Curriculum Renewal in Interprofessional Education in Health: Establishing Leadership and Capacity

Report to the Office for Learning and Teaching 2016

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More particularly, I would like to thank my colleagues who have worked as part of the management of the two fora. Their support, energy, insights and advice have been invaluable.

Roger Dunston, Project Leader

[1] The activities of Health Workforce Australia have now been transferred to the Commonwealth Department of Health.

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Abbreviations

AHPRA	Australian Health Practitioner Regulation Agency
AIPPEN	Australasian Interprofessional Education and Practice Network
ANZAHPE	Australian and New Zealand Association for Health Professional Educators
ASQA	Australian Skills Quality Authority
CRS	Curriculum Studies Renewal programme
CS&HISC	Community Services and Health Industry Skills Council
ELC	Establishing Leadership and Capacity – this particular study
HWA	Health Workforce Australia
IPE	Interprofessional Education
IP	Interprofessional Practice
LTAS	Learning and Teaching Academic Standards
NF	National Forum
NWP	National Work Plan
OLT	Office for Learning and Teaching
TESQA	Tertiary Education Quality and Standards Agency
WAF	Western Australian Forum

Executive summary

The Curriculum Renewal for Interprofessional Education in Health: 'Establishing Leadership and Capacity' (ELC) project builds from a number of Australian and global studies and reports that address a range of critical issues associated with the development of interprofessional education (IPE) and interprofessional practice (IPP) within Australia and globally[2].

Informing the focus and design of the project was the view that Australian IPE had reached a point where a whole of system approach to development was now possible and required. This was talked about in terms of Australian IPE development having reached a 'tipping point'; and Australian IPE now needing a new and scaled-up change focused methodology. There was also a sense that project based initiatives, whilst important, were unable to generate the momentum and system wide buy-in that was now seen as necessary. These views are not surprising as one of the most consistent findings from studies of IPE in Australia is that it has been local and disconnected from a broader national context.

The ELC project took these views as its point of departure. The project aimed, firstly, to test these views – did they represent a broad based consensus position; and, secondly, if they did, was it possible to identify what an Australian whole of system approach would look like? Clearly, testing and working with these ideas would require an inclusive 'national conversation'. As a way of creating such a conversation, the project held two fora in 2014 – a national forum in Sydney, New South Wales, and a state based forum in Perth, Western Australia. The fora brought together a diverse group of stakeholders engaged in various aspects of IPE and IPP, and, more broadly, from Australian health professional education. Participants – individuals and groups - represented key bodies from higher education, health service provision, the health professions, government agencies, workforce development and regulatory bodies.

To keep the work of the fora focused and based on previous Australian learning, the fora were structured in relation to the findings and recommendations identified in the Curriculum Renewal Studies (CRS) development and research programme (see below).

What emerged from the fora, and what is reported below, can be described as the design for a 'national IPE architecture'. This architecture is defined by a 'National Work Plan' (NWP). The aim of the NWP is to build an inclusive, collegial and participatory national approach to understanding, communicating, learning about and developing IPE/IPP in Australia. Most critically, the NWP is about the development of an interprofessional approach involving the widest possible participation of all groups involved with or impacted by IPE/IPP.

The NWP is structured to align with the key recommendations of the CRS. It proposes the establishment of a governance and development framework that addresses:

- National leadership
- Curriculum and standards development
- IPE capability development in all relevant faculties/schools etc.
- Research, and knowledge development, management, utilisation and dissemination
- Sustainability.

[2] These reports are cited below and, where relevant, a brief outline of their focus and findings is provided.

Background

The Curriculum Renewal for Interprofessional Education in Health: Establishing Leadership and Capacity (ELC) project was funded by the Office for Learning and Teaching (OLT) in late 2013. The project was designed to focus the attention of a diverse range of stakeholders, organisations and individuals, on the further development of interprofessional, education (IPE) and interprofessional learning (IPL) (in this report the term IPE is used as inclusive of IPL) and interprofessional practice (IPP) in Australia. Although the project focussed on pre-registration health professional education – allied health, nursing and midwifery, and medicine – the need to extend this focus to address the development of interprofessional and collaborative education across a career-wide continuum was a consistent issue raised by all stakeholder groups.

The project was designed as a transitional activity that followed a series of studies and projects focusing on IPE and IPP development in Australia. These initiatives had in part focused on the development of pre-registration curriculum in the area of health professional education in the higher education sector and, in part, focused on the way that IPP and, therefore, IPE, were increasingly being promoted in national and state health policy, in accreditation guidelines and in areas such as field placements and team based simulation. More particularly, ELC is referenced to six Australian studies addressing IPE curriculum and capacity development, four directly, and two as part of a broader study focus:

1. Learning and Teaching for Interprofessional Practice, Australia, Interprofessional Health Education in Australia, The Way Forward. Dunston et al 2009. http://www.aippen.net/docs/LTIPP_proposal_apr09.pdf
2. Interprofessional Education: a National Audit. Report to Health Workforce Australia. The Interprofessional Curriculum Renewal Consortium, Australia 2013. http://www.ipehealth.edu.au/library/content/gateway/IPE_National_Audit_Report_Australia_2013.pdf
3. Interprofessional Education for Health Professionals in Western Australia: Perspectives and Activity, Nicol, P. 2012, University of Technology, Sydney Centre for Research in Learning and Change, Sydney, NSW. http://www.ipehealth.edu.au/library/content/gateway/IPE_for_Health_Professionals_in_WA.pdf
4. Curriculum Renewal for Interprofessional Education in Health. The Interprofessional Curriculum Renewal Consortium, Australia, 2014, Canberra, Commonwealth Department of Health Australia, Office for Learning and Teaching. http://www.ipehealth.edu.au/library/content/gateway/OLT_Interprofessional_Education_in_Health_Report.pdf

The studies 2–4 are referred to as the Curriculum Renewal Studies research programme (CRS).

5. O'Keefe, M., Henderson, A. & Pitt, R. 2010, Learning and Teaching Academic Standards (LTAS) Project Health, Medicine and Veterinary Sciences Academic Standards Statement June 2011, Australian Learning and Teaching Council (ALTC), Sydney.
6. Harmonising Higher Education and Professional Quality Assurance Processes for the Assessment of Learning Outcomes in Health, (2014), Maree O'Keefe, Amanda Henderson, Brian Jolly, Lindy McAllister, Louisa Remedios, Rebecca Chick, Canberra, Commonwealth of Australia, Office for Learning and Teaching. http://www.olt.gov.au/resource-harmonising-higher-education-professional-quality-assurance-assessment-health

ELC was designed to bring as many relevant organisations and individuals together to 'act' in support of the future of IPE in Australia. It was designed and presented as a project that:

- Would provide opportunities for collective decision making, action and leadership
- Was informed by what we had been learning through many IPE research and development studies
- Would focus on national action in support of more coherent and coordinated local action.

The need for a nationally coherent and coordinated approach involving all relevant stakeholders had been a constant theme throughout CRS consultations. It seemed a time was reached within the Australian context where stakeholders were ready to move from a project based approach to a system wide approach to development.

As a study management group developing the CRS, the project team has talked about this shift in terms of a new or second stage of IPE development in Australia. Defining characteristics of this second stage being interprofessional, collective, connected, informed by shared learning, coordinated and nationally purposeful. Woven into all our communication and into the design of ELC has been an emphasis on collective action, on the interprofessional, and on working across professional boundaries.

The national and Western Australian fora and the National Workplan

As a way of enabling national and system wide action the project team decided to host two fora: a national forum in Sydney (NF), and a state based forum – the Western Australian Forum (WAF) –- held in Perth, Western Australia (WA). Western Australia was chosen as the site for a state based forum as four of the five WA universities had participated in the CRS.

To keep the work of the fora focused and based on previous learning, we structured them in relation to the five consensus recommendations identified in the CRS. These recommendations constitute a well-developed national consensus arising from the work of many studies developed over a six year period.

Figure 1: The Five CRS Recommendations

Recommendation 1

Establish inclusive and ongoing structures and processes to provide national leadership in the development of IPE across higher education, health, the professions and government.

Recommendation 2

Develop a nationally coordinated approach to building IPE curriculum and related faculty capacity.

Recommendation 3

Incorporate IPP standards and interprofessional learning outcomes into the accreditation standards of all Australian health professions and recognise that meeting these learning outcomes will require the application of IPE pedagogies.

Recommendation 4

Establish ongoing research to ensure the development of new knowledge and learning to inform IPE curricula and practice.

Recommendation 5

Develop a virtual knowledge repository that organises and disseminates information and knowledge about IPE. This repository would link with other international IPE networks.

The National Workplan

To provide a mechanism for the work of the two fora to be translated into action, we adopted the idea of a NWP. We saw the NWP as something that could be used to focus attention on action. Like any work plan we hoped discussions and decisions at the fora would allow us to specify actions, responsibilities, time-frames, deliverables and the conditions required.

Who attended the two fora?

Participants were chosen carefully. We thought it critical to attract a significant number of people in leadership/decision making roles across all areas of interest: higher education, health, the professions, the regulatory bodies and government. We also wanted to attract a number of people in less senior roles but with a particular responsibility for curriculum decisions and curriculum design. Details of attendees are provided in appendices 1 and 2. Considerable effort was invested in the process of inviting, liaising and encouraging attendance. We were immensely pleased with attendance and participation. Both fora represented rich, diverse and productive discussion – a demonstration of a productive process operating across professional boundaries and discourses.

The national forum

Interprofessional Education in Health National Forum, Sydney

The Interprofessional Education in Health National Forum took place in May 2014, at the Arial Function Centre, University of Technology, Sydney (UTS).

The recruitment of key forum participants resulted in representatives from the OLT, the Australian Health Practitioner Regulation Authority (AHPRA), Health Workforce Australia (HWA), nine health professions accreditation councils and national boards, nine health industry peak bodies, three education peak bodies and providers, and 14 universities attending the Forum. Sixty-four individual participants attended in total. A detailed list of participants' organisations can be found in Appendix 1.

The forum was opened by Professor Shirley Alexander, Deputy Vice-Chancellor (Teaching, Learning and Equity), UTS, and Professor Attila Brungs, Deputy Vice-Chancellor (Research), UTS. Australia's Nursing and Midwifery Chief Officer, Dr Rosemary Bryant, then launched the Curriculum Renewal for Interprofessional Education in Health Study (CRS) Report.

One immediate action recommended at the NF was for a letter to be sent to both the Federal Health and Education Minsters bringing to their attention to the work of the CRS, ELC and other Australian studies and asking for their commitment and support in implementing CRS/ELC recommendations. We received positive responses from both Ministers.

The Western Australian forum

Western Australian Forum on Interprofessional Education in Health

The Western Australian Forum on Interprofessional Health took place at The University of Notre Dame Australia, Fremantle campus on Thursday 23 October 2014.

Attendees included representatives from five WA universities, the WA Health, industry representatives from St John of God Hospital, Royal Perth Hospital and the Brightwater Care group and the WA consumer group, the Health Consumer Council. Forty two individual participants attended in total. A detailed list of participants' organisations can be found in Appendix 2.

The work of the two fora

The work of the two fora is presented as follows.

Firstly, discussions developed by participants in both fora are outlined. These discussions address the five consensus recommendations of the CRS and how these recommendations could be implemented. What is perhaps not surprising is that the underlying themes of the two fora are similar. As the issues identified in discussion of Recommendations 2 and 3 had many crossovers, these two recommendations are addressed conjointly.

Secondly, the proposed National Work Plan (NWP) is presented. Where particular or local comments were made relating to WA, these are specified either in the discussion section and/or in the NWP. A three-year time frame is suggested as a way of sequencing and connecting particular streams of action. Finally, some suggestions about capacity and what we see as enabling next steps are proffered.

It is important to note that the report and NWP is limited to a focus on pre-registration. However, the need to develop an IPE/IPP professional learning focus post registration with a requirement that achievement be identified as a condition for ongoing registration was a consistent and strong theme.

Discussions addressing the implementation of the five CRS recommendations

Recommendation 1: Establish inclusive and ongoing structures and processes to provide national leadership in the development of IPE across higher education, health, the professions and government.

A number of well-defined themes emerged from the discussions. First, there was a strong focus on repositioning and promoting IPE. Within both fora, at the national and state levels, there was a call to elevate and increase the visibility and prominence of IPE as part of the policy and education development process. Participants argued that such action would constitute one of the most important conditions to support the further development of IPE.

Second, across both fora there was a strong focus on the importance of 'collective' action at the national level. Within the NF the establishment of a national interprofessional group to take on a coordinating and leadership role was argued for strongly. Participants identified the bodies, organisations and individuals they thought should be involved. These were, for the most part, lead bodies operating across a diverse range of areas which together make up the territory of health professional education, practice and regulation and health workforce development. For example, Australian Health Practitioner Regulation Agency (AHPRA), Community Services and Health Industry Skills Council (CS&HISC), Health Workforce Australia (HWA), Higher Education Jurisdictions, Colleges, Australian Skills Quality Authority (ASQA) and Tertiary Education Quality and Standards Agency (TESQA).

Third, a way of working or mode of operating was identified. Not surprisingly, this approach was presented as inclusive and consultative – as an interprofessional approach. This approach echoes many conversations undertaken as part of the CRS, where individuals talked about the importance of developing a collegial and interprofessional approach to communication and decision making as a way of demonstrating a commitment to the shared work and collaborative nature of IPP.

The focus of initial action for such a leadership group was discussed as follows. The leadership group would take an active role in Identifying and lobbying for the actions and conditions that would be enabling to the further development of interprofessional, collaborative and team based education, learning and practice.(the NNWP aims to specify key actions that should/could be the focus of attention for the leadership group). Additionally, they would focus attention on the embedding of IPE/IPP into accreditation requirements and educational practices and more broadly into continuing professional development (CPD) and CPD requirements for ongoing registration. This activity would set the scene for a more coherent and coordinated national development and support pre-registration IPE curriculum and, more broadly, would support the development of IPE/IPP post registration. Importantly, such a body would legitimate and demonstrate an interprofessional approach to the future of health professional education and practice development

The above themes were also strongly present but differently expressed within the WAF. The idea of promoting IPE/IPP was discussed in terms of making IPE/IPP the 'cornerstone of

health care practice in relation to workforce development and challenges'. Achieving this, participants argued, would involve working closely with the Minister for Health and key health and accreditation bodies.

The national focus on collective action was discussed in terms of a WA IPE 'community of practice'. There was discussion about WA becoming an important case study and exemplar in this area. Whilst such a move is clearly ambitious there was a sense of possibility in moving in this direction. The defining characteristic – the leadership underpinning this kind of development was specified as needing to be interprofessional and collective.

There was also a strong focus on the patient in the WA Forum – identifying ways in which the patient could be part of the development of IPE/IPP. This theme – the patient being the active centre of effective and responsive health care – was consistently emphasised in the CRS and during ELC discussions. What was also strongly identified in both fora was the wish to identify and explore new as well existing IPE/IPP education and practice possibilities and, in support of this, to consider embedding IPE at earlier points in the curriculum. There was discussion about how the private and public sectors could work more purposefully together at this development task. The WAF identified the importance of actively working across the boundaries of education and health care practice. Finding ways to connect professional learning across the pre-registration/practice and university/health system divide was a constant point of discussion. (See the ANZAHPE, Gold Coast Declaration 2014. The Declaration addresses this issue.)

Finally, a focus on leadership within the IPP context was identified. This was particularly the case in the WAF. Whilst not specifically teased out, it seems to us what is being explored here is a question about the similarities and differences between uni-professional and interprofessional leadership. We could, perhaps, locate this question with similar questions that were explored in the CRS consultations in relation to the difference between uni-professional and interprofessional approaches to education, learning and pedagogy.

Recommendation 2: Develop a nationally coordinated approach to building IPE curriculum and related faculty capacity,

and

Recommendation 3: Incorporate IPP standards and interprofessional learning outcomes into the accreditation standards of all Australian health professions and recognise that meeting these learning outcomes will require the application of IPE pedagogies.

Whilst each of the CRS consensus recommendations addresses a critical element of IPE development, the focus of Recommendations 2 and 3 are so conceptually and educationally joined that we address them together. The two fora developed different but complementary foci. The NF focused on defining and establishing the interprofessional learning space, that is getting the educational and practice settings well defined in terms of standards, competencies, learning outcomes and educational methods and pedagogy (see also leadership above). The WAF picked up the issues of 'doing' – of utilising standards and competency requirements in the process of making things happen.

An overarching theme connecting Recommendations 1, 2 and 3, was the need for a well-articulated alignment between the changing context and demographics of Australian health service delivery, citizen expectation, industry requirements and professional standards, and how these issues are articulated as part of professional and educational standards, in health interprofessional competencies in learning outcomes, and in terms of educational methods, assessment, evaluation and research. This kind of foundational development addresses what arguably was the most consistent and problematic finding of the CRS, that is, the degree of design diversity and the lack of consistency and coherence in how IPE is thought about and developed at the local level. It was clear to the majority of individuals and organisations who participated in the CRS and the two fora that a significant and coordinated national effort is required to generate a set of shared understandings about the nature of IPP and the kinds of IPE that would support the acquisition of IPP competencies as a systematic outcome of health professional education across all professions and across all universities.

The process of developing consistent and shared definitions and understandings was extended into a discussion about developing an 'IPE/IP vocabulary', glossary or national statement of shared understandings. Such a vocabulary should consist of agreed understandings about the nature of IPE/IPP, which could then be used across all professions and, in particular, be specified in the accreditation standards developed by professions to guide the education process. This suggestion was made even more specific with a recommendation that AHPRA, the profession-specific accrediting councils and the higher education sector, work together to ensure that consistent IPP competencies are defined and linked to specific learning outcomes. This call for shared understanding, greater alignment and greater specificity also reiterates a major theme discussed in the CRS study, which is the need for a clearer specification of what the achievement of a particular educational standard would look like in an educational and practice context.

Whilst much remains to be done, there is a developing body of work on meanings, on IPP competencies, on the changing context of health professional practice and on the kinds of educational methods and pedagogy particularly suited to IPE/IPL that can be utilised. For example, the CRS has provided an analysis of national and international approaches to competencies, learning outcomes, educational methods, interprofessional pedagogy, assessment and evaluation. In doing this the CRS developed a four dimensional curriculum development framework (4DF), which is both a conceptual statement and, via the consideration of each dimension and the relationships between dimensions, also a reflexive and critical process through which organisations and educators can review existing curricula and develop new curricula (Steketee et al, 2014). The four curriculum dimensions are:

1. Future orientation of health practices – the relationships that exist between curriculum and the social, economic and political conditions that are shaping what health services and health professionals are required to deliver. For example, changing demographics, technologies, community expectations and resources (Dimension 1).

2. Knowledge, competencies and capabilities – the ways in which these requirements for current and future health practice, expressed in terms of competencies, capabilities and learning outcomes, are identified within the curriculum (Dimension 2).
3. Teaching, learning and assessment – the kinds of pedagogies and educational practices required to achieve the specified learning outcomes and capabilities. This is particularly the case for pedagogies congruent with the achievement of interprofessional capabilities (Dimension 3).
4. Institutional delivery – the ways in which local institutional factors are configured to enable or constrain achievement of the above – an area frequently neglected in curriculum development (Dimension 4) [Steketee et al 2014].

Comments in relation to Recommendation 2 and 3 also addressed the question of how best to assist IPE curriculum development at the local organisational level – the university. Two options were discussed. Firstly, the development of a 'model' or ideal type curriculum framework; secondly, the identification of standards and principles that would guide action but not specify what would and could occur at the local level. We can say with some confidence that the latter approach was the one favoured by the majority of people and organisations we consulted with during the CRS.

At a level closer to educational practice, the WAF focused on building increased understanding across all parties in the educational process – universities, industry/providers and students – about the opportunities for IPE and IPL across all sites of education and learning. The focus here was on what can be learned from working together. Additionally, the WAF identified the need for stronger promotion or engagement with key governance bodies in the area of service provision. One recommendation was for the Chief Medical Officer and the Chief Nursing and Midwifery Officer to model and publicise an interprofessional approach to policy and service development across the state. Individuals in these positions could champion the importance and value-add of IPE/IPP.

The WAF identified the importance of investing in the development of IPE/IPP education and training programmes. The parties would develop the shape of such education. One particular matter identified was for an increased recognition of the place and contribution of interprofessional simulation in the IPE area. The WAF identified two proposals for supporting and scaling up IPE within the WA education and practice contexts:

1. Require that all mandatory education/training provided by WA Health be based on and tested against an interprofessional and collaborative approach
2. Promote interprofessional timetabling across all WA universities as a critical enabling step to embedding IPE in all curricula.

Importantly, participants in the WAF identified the need for an organisation to coordinate and lead IPE focused action. The WA Clinical Training Network (CTN) was identified as a body whose remit, although not capacity, aligned well with much that was discussed. Other promotional activities, such as holding a WA IPE/P week and convening meetings with local health boards were also mentioned as ways to raise awareness of IPE/IPP.

Recommendation 4: Establish ongoing research to ensure the development of new knowledge and learning to inform IPE curricula and practice.

Both fora recognised the ongoing difficulty that deficits in research and evidence pose for the further development of IPE/IPP. This is particularly the case in a policy and practice context that is strongly committed to the idea of research evidence informing practice.

The findings and recommendation of the CRS studies were strongly supported. Both fora identified the need for urgent research and knowledge development at both the state and national levels. It was felt that such action would constitute a significant step forward within Australian education and health care practice. Participants emphasised the importance of coordinated and prioritised IPE/IPP focused research and evaluation, that is, action taken by all professions in conjunction with peak bodies in health and education.

The NF identified the importance of establishing a national lead group, (possibly) a working group of the national leadership group discussed in relation to Recommendation 1. It was suggested that such a group include people with expertise and experience in IPE/IPP or related areas and research. This group was identified as being able to both lead and support/enable the development of IPE/IPP related research capacity and capability across the higher education and health sectors. One particular task identified was the need for a national research mentoring network with a focus on IPE/IPP.

Importantly, what was also recognised was the theoretical, methodological and methods challenge that research and evaluation in IPE/IPP poses. There was strong support for the development of new ways of engaging with the process, impact and outcomes of IPE/IPP. Considerable interest was noted in approaches such as 'realist' research and evaluation (Pawson and Tilley 1997). Such approaches, which are drawn more from the social sciences, humanities and cultural studies, were seen as having much to offer. (For a more detailed discussion see the CRS).

Both fora emphasised the importance of utilising existing data more effectively, for example, health care complaints data was identified as having much to say about where communication is partial or ineffective. Suggestions were made about utilising the 4DF (see earlier comments) to frame research questions about patient outcomes and experiences, and about the impact and outcomes of using particular pedagogies and teaching methods. Identifying and focusing on areas where IPE/IPP is most in use and likely to make the biggest impact was also thought to be a useful way of prioritising sites for research. Identifying sources of funding for IPE/IPP research/evaluation was also discussed. Importantly, one final matter was emphasised, that is, the importance of disseminating and utilising what we already know about IPE/IPP across the global literature. Many participants felt there was much that could be done with what already is known. Such a process needed to be more coordinated, more active and more targeted. For instance, the importance of finding ways to communicate and update accrediting and regulatory bodies was seen as vital.

Proposed National Workplan

It was also recognised that implementing a knowledge development and research agenda would need to be conceived in small incremental steps. There was optimism that if this work was well led and coordinated significant progress could be made.

Recommendation 5: Develop a virtual knowledge repository that organises and disseminates information and knowledge about IPE.

As noted at the end of the last section on knowledge development and research, the importance of active/pro-active knowledge management, is increasingly critical. Considerable investments are being made in many areas of knowledge development – synthesis, distribution and translation – within the health and education sectors. Whilst there have been a number of significant IPE knowledge management and dissemination initiatives in the United Kingdom, Canada, Sweden, Japan and, most recently, in the United States of America, within the Australian context IPE/P knowledge management remains relatively little developed. This state of affairs constitutes a major constraint on the development of Australian curriculum and practice in health.

Over the past eight years, a network of educators and clinicians has come together as an informal mostly virtual network, the Australasian Interprofessional Practice and Education Network (AIPPEN). This organisation has sought to act as a point of reference, development and dissemination in the area of IPE/IPP knowledge management across Australia and New Zealand. As AIPPEN is a voluntary organisation with no funding source it is challenged to maintain and grow its activities. As discussed in the CRS Final Report, the further development of AIPPEN has consistently been seen as a useful starting point for a more effective, responsive and interactive approach to IPE/IPP knowledge management in Australian and New Zealand. Participants in both fora agreed that finding ways to support and extend the knowledge management and dissemination work of AIPPEN should be a key element of the NWP.

The NWP is informed by the findings of the CRS and the discussions of the NF and WAF. We are confident that the NWP represents the findings, the directions, the priorities and, more broadly, the thinking of the hundreds of individuals and organisations who have participated in the CRS programme and the two fora across a period of five years. It is important to note that the NWP does not attempt to make a final and definitive statement about IPE/IPP development in Australia, on the contrary, the NWP aims to create structures and activities that will bring individuals from different professions, from government, from health providers etc., together to discuss and determine how Australian IPE/IPP can evolve and improve.

It is our hope that the NWP will guide and enable a new stage of IPE/IPP development in Australia. It is also important to note that we would not expect the activities identified below to produce a prescriptive approach to or a 'total' consensus about the development of IPE/IPP in Australia. This is not the aim. Rather, the aim of the NWP is to build a different approach – a national approach – to how we understand, communicate, learn about and develop IPE/IPP in Australia. Most critically, the NWP is about an interprofessional approach – a collective and collaborative approach – involving the widest possible participation of all groups involved with or impacted by IPE/IPP.

In what follows we suggest an initial time frame of three years. We think this time frame is commensurate with the work and achievements required.

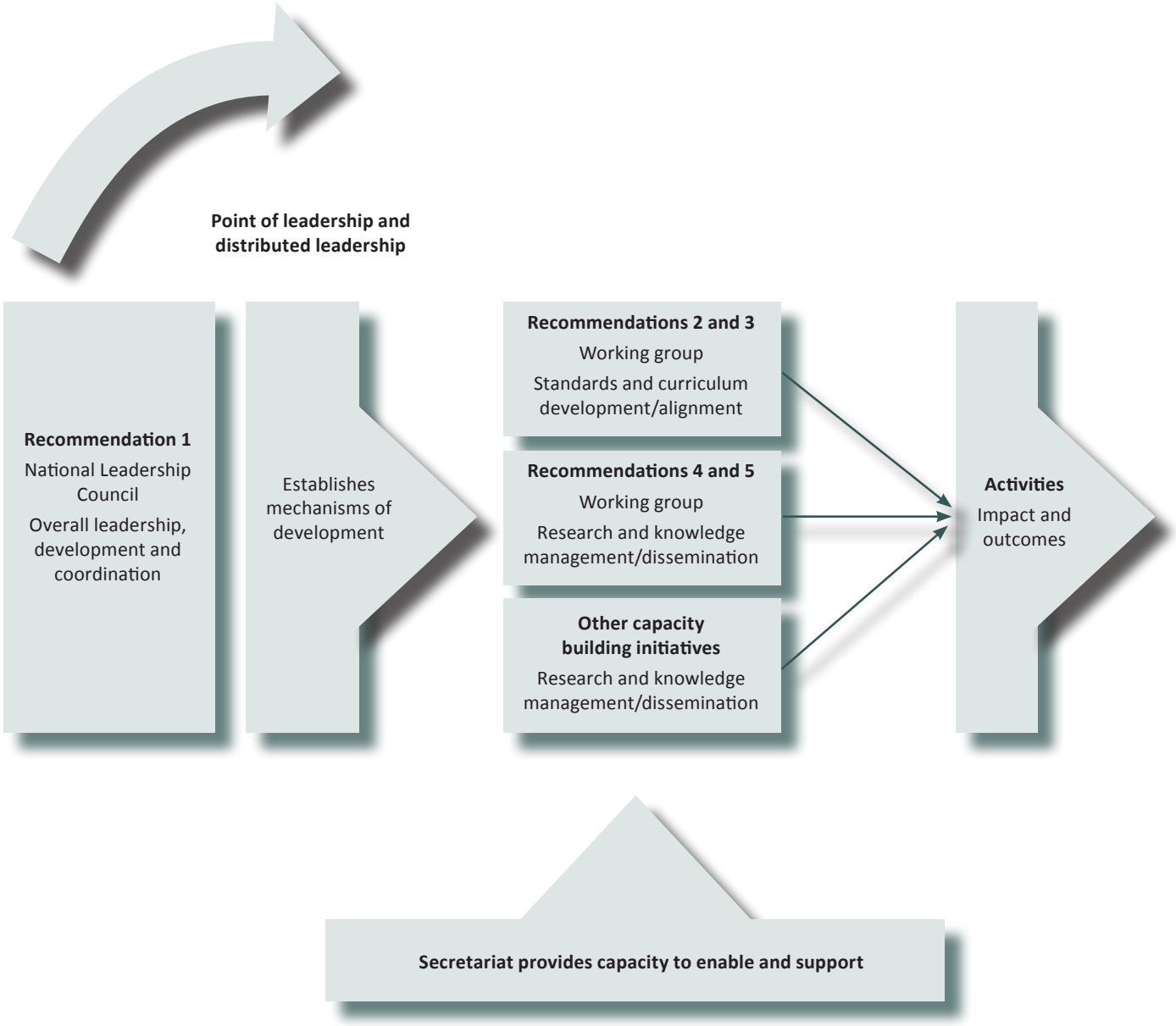
The NWP is structured to align with the key recommendations of the CRS:

- National leadership with structures and processes to enable such leadership to shape and develop IPE/IPP in an ongoing way (Recommendation 1) – we suggest a National Leadership Council to provide national leadership
- Curriculum and standards development (Recommendations 2 and 3) – we suggest a working group to address these tasks and to operate across the initial three years of the NWP
- Knowledge development, management, utilisation and dissemination (Recommendations 4 and 5) – we suggest a working group to address these tasks and to operate across the initial three years of the NWP
- Capacity structured to provide maximum support and enabling for the Leadership Council and working groups.

As identified consistently across CRS consultations and the two fora, the kind of leadership approach that would be required would need to be collegial, collaborative, networked and inclusive. In short, a leadership system that would demonstrate an interprofessional approach to deliberation, decision making, review and learning. Each of the elements of the NWP – the Council and the two working groups, would constitute well connected points of interprofessional leadership in their respective areas. Finally, the NWP identifies the critical

importance of dedicated and coordinated capacity to support the work of the National Leadership Council and the two working groups during the initial three years of the NWP. Figure 2 diagrammatically depicts the alignment between the CRS recommendations and the comments and elaboration of the two fora. What has characterised the development of IPE in Australian higher education is, amongst other things, a lack of funding and human resource capacity. Programmes and staff have been for the most part project based. As a consequence, innovative and productive programmes have been short lived with staff often having to move on to obtain more secure employment. This issue and its problematic implications for curriculum development, for educational practice, for staff retention, for sustainability, for research, knowledge development and dissemination, and, critically, for the provision of the best learning experiences for students, has been a constant theme in the consultations we have conducted over the past seven years.

Figure 2 – Alignment of CRS recommendations with NWP structure and focus



In what follows we briefly comment on each of elements of a national IPE leadership system.

National leadership

We have looked at this issue in terms of a 'National Leadership Council'. The Council would take responsibility for promoting the principles, values, development and visibility of IPE at the most senior level in the areas of higher education, health service provision, the professions, educational standards and regulation, health professional regulation, safety and quality and continuing professional development. This body would be senior, inclusive and collegial in its approach and decision making. This group would use its collective legitimacy and influence to lobby, promote, suggest and advise particularly as this relates to education and health policy and to the development and regulation of Australian health professionals and health professional education.

More particularly, this group would support the aims and focus of the national recommendations identified by the CRS and confirmed by the NF and WAF. It would take responsibility for developing mechanisms, arrangements, projects etc., which lead to the further development of IPE and its target outcome, effective IPP leading to more effective, sustainable and patient responsive health care.

Composition

This body to be formed with representatives of key bodies such as the Australian Health Practitioner Regulation Authority (AHPRA), Community Services and Health Industry Skills Council (CS&HISC), Higher Education Jurisdictions, Colleges, Australian Skills Quality Authority (ASQA), Tertiary Education Quality and Standards Agency (TEQSA), Australian and New Zealand Association for Health Professional Educators (ANZAHPE), Health Professions Accreditation Councils Forum, the Australian Council of Pro Vice-Chancellors and Deans of Health Sciences, the Australasian Interprofessional Education and Practice Network (AIPPEN) and chair and co-chair of the IPE Curriculum Renewal Consortium, Australia. Particular individuals who have been significantly engaged in IPE/IPP development should also be identified and invited.

Recruitment of National Leadership Council members

An invitation to participate from the Federal Minister of Education and Training and the Federal Minister for Health would model an interprofessional approach and accord a significant degree of national legitimacy and visibility to the work of the National Leadership Council.

Meeting arrangements

We suggest two meetings each year during the three year period. As much as possible we believe these meetings should bring members together in a geographical sense. (These meetings could, perhaps, be collocated with a one day conference or consultation relevant to the work of the National Leadership Council and/or other working groups.)

Working group 1 – standards and curriculum development and alignment

The need for conceptual and practical development work and curriculum alignment was arguably the most discussed issue in the CRS programme and in the NF and WAF. In summary, the work of this group would be to build on the curriculum development and alignment work of the CRS and other Australian higher education and health research and development projects. There is also a considerable amount of international development activity that can be drawn on.

This work would be consultative and would focus on five areas of development:

1. Articulating and agreeing on a set of IPP competencies that are relevant and meaningful across all areas of health professional practice. Much of this work has been done. However, refinements and agreements in the Australian context are required. (A recent example of this kind of national development is occurring through the work of the Interprofessional Education Collaborative in the United States of America http://www.ipecollaborative.org)
2. Articulating and agreeing on the scope and degree of interprofessional practice attainment as a result of participation in IPE and other practice focused learning experiences. The need for standards specification in this area was identified by many participants as critical and urgent
3. Developing new conceptual and practice understandings about interprofessional pedagogy, educational methods and the educational and organisational conditions that will support the achievement of IPP competencies and outcomes
4. Developing new conceptual and practice understandings about the assessment of student learning and competencies as part of their participation in IPE activities
5. Developing new conceptual and practice understandings about the evaluation of IPE activity.

One outcome to be developed across the work of this group would be a 'Statement of Understandings'. This document would briefly identify key definitions and elements of IPE, curricula, teaching methods and pedagogy. It would provide a brief orientation to IPE. The need for as much specificity as possible in relation to all of the above was identified as critical.

The National Leadership Council would take an active role in supporting, promoting and utilising the work of this working group.

Accountability

This working group would report to the National Leadership Council.

Deliverables

- Competency statements
- Menu of learning activities
- Faculty development guide
- Assessment menu and tools
- Evaluation guidelines.

Working group 2 – research and knowledge management

The second working group addresses a set of national and global issues that are critical to our ability to inform and improve education and health practice through the use of research. Research and the organisation and dissemination of knowledge in the areas of professional practice and its linkage to/association with particular kinds of outcomes – patient satisfaction and health outcomes, student learning outcomes, team performance outcomes, sustainability outcomes, staff retention outcomes etc., is still relatively undeveloped. This is even more the case for IPE/IPP, an area of practice that requires research that engages with a more complex set of human, knowledge and organisational variables.

Both fora identified a number of areas of inquiry and development that could constitute the initial focus and development agenda for this group. Two establishment tasks were identified:

- Scoping the state of IPE/IPP knowledge. Such scoping activity is already being discussed with other global IPE/IPP centres. Australia would develop a particular focus on Australian IPE/IPP activity. It would also contribute to and benefit from being part of a global collaborative.
- As a result of the above, the working group in consultation with key stakeholders and working closely with the National Leadership Council would develop and seek to implement a number of Australian research priorities.

A number of more particular issues were identified for consideration:

- The need to utilise existing data more effectively, for example, health care complaints data was identified as |having much to say about where communication is partial or ineffective
- The use of the 4DF (see earlier comments) to frame research questions about patient outcomes and experiences, and about the impact and outcomes of using particular pedagogies and teaching methods
- Whilst posing considerable challenges, many participants believed urgent research development was required to investigate the complex educational and practice relationships between IPE and the development of IPP competency and capability, and the relationships between IPP and health outcomes. This work could become an important focus for a global research effort
- Identifying and focusing on areas where IPE/IPP is most in use and likely to make the biggest impact was also thought to be a useful way of prioritising sites for research
- Addressing the theoretical, methodological and methods challenges that research and evaluation in IPE/IPP poses. There was strong support for the development of new ways of engaging with the process, impact and outcomes of IPE/IPP. Considerable interest was noted in approaches such as 'realist' research and evaluation.
- The importance of disseminating and utilising what we already know about IPE/IPP from the national and international literatures was identified as a priority. Many participants felt there was much that could be done with what already is known. Such a process needed to be more coordinated, more active and more targeted. For instance, the importance of finding ways to communicate and update accrediting and regulatory bodies was seen as vital
- Identifying sources of funding for IPE/IPP research/evaluation was also discussed. Clearly this is a critical issue. Given the need for methodological and methods innovation, we have often wondered about the establishment of a small funding stream dedicated to seeding pilot and proof of concept research in the areas of Australian IPE/IPP
- Utilising and building on the already significant achievements of AIPPEN in the area of regional knowledge organisation, management and dissemination. Seeking additional funding for AIPPEN was identified as a priority.

We see a significant opportunity to locate AIPPEN as a key element of the national development process and infrastructure. Utilising AIPPEN as the key mechanism for organising and disseminating information and knowledge about Australian IPE/IPP activity and development would be a significant step in improving IPE/IPP knowledge management and dissemination in Australia. AIPPEN also has an important role to play in being an interface and conduit for knowledge dissemination at a global level – being a point of contact for Australian bodies and individuals wishing to access global knowledge and being a point of access for international colleagues being able to access information about Australian IPE/IPP. We recommend AIPPEN be located, developed and utilised as part of the Australian model. AIPPEN would work closely with working group 3.

The National Leadership Council would take an active role in supporting the cycle of knowledge development, research and evaluation and knowledge management and dissemination.

Composition

Both fora suggested that members of this group should include people with expertise and experience in IPE/IPP or related areas and research. This group was identified as being able to lead, support and enable the development of IPE/IPP related research capacity and capability across the higher education and health sectors. AIPPEN would have membership on and work closely with this working group.

Accountability

This working party would report to the National Leadership Council.

Deliverables

- Register of current research
- Identification of data being collected that may be used to compare outcomes for different types of practice delivery
- Guidelines for research
- Leading on the development of national capacity in IPE/IPP research
- Enabling the development of methodological and methods innovation
- Enabling the conduct of relevant research
- Leading/coordinating the development of conferences, workshops, knowledge exchange and dissemination etc.

Capacity – what capacity will be needed to enable and support and the work of the National Leadership Council and the two working groups?

To maximise the success of Australia's first IPE NWP, both fora were clear that capacity commensurate with identified tasks would be critical. That is, investment will be required. In this section we suggest the types of enabling capacity identified in the CRS and by fora participants. What we identify is targeted at enabling the work and development of the National Leadership Council and of the working groups (or other governance structure or process established by the Council). We have used the term 'secretariat' for this group. By secretariat we mean a defined and dedicated capacity utilised to provide certain kinds of functionality. We have expressed capacity in terms of 'people' who provide such functionality. We identify a number of areas in which capacity/dedicated functionality will be required:

- **High-level coordination and support activity.** We suggest the person who undertakes this work should be senior and experienced in the areas of IPE/IPP and, more broadly, health professional education and complex programme management. The coordinator would work closely with and support the deliberations and activity of the National Leadership Council
- **Operational support.** This position, we think, needs to be at least one full time position or two part time positions. We see this type of capacity as being provided by one or more people with professional support or research assistant experience. This position/positions would work closely with the coordinator above and provide operational support to the two working groups
- **Knowledge management and dissemination.** Functionality in this area is critical. As noted in the CRS and across the two fora, an investment in this area would enable AIPPEN to build on and extend its work nationally and regionally. Two areas of capacity have consistently been identified. Firstly, an investment in a user-friendly and interactive web based evidence and information repository. This would require updating and upgrading AIPPEN's existing web based capacity. Secondly, a small investment in an information officer who would ensure that AIPPEN evidence and information is updated.
- **Capacity building.** There is a range of possibilities that would add considerable value for minimum cost. For example, one or two scholarship supported doctoral students could be located as part of the secretariat and be allocated to particular doctoral research in areas determined by the National Council and working groups. Appropriate supervisory arrangements would be negotiated. Short to medium term periods where health practitioners with an interest in IPE/IPP and educators with an interest in IPE, curriculum and pedagogy could be seconded to the secretariat to work on particular projects or to work with one or more of the working groups.
- **Evaluation and learning.** One important area of capacity building is for the development of the NWP to be a national initiative that is evaluated in terms of formative development and summative impacts and outcomes. Such an evaluation for learning would also offer considerable knowledge and practice development opportunities. We suggest a formal brief for a learning focused evaluation be identified and funded as an initial set up step of the leadership body.

Locating the secretariat

Discussions are currently occurring as to locating the secretariat with one of the lead CRS/national universities.

Accountability

The operational team would report to the National Leadership Council.

Building national capacity – final comments

A local opportunity

As part of discussions within the CRS study team, within the CRS studies and as part of the NF and WAF the possibility of ANZAHPE contributing to various areas of IPE leadership and development has been raised. For many of us involved with the regional development of IPE/IPP in Australia and New Zealand, this always seemed an extremely useful possibility to explore. In informal discussions with senior members of the ANZAHPE executive this idea was of interest. At the very least, collocating IPE/IPP conference activity as part of the ANZAHPE remit would be valuable. The role could be far more extensive. We would suggest that there be formal discussions as to a possible leadership role for ANZAHPE in the further development of Australian and New Zealand IPE/IPP.

A global opportunity

At the beginning of this report we identified the particular opportunity and momentum that currently exists in relation to IPE/IPP development in Australia. Through the collaborative work that is occurring between Australian IPE/IPP focused educators and health professionals and their counterparts globally, we can say with confidence that this opportunity and momentum exists globally. What this offers to Australian and global health professional education/educators and health professional practice/practitioners is, we think, substantial.

Where to from here?

The NF and WAF and the development of the national IPE/IPP workplan are two final steps in a series of studies that have focused on the potential of and need for a national approach to IPE/IPP development in Australia. This is in no way to suggest that local efforts and progress are not innovative, continuous and substantial. Much is occurring and much is being achieved. Rather, the focus of the CRS, the two fora and the NWP has been to present the need for an active national process that would add value and create opportunities that simply cannot exist through uncoordinated local development. Connecting local with national development – a conversation between the local and the national – is fast becoming the approach being taken up by many nation states and, more broadly, by regional groupings. Our current constraint is that there is no capacity and no mechanisms existing at the national level through which work of development can occur. Without capacity and evolving mechanisms this work will not be able to occur.

As members of the CRS and fora management team, we will take the following steps:

- Distribute this report and NWP as widely as possibly. We will seek support and participation in the next stages of Australian IPE/IPP development
- Providing the report to the Minister for Health and the Minister for Education and Training. We will also seek to meet with and brief the two Ministers
- A number of other lead organisations, for example, AHPRA, have asked for us to meet with them regarding the report and NWP
- We will be talking with colleagues from overseas to consider collaborative research and development options.

At the end of the above, we will report back to all fora and CRS participants and to all relevant higher education, health, government, and professional bodies.

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Appendices

Appendix 1 List of National Forum participant organisations
Appendix 2 List of WA Forum participant organisations

Appendix 1. List of National Forum participant organisations

Interprofessional Education in Health National Forum

Welcome

Professor Shirley Alexander, Deputy Vice-Chancellor (Teaching, Learning and Equity) and Professor Attila Brungs, Deputy Vice-Chancellor (Research) welcome participants to UTS

Launch of the CRS Final Report

Australian Nursing and Midwifery Chief Officer Rosemary Bryant

Participants

Government

Department of Health

Office for Learning and Teaching

Health Workforce Australia

Australian Health Practitioner Regulation Authority

Health Education and Training Institute, NSW Health

Queensland Health

Health Professions Accreditation Councils and National Boards

Australian Medical Council

Australian Nursing and Midwifery Accreditation Council

Australian Dental Council

Australian Pharmacy Council

Occupational Therapy Council Australia and New Zealand

Australian and New Zealand Podiatry Accreditation Council

Australian and New Zealand Osteopathic Council

Council on Chiropractic Education Australasia

The Nursing and Midwifery Board of Australia

Industry Peak Bodies

Royal Australian College of General Practitioners

Australian Nursing and Midwifery Federation

Allied Health Professions Australia

Future Health Leaders

Indigenous Allied Health

Society of Hospital Pharmacists Australia

Australian Psychological Society

Dieticians Association Australia

Mental Health Professionals Network

Education Peak Bodies and Providers

Deans of Medicine, Australia and New Zealand

Australian Council of Pro-Vice Chancellors and Deans of Health Sciences

Australian College of Nursing

Universities

Monash University, Faculty of Medicine, Nursing & Health Sciences

Victoria University, Office for the Centre of Collaborative Learning and Teaching

Victoria University, Interprofessional Education Executive

The University of Sydney, Work Integrated Learning

University of Sydney, Faculty of Education and Social Work

The University of Adelaide , Faculty of Health Sciences

The University of Queensland, Faculty of Health and Behavioural Sciences

University of Queensland, School of Medicine

The University of Notre Dame, Freemantle, School of Nursing and Midwifery

Notre Dame University, Sydney, School of Medicine

Charles Sturt University, The Education for Practice Institute

The University of Newcastle, School of Medicine and Public Health

Flinders University, School of Medicine

University of Dundee, Scotland, School of Nursing and Midwifery

Southern Cross University, School of Health and Human Sciences

Griffith University, School of Medicine and Health Institute for the Development of Education and Scholarship (Health IDEAS)

Central Queensland University, School of Human, Health and Social Sciences

Central Queensland University, School of Medical and Applied Sciences

University of Technology, Sydney, Graduate School of Health

Appendix 2. List of WA Forum participant organisations

Attendees Western Australian Forum on Interprofessional Education in Health

Universities

Organisation	Position
The University of Notre Dame Australia	Pro-Vice Chancellor and Head of Fremantle Campus
	Dean, School of Medicine, Fremantle
	Clinical Education Coordinator
	Lecturer, Aboriginal Health
	Associate Dean, Aboriginal Health
	Associate Dean, Teaching and Learning, School of Medicine Fremantle
	Head of Biomedical Science, School of Health Sciences
	President, Medical Students' Association of Notre Dame
	Student Liaison Officer, School of Medicine
	Dean, School of Health Sciences, Fremantle
Edith Cowan University	Lecturer, School of Exercise and Health Sciences
	Manager Strategic Health Projects, Office of the Pro-Vice-Chancellor
	Postgraduate Courses Coordinator, School of Nursing & Midwifery
	Project Coordinator for the Health Interprofessional Simulation Challenges
Murdoch University	Head of Discipline, Nursing
	Lecturer, Nursing
The University of Western Australia	Director, Centre for Aboriginal Medical and Dental Health
	Clinical Academic, Western Australian Centre for Rural Health
	Medical Educator, School of Paediatrics and Child Health
	Manager, Workforce Education and Reform
	Course Coordinator, School of Population Health
	Medicine and Pharmacology, School of, QEII Medical Centre Unit
Curtin University	Director of Teaching and Learning, School of Physiotherapy and Exercise Science
	Head of School, Occupational Therapy and Social Work
	Deputy Director, Health Sciences Teaching and Learning
	Head of School, Pharmacy
	President, Curtin Association of Nursing, Paramedicine and Midwifery Students
University of Technology, Sydney	Assoc. Director, International Research Centre for Health Communication

Government

Department of Health, WA	Chief Health Professions Officer
	Chief Nursing and Midwifery Officer
	Acting Senior Nursing Officer, Nursing and Midwifery Office
	WA Clinical Training Network Manager
	Child and Adolescent Health Service
	Assistant Manager, Workforce Education and Reform

Industry

St John of God Hospital, Murdoch	Manager Learning & Organisation Development
Brightwater Care Group	Chief Executive Officer
	IPE Project Manager
	General Manager, Services for Younger People & Major Projects
	Acting Senior Research Officer
Royal Perth Hospital	Student Training Ward

Consumer Groups

Health Consumers Council	Aboriginal Advocacy Program Manager