# Training and Deployment of Facilitators to Master Interprofessional Education

*Sharron Blumenthal, Melissa Owens, Elizabeth Anderson, Patricia Bluteau und Susanne Lindqvist*

## 1. Introduction: The Need for Interprofessional Collaborative Practice

Interprofessional collaborative practice (ICP) is »when multiple health workers from different professional backgrounds work together with patients, families, carers and communities to deliver the highest quality of care across settings« (World Health Organisation, WHO 2010: 13). In every healthcare system, integrated health and social care services must align the different professions that collaborate to support patients having complex healthcare needs (Barr et al. 2024a: 978). The WHO states that pre-registration students must be »collaborative-practice ready« at the point of registration and remain so throughout their careers (WHO 2010: 35).

The benefits of effective ICP are multifaceted. For the patient, there is an improved coordination of care and safety, reduced mortality rates and adverse consequences, as well as increased satisfaction with overall care. For health and social care providers, ICP helps improve service delivery costs through shortening or preventing hospital stays, minimising duplication and increasing productivity (Frenk et al. 2022: 1544). For staff, ICP can help enhance job satisfaction (McLaney et al. 2022: 112; Wei et al., 2022: 735; Bogossian et al. 2023: 244).

## 2. The role of interprofessional education

Historical learning saw pre-registration students socialised into uni-professional ways of viewing and interacting with the world, including maintaining the status quo in terms of interprofessional hierarchical relationships, and a lack of skills in communicating or collaborating interprofessionally (Owens 2015: 18). To become »collaborative-practice ready« (WHO 2010: 13), our future healthcare practitioners therefore need to be equipped with the knowledge, skills and behaviours for

this. Organisations such as the Canadian Interprofessional Health Collaborative (CIHC) (CIHC 2024: 5) and the Interprofessional Education Collaborative (IPEC) (IPEC 2023: 15) have set about identifying the core competencies that define the attributes required. Despite increased recognition for addressing today's care delivery requirements, moving away from siloed profession-specific training remains a challenge. Interprofessional education (IPE), therefore, is needed to ensure practitioners can adapt and adjust their team endeavours to address local needs, solve complex problems and mobilise resources as needed (Barr et al. 2024 b: 992). The globally recognised definition of IPE is that »interprofessional education occurs when two or more professions learn with, from and about each other to improve collaboration and quality of care« (CAIPE 2006), with its provision now widespread, and a recent global situational analysis identifying IPE provision in Africa, Asia, Australasia, Europe and the pan-American region(Khalili et al. 2024: 389).

IPE initiatives may be found in different settings, with students moving from classroom-based activity to simulation-based learning experiences and interprofessional placements in practice. In this way, early theory, an understanding of team working and the interplay with different professions can be applied to the realities of practice.

The need to develop and continue developing skills in collaborative working should continue post registration. Similarly to pre-registration students, IPE can take place in different settings. By continuing to learn »with, from and about each other« (CAIPE 2006), practitioners continue to develop professionally and ensure they remain effective ICP practitioners who have a positive impact on care and service delivery. This continuum of the learning approach to IPE allows learners to integrate theory and practice-based learning, and thus prepares health and social care practitioners for safe and effective collaborative practice (Barr et al. 2017: 7).

## 3. Barriers linked to interprofessional education

Despite increased recognition and spread, there remain barriers associated with fully integrating IPE into health and social care curricula and professionals‹ lifelong learning. At an institutional level, these can be affected by a lack of support influencing how, or even if, IPE is prioritised as well as the time, funding and resources, including staff, that are made available. In addition, high student numbers, timetabling barriers, rigid curricula and the quality of IPE facilitator training can also have an impact (Lawlis et al. 2014: 307; Reeves et al. 2016: 659; Lindqvist et al. 2018: 194; Beckinsale et al. 2023: 637f.; Khalili et al. 2024: 390). Furthermore, planning and delivery of IPE is complex and, as such, far more resource-intensive, lasting up to three times longer than standard course development (El-Alwaisi et al. 2021: 760).

In addition to institutional barriers, there are also individual barriers. For example, many faculty staff will not have been exposed to IPE themselves during their own pre-registration training, which can affect attitudes, levels of knowledge, values, understanding and skill level. A lack of rewards associated with IPE, recognition of the high staff workload and professional conflicts can also create additional competing demands (Lawlis et al. 2014: 307; Lindqvist et al. 2018: 194; Khalili et al. 2024: 390; Hall/Zierler 2015: 3).

To help address these barriers, it is important to capitalise on the existing momentum addressing the recognised need for IPE. To do this, we need to develop our faculty – especially those who will be actively involved in taking this work forward. In the following sections we explain what we mean by faculty development, why it is needed, and consider how it can best be achieved.

## 4. Faculty Development

### 4.1 What is faculty development and why is it needed?

Faculty development (FD) can be defined as the provision of ongoing training and support for all staff involved in the development of IPE curricula and delivery of IPE interventions (CAIPE 2025). This training should provide the tools needed to develop IPE curricula and successfully teach, facilitate and role model behaviours within interprofessional teams and to students (Babin et al. 2023: 2; Bogossian et al. 2023: 272). For those in leading roles, this training means immersion into how to build an effective curriculum in which IPE is an integrated component, and for those required to facilitate, it demands an appreciation of the chosen pedagogical approaches and an ability to support or facilitate learning together. Hence, FD opportunities should be broader than the facilitation of IPE alone and also enable faculty to make contributions to IPE development, leadership and organisational change (Grymonpre 2016: 516). Additionally, programmes should be ongoing and responsive to local context and feedback in relation to evaluation (Ratka et al. 2017: 8; Anderson et al. 2025: 336f.). As such, to be successful, faculty engaged in IPE needs to move beyond single professional approaches to learning and be equipped with the necessary knowledge, skills, attributes, attitudes and behaviours (El-Awaisi et al. 2021: 761; Bogossian et al. 2023: 244).

### 4.2 What makes faculty development effective?

Effective IPE requires careful planning, both operationally and strategically. To ensure these both take place, it is important to identify a person within the faculty who

is considered a *champion* of IPE. This champion should be additional to those persons tasked with leading on its delivery (Anderson et al. 2025: 334). Table 1 below provides a definition of the different roles and responsibilities of those involved in FD.

*Table 1: Definitions of different roles involved in the development and delivery of IPE*

| Title | Definition |
|---|---|
| IPE champion | »*The leader and ambassador for both the strategic and operational aspects of the curriculum with management and research responsibilities*« (Anderson et al. 2025: 4). |
| IPE lead | »*Individuals with in-depth understanding about their profession-specific curriculum, to work collaboratively with the champion*« (ebd.: 4). |
| IPE facilitator | »*An educator who adopts an education approach of listening and eliciting student understanding in which students and educators share the responsibility for learning*« (CAIPE 2025). |

FD, therefore, needs to be designed with these roles in mind to ensure role holders are adequately prepared and supported. For the purpose of this chapter, we will focus on FD linked to the IPE facilitator. All those who support learning in the teaching moment are referred to as *facilitators* because they help the students find meaning through discursive pedagogy. Facilitators are, in the main, trained, experienced educators, but trained students or patients can also step up to assume a supportive facilitation role within IPE.

## 5. IPE Facilitators

Being an IPE facilitator is an active role that supports and facilitates the learning process *in action* through critical reflection, debate and discussion (Anderson et al. 2025: 330). Facilitation of interprofessional *learning* (IPL) is an essential element of IPE as it enables learners to understand and develop the knowledge, skills, attributes, attitudes, and behaviours underpinning collaborative practice, whilst maintaining their own professional identity (Ruiz et al. 2013: 489). However, facilitators report that this role can be challenging as they are required to adjust their usual teaching approaches as they promote learning across many professions (ebd.: 489). Hence, some feel they lack specific skills linked to the facilitation of interprofessional activities, which can lead to anxiety (Beckinsale et al. 2023: 641). As we recognise that these interactions between different professional groups are essential for the success of IPE (Freeman et al. 2010: 380), this is where much of

the focus of FD lies. Thus, the ultimate success of IPE is dependent on the quality of facilitation (Hammick et al. 2007: 743; Bluteau/Jackson 2009: 664; Reeves et al. 2016: 665; El-Awaisi/Waller 2024: 5). The key elements of FD for IPE facilitators are discussed later in this chapter. IPE facilitators are often the staff who develop and deliver IPE interventions and promote IPE in the academic and/or practice environment, but they can also be patients, carers and students.

## 5.1 Patients and carer involvement

The importance of the patient and carer voice has long been recognised in the planning and delivery of pre-registration healthcare programmes to the extent that they are now considered partners alongside faculty staff (Health Council of Canada 2006: 13; WHO 2016: 4ff.; Health Care Professions Council 2017: 20). The patient voice is vital for helping students understand how to improve their practice through better practitioner-patient relationships, improved systems and ensuring partnership working (Towle et al. 2010: 69f.; Boshra et al. 2022: 47).

Patients and carers can also play a valuable role in facilitating IPE as they know what it means to be supported by different professions and how teams manage their care (Cooper/Spencer-Dawe 2006: 612). However, there are few publishes examples that have involved patients in IPE design and delivery (Winn/Lindqvist 2019: 185; Anderson et al. 2025: 9). Nevertheless, we strongly advocate that they are included as part of the IPE curriculum design and delivery. Patient involvement means developing and co-creating IPE together and this may take time and extra funding in addition to that needed to pay for their contribution. Table 2 below identifies the key points we believe are important to relay when including patients and carers in FD for IPE.

*Table 2: Key points to include when training patients and carers as facilitators of IPE*

| |
|---|
| - Expectations and courses differ across professions, which can lead to IPE groups of students not always agreeing. |
| - Interprofessional groups of students may struggle to form learning teams as quickly as uni-professional groups because they may be wary of each other and not know one another. |
| - Students learn as much from positive examples when teams work, as from negative experiences. |
| - If a story is shared with students where someone from a particular profession did not meet expectations, be mindful of how this is communicated to the interprofessional community of learners so that whatever happened can be discussed for all to benefit and without a sense of blame. |

Patients will require support before, during and after any IPE teaching, and time should be set aside for this (Winn/Lindqvist 2019: 186). It is vital that patients are not used in a uni-professional way, but that the patient voice helps unpack how the different professions should work together (Anderson et al. 2025: 8). For learning to remain safe and productive, it is important to involve trained IPE facilitators.

## 5.2 Students as IPE facilitators

Peer teaching and learning, whereby students actively take on teaching and facilitation roles, has been acknowledged as a method to support resource provision and student learning within health profession education (Zhang et al. 2022: 1; Avonts et al. 2023: 2). Peer teaching and learning has been reported by students to increase content-specific and pedagogical knowledge as well as generic skills such as improved communication, leadership and teamwork (Zhang et al. 2022: 1f.; Tanveer et al. 2023: 727). Peer teaching and its impact on learning seems to be supported by the theory of social constructivism, whereby learners build on existing knowledge to develop new knowledge and understanding through social interactions with other students (Zhang et al. 2022: 19).

Students have also been successfully used for IPE facilitation (Baker et al. 2018: 477; van Diggele et al. 2022: 2; He et al. 2024: 10) and report the benefits of undertaking the role in relation to academic and personal growth, as well as the development of skills that would be useful for professional practice (Baker et al. 2018: 476f.). We believe that involving students as IPL facilitators can also help their development of knowledge, skills, attributes, attitudes and behaviour, and thus help bridge the gap into practice as they become practitioners and facilitate IPL and IPE in clinical practice with colleagues and students as they care for patients.

## 5.3 The Key Elements of Training IPE Facilitators

All IPE facilitators need to complete training and be provided with guidance and support. The overarching aim of this is to guide them to be able to provide an optimal learning environment to support IPL in groups (Freeman et al. 2010: 376). As we highlighted earlier, facilitators may not have been exposed to IPE during their own pre-registration training and, as such, we believe that developing the knowledge, skills, attitudes and behaviours required to facilitate IPE cannot be achieved quickly. IPE facilitation is not about teaching others, but about enabling them to learn »with, from and about each other« (CAIPE 2006). It is also about ensuring a shared way of thinking, rather than simply of *doing* from one specific professional stance (Anderson et al. 2025: 2). For many, these may be new concepts and, therefore, will need time to develop. Consequently, facilitator training is best delivered over a series of interactive workshops, rather than as a one-off activity, with opportunities

to be mentored by a more experienced facilitator, thereby enabling the facilitators to develop and practice new knowledge, skills and attributes over time (Freemen et al. 2010: 378).

In Table 3 below, we have identified the key requirements of an IPE facilitator that should be considered in any IPE facilitator training (Sargeant et al. 2010: 129; Ruiz et al. 2013: 494; LeGros et al. 2015: 598; Grymonpre 2016: 516f.; Ratka et al. 2017: 3ff.; Baker et al. 2018: 475; Chitsulo et al. 2021: 30f.; Babin et al. 2023: 9), with the content of training adjusted to consider the needs and requirements in relation to the approach used and facilitation needed.

*Table 3: Knowledge, skills, attributes, attitudes and behaviours required in IPE facilitators*

| **Knowledge** | **Skills** |
|---|---|
| Theoretical underpinnings of IPE and ICP:<br>- Theory, policy, drivers and research<br>- Competency and capability frameworks/learning outcomes<br><br>Key elements of IPE and ICP:<br>- Roles and responsibilities of each profession, including hierarchical structures and stereotyping that may exist between them<br>- Team working and communication, including terminology used<br>- Barriers and facilitators, including conflict management<br><br>Teaching/facilitating strategies:<br>- Meaning of psychological safely<br>- Meaning of *teachable moments*<br>- IPE assessment strategies<br>- IPE evaluation methods/tools | Key skills relating to IPE:<br>-Encourage students to learn with, from and about each other<br>-Demonstrate good interprofessional communication and feedback<br>-Facilitate mixed professional groups<br>-Support students who solely revert to profession-specific stances to critically reflect from an interprofessional perspective<br>-Brief and debrief interprofessionally<br>-Provide effective feedback<br>-Promote interaction and inclusion across all in the classroom<br><br>Generic teaching/facilitating strategies:<br>- Encourage effective student engagement<br>- Deal with different levels and types of student engagement<br>- Recognise and respond to teachable moments<br>- Balance the needs of individuals as well as the group/team |
| **Attributes/attitudes** | **Behaviours** |
| - Belief in self and role as IPE facilitator<br>- A good sense of humour<br>- Confidence to work collaboratively and in the application of IPE<br>- A non-judgemental outlook<br>- Credibility and integrity<br>- Commitment<br>- Hold values required to embrace diversity and acknowledge the unique contributions of individuals and professions<br>- Identify as a facilitator of IPL | Key behaviours relating to IPE:<br>- Act as a role model with students and staff<br>- Remain professionally neutral<br>- Promote collaboration and teamwork<br>- Demonstrate enthusiasm and commitment<br>- Serve as ambassador at classroom and organisation level<br><br>Generic teaching/facilitating strategies:<br>- Focus on learning rather than on teaching<br>- Demonstrate diplomacy/trust/respect towards others<br>- Address and resolve difficult situations, act flexibly<br>- Suggest ways to reach consensus and deal with conflict |

Whilst there are core elements of training that IPE facilitators need, different types of IPE activity may require additional, or sometimes different, knowledge skills and behaviours. One such example is Sim-IPE (simulation-based education

[SBE] and IPE), which uses a blend of two pedagogies. SBE is now well-established in both medical and nursing education and beyond, and as such lends itself well to IPE. Benefits include opportunities to practice new skills using real-life scenarios in a controlled environment, enabling repetition of practice. It requires students to interact and is known to help enhance communication and critical thinking skills as well as patient safety (WHO 2013: 23; Ozkara San 2015: 238; Nelson 2016: 20; Lavoie/Clarke 2017; Copley 2024: 534), which are similar to the key benefits of IPE (Anderson et al. 2011: 15; Anderson et al. 2025: 8). The definition of Sim-IPE is that it occurs when »participants and facilitators from two or more professions are engaged in a simulated healthcare experience to achieve shared objectives and outcomes« (Decker et al. 2015: 294). Consequently, it shares elements of best practice of both SBE and IPE. However, facilitators of Sim-IPE will need to be equipped with the skills associated with both SBE and IPE. For example, whereas debriefing is considered an essential element of both SBE and Sim-IPE, IPE facilitators need to ensure that the focus is on the interprofessional interactions and working, rather than the clinical skills themselves (Decker et al. 2015: 295; Nagraj et al. 2018: 504; Webb et al., 2018: 451).

Regardless of the pedagogical approach, Grymonpre (2016: 517) proposed developing a theoretical framework and suggested using a modified Kirkpatrick's educational outcomes to guide FD outcomes. Table 4 presents an adapted version of Kirkpatrick's model considering IPL and FD outcomes to support the appropriate training of IPL facilitators (Hammick et al. 2007: 737; Grymonpre 2016: 517).

*Table 4: Desired outcomes linked to IPL and FD*

| **Level** | **IPL outcome** | **FD outcome** |
|---|---|---|
| Level 1: Reaction | Improved views on the experience and its interprofessional nature | Improved views of the FD programme |
| Level 2a: Modification of perceptions & attitudes | Positive changes in reciprocal attitudes or perceptions between participant groups<br>Enhanced changes in perception or attitude towards the value and/or use of team approaches to caring for a specific client group | Enhanced perception of IPE and commitment to the need for IPE in education and willingness to support its delivery |

| | | |
|---|---|---|
| Level 2b: Acquisition of knowledge & skills | New knowledge and skills linked to interprofessional collaboration | New knowledge in relation to IPE and its impact on IPC<br>Further knowledge about IPC competencies and theories<br>New skills that enable effective facilitation of IPL |
| Level 3: Behavioural change | Understanding how IPL can be transferred to the practice setting and how changes can be made to professional and interprofessional practice | Understanding how the role can shape the learning environment and transfer it into practice<br>Confidence in the ability to facilitate IPL |
| Level 4a: Change in organisational practice | Changed and improved practice within the organisation, be it as role models of IPE or changing practice | Learner acts as an ambassador for IPE and actively contributes to IPE delivery and programme development, not only during the actual intervention but in their everyday life, thus positively changing the organisational culture |
| Level 4b: Benefits to patients/clients | Improved interprofessional practice that positively impacts the health and/or well-being of patients and/or staff | Learners achieve the intended learning outcomes, whether in the university or practice setting |

## 6. Concluding Remarks

Overall, the important overarching principles for any FD – particularly those linked to the training of facilitators involved in IPE – include:

- The involvement of relevant stakeholders
- Appropriate tailoring to its audience
- Considering how to incorporate mentoring/pairing experience with less experienced facilitators during deployment of the facilitators
- Ensuring positive role modelling
- Evaluating the effectiveness of facilitation so that it continues to evolve and improve
- Emphasising the importance of always being mindful of sustainability and how this is always going to be work *in progress*

The authors of this chapter are all members of the United Kingdom (UK) Centre for the Advancement of Interprofessional Education (CAIPE). CAIPE is a small charity

with many passionate members who care about IPE and the training and deployment of facilitators who master and guide interprofessional education. Although we may never quite master this, what we can do is to practice what we preach and collaborate across borders to help learn lessons and share experiences. To conclude this piece, we share three case studies that have some commonalities and also some helpful differences.

Much of this chapter has originated from individual experiences but, importantly, also from the current leads of one of CAIPE's Strategic Priority Groups that centres around FD: Sharron Blumenthal and Melissa Owens. One of the CAIPE Chairs, Elizabeth Anderson, and also Patricia Bluteau and Susanne Lindqvist have contributed a wealth of experience in this area, each providing a case study. Elizabeth is President of CAIPE and Susanne CAIPE Chair.Readers are welcome to contact CAIPE for further support and, likewise, we appreciate learning from others. In this vein, we can jointly celebrate the accomplishments of the project and not only achieve, but exceed our goals around IPE and its reach into practice and the people we care for.

*Table 5: Case study: University of Leicester*

| |
|---|
| When the interprofessional curriculum was being developed in 2000, CAIPE, aware of the lack of understanding across all faculty of what IPE aimed to achieve, was invited to facilitate a deeper appreciation of IPE and its associated andragogy. Led by external expert facilitators, away days were held in a venue separate from the university to develop an appreciation of IPE and to cement collaboration between educators from different schools. These sessions formed long-standing positive working relationships essential for agreement on the local IPE curriculum. As educators were assigned to IPL, concerns about teaching students of another profession were identified. These concerns spanned the science-to-social-science professional programmes and the educators‹ fears were real. This was not a surprise, as in a nurse-led innovation for medical students we had discovered a lack of confidence in nurses teaching medical students, which was addressed through training (Anderson et al. 2004: 140). It was clear that everyone needed a deeper appreciation of IPE.<br>A master's-level module on IPE was designed within our local healthcare educator diploma-master's programme, accessible to anyone as a stand-alone module, to offer a deeper appreciation of IPE for all staff. All new health and social care educators take the master's course. Here, learners reflect on i) local and national policy, ii) professional body requirements, iii) common areas in the curriculum where uni-professional content could be made interprofessional, iv) learning outcomes for IPE, v) andragogy, including theories for discursive learning, vi) small group management of diverse groups, including facilitation skills, vii) alignment of IPE with the main curriculum (sign-posting), viii) assessment of IPE, and ix) evaluation and scholarly research in the field (Anderson et al. 2009: 84). In addition, we conduct pre- post-IPE event briefings (before event), post-IPE debriefings (after event) and offer faculty guides for all IPE. Our patients and carers take part in a two-hour workshop in which they are told about the differences between uni-professional learning and IPL. |

*Table 6: Case study: University of East Anglia (UEA)*

Since 2002, IPE at the University of East Anglia in the UK has been developed and delivered with the support of their Centre for Interprofessional Practice (CIPP). When we started out, students engaged in learning within interprofessional groups of five to eight students and engaged in *case-based learning* (Lindqvist et al. 2005: 511; Wright/Lindqvist 2008: 483). We were clear that the groups needed support from IPL facilitators and soon discovered the distinctiveness of the IPL facilitator vs. facilitation of uni-professional groups (Lindqvist/Reeves 2007: 405). Student learners engaged with IPL in their mixed-professional groups over several weeks. They met with facilitators in one week and then continued on their own in the other, which worked well as students also need time to develop group dynamics on their own. Facilitators were all academic staff, and many had clinical experience. They all had to complete the training, which was delivered over 12 hours across one month. We developed a comprehensive training package together with our facilitators, and defined the role and skills needed to facilitate IPL (Freeman et al. 2010: 378). Looking back, the most challenging obstacles during these early years included: i) asking the facilitators to be professionally neutral, which many struggled with as they wanted to share their experience and expertise; and ii) the fact that that they needed training, as they were used to working as part of multidisciplinary teams.

Over time, as IPL opportunities evolved, we needed to consider sustainability and resources. To address this and capitalise on students‹ enthusiasm to become more involved, we piloted the involvement of students as facilitators. This resulted in us updating the role and skills of the facilitator (Baker et al. 2018: 475). Student facilitators had all completed the first level of IPL (IPL1), and we always aimed for half of the facilitators to be staff and the other half students. In 2015/16, in response to feedback from facilitators and management, the training was shortened to six hours and delivered in one day. Today, IPL1 facilitators receive one two-hour training session, which is offered synchronously online a few times, and is recorded. Facilitators also attend a brief before and a debrief after they have facilitated. They all receive a certificate.

Compared to where we started off, the IPL facilitator has less opportunity to support students, simply because the group does not have enough time to go through the different stages of group development (Tuckman 1965). They are unlikely to experience disagreement, truly get to know each other, and thus learn about teamwork, in this case interprofessional teamwork. Saying that, IPL1 still offers an important role in introducing the concept of IPE at an early stage, and many students in their second year have asked to facilitate IPL1. This is very positive since, regardless of what IPL they will engage with during their course, they will graduate, and later supervise other students in clinical practice. If we can encourage future clinicians – where possible – to engage students from their own profession in meaningful learning activities that also include students from other professions, appreciating the challenges and opportunities with interprofessional collaborative practice, then this is a very positive step forward.

*Table 7: Case study: University of Coventry*

In 2002, Coventry University joined a group of UK universities in addressing a national concern which considered that pre-registration health professional education required modernisation. We quickly decided that we needed to include other professional groups outside of our existing allied health professions (AHP) student cohorts, and moved to include nursing and midwifery students. However, we also extended to collaborate with the Warwick Medical School at the University of Warwick for the development of authentic, small, face-to-face group IPL delivered at scale (Bluteau/Jackson 2005). The engagement of two universities that were close in physical proximity but cultural worlds apart was not without its challenges.

The period from 2002–2005 led to joint regulatory approval in 2005 to embed interprofessional education into the curricula of all Coventry courses, including physiotherapy, occupational therapy, all fields of nursing and midwifery, operating department practice, social work, youth work, dietetics, paramedic science and medicine (with agreement from Warwick Medical School). The decision was made to present a fully online model – a decision based primarily on organising and logistically managing 1,200 students and 60 facilitators. It was decided at a senior level that the initial model should be created online to enable all students and facilitators to participate – termed the interprofessional learning pathway (IPLP) (Jackson/Bluteau 2007; Bluteau/Jackson 2009). Whereas facilitators had been trained to deliver face-to-face activities, facilitation online required new specific training which emphasised the importance of both online facilitation and interprofessional engagement (Bluteau/Jackson 2010).

By 2008, we had moved on and created new case studies, but with the focus on the wider experiences of the whole family. These case studies were developed into a cartoon strip called *The Street* (Bluteau et al. 2014). Facilitation was becoming an important part of staff development, and whereas we now had a group of very experienced facilitators, the ongoing training of new academics was an important feature of our continued development. We also developed a team of enthusiastic final year student facilitators who were supported by the academic mentors to engage with first- and second-year student groups. Moving forward to 2013, a review of the 2008 curriculum led to a new model of delivery. A blended model enabled both face-to face and online activity to be embedded into discrete modules. A new Collaborative Capability Framework was developed, drawing on a selection of relevant frameworks (Walsh et al. 2005; CIHC 2010; Brewer/Jones 2013). The 2013 curriculum introduced HOLLIE – a virtual patient we crafted, which enabled students to collaborate online to care for her and keep her alive (Adefila et al. 2018: 50). The number of students engaging in modules at the same time was high, and the organisation of finding enough trained facilitators and enough rooms of the right size was challenging. By 2019, a new iteration allowed new opportunities which for the first time allowed Sim-IPE. We still maintained interprofessional modules but split the delivery to enable students to be spread across the year, with the same modules being offered at different points throughout the year, increasing the number of facilitators needed as required.

Cultivating the interprofessional curriculum at Coventry has enabled students to grow and thrive, developing confidence in practice settings when working with other students from the range of professions that support differing patient groups in different areas. IPE leads and the team of facilitators within higher education are essential for developing, delivering and evaluating learning, alongside being responsive to the multiple logistic issues that emerge from a large-scale learning activity. Equally, their passion is key in the defence of keeping IPE at the heart of the curriculum changes (Bluteau/Jackson 2010).

## References

Adefila, Arinola/Opie, Joanne/Ball, Steven/Bluteau, Patricia (2018). Students‹ engagement and learning experiences using virtual patient simulation in a computer supported collaborative learning environment. In: Innovations in Education and Teaching International, 57 (1), pp. 50–61. DOI: 10.1080/14703297.2018.1541188

Anderson, Elizabeth/Lennox, Angela/Petersen, Stuart (2004). New opportunities for nurses in medical education: facilitating valuable community learning experiences. In: Nurse Education in Practice, 4 (2), pp. 135–142. DOI: 10.1016/S1471-5953(03)00036-2

Anderson, Elizabeth/Cox, Dan/Thorpe, Lucy (2009). Preparation of educators involved in interprofessional education. In: Journal of Interprofessional Care, 23 (1), pp. 81–94. DOI: 10.1080/13561820802565106

Anderson, Elizabeth/Ford, Jenny/Thorpe, Lucy (2019). Perspectives on patients and carers in leading teaching roles in interprofessional education. In: Journal of Interprofessional Care, 33 (2), pp. 216–225. DOI: 10.1080/13561820.2018.1531834

Anderson, Elizabeth/Thorpe, Lucy/Hammick, Marilyn (2011). Interprofessional staff development: Changing attitudes and winning hearts and minds. In: Journal of Interprofessional Care 25 (1), pp 11–17. DOI: 10.3109/13561821003721311

Anderson, Elizabeth/Bennett-Weston, Amber/Ford, Jenny (2025). Where is the voice of lived experience in interprofessional care? A scoping review. In: Journal of Interprofessional Care 24 (1), pp. 13. DOI: 10.1080/13561820.2025.2452977

Anderson, Elizabeth/Lindqvist, Susanne (2025) Faculty Development in the Health Professions: A Focus on Research and Practice. Singapore: Springer

Avonts, Marjke/Bombeke, Katrien/Michels, Nele R./Vanderveken, Oliver/De Winter, Benedict (2023). How can peer teaching influence the development of medical students? A descriptive, longitudinal interview study. In: BMC Medical Education, 23 (1), p 861. DOI: 10.1186/s12909-023-04801-4

Babin, Cheryl/Salem, Yasser/Quiben, Myla/Davis, Beth (2023). Interprofessional education (IPE) faculty development – a scoping review. In: Health, Interprofessional Practice and Education, 5 (2), pp. 1–26. DOI: 10.61406/hipe.269

Baker, Becky/Drane, Coral/Chambers, Joshua/Lindqvist, Susanne (2018). Training students as interprofessional learning facilitators: An exploratory study highlighting the need to build confidence. In: Journal of Interprofessional Care, 32 (4), pp. 473–480. DOI: 10.1080/13561820.2018.1442323

Barr, Hugh/Anderson, Elizabeth/Hutchings, Maggie (2024). Understanding integrated care. In: Journal of Interprofessional Care, 38 (6), pp. 974–984 DOI: 10.1080/13561820.2024.2405550

Barr, Hugh/Anderson, Elizabeth/Hutchings, Maggie (2024). Interprofessional learning to integrate care: Organic strategic and systemic responses for

change. In: Journal of Interprofessional Care, 38 (6), pp. 985–996 DOI: 10.1080/13561820.2024.2405556

Barr, Hugh/Ford, Jenny/Gray, Richard/Helme, Marion/Hutchings, Maggie/Low, Helena/Machin, Alison/Reeves, Scott (2017). CAIPE Interprofessional Education Guidelines. Online: https://www.caipe.org/resources/publications/caipe-publications/caipe-2017-interprofessional-education-guidelines-barr-h-ford-j-gray-r-helme-m-hutchings-m-low-h-machin-reeves-s

Beckingsale, Louise/Brown, Melanie/McKinlay, Eileen/OLeary, Marissa/Doolan-Noble, Fiona (2023). Sustainable interprofessional education programmes: What influences teachers to stay involved? In: Journal of Interprofessional Care, 37 (4), pp. 637–646. DOI: 10.1080/13561820.2022.2115470

Bluteau, Patricia/Jackson, Ann (2005). Recycling established patterns of working: A method for implementing interprofessional learning. In: CAIPE Bulletin, Spring.

Bluteau, Patricia/Jackson, Ann (2009). An e learning model of interprofessional education. In Bluteau, Patricia/Jackson, Ann (Eds.). Interprofessional Education: Making it Happen. London: Palgrave.

Bluteau, Patricia/Jackson, Ann (2010). Developing an interprofessional e-learning pathway: Leading academics through the change challenge. In: Bromage, Adrian/Clouder, Lynn/Thistlethwaite, Jill/Gordon, Frances (Eds.). Interprofessional E-Learning and Collaborative Work: Practices and Technologies. UK: IGI Global.

Bluteau, Patricia/Jackson, Ann/Clouder, Deanne/Davies, Bernie (2014). Lessons in implementing IPE. In: Barr, Hugh/Helme, Marion/D'Avray, Linda (Eds.). Review of Interprofessional Education in the UK 1997–2003. London: CAIPE.

Boshra, Mina/Lee, Alex/Kim, Isaac J./Malek-Adamian, Elise/Yau, Man Ting/LaDonna, Kori. (2022). When patients teach students empathy: A systematic review of interventions for promoting medical student empathy. In: Canadian Medical Education Journal, 13 (6), pp.46-56. DOI: 10.36834/cmej.73058

Bogossian, Fiona/New, Karen/George, Kendall/Barr, Nigel/Dodd, Natalie/Hamilton, Anita/Nash, Gregory/Masters, Nicole/Pelly, Fiona/Reid, Carol/Shakhovskoy, Rebekah/Taylor, Jane (2023). The implementation of interprofessional education: A scoping review. In: Advanced Health Sciences Education and Theory Practice, 28 (1), 243–277. DOI: 10.1007/s10459-022-10128-4

Brewer, Margo/Jones, Sue (2013). An interprofessional practice capability framework focusing on safe, high-quality, client-centred health service. Journal of Allied Health, 42 (2), pp. 45–49. PMID: 23752243

CIHC (Canadian Interprofessional Health Collaborative) 2024, Competency Framework for Advancing Collaboration. Online: https://cihc-cpis.com/wp-content/uploads/2024/06/CIHC-Competency-Framework.pdf

CAIPE (Centre for the Advancement of Interprofessional Education) (2006). Statement on the Definition and Principles of Interprofessional Education (reissued). In: Bulletin no. 26, Autumn.

CAIPE (Centre for Advancement of Interprofessional Education) (2025). Quality standards for the design, management, and delivery of pre-registration interprofessional education in the United Kingdom. Manuscript in preparation.

Chitsulo, Caroline/Chirwa, Ellen M./Wilson, Lynda (2021). Faculty knowledge and skills needs in interprofessional education among faculty at the College of Medicine and Kamuzu College of Nursing, University of Malawi. In: Malawi Medical Journal, 33 (Postgraduate supplementary iss.), pp. 30–34. DOI: 10.4314/mmj.v33iS. 6

Coles, Colin R/Grant, Janet G. (1985). Curriculum evaluation in medical and healthcare education. In: Medical Education,19 (5), pp. 405–422.

Cooper, Helen/Spencer-Dawe, Eileen (2006). Involving service users in interprofessional education narrowing the gap between theory and practice. In: Journal of Interprofessional Care, 20 (6), pp. 603–617. DOI: 10.1080/13561820601029767

Copley, Jodie/Martin, Romany/Dix, Clare/Forbes, Roma/Hill, Anne/Mandrusiak, Allison/Penman, Adriana/Patterson, Freyr/Davies, Sarah/Jauncey-Cooke, Jacqueline/Mahendran, Niruthikha/Hooper, Kelly/Collins, Cheryl (2024). Fostering collaborative practice through interprofessional simulation for occupational therapy, physiotherapy, dietetics, and nursing students. In: Journal of Interprofessional Care, 38 (3), pp. 534–543. DOI: 10.1080/13561820.2024.2303499?needAccess=true

Decker, Sharon I./Anderson, Mindi/Boese, Teri/Epps, Chad/McCarthy, Jennifer/Motola, Ivette/Palaganas, Janice/Perry, Carolyn/Puga, Frank/Scolaro, Kelly (2015). Standards of best practice: Simulation standard VIII: Simulation-enhanced interprofessional education (Sim-IPE). In: Clinical Simulation in Nursing, 11 (6), pp. 293–297. DOI: 10.1016/j.ecns.2015.03.010

El-Awaisi, Alla/Sheikh, Ali/Abu, Nada/Rainkie, Daniel/Awaisu, Ahmed (2021). Insights from healthcare academics on facilitating interprofessional education activities. In: Journal for Interprofessional Care, 35 (5), pp. 760–770. DOI: 10.1080/13561820.2020.1811212

El-Awaisi, Alla/Waller, Susan (2024). Developing a novel health IPECP curriculum: Strategies and implementation. In: Alnaami, Mohammed Y./Alqahtani, Dalal A./Alfaris, Eiad A./Abdulghani, Hamza M./Mohammed, Ciraj A. (Eds.). Novel Health Interprofessional Education and Collaborative Practice Program. Singapore: Springer.

Frenk, Julio/Chen, Lincoln C./Chandran, Latha/Groff, Elizabeth/King, Roderick/Meleis, Afaf/Fineberg, Harvey V. (2022). Challenges and opportunities for educating health professionals after the COVID-19 pandemic. In: Lancet, 400 (10362), pp.1539-1556. DOI: 10.1016/S0140-6736(22)02092-X

Freeman Sarah/Wright, Anna/Lindqvist, Susanne (2010). Facilitator training for educators involved in interprofessional learning. In: Journal of Interprofessional Care, 24 (4), pp. 375–385.

Grymonpre, Ruby (2016). Faculty development in interprofessional education (IPE): Reflections from an IPE coordinator. In: Journal of Taibah University Medical Sciences, 11 (6), pp. 510–519.

Hall, Leslie W./Zierler, Brenda (2015). Interprofessional education and practice guide No. 1: Developing faculty to effectively facilitate interprofessional education. In: Journal of Interprofessional Care, 29(1), pp. 3–7. DOI: 10.3109/13561820.2014.937483

Hammick, Marilyn/Freeth, Della/Koppel, Ivan/Reeves, Scott/Barr, Hugh (2007). A best evidence systematic review of interprofessional education: BEME Guide no. 9. In: Medical Teacher, 29 (8), pp. 735–51. DOI: 10.1080/01421590701682576

He, Qing/Lei, Junru/Chong, Doris/Luk, Pauline/Chan, Enoch/Shen, Xiaoai/Tipoe, George L./Chan, Linda/Manio, Michael M./Dizon, John/Ganotice, Fraide (2024). Unpacking the perceptions and experiences of student facilitators in interprofessional education: A qualitative study. In: Medical Education Online, 29 (1), pp. 1–14. DOI: 10.1080/10872981.2024.2330257

Health and Care Professions Council (2017). Standards of Education and Training Guidance. HCPC: London. Online: https://www.hcpc-uk.org/globalassets/resources/guidance/standards-of-education-and-training-guidance.pdf?v=637660865510000000 Accessed 30th July 2025.

Health Council of Canada (2006). Primer on Public Involvement. Toronto: Health Council of Canada. Online: https://publications.gc.ca/site/eng/430677/publication.html Accessed 30th July 2025.

IPEC (Interprofessional Education Collaborative) (2023). IPEC Core Competencies for Interprofessional Collaborative Practice: Version 3. Online: https://www.ipecollaborative.org/assets/core-competencies/IPEC_Core_Co mpetencies_Version_3_2023.pdf Accessed 30th July 2025.

Jackson, Ann/Bluteau, Patricia (2007). At first it's like shifting sands: Setting up interprofessional learning within a secondary care setting. In: Journal of Interprofessional Care, 21 (3), pp. 351–353. DOI: 10.1080/13561820701233905

Jackson, Ann/Bluteau, Patricia (2009). A practice model of interprofessional education. In: Bluteau, Patricia/Jackson, Ann (Eds.). Interprofessional Education: Making it Happen. London: Palgrave.

Khalili, Hossein/Lackie, Kelly/Langlois, Sylvia/da Silva Souza, Camila/Wetzlmair, Lisa-Christin (2024). The status of interprofessional education (IPE) at regional and global levels – update from 2022 Global IPE Situational Analysis. In: Journal of Interprofessional Care, 38 (2), pp. 388–393. DOI: 10.1080/13561820.2023.2287023

Lavoie, Patrick/Clarke, Sean P (2017). Simulation in nursing education. In: Nursing 47 (7), pp.18-20.

Lawlis, Tanya/Anson, Judith/Greenfield, David (2014). Barriers and enablers that influence sustainable interprofessional education: A literature review. In: Journal of Interprofessional Care, 28 (4), pp.305-10. DOI: 10.3109/13561820.2014.895977

LeGros, Theresa A/Amerongen, Helen/Cooley, Janet/Schloss, Ernest (2015). Using learning theory, interprofessional facilitation competencies, and behavioral indicators to evaluate facilitator training. In: Journal of Interprofessional Care, 29 (6), pp. 596–602. DOI: 10.3109/13561820.2015.1040874

Lindqvist, Susanne/Reeves, Scott (2007). Facilitator's perception of delivering interprofessional education: A qualitative study. In: Medical Teacher, 29 (4), pp.403-405.

Lindqvist, Susanne/Duncan, Anna/Shepstone, Lee/Watts, Fiona/Pearce, Shirley (2005). Case-based learning in cross-professional groups – the development of a pre-registration interprofessional learning programme. In: Journal of Interprofessional Care, 19 (5), pp. 509–520. DOI: 10.1080/13561820500126854

Lindqvist, Susanne/Vasset, Frøjdis/Iversen, Hans Petter/Hofseth, Almås Synnøve/Willumsen, Elizabeth/Ødegård, Atle (2018). University teachers‹ views of interprofessional learning and their role in achieving outcomes – a qualitative study. In: Journal of Interprofessional Care, 33 (2), pp. 190–199. DOI: 10.1080/13561820.2018.1534809

Marion-Martins, Alexandra D./Pinho, Diana (2020). Interprofessional simulation effects for healthcare students: A systematic review and meta-analysis. In: Nurse Education Today, 94, 104568 pp. 1–7. DOI: 10.1016/j.nedt.2020.104568

McLaney, Elizabeth/Morassaei, Sara/Hughes, Leanne/Davies, Robyn/Campbell, Mikki/Di Prospero, Lisa (2022). A framework for interprofessional team collaboration in a hospital setting: Advancing team competencies and behaviours. In: Healthcare Management Forum, 35 (2), pp. 112–117. DOI: 10.1177/08404704211063584

Nagraj, Shobana/Harrison, Julie/Hill, Lawrence/Bowker, Lesley/Lindqvist, Susanne (2018). Promoting collaboration in emergency medicine. In: The Clinical Teacher, 15, pp. 500–506.

Nelson, Roxanne (2016). Replicating real life: Simulation in nursing education and practice. In: American Journal of Nursing May, 116 (5), pp. 20–21.

Owens, Melissa (2015). An exploration of collaborative practices and non-formal interprofessional education by medical and nursing students in the primary care setting [Doctoral thesis, University of Huddersfield].

Ozkara San, Eda (2015). Using clinical simulation to enhance culturally competent nursing care: A review of the literature. In: Clinical Simulation in Nursing, 11 (4), pp. 228–243.

Ratka, Anna/Zorek, Joseph A./Meyer, Susan M. (2017). Overview of faculty development programs for interprofessional education. In: American Journal of Pharmacy Education, 81 (5), pp 1–10. DOI: 10.5688/ajpe81596

Reeves, Scott/Fletcher, Simon/Barr, Hugh/Birch, Ivan/Boet, Sylvain/Davies, Nigel/McFadyen, Angus/Rivera, Josette/Kitto, Simon (2016). A BEME systematic review of the effects of interprofessional education: BEME Guide no. 39. In: Medical Teacher, 38 (7), pp. 656–668. DOI: 10.3109/0142159X.2016.1173663

Ruiz, Maria/Ezer, Helene/Purden, Margaret (2013). Exploring the nature of facilitating interprofessional learning: Findings from an exploratory study. In: Journal of Interprofessional Care, 27 (6), pp. 489–495. DOI: 10.3109/13561820.2013.811640

Sargeant, Joan/Hill, Tanya/Breau, Lynn (2010). Development and testing of a scale to assess interprofessional education (IPE) facilitation skills. In: Journal of Continuing Education of Health Professions, 30 (2), pp. 26–31. DOI: 10.1002/chp.20069

Tanveer, Mohammed/Mildestvedt, Thomas/Skjærseth, Idun/Arntzen, Harlad/Kenne, Ellinor/Bonnevier, Anna/Stenfors, Terese/Kvernenes, Monika (2023). Peer teaching in undergraduate medical education: What are the learning outputs for the student-teachers? A systematic review. In: Advancement in Medical Education Practice, 11 (14), pp. 723–739. DOI: 10.2147/AMEP.S401766

Towle, Angela/Bainbridge, Lesley/Godolphin, William/Katz, Arlene/Kline, Cathy/Lown, Beth/Madularu, Ioana/Solomon, Patricia/Thistlethwaite, Jill (2010). Active patient involvement in the education of health professionals. In: Medical Education, 44 (1), pp. 64–74. DOI: 10.1111/j.1365-2923.2009.03530.x

Tuckman, Bruce W. (1965). ›Developmental sequence in small groups‹. In: *Psychological Bulletin*, 63, pp. 384–399.

van Diggele, Christine/Lane, Stuart/Roberts, Chris (2022). Student Interprofessional Facilitator Training (SIFT) program: Building capacity in clinical education leadership. In: BMC Medical Education, 22 (665), pp. 1–11. DOI: 10.1186/s12909-022-03725-9

Walsh, Claire/Gordon, M. Frances/Marshall, Michelle/Wilson, Fiona/Hunt, Tim (2005). Interprofessional capability: A developing framework for interprofessional education. In: Nurse Education in Practice, 5 (4), pp. 230–237.

Webb, Lucy/Lindqvist, Susanne/Bowker, Lesley/Leinster, Sam (2018). Clinical skills as a vehicle for interprofessional learning. In: The Clinical Teacher, 15, pp. 1–6.

Wei, Holly/Horns, Phyllis/Sears, Samuel/Huang, Kun/Smith, Christopher/Wei, Trent (2022). A systematic meta-review of systematic reviews about interprofessional collaboration: Facilitators, barriers, and outcomes. In: Journal of Interprofessional Care, 36 (5), pp. 735–749. DOI: 10.1080/13561820.2021.1973975

Winn, Sarah/Lindqvist, Susanne (2019). Purposeful involvement of experts by experience. The Clinical Teacher, 16, pp. 183–188. DOI: 10.1111/tct.13032

WHO (World Health Organisation) (2010). Framework for action on interprofessional education and collaborative practice. Online: Framework for action on interprofessional education & collaborative practice Accessed 30th July 2025.

WHO (World Health Organisation) (2013). Transforming and scaling up health professionals‹ education and training. World Health Organization Guidelines. Online: https://iris.who.int/bitstream/handle/10665/93635/9789241506502_eng.pdf Accessed 30th July 2025.

WHO (World Health Organisation) (2016). Patient engagement: Technical series on safer primary care. WHO, Geneva. Online: https://apps.who.int/iris/bitstream/handle/10665/252269/9789241511629-eng.pdf Accessed 30th July 2025.

WHO (World Health Organisation) (2022). Global Competency Framework for Universal Health Coverage. Online: https://www.who.int/publications/i/item/9789240034686 Accessed 30th July 2025.

WHO (World Health Organisation) (2024). Global competency and outcomes framework for the essential public health functions. Online: https://iris.who.int/bitstream/handle/10665/376577/9789240091214-eng.pdf Accessed 30th July 2025.

Wright, Anna/Lindqvist, Susanne (2008). The development, outline and evaluation of the second level of an interprofessional learning programme – listening to the students. In: Journal of Interprofessional Care, 22 (5), pp. 1–14.

Zhang, Hui/Liao, Ariel/Goh, Sam/Wu, Xi/Yoong, Si (2022). Effectiveness of peer teaching in health professions education: A systematic review and meta-analysis. In: Nurse Education Today, Nov:118:105499, pp. 1–25. DOI: 10.1016/j.nedt.2022.105499