific performance criteria relating to interprofessional education are embedded within the assessment of student competence • Students value interprofessional education as a means to develop a professional identity and develop interprofessional competence

	programmes resulting in an award.	professional identity and develop interprofessional competence • Students are more able to cope with the progression from student to practitioner • Students achieve interprofessional competences and/or capabilities • Interprofessional education competences are essential components of all health and social care education and training • Service users benefit from a workforce capable of working together to provide effective services
7	**Employers, commissioners** and **educators**, in partnership with **patients/service users and carers**, adopt and sustain a systematic approach to interprofessional practice based learning.	• Campus and practice-based learning are considered equally important to the development of competence and capability • Partners share responsibility for learning outcomes/students • The practice-based element of pre-registration education is commissioned jointly with the campus based element • Practice and campus based facilitators take joint responsibility for students learning and development
8	**Commissioners, employers, education providers** and **Professional Bodies** ensure that interprofessional champions and/or co-ordinator roles are established/sustained within all organisations.	• All education institutions offering health, social care and children's services programmes and their placement partners have interprofessional champions and/or co-ordinators • The role of interprofessional champions and/or co-ordinators are established formally • Time and funding for these roles are protected as part of their job descriptions
9	**Professional Bodies, commissioners, education providers** and **employers** ensure that interprofessional staff development is mandatory	• Those who teach, facilitate and assess interprofessional education on campus and in practice undergo interprofessional training • The quality of interprofessional education is improved

	and ongoing for all those who facilitate interprofessional learning and assessment in practice and the classroom.	
10	**Commissioners, Professional Bodies, quality assurance bodies** and **education providers** ensure that evaluation is embedded within all interprofessional education initiatives.	• Evaluation is embedded in all stages of commissioned programmes of interprofessional education • Outcomes of evaluations are shared with and jointly owned by all partners and publication will be encouraged • Dissemination and learning from evaluations is evidenced as part of the quality assurance programme • The quality of interprofessional education is improved • Recommendations for change from evaluations informs the monitoring process of all interprofessional initiatives • Evaluation processes are undertaken in partnership
11	**Commissioners, education providers, employers and Professional Bodies** work with **CAIPE** and the **Higher Education Academy** to identify and encourage interprofessional good practice.	• Interprofessional champions/coordinators are encouraged and enabled to become part of the community of interprofessional practice e.g. CAIPE • Organisations share examples of good interprofessional practice regionally and nationally
12	**Stakeholders,** together with **CAIPE,** should develop a national mechanism to recognise and reward organisations with a sustainable collaborative culture.	• Interprofessional champions/coordinators are encouraged and enabled to share experiences locally, nationally and internationally • Organisations are encouraged by CAIPE to work together to identify a national process for rewarding organisations achieving a sustainable collaborative culture

APPENDIX A: STAFF & ASSOCIATES OF CIPW

Lisa Hughes	Director
Tracey Marsh	Project Coordinator
Bryony Lamb	CIPW Associate /CAIPE Vice Chair/PIPP Associates
Barbara Clague	CAIPE Chief Executive
Helena Low	CAIPE Development Manager
Hugh Barr	CIPW Supplement Author/ CAIPE President
Rosie Tope	CIPW Supplement Author/ CAIPE Vice Chair/ HERC Associates
Geoff Meads	CIPW Supplement Author/ CAIPE Chair
Siobhan Ni Mhalrounaigh	CIPW Development Associate
Julia Rout	CIPW Development Associate
Pat McMorran	CIPW Development Associate
Nicky Burns	CIPW Development Associate
Eileen Huish	Chair CIPW Learning in Practice Working Group
Anne O'Connor	Chair CIPW Regulation & Quality Assurance Working Group
Janet Hadfield	Chair CIPW Commissioning Working Group
Isabel Jones	Chair Working with the Voluntary Sector Working Group
Colin Day/ Frances Harkins/ John Cowles/ Adiba Enwonwu	Department of Health

APPENDIX B: Attendees at CIPW participant events

FAF Forging Ahead Forums
SCE Stakeholder Consultation Event
REF Reference Group
TT Think-Tank, 27th September 2006
SHA Strategic Health Authority Network
ETT Electronic Think-Tank

WG Working Groups
RQA Regulation & Quality Assurance Working Group
VS Working with the Voluntary Sector Working Group
CE Commissioning Education Working Group
LiP Learning in Practice Working Group

Name	Organisation	FAF	SCE	REF	TT	SHA	WG	ETT
Alan Bleakley	Peninsula Medical School		✓					
Alireza Irajpour	PhD Student, University of Westminster		✓					
Alison Davidson	Northumbria University	✓						
Alison Proudfoot	North Tyneside PCT	✓						
Alison Smith-Robbie	Brighton & Sussex University Hospitals Trust	✓						
Amanda Hatton	Skills for Care			✓				
Andrea Oz	Conference of Cancer Self-help Networks						VS	
Ann Clarke	Service user	✓						
Ann Huitson	Community Mental Health Sunderland Partnership	✓						
Ann Wakefield	University of Manchester	✓						
Anna Walmsley	Taylor & Francis Events				✓			
Anne Benson	Royal College of Nursing		✓					
Anne Booler	Service User	✓						
Anne Devlin	Peterborough District Hospital	✓						
Anne Gavin-Daley	Cumbria & Lancashire SHA					✓		
Anne Martin	West Sussex Health & Social Care NHS Trust	✓						
Anne O'Connor	Surrey & Sussex Strategic Health Authority		✓	✓	✓	✓	RQA (chair), VS	
Barbara Clague	Centre for the Advancement of Interprofessional Education (CAIPE)		✓	✓	✓	✓	RQA, VS	
Barbara Lund	South West Peninsula SHA					✓		
Barbara Pennant	Service User/Carer		✓					

Name	Organisation	FAF	SCE	REF	TT	SHA	WG	ETT
Baz Booler	Service User	✓						
Becci Martin	Sandwell Mental Health & Social Care NHS Trust						VS	
Ben Griffiths	General Medical Council						RQA	
Beshlie Squires	Department of Health		✓					
Bridie Kelly	Service User		✓					
Bryony Lamb	CAIPE/CIPW Associate		✓	✓	✓	✓	RQA, VS, CE, LiP	✓
Carol Bell	Brighton & Sussex University Hospitals NHS Trust	✓						
Cath O'Halloran	University of Southampton		✓					
Cath Wright	Hambeldon & Richmondshire PCT	✓						
Catherine O'Sullivan	Birmingham & The Black Country SHA					✓		
Catherine Powell	Department For Education and Skills		✓					
Chantal Gosselin	North Hampshire Hospital	✓						
Charmagne Barnes	Middlesex University	✓						
Chris Archer	Royal Sussex County Hospital	✓						
Chris Bowden	Gloucestershire Academy	✓						
Chris Holroyd	West Yorkshire SHA					✓		
Chris Turnock	Making Practice Based Learning Work	✓	✓					
Christine Whitehead	Dorset & Somerset SHA					✓		
Chrsitine Price	Royal West Sussex NHS Trust	✓						
Claire Dickinson	Newcastle University	✓						
Claire Perry	Lewisham Hospital NHS Trust		✓					
Claire Torkington	Skills for Care						VS	
Clare Chivers	South West Peninsula Strategic Health Authority		✓	✓	✓		CE	
Clare Walsh	Sheffield University	✓						
Colin Day	Department of Health		✓	✓				
Colin Stanley	University of Plymouth				✓			
Colin Whittington	Independent Consultant		✓					
Cyndy Whiffin	General Social Care Council						RQA	
Cyril Murray	University of Salford	✓						
Daniel Webster	University of Plymouth	✓						
Darren Pirson	Ashford & St Peter's Hospital	✓						

Name	Organisation	FAF	SCE	REF	TT	SHA	WG	ETT
Dave Jones	Cheshire & Merseyside SHA					✓		
David Briggs	University of Hertfordshire				✓			
David Pearson	Bradford City PCT				✓			
David Pierce	Independent Consultant	✓	✓					
Dawn Foreman	University of Derby		✓					
Debra Humphris	University of Southampton	✓						
Don Brand	Social Care Institute for Excellence		✓					
Ed Young	Northumberland, Tyne & Wear SHA	✓				✓		
Eileen Huish	University if Hertfordshire	✓		✓	✓		LiP (chair)	
Elaine Curno	Expert Patients Programme		✓					
Elaine Moran	Newcastle Social Services	✓						
Elisa Pruvost	Council for Healthcare Regulatory Excellence				✓		RQA	
Elizabeth Howkins	PIPE Project		✓					
Elspeth McClean	University of Liverpool	✓						
Emma Thompson	Gateshead Health NHS Trust	✓						
Fanny Mitchell	Thames Valley University	✓						
Filao Wilson	Skills for Health		✓	✓	✓		RQA	✓
Fiona Nixon	Health Professions Council		✓					
Fiona Shields	Shropshire & Staffordshire SHA					✓		
Fran Wiles	General Social Care Council		✓					
Frances Gordon	Sheffield Hallam University		✓		✓		RQA	
Frances Harkins	Department of Health				✓		CE	
Gail Crawford	Barnsley PCT	✓						
Gail Jefferson	North Cumbria Acute NHS Trust				✓		LiP	
Gaye Jackson	Greater Manchester Strategic Health Authority		✓		✓	✓		
Geoff Meads	CAIPE		✓	✓	✓			
Geoff Nykurz	University of Westminster		✓					
Gillian Arblaster	University Hospitals Coventry & Warwickshire	✓						
Gordon Spence	Department of Health				✓			
Graham Ixer	General Social Care Council		✓					
Hasel Daniels	Open University	✓						

Name	Organisation	FAF	SCE	REF	TT	SHA	WG	ETT
Hazel Moggett	Newcastle upon Tyne	✓						
Heather Owen	Welsh Assembly		✓					
Helen Armitage	Sheffield Hallam University	✓	✓		✓		LiP	
Helen Bywater	Sheffield Hallam University	✓	✓	✓				
Helen Green	Castelford, Normanton & District Hospital	✓						
Helena Johnson	University of Teeside	✓						
Helena Low	CAIPE		✓	✓	✓		CE, LiP	
Hilary Thompset	Kingston University & JUSWC		✓					
Hugh Barr	CAIPE		✓	✓	✓			✓
Ieuan Ellis	Leeds Metropolitan University				✓		CE	
Isabel Jones	University of Derby		✓	✓	✓		VS (chair)	
Jane McLenachan	Sheffield Hallam university	✓						
Jane Miles	Thames Valley SHA					✓		
Jane Nicklin	Essex Strategic Health Authority		✓			✓		
Janice Gosby	Nursing and Midwifery Council						RQA	
Janis Stout	Care Service Improvement Partnership				✓			
Jann Hadfield	North West London SHA					✓	CE (chair)	
Jaqui Potter	University of East London	✓						
Jayne Andrew	South Yorkshire SHA		✓		✓	✓	CE	
Jean Walton	Service User	✓						
Jeanie Molyneux	University of Newcastle and Northumbria	✓						
Jenny Brown	North & East Yorkshire & North Lincolnshire SHA					✓		
Jenny Harvey	University of Portsmouth				✓		LiP	
Jenny Powell	West Midlands South SHA					✓		
Jim Connelly	Trent SHA					✓		
Jo Mainwaring	University of Coventry	✓						
Joan Fletcher	NHS London				✓	✓	VS	
Joan Mullholland	Making Practice Based Learning Work		✓		✓		LiP	
Joanne Hartland	Avon, Gloucester & Wiltshire SHA					✓		
Joanne Ord	Sunderland Teaching PCT	✓						
Joe McEvoy	South West Peninsula SHA		✓					

Name	Organisation	FAF	SCE	REF	TT	SHA	WG	ETT
John Cowles	Department of Health		✓	✓				
John Gilbert	University of British Columbia		✓					
John Horder	CAIPE		✓		✓			
John Salkeld	South of Tyneside & Wearside Mental Health NHS Trust	✓						
John Stevens	University of Newcastle and Northumbria	✓						
Joy Needham	Canterbury Christchurch University	✓						
Judith Whittam	Department of Health	✓						
Julia Birchell	University Hospital of North Staffordshire	✓						
Julia Waldman	Higher Education Academy: Social Policy & Social Work				✓			
Julie Irvine	Northumbria University	✓						
Julie Laxton	West Yorkshire SHA						LiP	
Julie Sparrow	University of Teeside	✓						
Julie Stone	Council for Health Care Regulatory Excellence		✓					
Karen Bloomfield	Bedfordshire & Hertfordshire SHA					✓		
Karen Davies	University of Coventry	✓						
Karen Holland	University of /Salford	✓						
Karen Kniveton	University of Salford	✓						
Karen Postle	University of East Anglia	✓						
Kate McMullen	General Social Care Council	✓						
Kay East	Department of Health		✓					
Laurence Leonard	Kingston University	✓						
Lesley Sheldon	Hampshire & Isle of Wight SHA	✓				✓		
Linda D'Avray	Kings College London		✓					
Linda Lang	Sheffield Hallam University		✓					
Lindsey Proctor	Department of Health		✓					
Lisa Hughes	CIPW	✓	✓	✓	✓	✓	RQA,VS CE, LiP	✓
Liz Ballantyne	South West Peninsula SHA						RQA	
Lewis Atkinson	Sheffield Care Trust Council	✓						
Manda Glenn	Eastleigh and Test Valley South PCT	✓						
Margaret Shaw	Essex Ambulance Service Patient & Public Involvement Forum		✓				LiP	
Margaret Sills	Higher Education Academy: Health Science & Practice Subject Centre		✓		✓			

Name	Organisation	FAF	SCE	REF	TT	SHA	WG	ETT
Maria Ponto	Kingston University	✓						
Marilyn Hammick	CAIPE			✓				✓
Marion Helme	European IPE Network (EIPEN)	✓		✓	✓			✓
Mark Day	Simply Health				✓			
Martin Green	English Community Care Association						VS	
Martina Ellery	West Midlands SHA	✓						
Mary Embleton	Society of Radiographers			✓	✓		RQA	
Mary Watkins	University of Plymouth		✓					
Matthew House	North Central London SHA	✓				✓		
Maureen Morgan	Department of Health		✓					
Megan Quentin-Baxter	Higher Education Academy: Medicine, Dentistry & Veterinary Medicine Subject Centre		✓		✓			
Melissa Owen	Bradford Teaching PCT		✓					
Meriel Best	University of Leeds	✓						
Michael Boggins	Hasting and St. Leonard's PCT	✓						
Michael Guthrie	Health Professions Council						RQA	
Michael Leadbetter	Practice Learning Taskforce		✓					
Michaela Musk	Sunderland Teaching PCT	✓						
Monica Clarke	NHS Clinical Governance Support Team (Carer)				✓		VS	
Neal Patel	National Pharmaceutical Association		✓					
Neil Graham	Milton Keynes General Hospital & PGMDE Oxford		✓		✓		LiP	
Neil Simmonite	University of /Southampton	✓						
Nic Greenfield	Department of Health		✓					
Nick Johnson	Social Care Association		✓					
Nick Lewis-Barned	Northumbria Healthcare Trust	✓						
Nicky Burns	Gloucestershire Academy	✓						
Nicky McVeagh	Frimley Park Hospital	✓						
Nicola Horne	Skills for Care						LiP	
Nicola Maskrey	Sheffield Hallam University	✓						
Pat Bluteau	University of Coventry	✓						
Pat Lindsey	Manchester City Council	✓						
Pat McMorran	University of Hertfordshire/CIPW Development Associate			✓	✓			

Name	Organisation	FAF	SCE	REF	TT	SHA	WG	ETT
Patricia Saunders	Department of Health		✓		✓			
Paul Loveland	Department of Health		✓		✓			
Paul Stanton	Department of Health				✓			
Paul Steward	Norfolk, Suffolk & Cambridgeshire SHA	✓				✓		
Pauline Pearson	University of Newcastle		✓		✓			
Pauline Yarker	County Durham & Tees Valley SHA					✓		
Peter Milford	South West Peninsula SHA		✓		✓			
Peter Rolland	Leicester, Northamptonshire & Rutland SHA					✓		
Philomena Harrison	University of /Salford	✓						
Pippa Gough	The Kings Fund		✓					
Rebecca McNamara	Rotherham PCT	✓						
Renata Eyres	Salford University		✓					
Roger Thompson	Nursing and Midwifery Council		✓					
Ros Mead	Department of Health		✓					
Rosie Tope	CAIPE		✓	✓	✓		RQA	
Ruth Cartwright	British Association of Social Workers		✓					
Samantha Shann	University of Newcastle at Northumbria	✓						
Sandra Nightingale	University hospitals Coventry & Warwickshire	✓						
Sandra Rowen	County Durham & Tees Valley SHA	✓						
Sarah Fox	South East London SHA					✓		
Seamus Breen	Department of Health		✓					
Sean King	NHS Employers	✓						
Sharon Pickering	East Midlands Strategic Health Authority				✓		VS	
Sharon Summers	Hampshire & Isle of Wight SHA	✓						
Sheila Hawkins	Volunteering England				✓		VS	✓
Shelley Bellamy	Western Sussex PCT	✓						
Sonya Lam	NHS Education for Scotland		✓					
Steve Barnett	NHS Employers		✓					
Steven Cleverdon	South London SHA				✓			
Stuart Plant	Carer		✓					
Sue Braid	University of Salford	✓						

Name	Organisation	FAF	SCE	REF	TT	SHA	WG	ETT
Sue Butler	Sheffield Teaching Hospital	✓						
Sue Hill	Department of Health		✓					
Sue Morrison	University of Westminster		✓					
Sue Osborne	Teeside University	✓						
Sue Tatum	North East London SHA					✓		
Sue Welsh	Northumbria Care Trust	✓						
Susan Motague	University of Hertfordshire	✓						
Tom Muldowney	Guide Dogs for the Blind				✓		VS	
Tony Byrne	University of Southampton				✓			
Tracey Marsh	CIPW			✓				
Trish Jordan	Kent & Medway SHA					✓		
Val Heath	University of Plymouth		✓		✓			
Valerie Wigfall	Thomas Coran Research Institute				✓			
Verity Sutcliffe	South Devon Healthcare Trust				✓			
Wendy McCarthy	Mid Sussex PCT	✓						

APPENDIX C: Drivers underpinning the CIPW recommendations

Recommendation	Drivers
1. **Commissioners, education providers** and **employers** ensure that the active participation of **patients/service users, carers** and the **voluntary, community and independent sectors** is embedded in every aspect of workforce planning for the health, social care and children's workforce.	Our Health, Our Care, Our Say Independent Sector Treatment Centre Training Policy The Local Government and Public Involvement in Health Bill Reward and recognition: the principles and practice of service user payment and reimbursement in health and social care A stronger local voice: A framework for creating a stronger local voice in the development of health and social care services. The Princess Royal Trust for Carers: Carers' views of carer awareness training for professionals Volunteering England: Volunteering in the public sector Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England: Social Care Green Paper No excuses. Embrace partnership now. Step towards change! Report of the third sector commissioning task force
2. **Employers** and **education providers** provide the **wider health, social care and children's workforce** with access to interprofessional learning and development opportunities that are appropriate to the individual's current and future role and scope of practice.	Learning for a change in healthcare Foundation Degree Modern Apprentiships National Vocational Qualifications Sector Skills Agreement for Health Every Child Matters Widening Participation in Learning Agenda for Change

3. **Commissioners, education providers, employers, patients/service users** and **carers** work in partnership to strengthen the interprofessional elements within local education and training quality assurance arrangements.	Statements of Common Purpose for Subject Benchmark Statements for Health and Social Care Professions Quality Assurance Framework for NHS Funded Healthcare Learning National Occupational Standards The 2006 Social Work Education Quality Assurance Report QAA: Major review of healthcare education reports Interprofessional Education: Today, Yesterday and Tomorrow Promoting High Quality Dentistry
4. **Commissioners**, **education providers, patients/service users, carers** and **employers** work in partnership to integrate the commissioning, planning, delivery and evaluation of interprofessional education for health, social care and children's services.	The Local Government White Paper: Strong and Prosperous Communities Statement of guiding principles relating to the commissioning and provision of communication skills training in pre-registration and undergraduate education for healthcare professionals Health reform in England: update and commissioning framework Strategic Learning and Research Advisory Group for Health and Social Care Cost benefit analysis of health impact assessment - final report House of Commons Health Committee Workforce Planning Fourth Report of Session 2006–07 Volume I Practice based commissioning: practical implementation Our Health, Our Care, Our Say Making Partnership Work for Patients, Carers and Service Users: A Proposed Strategic Partnership Agreement Between the Department of Health, the NHS and the Voluntary and Community Sector

5. Professional Bodies, Sector Skills Councils, quality assurance bodies, commissioners, education providers and **employers** work together to ensure that the quality of the interprofessional elements of health, social care and children's services education programmes is monitored continually.	White Paper: Trust, Assurance and Safety - The Regulation of Health Professionals Health and Education Strategic Partnerships (HESPs) Health Professions Council Standards of Education and Training GMC: Tomorrow's Doctors NMC: Standards of proficiency for pre-registration nurse education The College of Radiographers: Approval and accreditation timeline GSCC: Annual quality-assurance report
6. Commissioners, education providers and **employers** ensure that interprofessional education is mandatory and assessed within health, social care and children's services and training programmes resulting in an award.	The NHS Plan: a plan for investment, a plan for reform Benchmark pricing and national standard framework contract for professional health training HR in the NHS Plan Delivering the HR in the NHS Plan Learning together to work together for health: report of a WHO Study Group on Multiprofessional Education of Health Personnel: the Team Approach European Working Time Directive
7. Employers, commissioners and **educators**, in partnership with **patients/service users and carers**, adopt and sustain a systematic approach to interprofessional practice based learning.	GSCC & Skills for Care Joint guidance on the assessment of practice in the workplace Modern Apprentiships National Vocational Qualifications Inter-Professional Computer Assisted Learning

8. **Commissioners, employers, education providers** and **Professional** Bodies ensure that interprofessional champions and/or co-ordinator roles are established/sustained within all organisations.	NMC standards to support learning and assessment in practice HPC Standards of Education and Training Good Doctors, Safer Patients Dental Education and Professional Self-regulation
9. **Professional Bodies, commissioners, education providers** and **employers** ensure that interprofessional staff development is mandatory and ongoing for all those who facilitate interprofessional learning and assessment in practice and the classroom.	Working together, learning together The Skills Escalator GSCC UK Post Qualifying Framework Assuring quality for Child Care Social Work requirements for the Post-qualifying Child Care Award Approval, review and inspection of child care programmes The NMC code of professional conduct: standards for conduct, performance and ethics HPC: Continuing Professional Development and your Registration Good Doctors, Safer Patients The regulation of the non-medical healthcare professions: a review by the Department of Health Dental Education and Professional Self-regulation
10. **Commissioners, Professional Bodies, quality assurance bodies** and **education providers** ensure that evaluation is embedded within all interprofessional education initiatives.	Effective Interprofessional Education - Argument, Assumption and Evidence Effective Interprofessional Education - Development, Delivery and Evaluation The Case for Interprofessional Collaboration Journal of Interprofessional Care Journal of Integrated Care Practice A Critical Review of Evaluations of Interprofessional Education Evaluating Interprofessional Education: A Self-Help Guide

11. Commissioners, education providers, employers and Professional Bodies should work with **CAIPE** and the **Higher Education Academy** to identify and encourage interprofessional good practice.	NHS Networks UK Centre for the Advancement of Interprofessional Education (CAIPE) Higher Education Academy Medicine, Dentistry and Veterinary Medicine Subject Centre Higher Education Academy Social Policy and Social Work Subject Centre Higher Education Academy Health Sciences and Practice Subject Centre European Interprofessional Education Network (EIPEN) International Association for Interprofessional Education and Collaborative Practice
12. Stakeholders, together with **CAIPE,** should develop a national mechanism to recognise and reward organisations with a sustainable collaborative culture.	Institute for Innovation and Improvement: Health and Social Care Awards Collaborative Teamwork Skills: How Are They Developed Through Interprofessional Education and Are They Applicable In the Practice Setting CSIP Positive Practice Awards 2007

APPENDIX D: CIPW DOCUMENTS

The following documents relating to the Creating an Interprofessional Programme can be found at www.dh.gov.uk and www.caipe.org.uk.

Armitage, H., & Bywater, H. (2005) *Report of the Forging Ahead Creating an Interprofessional Workforce Programme Forums*
Barr, H. (2006) *Interprofessional Education in the UK: Some Historical Perspectives*: *The Second Supplement to Creating an Interprofessional Workforce: An Education and Training Framework for Health and Social Care in England*
Hughes, L., & Lamb, B. (2007) *The Report of the Creating an Interprofessional Workforce Programme Working Groups*
Hughes, L. (2005) *Planning for an Interprofessional Workforce: A Report of the Creating an Interprofessional Workforce Programme*
Hughes, L. (2007) *Creating an Interprofessional Workforce: An Education and Training Framework for Health and Social Care in England*
Lamb, B., Hughes, L. & Marsh, T. (2006) *Key Messages from the Creating an Interprofessional Workforce Programme Consultation Event*
Meads, G. (2006) *Walk the Talk*: *The Third Supplement to Creating an Interprofessional Workforce: An Education and Training Framework for Health and Social Care in England*
Tope, R. & Thomas, E. (2006) *Health and Social Care Policy and the Interprofessional Agenda: The First Supplement to Creating an Interprofessional Workforce: An Education and Training Framework for Health and Social Care in England*

APPENDIX E: REFERENCES

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