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The CAIPE Journey—Vision, Resilience and Sustainability

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The Centre for the Advancement of Interprofessional Education (CAIPE) was established in 1987 as a United Kingdom charitable trust following a series of conferences and workshops organised by the Middlesex Polytechnic (now university). John Horder who had recently retired following a distinguished career in medicine was invited to be its leader. He saw the invitation as an opportunity to promote team-based primary health care, drawing on his pioneering work as a general practitioner in North London. To imply that his vision extended no further would be to do him less than justice. CAIPE, as Horder envisaged it,

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would be a regional network with a national council representing the professions supported by paid staff:

- to foster and improve interprofessional cooperation in the interests of a comprehensive and effective service to patients and clients;
- to promote development, practice and research in interprofessional education for practitioners associated with primary health care (CAIPE, undated).

Interprofessional education (IPE) would be the key to unlock relationships between General Practitioners (family doctors in the UK), nurses, midwives and social workers practising together in community teams. In this way it was envisaged they could resolve problems through mobilising their collective expertise and experience to improve and extend primary health care services. It would be work-based, person-centred and practice-led. These values endure in CAIPE and throughout the interprofessional movement today.

Horder eschewed the limelight. Leading by example, he set CAIPE's agenda simply and clearly, demanding impeccable standards from himself and colleagues to whom he invariably gave credit. Unwavering in commitment to his own profession, he succeeded for many in embodying the interprofessional ethos, imprinting his indelible leadership style on CAIPE during its formative years, indeed throughout his time as chair and later president (Horder, 2003).

One of us (HB) succeeded Horder as president following his own term as chair. He sought to emulate Horder's style of leadership. He welcomed opportunities to represent CAIPE, addressing conferences nationally and internationally and writing extensively for publication, concurrently editing the Journal of Interprofessional Care for much of the time.

The challenge for all who followed in Horder's footsteps was to hold fast to his vision whilst measuring up to mounting expectations within the constraints of a small charity with limited resources. Recurrent financial crises drove CAIPE on to the back foot, followed invariably by renewed pressure to do more with less. Closure loomed more than once. There were no quick fixes. Government made clear that pump priming for IPE would not be extended. Personal and charitable donations

solicited by Horder were too small to retain staff and rent accommodation. For a while a business model seemed promising. Income was generated from membership subscriptions and successful bids which, however, dictated priorities and were prone to conflict with CAIPE's strategic objectives.

Escape from recurrent crises demanded a more radical solution now being put to the test. CAIPE has become a 'virtual membership organisation' no longer at the mercy of hiked office rents and no longer struggling to pay staff commensurate with their abilities. Free from these burdens CAIPE has regained its cherished independence.

Preoccupied though it often was with its survival, CAIPE remained outward looking: defining IPE; reconciling differing perceptions and expectations; delineating learning methods; enunciating principles; and weaving interprofessional perspectives into professional education (CAIPE, 2002, 2011, 2017). These tasks were hard enough to effect in primary health care, harder as CAIPE extended into other fields of practice including child protection, health promotion, acute care and patient safety.

Each of the nine chairs who followed Horder brought their distinctive personalities, preferences and priorities. All strived by one means or another to ensure CAIPE remained viable and relevant to its members, ably supported by dedicated administrative and professional staff (all but one of whom were part-time). They adopted different strategies to find common ground between stakeholders: enlist the professional associations as partners; generate income; raise CAIPE's profile; attract more members; secure the IPE evidence base, instil academic credibility; balance the books and build a viable virtual organisation, all of which became part of CAIPE's modus operandi (CAIPE, 2019; Gray, 2015).

It is difficult and arguably unhelpful to distinguish between activities instigated by CAIPE, by its individual members, its corporate members and in partnership with other organisations. Collaboration with the Learning for Partnership Network, Creating an Interprofessional Workforce, especially three of the subject centres of the Higher Education Authority and other organisations, was productive but short-lived, leaving CAIPE with the unfinished business.

In response to government (Department of Health, 2000), IPE in the UK from the turn of the century became predominantly university led, located in and integral to their professional registration programmes. Interprofessional, post-registration workshops and short courses continued but were cast in the shadows. University-led post-registration programmes were slow to take off. One priority for CAIPE was to support interprofessional activists in universities to articulate theoretical foundations, build in evaluation and secure evidence bases to win acceptance in academe (CAIPE, 2017). Another was to affirm the centrality of team-based practice learning (Brewer & Barr, 2016). Yet another was to project a continuum of interprofessional learning extending beyond qualifying courses into supervised learning in the workplace, virtual study and post-qualifying courses (CAIPE, 2017). All these outreached CAIPE's capacity alone. The solution, in part, lay in working with like-minded organisations to convene conferences, run workshops, conduct surveys, draft guidelines, and promote research with systematic reviews (Gray, 2015).

Relationships with the UK Department of Health became more tenuous as it devolved responsibility for health and social care in Scotland, Wales and Northern Ireland and entrusted professional education to the regulatory bodies. Building and sustaining relationships with a wide spectrum of organisations made heavy claims on CAIPE's resources; concurrently supporting a lengthening list of corporate members. CAIPE welcomed growing support from regulatory bodies, collaborating with them during twice-yearly group meetings that give CAIPE opportunities to influence their references to IPE standards and competencies, albeit at times reluctant to go beyond endorsing IPE outcomes, leaving CAIPE to explain the means.

Over the years, CAIPE members and staff have published seven books with Blackwell and now Routledge, been instrumental in launching and sustaining the Journal of Interprofessional Care and mounting two prestigious conferences; nationally with the St. Catherine Foundation at Cumberland Lodge and three globally in the Altogether Better Health series. Concurrently, they have advised and assisted the promotion of waves of interprofessional development in sub-Saharan Africa, Latin America, the Arab speaking countries, Australasia, Canada, Europe, the

Pacific region and Japan, establishing and supporting 'Interprofessional. Global' as the umbrella body (Box 3.1).

Box 3.1: Case Study—An Example of How CAIPE Nurtures and Develops IPE
Case study. The University of Leicester

The revelation, which would change our understanding of teaching and learning in Leicester, took place in 1995 in designing new training for medical students about patients who lived in areas of disadvantage and poverty. As the ideas permeated around the medical school a GP offered up a green leaflet entitled 'The UK Centre for the Advancement of Interprofessional Education'. Apparently in a conversation with John Horder he had shared our recent thinking for extending medical students' learning beyond primary care to the wider community and the possibility of linking up with the nursing and social work students. Did we not know that CAIPE could help, was his reply? As a team we had neither heard of CAIPE nor of interprofessional education.

CAIPE, in the late 1990s, was based in Gray's Inn Road, central London. For all who entered there was a warm welcome from Hugh Barr, Barbara Clague and Helena Low (then chair, CEO and development officer respectively). Listening, encouragement and support abounded. From hearing more about our evolving work in Leicester came an invitation to share our practice-based interprofessional learning at a CAIPE meeting. In October 1998, what was to become the Leicester model of IPE was the first to be shared; practice-learning in the inner city aligning medical students from one university with nursing and social work students from an adjacent university (Anderson, Ford, & Kinnair, 2016). CAIPE publications at that time were prolific, benefitting from active engagement in research and scholarly synthesis in the Journal of Interprofessional Care. These outputs included re-affirming the definition, guidelines and principles for IPE. An analysis of our work was summarised as one of the many IPE developments taking shape in the UK at that time (Barr, 2002).

The CAIPE Board then comprised representatives from different professional bodies plus the voluntary sector. These included education, housing and police, representatives of different subject centres of the UK Higher Education Academy, along with academics and professionals in the forefront of embedding this learning within health and social care curricula. Within this atmosphere, the tools for creating a solid sustainable interprofessional curriculum could be found. Here we absorbed the sensitivities for this learning. We were now able to share these understandings

locally with academic subject leads across our two higher education institutions—Leicester and De Montfort universities—to generate a local, East Midlands, activity centre for IPE.

In 2001, we missed out on the cash injection from the Department of Health initiative—the Common Learning Bids—rejected because we could not offer common learning as we were two universities. We went on to find support from our Regional Health Authority to shape our local IPE curriculum. This injection of money could not create new academic posts but could employ help from CAIPE and a researcher. CAIPE executive members led a series of faculty development workshops. This support cannot be overstated as academics came together across two universities, bridging our differences and forming relationships with CAIPE at the helm. CAIPE as a knowledgeable external charitable organisation had ensured harmony within the leadership team across the two universities and helped to propel our strategy. This early support has led to a sustained evaluated curriculum and university alliances which have lasted for over twenty years (Anderson, Smith, & Hammick, 2015). In 2005 we launched the three-strand model curriculum for the East Midlands (Leicester and Northampton) in an informal meeting of Deans, the Regional Health Authority and local university leads with a keynote address from Hugh Barr. We have gone on to share our model widely, initially published in the CAIPE Bulletin (Anderson & Knight, 2004).

CAIPE offered constant encouragement as our teaching evolved from the medical student course (Lennox & Petersen, 1998) into an interprofessional practice-based researched model, evaluated throughout its iterative development over a further ten years (Anderson & Lennox, 2009). Hugh Barr urged us to publish our experience and Marilyn Hammick ensured the Leicester Model was ready for publication by the Higher Education Academy (Lennox & Anderson, 2007). Hammick, as a CAIPE scholar and chair, went on to become our external consultant for the evaluation of our local IPE curriculum (Anderson, Smith, & Hammick, 2015).

CAIPE support remains pivotal to our regional success so far lasting twenty years, exemplifying that which CAIPE offers to its corporate members and reflected in its publications, e.g. Barr (2007a, 2007b), Barr & Low (2013), Barr et al. (2014), and Colyer, Helme, & Jones (2005).

The depth of CAIPE, as we encounter it in Leicester, centres on its ability to listen and learn with and from the experiences of its members, putting interprofessional values into action. CAIPE remains a vibrant meeting point to debate and discuss the meaning of interprofessional learning and to share and consider the many challenges we all face. Our relationship with CAIPE is symbiotic; give and take, share and receive for constant energy and commitment to furthering IPE.

Through our alliance with CAIPE we have shared our experiences globally with other universities building collaborations which continue today,

for example, with Chiba and Niigata universities in Japan in exchanging undergraduate students for placements and electives. In Leicester our two universities have helped CAIPE host international visitors supporting global alliances for the exchange of ideas with colleagues from Australia, Canada, Finland, Norway, Sweden and the USA, and many more. Remaining corporate members of CAIPE continues to sustain and re-energise our work.

Most of CAIPE's development is now assigned to working groups mobilising Board members' experience and expertise:

- to promote CAIPE and develop effective social media and communications platforms;
- to explore learning and teaching methodologies and apply technological assisted learning in IPE;
- to develop and provide workshops on IPE and collaborative working;
- to provide a platform for international liaison with IPE colleagues and share resources;
- to add publications to the collaborative practice series with Routledge;
- to enhance further CAIPE's scholarly reputation, promoting research and evaluation throughout the CAIPE membership;
- to engage students as the future workforce in the development and promotion of IPE and collaborative practice;
- to explore how scholarship awards might be made for individuals, students and service users, maintaining the John Horder Award;
- to continue to develop resources for individual members;
- to provide bi-annual forums hosted by corporate members to share innovations and good practice; and
- to engage further service users and carers.

A recurrent challenge for CAIPE is to anticipate, respond and strive to influence policy developments impacting on IPE and collaborative practice. Current moves, for example, towards integrating health and social care services, are pregnant with implications for professional and interprofessional education (Valentijn et al., 2015). Organisational solutions

alone falter, as CAIPE has learnt from experience. Managing change successfully depends on enlisting the workforce in planning and implementation, resolving tensions as boundaries between professions are redrawn, duties reassigned and powers redistributed, all of which entails interprofessional learning.

Work, as we write, with the south and midlands and east regions of Higher Education England involves piloting an IPE practice workbook underpinning integrated care and with NHS Education for Scotland (NES). This work promotes CAIPE, the IPE Review and its recommendations (Barr, Helme, & D'Avray, 2011) involving the Scottish Clinical Skills Network and the Scottish Heads Association of Nurses and Allied Health Professionals.

CAIPE is being urged from within to assume an audit role to complement that of the regulatory bodies. One of its working groups is exploring in consultation with UK regulatory bodies, professional associations and universities the feasibility and desirability of developing national standards for the management and delivery of IPE to even up its quality.

CAIPE is grasping technology to promote and sustain many of its activities but remains ever mindful of the need for real time, face-to-face interprofessional communication to improve the quality of care and ensure patient safety. Its revised website launched in September 2016 provides a platform of resources, information, support and innovations in interprofessional education and collaborative practice for CAIPE members and the wider interprofessional community. Engagement with digital technology is assisting CAIPE in ensuring its sustainability and resilience as a virtual organisation through its monthly e-newsletter, virtual meetings, podcasts, digital stories and partnership with other web resources. These include Care Opinion (www.careopinion.org.uk); the (US) National Center for Interprofessional Practice and Education (https://nexusipe.org); the International Foundation for Integrated Care (https://integratedcarefoundation.org/); and Interprofessional.Global (https://interprofessional.global). CAIPE is capitalising on the popularity of Twitter and social media forums amongst students and their generation to increase participant engagement, attention and interaction (Mckay, Steiner Sanko, Shekhter, & Birnbach,

2014). Students reportedly prefer near instantaneous access to information and constant connectivity (Fox & Varadarajan, 2011). Many educators are 'digital novices' born or brought up before widespread use of digital technology and needing to learn how to be creative and innovative in their strategies to keep the attention of today's learner. Recognising this, CAIPE has engaged with a Twitter Account, @CAIPEUK, to share IPE/IPC developments. Twitter is now one of the main sources of IPE traffic to the CAIPE website. Through an initiative of the Student Working Group we engage in monthly Twitter Chats on a current IPE topic.

CAIPE as a virtual organisation is financially stable, but heavily dependent on its volunteer workforce and goodwill. This is especially true for the chair, board members and fellows, including the late Scott Reeves, appointed from the membership in recognition of their sustained and influential contributions to IPE to support its strategic thinking. To add yet more demands might call into question how long CAIPE can remain 'virtual', reactivating the case for recruiting professional and administrative staff if and when financial backing can be assured.

This unique ability to remain purposeful and relevant owes much to the commitment and dedication of its members and leaders. We might postulate that the sustainability of CAIPE comes from having been one of the earliest bodies to lead the IPE global understandings through scholarship, in shaping a definition and principles upon which others could build. Staying connected to the local, UK, policy developments and remaining faithful to its members (organisations and practitioners/academics) from which its core memberships arise, remains essential. Involving students and service users on the CAIPE Board ensures a vital litmus test of whether the aspirations for interprofessional learning have been achieved. While we see evidence of team working and collaborative practice in the UK, sadly we hear too often from the naive observers (students) and disappointingly from receivers (patients and carers) that there is still much more to be done. In this way CAIPE remains relevant, having been sustained over thirty years with resilience and hopefully for a further thirty years.

References

Anderson, E. S., Ford, J., & Kinnair, D. (2016). Interprofessional education and practice guide no. 6: Developing practice-based interprofessional learning using a short placement model. *Journal of Interprofessional Care, 30*(4), 433–440. http://www.tandfonline.com/doi/full/10.3109/13561820.2016.1160040.

Anderson, E. S., & Knight, T. (2004). *The three strand model of interprofessional education in Leicestershire, Northamptonshire and Rutland workforce development confederation.* Winter 2004/5 CAIPE Bulletin, 12.

Anderson, E. S., & Lennox, A. (2009). The Leicester model of interprofessional education: Developing, delivering and learning from student voices for 10 years. *Journal of Interprofessional Care, 23*(6), 557–573. https://doi.org/10.3109/13561820903051451.

Anderson, E. S., Smith, R., & Hammick, M. (2015). Evaluating an interprofessional education curriculum: A theory-informed approach. *Medical Teacher, 36,* 495–504. https://doi.org/10.3109/0142159X.2015.1047756.

Barr, H. (2002). *Interprofessional education, today, yesterday and tomorrow* (Occasional Paper 1). The Higher Education Academy, Health Sciences and Practice: CAIPE, HEA Kings College London.

Barr, H. (2007a). *Interprofessional education in the United Kingdom 1966 to 1997* (Occasional Paper 9). Higher Education Academy.

Barr, H. (Ed.). (2007b). *Piloting interprofessional education—Four English case studies* (Occasional Paper 8). Higher Education Academy-Health Sciences and Practice.

Barr, H., Helme, M., & D'Avray, L. (2011). *Developing interprofessional education in health and social care courses in the United Kingdom: A progress report* (Centre Occasional Paper 12). Higher Education Academy, Health Sciences and Practice Subject.

Barr, H., Helme, M., & D'Avray, L. (2014). *Review of interprofessional education in the United Kingdom 1997–2013.* CAIPE. www.caipe.org/.

Barr, H., & Low, H. (2013). *Introducing interprofessional education.* CAIPE. www.caipe.org/.

Brewer, M. L., & Barr, H. (2016). Interprofessional education and practice guide no. 8: Team-based interprofessional practice placements. *Journal of Interprofessional Care, 30,* 747–753.

CAIPE. (undated). *The centre for the advancement of inter-professional education in primary health care.* Attributable to John Horder. Circulated as a pamphlet soon after CAIPE was established in 1987.
CAIPE. (2002). *Interprofessional education—A definition.* www.caipe.org/.
CAIPE. (2011). *Principles of interprofessional education.* www.caipe.org/.
CAIPE. (2017). *Interprofessional education guidelines.* www.caipe.org/.
CAIPE. (2019). *The history of CAIPE.* www.caipe.org/.
Colyer, H., Helme, M., & Jones, I. (2005). *The theory-practice relationship in interprofessional education* (Occasional Paper 7). Higher Education Academy, Centre for Health Sciences.
Department of Health. (2000). *A health service for all the talents: Developing the NHS workforce.* London: Department of Health.
Fox, B. I., & Varadarajan, R. (2011). Use of Twitter to encourage interaction in a multi-campus pharmacy management course. *American Journal of Pharmaceutical Education, 75,* 88.
Gray, R. (2015). Changing times in the United Kingdom: The centre for the advancement of interprofessional education responds to the challenges. *Journal of Interprofessional Care, 29*(2), 93–94.
Horder, J. (2003). *A history of the Centre for the Advancement of Interprofessional Education (CAIPE) 1987–2003.* www.caipe.org/.
Lennox, A., & Anderson, E. S. (2007). *The Leicester model of interprofessional education: A practical guide for implementation in health and social care.* Higher Education Academy, subject centre. https://www.heacademy.ac.uk/knowledge-hub/leicester-model-interprofessional-education.
Lennox, A., & Petersen, S. (1998). Development and evaluation of community based, multi-agency course for medical students: Descriptive study. *British Medical Journal, 316,* 596–599.
Mckay, M., Steiner Sanko, J., Shekhter, I., & Birnbach, D. (2014). Twitter as a tool to enhance student engagement during an interprofessional patient safety course. *Journal of Interprofessional Care, 28*(6), 565–567.
Valentijin, P. M., Boesveld, I. C., van der Klauw, D. M., Ruwaard, D., Struijs, J. N., Molema, J. J. W., … Vrijhoef, H. J. M. (2015). Towards a taxonomy for integrated care: A mixed methods study. *International Journal of Integrated Care, 15,* 1–18.