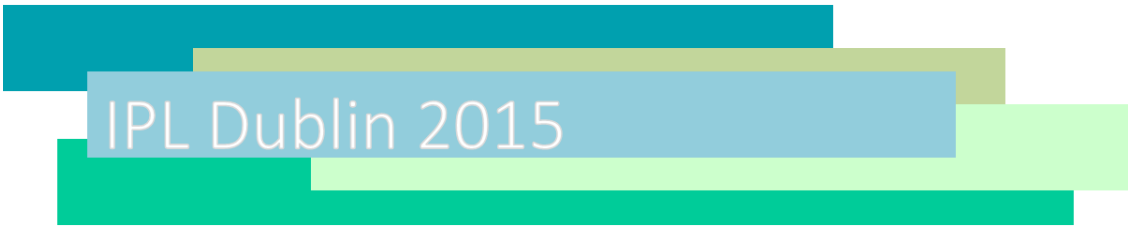
Health and Social Care Interprofessional Learning Conference
Dublin Castle, October 6, 2015



"Advancing health and well-being through interprofessional learning for collaborative practice: Good practice, Dilemmas and Future Directions"

May 2016

Bord Altranais agus Cnáimhseachais na hÉireann
Nursing and Midwifery Board of Ireland

CORU
Ag Rialáil Gairmithe Sláinte agus Cúraim Shóisialaigh
Regulating Health + Social Care Professionals

Comhairle na nDochtúirí Leighis
Medical Council

PSI
CUMANN CÓGAISEOIRÍ NA hÉIREANN
The Pharmaceutical Society of Ireland
AN RIALTÓIR CÓGAISÍOCHTA
THE PHARMACY REGULATOR

IPL Dublin 2015

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The Inaugural Health and Social Care Interprofessional Learning Conference

Summary

The inaugural Health and Social Care Interprofessional Learning Conference was jointly hosted by the health and social care regulators: Nursing and Midwifery Board of Ireland, Health and Social Care Professionals Council (CORU), the Medical Council, and the Pharmaceutical Society of Ireland (PSI), and supported by the Dental Council and the Department of Health, at Dublin Castle on 6 October 2015. The conference attracted over 160 participants from a range of health and social care professions, patients' representative groups, government representatives, education and training providers, employers and students. The conference facilitated Irish and international speakers to come together and discuss future directions for interprofessional health and social care learning in Ireland.

Under the broad theme "Advancing health and well-being through interprofessional learning for collaborative practice: Good practice, Dilemmas and Future Directions", the conference's primary aim was to commence dialogue on the nature and significance of interprofessional education and learning, and future directions for interprofessional and collaborative practice in Ireland.

The conference was envisaged as another mechanism to improve patient outcomes and safety in an environment of changing demographics with an increasing number of older people, often with co-morbidities, and where the potential for interprofessional health and social care interventions present. There was also consideration given to several well-documented failures in patient care, which had been ascribed to poor communication between care professionals and workers.

Including two international keynote speakers, the conference programme contemplated future directions for shared learning from a range of perspectives. Throughout the conference there was repetition of the need to embed interprofessional care, communication and learning from the earliest stages of undergraduate education and continuing throughout the lifelong learning spectrum, as part of continuing professional development.

The key themes emerging from the conference include:

- Systems-level support will be required to implement on a wider scale the valuable interprofessional learning (IPL) initiatives being rolled-out in the higher education institutions and health and social care settings
- Efforts are necessary to minimise the barriers to the introduction of a greater degree of IPL for health and social care in education and practice, including issues around fear of loss of professional identity, overcoming timetabling constraints for education providers and the impact of traditional hierarchies in health and social care provision
- IPL in undergraduate health and social care education and the early introduction of such learning will enhance the patient experience and ultimately patient care. Efforts to resource the development of the evidence-base for such impacts will be necessary to inform the decision-making of workforce development planners.

The conference identified that the main challenge will be to effect the necessary fundamental changes, systemically, organisationally and culturally, during a period of economic austerity.

The positive response to the event illustrates the level of interest and appetite to progress developments in the area of IPL and collaborative practice in Ireland. It is the intent of the health and social care regulatory bodies to continue to work together, and with key stakeholders, to progress the IPL agenda in Ireland.

Conference Introduction

Welcome to the conference was provided by Marita Kinsella, the CEO and Registrar of the Pharmaceutical Society of Ireland, who explained that the conference was a unique initiative by the five Irish health and social care regulators, which collectively regulate almost 20,000 health and social care professionals in Ireland. She mentioned the public health and safety aspect to the conference theme and the broader focus of the day. She stressed that the accreditation of degrees and courses by the regulators, and the standards they set, always aims at achieving the best outcomes for patients and clients. As those standards are all underpinned by patient safety and address matters such as communication and teamworking, as regulators, a shared understanding regarding expectations set out in those accreditation standards is key. According to Ms Kinsella, interprofessional working, and indeed learning, should take place from the earliest stages, from undergraduate courses through to professional practice.

Opening Address

Pat O'Mahony, Deputy Secretary General and Head of Governance and Performance at the Department of Health, delivered the Opening Address**.** He stressed the crucial role of interprofessional working in advancing the care and wellbeing of patients, emphasising its strategic importance for policy-makers, regulators, academics and workforce planners. He expressed his opinion that 'good practice' is more preferable than the term 'best practice' as the latter is not measurable and implies there is no scope for improvement. He noted that good practice is likely to be more sustainable. He pointed out that all patients and clients interact with a range of health and social care professionals and that the best patient care will lead to the best patient outcomes.

He reminded the delegates of the WHO definition of IPL as including the concept of healthcare students learning 'with, from and about' each other[1], leading to healthcare professionals aligning their systems to provide optimal care. He told the meeting that his role as Head of Governance and Performance reaches across the whole range of service providers and that, in his experience, there was already much good practice in Ireland.

[1] The WHO definition of IPL draws on that articulated in 2002 by the Centre for the Advancement of Interprofessional Education (CAIPE)

Morning Keynote Address - Developing Collaborative Practice through Interprofessional Education
Dr John Gilbert

The morning Keynote Address was presented by Dr John Gilbert, Professor Emeritus, University of British Columbia, and Senior Scholar, WHO Collaborating Centre on Health Workforce Planning and Research, Dalhousie University, Canada. Dr Gilbert is a Member of the Order of Canada in recognition of his leadership in the development of interprofessional education and collaborative care. These concepts are now part of university, college and institute health sciences training in many centres across Canada.

Dr Gilbert began his presentation by outlining the current context for IPL; despite notions of IPL existing for the last 60 years, ministers of health and governmental strategy tends to concentrate on employment opportunities for health and social care professionals rather than on their education. He described some of the barriers to interprofessional education as silos that subject areas and professions have erected through self-protective and insular attitudes. He traced this back to the Flexner Report on medical education in the USA in the early twentieth century and its recommendations which called for the restriction of medical education to university faculties. He noted the example of the propensity of powerful subject areas to separate themselves physically from other cognate areas by insisting on separate areas of buildings, or even, on separate buildings. He explained that this 'silo-ing' effect can impede health and social care professions from seeing beyond their own area of interest or expertise, rather than viewing the patient, the ultimate recipient of their expertise, as a whole. Dr Gilbert alluded that shared facilities are now being built but noted there is little evidence of curricular reform taking a more inclusive, interprofessional turn which should be a key driver for reforming the healthcare system. He suggested that if there is going to be reform across one section of the profession, there should be reform across all; this would result in consistency across the system, and create collaborative relationships between the various disciplines.

Dr Gilbert explained that in the complex world of health and social care, care professionals view aspects of patient care from a range of perspectives about what healthcare is, was and should be. Dr Gilbert used the example of chart writing, electronic reports and patient points of contact which he considers demonstrative of a 'variegated' patient experience. He called for the healthcare system to 'iron out the creases' between different disciplines to arrive at a greater sense of shared understanding and collaboration between and within health and social care. He also stressed that the healthcare workforce is complex, including not only health and social care professionals but also clerks, porters, cleaners and others, all of whom contribute to the delivery of healthcare.

Dr Gilbert went on to define the term 'interprofessional' in terms of the WHO three-part definition[2], as:

- Learning, with, from, and about
- For the purposes of *collaboration*
- To improve the *quality of care*

[2] The WHO definition draws on the 2002 CAIPE definition

He went on to stress that students need to understand from an early stage in their education that there is always more than one care professional involved in patient care and that 'quality of care' is not simply terminology but rather how the patient has been treated. He affirmed that the role of the professional in a care team is dependent on three factors: the patient population or setting, the legislated scope of practice, and the professional's personal competence. He noted that the professional needs to be aware of their own scope of practice and that of others.

In terms of educational strategies, he suggested that educationalists:

- build knowledge about what works in specific situations and contexts, by drawing on others' knowledge and experience to explore examples of practical application which they have trialled, and asking the questions;
    - Did their models work?
    - What element could have been done better?
    - What did they learn?
    - Is there a benefit in this type of framework?
- design and implement system-wide reform, with governments, adopting a universal approach to all disciplines and;
- develop adult learning competency-based approaches to interprofessional education (IPE) e.g. problem-based learning, case-based learning, simulation . Thus, all healthcare professionals can develop together to ensure there is a form of quality assurance.

Dr Gilbert shared with the delegates that about 70,000 complaints about the healthcare system in British Columbia are made every year, of which only 200 warranted further investigation. In Dr Gilbert's opinion, this was a result of a lack of ability amongst professionals working in the health and social care system to talk to each other, to patients and their families, and to the communities in which the healthcare is undertaken. He suggested that in order to achieve effective reform, governments must listen to the complaints submitted by patients, interpret the information and initiate appropriate change. He argued this would create a sense of impact, although its effects on the system would only be felt 10 years hence, underlining the importance of the need for expedient change

Similarly, on the practice side, Dr Gilbert noted that practitioners should:

- build a key health workforce strategy, which should be balanced between all sectors, ensuring that an appropriate space is created for collaboration between all divisions;
- design and implement system-wide, coordinated collaborative connections between educational and practice partners, including devising a budget that is distributed evenly across the various care sectors and which is supportive of IPL.

He opined that healthcare professionals are good at examining themselves, but less good at interpreting information gathered, and should learn from other systems. He noted that workforce development should be based on need e.g. the need for more homecare assistants to cope with an ageing population.

He also stressed that it was crucial to coordinate different healthcare students undertaking experiential IPL. All students at undergraduate level might be on placement together to learn from each other.

Dr Gilbert emphasized the concept of collaborative care, with the patient at the centre of the process, rather than on the periphery. He quoted from the British Columbia Patient Care Quality Improvement data showing that the top 5 areas of patient complaint in 2013-14 were care, attitude and conduct, accessibility, communication and discharge arrangements. He suggested these complaints reflected the lack of cooperation in healthcare which he described as “hearing but not listening”, and although 84% of respondents were happy with the care they had received, Dr Gilbert stressed that the 16% of dissatisfied patients should nonetheless form the focus of efforts to redress perceived failings of the health and social care system.

He proposed a number of Interprofessional Education Collaborative Practice (IPECP) strategies:

- Curriculum development: to set teaching, learning and practice in an appropriate framework by evaluating, measuring and monitoring outputs, outcomes and impacts, and assigning responsibility appropriately and effectively.
- Practice: to build a clear work plan, to design appropriate space and systems of administrative support, and to develop equitable funding and accountability.
- Collaborative patient care: to encourage teamwork. In particular, Dr Gilbert emphasized that the practice educators, often the unsung members of the healthcare educational care team, should be engaged, encouraged and appropriately rewarded as “the best lessons come from interactions with patients, not what is in the textbooks”.

In the question-time following his presentation Dr Gilbert told the conference he was unsure of the value of telemedicine in IPL but knew that there was work being undertaken in this regard using social media channels. He also emphasized that it was vital employers had a role in any curriculum redesign as currently most healthcare graduates are not “practice-ready”. He concluded by stressing the importance of financial accountability so that those providing the financial support for IPL developments could monitor how the resources were being used.

Morning Parallel Workshop Sessions

Theme: Developing Collaborative Practice through Interprofessional Learning

Morning Workshop 1: Teaching Methodologies for the Development of Collaborative Practice	
Presentation 1 Interprofessional student teams as medication safety 'watchdogs' in the hospital Dr Aislinn Joy and Dr Laura Sahm, University College Cork	Presentation 2 Investigation of palliative care education as a setting for undergraduate interprofessional learning Dr Catherine Sweeney, University College Cork

Morning Workshop 2: Interprofessional Education and Alignment to Collaborative Practice		
Presentation 1 Becoming 'Clinical Therapies'. The experience of aligning practice education curricula Marie O'Donnell, University of Limerick	Presentation 2 Promoting interprofessional teaching and supporting clinical education in a teaching hospital Noreen O'Shea and Ide O'Shaughnessy, St. James's Hospital, Dublin	Presentation 3 Learning together – using common conditions in primary care Johanne Barry, Queen's University Belfast

Morning Workshop 3: Interprofessional Learning for Patient-Centred Care		
Presentation 1 Putting the patient at the centre of IPE – lessons from a new medicine and pharmacy initiative Dr Judith Strawbridge, Royal College of Surgeons in Ireland, Dublin	Presentation 2 Clinicians, patients and family members: utilisation, opinions and experiences of patient and family participation in the design and delivery of healthcare services from a mental healthcare and a medical healthcare perspective Lucy Whiston, Trinity College Dublin	Presentation 3 Team and patient-centred communication: a foundation for safe quality care Thomas Kearns and Dr Eva Doherty, Royal College of Surgeons in Ireland, Dublin

Morning Workshop 4: Interprofessional Learning: Facilitating and Evaluating		
Presentation 1 The next steps: considering the implementation of a case-based IPE model in practice education Mairead Cahill, University of Limerick	Presentation 2 Evaluating an online, values-based decision-making interprofessional learning programme in pre-registration health and social care students Dr Heike Felzmann and Dympna Casey, NUI Galway	Presentation 3 An evaluation of the clinical interprofessional learning experience for trainee general practitioners in an academic urban minor injury unit with advanced nurse practitioners Julie O'Driscoll and Bernadette Carpenter, Mater Misericordiae University Hospital, Dublin

Morning Workshop 1 - Teaching Methodologies for the Development of Collaborative Practice

This session contained two presentations from University College Cork.

The first, *Interprofessional Student Teams as Medication Safety 'Watchdogs' in the Hospital*, was presented by Drs Aislinn Joy and Laura Sahm. It reported on an IPL initiative at UCC's College of Medicine and Health. Starting in 2009, with funding from the Network for Advancing Integration of Research, Teaching and Learning (NAIRTL), it involved teams of medical and pharmacy students working together as medication safety 'watchdogs' in the hospital.

The project was initiated following the occurrence of prescribing errors, as part of curriculum reform, and attempts to link classroom learning with patient experiences. One of the objectives was the assessment of students' readiness for IPL using the Readiness for Interprofessional Learning Scale (RIPLS). During a morning's work on a bimonthly basis, information from three sources (patient, Kardex and record/chart) was reconciled and recommendations made for any changes to prescribing or medication practice. During the same exercise, students learned about, from and with each other by together taking a full history from patients, rewriting drug Kardexes as well as writing sample discharge prescriptions.

One outcome of the project was that the medical students involved quickly improved their RIPLS scores during the programme. The pharmacy students were also found to become increasingly aware of their role as medicines experts, as part of the healthcare team. The implementation of this initiative over the last five years has also generated a repository of cases, as each team generates a collaborative report about its patient.

The second presentation by Dr Catherine Sweeney, *Investigation of Palliative Care Education as a Setting for Undergraduate Interprofessional Learning,* emphasised that palliative care is a specialty where an interprofessional team approach can be utilised to maximise the quality of life of patients with life-limiting illnesses, and support their families. Palliative care is a suitable setting for education in relation to working with other professions, although to date it has not been well used or studied for this purpose.

In University College Cork a 5-credit module entitled Palliative Care: an Interdisciplinary Approach was developed in 2012. It is offered annually on a voluntary basis to 20 medical and 20 nursing undergraduate students. Due to timetabling issues the module cannot currently be offered to other disciplines. The main foci of teaching and learning are palliative care and teamwork. In addition to teaching principles of teamwork, students work in small interdisciplinary teams, working on case-based learning and role-plays that highlight the need for clinical professions to collaborate and learn from each other. The module includes 20 face-to-face teaching hours and 6 hours of online work. Students appear to choose the module in order to study and experience palliative care rather than for its interprofessional element, but nonetheless, understanding of the value of interprofessional working improved.

Morning Workshop 2 - Interprofessional Education and Alignment to Collaborative Practice

The first presentation, *Becoming "Clinical Therapies". The Experience Of Aligning Practice Education Curricula,* was made by Marie O'Donnell and Mairead Cahill of the University of Limerick. The project related to students of occupational therapy, physiotherapy, and speech and language therapy. The presentation described how the development of a new Health Science Building facilitated the alignment of curricula in the newly formed Clinical Therapies Department at the University. This is an approach consistent with the World Health Organisation's concept of "learning together to work together for better health". The University is still in the implementation stages of this initiative, and it is anticipated that it will take 10 years to feel its impact.

The presentation outlined how new programmes were developed with an emphasis on the alignment of placement calendars to ensure that all students from different disciplines are on placement in the community environment together in order to apply IPL in a practical setting. Resources have been developed to support the Practice Education component of the programmes. The project demonstrated that there is a demand for the enhancement of communication skills/relationships in order to optimise the learning outcomes.

The discussion following the presentation highlighted the challenge of integrating timetables of previously separate disciplines to align placements so students might learn from one another in practice settings. In addition, learning outcomes had to be carefully considered to highlight course commonalities and other requirements which might be specific to each discipline. This was described as a prominent risk to the restructuring of curricula. This issue was resolved however through the development of shared modules common to each discipline and course specific modules and attendant handbooks.

The presentation by Noreen O'Shea Waugh and Ide O'Shaughnessy of St James's Hospital Dublin, *Promoting Inter-professional Teaching and Supporting Clinical Education in a Teaching Hospital*, described the aim of increasing the number and quality of clinical placements available for Trinity College Dublin (TCD) healthcare undergraduate students, and to ensure collaboration at an educator and a student level through the following means:

- creating and facilitating a hospital-wide Clinical Supervisor Education network to disseminate resources, educational ideas and initiatives
- increasing the enthusiasm for clinical teaching and therefore the number and quality of available clinical placements
- encouraging and promoting a collaborative working environment and,
- providing local support and preparation for clinical educators.

The rationale for investigating clinical education in a teaching hospital had been a result of restrictions to the supply of placements for students during 2013/2014. The study was designed to investigate factors influencing clinicians opting in/out of clinical teaching.

Information gathered showed that:

- preparation for clinical placements is time-consuming
- workloads increase
- there is a lack of resources

- there is little acknowledgement from the health system of the work undertaken by practice educators
- placements vary in quality
- practice educator attributes might be passed on to the junior consultant/student.

The study also questioned if the quality of care diminishes or is enhanced when students are on-site.

In conclusion, the speaker was of the opinion that IPE needs to be employer-driven and that employers should acknowledge health care professionals in hospitals are at the forefront of the healthcare system.

The third presentation, *Learning Together: Using Common Conditions In Primary Care,* by Johanne Barry of Queen's University Belfast, reported on undergraduate medical and pharmacy students working together in a simulated setting to address common conditions found in primary care. These sessions were part of a pilot in 2015 and, following the programme's success, are to be rolled out to all students in 2015/2016.

As part of the initiative, three pilot workshops were attended by Queen's University Belfast (QUB) Level 3 and 4 MPharm students (n= 25) and medical students (n=55) completing their GP rotation. Each session was facilitated by a pharmacist and a general practitioner, each with an academic QUB role, but who also works in primary care. The first two workshops took place in a health centre teaching room, the final workshop in the Pharmacy Practice Unit (PPU) of the QUB School of Pharmacy.

The use of the PPU allowed for peer observation of the dispensing process and patient counselling within a simulated community pharmacy setting. The aims were to:

- create awareness of some of the common conditions that present in general practice,
- provide an opportunity for the students to consider pharmacological and non-pharmacological approaches in the management of various conditions,
- allow students to consider the management of these conditions in the context of co-existing chronic conditions, and
- highlight the principles of good practice when writing a prescription.

Morning Workshop 3 - Interprofessional Learning for Patient-Centred Care

This workshop session consisted of three presentations on the theme of *Interprofessional Learning for Patient-Centred Care.*

The first presentation*, Putting the Patient at the Centre of IPE: Lessons from a new Medicine and Pharmacy initiative* by Dr Judith Strawbridge of the Royal College of Surgeons in Ireland, described a novel patient-centred IPL initiative. The initiative was developed in 2015 to enable third year pharmacy students and second year graduate-entry medical students to learn with, from and about each other in the context of the care of a patient with diabetes and a patient with a rheumatological condition.

The pharmacy cohort benefitted from increased access to patients, while the medical cohort benefitted from the application of pharmacy training in a patient setting. Similar numbers in each cohort of students allowed students to be divided evenly into small groups. Working in their groups, the students compiled a list of questions to address to the patient and wider multidisciplinary team. The students then came together in a large group and had the opportunity to direct their questions to the patients, and the team.

Included in the initiative were also short presentations by other medical specialists, and an interactive session on how to review a Kardex. Students were required to collaborate in undertaking a Kardex review and submit it along with a joint reflection on the experience. Student feedback confirmed the benefits of the holistic insight which the IPE approach fostered, with pooled knowledge benefitting all parties. The initiative however provided some dilemmas; the perception of professions, some degree of intimidation felt by pharmacy students, especially in relation to patient interaction, and the perception amongst some students that the experience would not be fully 'examinable'.

The second presentation was by Lucy Whiston, Joe Barry and Catherine Darker, entitled *Clinicians, Patients and Family Members: Utilisation, opinions and experiences of patient and family participation in the design and delivery of healthcare services from a mental healthcare and a medical healthcare perspective* from Trinity College Dublin. It described how patient and family experience of healthcare delivery improves when the views of patients and family members are sought and taken into account in designing, delivering and improving new and existing healthcare services. Internationally, a number of interventions to encourage patient and family participation have been examined. However, no consensus on the matter appears to have been reached.

This study aimed to explore the utilisation, opinions and experiences of patient and family participation (PFP) in healthcare design and delivery in Ireland from a mental and a medical healthcare service perspective. The mental healthcare service was a psychiatry service and the medical healthcare service was a type 2 diabetes service. Patients, family members, clinicians and policy leaders were included in the study. Clinical disciplines involved include nursing, psychiatry, endocrinology, psychology, occupational therapy, dietetics and podiatry. Questionnaires were completed with patients and family members. Focus groups and interviews with patients, family members, clinicians and policy leaders were also employed. Some differences were noted among participants in relation to the extent/understanding of participation, with some examples cited of limited or no participation.

There was support for PFP among clinicians, but barriers (including service pressures) were acknowledged, including setting realistic expectations regarding what can and might not be achieved through PFP. It was noted in the discussion that there is limited research currently being carried out in Ireland on this important topic.

Thomas Kearns and Eva Doherty of the Royal College of Surgeons in Ireland made the third presentation, *Team and Patient-centred Communication: A foundation for safe quality care*. They described how Irish data support the assertion that good communication underlies successful healthcare, and that communication and interpersonal competencies are a fundamental requirement for professional healthcare practice.

It is internationally recognised that better communication leads to better healthcare and increased patient satisfaction. Thus, there is strong evidence that communication deficits account for a significant proportion of complaints and adverse events. Improving this situation includes ensuring learning objectives are set to ensure that both verbal and non-verbal communications remain the focus in small group settings. The programme must be adaptable for learner needs, facilitate reflection, and create the time and space to ensure that all participants are equal in the learning transaction. The discussion highlighted the importance of providing a safe environment for learning the skills of good communication.

The first presentation, *The Next Steps. Considering the implementation of a case-based IPE model in practice education,* by Marie O'Donnell and Mairead Cahill from the University of Limerick, described how healthcare workers are increasingly called upon to work collaboratively in practice to improve patient care.

The process and the educational outcomes of a client-centred, case-based model of IPE in practice placement sites were described. Evaluation of this model of education resulted in suggestions for services to consider the implementation of similar projects and concluded that IPE in the clinical setting, using the client-centred MAGPIE model, could provide a strong foundation for enhanced learning in practice education contexts.

Feedback illustrated that the model:

- was a motivating experience
- assisted relationship-building between professions
- enhanced learning
- presented opportunities to change the professional culture; in particular a lack of clarity and coordination within interprofessional groups.

The study's findings suggest that the MAGPIE model might be applicable to numerous healthcare settings at a range of placement levels. This study also showed that the clarity of expectations for a specific placement is enhanced through more explicit goal-setting and associated assessment and measurement.

Recent curricular changes in the Clinical Therapies at the University of Limerick have resulted in placement alignment across disciplines. This has offered opportunities for the University of Limerick practice education teams to resume implementation of this model through the mid-west area in the forthcoming academic year. The discussion highlighted that the experience of interprofessional working had motivated the students and enhanced the depth of their learning.

The second presentation, *Evaluating an Online Values-based Decision-making Interprofessional Learning Programme in Pre-registration Health and Social Care Students*, was presented by Dr Heike Felzmann of NUI Galway.

She described a six-week online IPL programme that focussed on values-based decision-making in ethically problematic healthcare situations and was designed to promote collaborative practice. 166 students from five pre-registration health and social care courses (medicine, nursing and midwifery, occupational therapy, social care and speech and language therapy) at NUI Galway consented to enrol in the programme and allow their data to be analysed for research purposes. Over the six weeks of the programme, students were presented with a total of six case scenarios which they worked on collaboratively within their IPL group.

The educational model underpinning the programme draws on several pedagogical approaches including student-centred learning, problem- and group-based learning as well as self-directed engagement. The programme utilises a range of interactive learning tools allowing students to solve problems collaboratively in a context specifically designed to make judgements transparent.

Reviewing the programme subsequent to its completion, a number of issues were identified and included:

- the complexity of the online interface
- a demanding level of workload
- an imbalance of input vs output (i.e. lots of work for minimal number of course credits), and
- an unequal involvement of participants from different disciplines.

To resolve these issues, it will be necessary to review the workload, make participation mandatory, and improve training in the use of the online portal.

The third presentation, *An Evaluation of the Clinical Interprofessional Learning Experience for Trainee General Practitioners in an Academic Urban Minor Injury Unit with Advanced Nurse Practitioners,* by Cora O'Connor and Julie O'Driscoll described the 2010 establishment of an academic urban minor injury unit in an overcrowded, busy emergency department in a bid to improve waiting times.

In 2011, general practitioner (GP) trainees commenced a clinical rotation through the unit focusing on minor injury assessment, treatment and care. To date, ten GP trainees have availed of the training scheme which was facilitated by registered advanced nurse practitioners (RANP). This case study sought to explore the IPL experience of participants with a focus of the specific experience of the trainee GPs.

Feedback from trainee GPs indicated high levels of personal and professional gain through exposure of the GPs to the nursing profession, the building of rapport and collegiality, and an appreciation of the RANP as a suitable and valuable educator in this context. The key messages emerging from the study were that practice is enhanced through exposure in a safe and controlled learning environment to different healthcare professionals and that the teaching role of the RANP is acknowledged and valued. This acknowledgement and explicit value attached to the RANP collaboration also acts as a factor to reinforce and motivate IPL practices further. The discussion noted that one of the impacts of the collaboration had been that fewer patients had been sent for unnecessary X-rays.

Morning Plenary Panel Session 1 - European Agenda for Effective, Resilient and Accessible Health Systems
Caroline Hager

The first plenary speaker was Caroline Hager of the European Commission Directorate General for Health and Food Safety on the subject of *European Agenda for Effective, Resilient and Accessible Health Systems.* Mrs Hager highlighted the impact of the recent economic crisis which led to a cost-cutting exercise in health and social care. She told the conference that governments have a primary role in healthcare reforms and referred to a number of initiatives through which the EU can support policy makers to strengthen effectiveness, with the aim of improving health outcomes, increasing accessibility, and improving resilience with limited resources.

She described how the EU funded several healthcare organisations to investigate outcomes via continuing professional development (CPD), highlighting the need to increase IPL learning. To strengthen effectiveness, she proposed health systems performance assessment, patient safety and quality of care, and integration of care as key drivers. To increase accessibility she stressed the need for healthcare workforce planning, telling the meeting it is predicted that there will be a one million shortfall of healthcare professionals in the EU by 2020. She cited the example of Bulgaria where 80% of doctors trained in the country subsequently leave. Thus, planning and forecasting is necessary, along with serious consideration of career development opportunities, supportive workplaces, appropriate salary structures, and the cost-effective use of medicines.

In terms of increasing resilience, she considered that the education and training of healthcare professionals is still seen as a burden by governments, and that there must be a move away from the silo approach described earlier by Dr Gilbert, towards a more integrated approach that will lead to true patient-centred care that deals with the human being, rather than treating illness alone and provides greater empowerment of patients..

Morning Plenary Panel Session 2 - WHO Patients for Patient Safety Network Margaret Murphy

The second plenary speaker was Margaret Murphy, patient advocate and the External Lead Advisor for the WHO Patients for Patient Safety Network, whose son died as the result of medical errors.

Margaret emphasized from the outset the need to treat the patient rather than just the disease. She argued that at the heart of patient safety should be:

- patient and family engagement in the care process,
- the need to value and validate the patient experience,
- the need to recognise patient experience as a patient safety indicator and driver for healthcare improvement,
- that the patient has the greatest vested interest in the outcome, and
- recognition of the challenge to provide patient-centred and seamlessly integrated care.

She pointed out that the patient is the one constant in the healthcare process, and suggested that the '3 H's' should always be borne in mind:

- the 'Head' in terms of intellect,
- the 'Heart' in terms of emotion, and
- the 'Hands' in terms of skill.

She referenced Conway's notion of "making the status quo uncomfortable, while making the future attractive", with a culture of openness, transparency and true professionalism. True professional integrity she suggested is having the past inform the present, having the present inform the future, and accepting disclosure of failings.

She related her experiences of meeting medical students to narrate the catalogue of events and missed opportunities leading to her son's untimely death. She called for greater integrity, humility and compassion among health and social care professionals and stressed that the care of patients as human beings is not taught. She emphasised the value of the patient experience/the story as a learning tool using the quote from Vera Keane in the Bulletin on Nurse Midwifery (1967) which states that "facts do not change feelings, and feelings are what influence behaviours. The accuracy, the clarity with which we absorb information has little effect on us; it is how we feel about the information that determines whether we will use it or not".

She asserted that there should be an attempt to achieve a common ethos in relation to patient-centred care. Students of all disciplines should be exposed to the reality of the patient experience, including gaining insight into what it is like to be a patient, family member or clinician when things go wrong. Appreciating the privilege of being a healthcare worker who is gifted with the opportunity to serve humankind on a daily basis is critical to the delivery of patient centred care. She used the telling statement that "Students remember what they learn from patients. The authentic and autonomous patient voice promotes the learning of patient-centred care".

Afternoon Keynote Address - Planning for an Integrated Health Workforce
Professor James Buchan

The afternoon keynote address was presented by Professor James Buchan, Adjunct Professor at the WHO Collaborating Centre, University of Technology Sydney, Australia, and Professor in the School of Health Sciences at Queen Margaret University, UK. Professor Buchan explained that his main role is in workforce planning and policy. He opened his presentation by saying that, although IPL can mean different things to different people and professions, it is the glue that keeps the healthcare workforce stimulated, and needs to be driven by policy-makers.

He went on to discuss global issues including what he described as the 'demographic double whammy' in Ireland and other EU/ OECD countries of an ageing population and workforce and the impact of the global financial crisis on funding for universal health coverage/access in underserved communities. He stressed that policy must be developed on health workforce sustainability and include:

- planning,
- retention,
- skills enhancement,
- team-work,
- integration, and
- long-term investment.

Like Dr Gilbert, Professor Buchan emphasised that everyone contributing to healthcare should be involved in workforce planning, not just healthcare professionals, but community health workers, volunteers and self-managed patients. He stressed that education should align with funding, regulation, service delivery and employment to create a workforce fit for purpose, and considered whether healthcare systems need more specialists or generalists. He referred to an OECD review of healthcare workforce planning, demonstrating that such planning is not an exact science. The review indicated that of 26 planning models in 18 different OECD countries, most were utilisation-based rather than needs-based, most are supply-driven, most do not address current imbalances, and few link with funding. Professor Buchan indicated that plans need to be costed for government consideration. The recommendations of the OECD review were that the long view should be taken, with a shift to multi-professional planning and a greater emphasis on geographic distribution of quality healthcare.

Professor Buchan told the delegates that workforce planning must integrate with service planning and funding; conversely IPL budgets tend to be the most susceptible to government funding cuts, and most countries do not plan for integrated healthcare teams.

He shared data showing that the workforce is not uniformly distributed in different countries. Austria and Australia have approximately three to four nurses per physician, but others, such as Argentina having the opposite ratio. He also pointed out that Ireland has approximately 2.5 times the proportion of non-Irish doctors than the OECD average. Thus, different education and backgrounds of professionals trained outside a country might pose additional barriers to planning interprofessional collaboration and working practices. He asserted that the concept of IPL would have to be explained to government ministers who are likely to focus on issues of employment

volumes, incentivisation and retention of workers, upskilling and improving productivity. Professor Buchan posed the questions:

- How can we plan how many health workers to educate, and employ?
- How can we improve recruitment, retention and return of workers?
- Which incentives are effective in motivating staff?
- How can we determine and deploy the most effective skill mix of different roles and staff?
- How do we improve productivity of staff?

He suggested a strong link between levels of expenditure and staffing levels. He noted that there was limited, but growing evidence base on links between education (and other staffing inputs) and outputs/outcomes. He explained that the political economy, IPL/E, skill mix and staff mix vary between organisations and countries, and there is virtually no research focussing on the broader political economy as an enabler/barrier to IPL/E, scope of practice, new roles and skill-mix changes.

In terms of IPL/E enablers and constraints, Professor Buchan listed, amongst others:

- workforce/health professional interests
- structure and organisation of care
- funding mechanisms
- financial/non-financial incentives, including the use of fees versus a salary structure, and
- legislation and regulation, including that around prescribing.

He ended his presentation by explaining that education is too important to be left to the educators. He outlined the next steps as:

- Integrate it: alignment with funding, planning and service delivery.
- Fund and sustain it: through community, staff and stakeholder engagement, mainstream/social media, politicians, policy makers, along with clarification of definitions/language.
- Prove it: improve the evidence base to focus on key messages and critical gaps in evidence, such as costs, outcomes, connections between IPL and team/organisational performance.

In the question-time which followed, Professor Buchan explained that government funding models are driven by health priorities, and tend not to be the drivers for IPL. He noted that different funding models lead to different behaviours and explained that major funding goes mainly to the hospital sector, hence reducing the impact in primary care.

He told the meeting that the differential impact of different remuneration models, such as fee for service or salaries, might be a determining factor in the behaviour of healthcare professionals towards patients. He highlighted that despite most health care being delivered by inter professional teams there tends to be no recognition of any need for remuneration rewards to healthcare worker teams. When asked if health worker education should be the responsibility of health or education, he asserted that the responsibility for the deciding on the allocation and targeting of funding of healthcare education initiatives should lie in the hands of departments of health, rather than departments of education, giving the example that, in Scotland, the chief Nursing Officer at the Health Department contracts funding with the providers of nursing education.

Afternoon Parallel Workshop Sessions

Theme: Aligning Systems for Future Collaborative Practice

Afternoon Workshop 1: Interprofessional Learning for Collaborative Practice: identifying opportunities and maximising impact	
Presentation 1 Increasing opportunities for interprofessional learning within professional qualification clinical therapies programmes Dr Ann Taylor, University of Limerick	Presentation 2 The work of CAIPE and its impact on interprofessional education throughout the UK Dr Richard Gray, Chair of the Centre for Interprofessional Education (CAIPE)
Afternoon Workshop 2: Interprofessional Education and Alignment to Collaborative Practice: Shared Competencies	
Presentation 1 The effectiveness of a physiotherapy-led football skills group for children in early intervention services on motor skills and health related quality of life Heather Kennedy and Cliona Murphy	Presentation 2 Developing shared competencies and digital resources from medicine, nursing and pharmacy to inform IPE Dr. Henry Smithson, University College Cork and Gerardina Harnett, IT Tralee

Afternoon Workshop 3: Facilitating Improved Interprofessional Communication		
Presentation 1 The benefits and challenges of student-led clinics – towards interprofessional education Jane Kavanagh, University of Limerick	Presentation 2 An action research inquiry into the potential role of a medical social worker for tuberculosis patients in an acute hospital outpatient setting Donna Stapleton and Maria Kane, St. James's Hospital, Dublin	Presentation 3 Generating student insight into interprofessional communication through a simulated patient workshop Dr Gopal Oliver, Nottingham University and Dr Rebekah Wilmington, Health Education East Midlands, UK

Afternoon Workshop 4: Interprofessional Learning for Collaborative Practice: Overcoming Challenges and Barriers	
Presentation 1 Benefits and challenges of interprofessional education in an acute hospital: occupational therapy and physiotherapy perspectives Valerie Flattery and Fiona Melia, Galway University Hospital	Presentation 2 Integrating elements of undergraduate curriculum learning Doris Corkin and Ann Devlin, Queen's University Belfast

Afternoon Workshop 1 - Interprofessional Learning for Collaborative Practice: Identifying opportunities and maximising impact

Afternoon Workshop 1 contained two presentations.
The first, *Increased Opportunities for Interprofessional Learning within Professional Qualification Clinical Therapies Programmes*, was presented by Dr Ann Taylor of the University of Limerick. She described how the formation of the Department of Clinical Therapies, by merging several previously separate departments at the University, had provided the opportunity to optimise IPE. This was achieved through the structural alignment of the physiotherapy, occupational therapy and speech and language therapy programmes' curricula and by creating shared modules between the groups of students, at undergraduate and postgraduate levels.

The physiotherapy programmes include a four-year undergraduate BSc and a two-year professional qualification MSc. The occupational therapy and speech and language therapy programmes are two-year professional qualification MScs. The presentation highlighted some of the challenges, issues and considerations that needed to be addressed over a three-year planning period to facilitate more opportunities for interprofessional learning between all the programmes. This included the challenge of differing terminologies and initial resistance to change, along with achieving the appropriate balance between professional specificity and commonality. In terms of pedagogy, common ground was found through the use of case-based, problem-solving learning approaches. The discussion following the presentation explored several issues of interest, one of which remains the selection of the most suitable means of evaluating the effectiveness of the approach. In response to a question about the roles and influences of the regulators, the meeting was told that several of the Irish health and social care professional regulators has IPL high on its list of requirements for the accreditation of education and training courses and programmes leading to professional qualification.

The second presentation, *The Work of CAIPE and Its Impact on Interprofessional Education Throughout the UK,* was presented by Dr Richard Gray, the Chair of the Centre for Interprofessional Education (CAIPE). He described how CAIPE aims to promote and develop effective IPE in health, social care and related fields.

CAIPE promotes IPE and collaborative working throughout the UK by working with commissioning, educational, professional and regulatory bodies to coordinate national policies, priorities, strategies and requirements for IPL and IPE within professional education. CAIPE also informs national policy by responding to and informing relevant consultative documentation. He described the critical success factors and relevant strategic and operational challenges to the Centre, and recommendations for successfully creating a Policy Platform for the Education of Health and Social Care Professions. He described CAIPE's priorities as exploring ways of channelling finite resources into the development of IPE in the UK to further collaboration in services for the chronically sick and vulnerable. The discussion highlighted the work of CAIPE in the promotion of research and publications on IPL learning and how the organisation is moving forward an international agenda through its engagement with the World Co-ordination Committee for IPE and Collaborative Practice.

Afternoon Workshop 2 - Interprofessional Education and Alignment to Collaborative Practice: Shared competencies

The first of two presentations in this workshop, *The Effectiveness Of A Physiotherapy-Led Football Skills Group For Children In Early Intervention Services On Motor Skills And Health Related Quality Of Life*, was by Heather Kennedy and Cliona Murphy. They described how a football skills group for children with complex needs was run by community physiotherapists using modified interdisciplinary strategies. Participation by the children was enhanced by using strategies learned from speech and language therapy, occupational therapy and psychology.

On the formal assessment of motor skills, significant improvements were found in all participants. Key to the assessment of participants and the delivery of the programme was the active engagement with the football group of parents as the primary care-givers. In order to assess the outcomes of the programme, parents were invited to submit an assessment report before and after the programme which provided qualitative data upon which the presentation was based.

Following analysis of reports, ball skills appeared substantially improved, but no significant improvement in quality of life was necessarily detected. Of particular importance was securing an active parental engagement to assist in directing approaches throughout the programme.

The second presentation, *Developing Shared Competencies And Digital Resources From Medicine, Nursing And Pharmacy To Inform IPE*, was by Dr Henry Smithson and Caroline O'Connor from University College Cork and IT Tralee. They described the development of an e-portfolio resource involving academics from a range of professions including medicine, nursing and pharmacy.

The shared competency framework and e-portfolio will be developed by overlaying existing professional competencies and learning logs, to establish shared competencies. It will then be refined by the project steering group and advisory focus groups of tutors, practitioners and students. Students will use a commercial e-portfolio platform to document shared and specific competencies, personal reflections and a record of achievement. An associated digital library will comprise webinars, clinical scenarios and links to relevant material. The webinars and scenarios will demonstrate the differing perspectives of medicine, pharmacy and nursing, thereby enhancing a continuation of IPL.

To further enhance interprofessional collaboration, the components of the project are developed jointly: pharmacy is leading on the common competency framework, nursing on the design of the e-portfolio, and medicine is leading the development of the tutorial platform and digital library. Surveys of relevant competencies as presented in regulator Competency Frameworks has allowed a categorisation of competencies. Cutting across frameworks and professional contexts, the categorisation can be summarised as:

- the professional as a practitioner,
- the professional as a scholar/lifelong learner, and
- the professional as a professional.

This approach allows profession-specific mapping of competencies alongside the common competencies shared across nursing, medicine and pharmacy.

Time was spent in discussion in relation to additional shared competencies which might be included (for instance cultural competence, leadership), and also the role of funding in developing competencies. In taking this collaborative approach, it is hoped that a framework can be developed which more accurately aligns similarities and differences between the professions and allows for IPL to flourish.

Afternoon Workshop 3 - Facilitating Improved Interprofessional Communication

The first of three presentations in this session was entitled *The Benefits and Challenges of Student-led Clinics: Towards IPE*. It was presented by Jane Kavanagh from the University of Limerick. It showed how student-led clinics can provide opportunities for students in health care professions to experience "real life" clinics while also providing beneficial outcomes for service users, and empowering students to collaborate to take responsibility for logistics and operational management of patient/client care.

The initiative for setting up the student-led clinics was prompted by a lack of available student experiential learning placements, further exacerbated by staff shortages. A review of the preliminary experiences from thirteen small unidisciplinary student-led clinics in the disciplines of occupational therapy, speech and language therapy, and physiotherapy was carried out by the Regional Placement Facilitators across the three disciplines. These clinics were part of the placement experience of the students in an Irish University between 2011 and 2013.

An interesting outcome within this study was that many of the challenges experienced led to initiatives and creativity within the placements. Shortage of space, time or resources compelled the students to address logistical issues that would not necessarily arise within a traditional placement model. This proved to be an asset for the students as it facilitated student learning and professional development in a comprehensive way. The teaching staff also noted an increase in student confidence, skills, and professional trustworthiness. Challenges related to physical resources, and staff buy-in.

The discussion following the presentation highlighted that this pilot project will be extended into a full IPL initiative. However, the different curricula will require careful aligning if the students are to feel the greatest benefit from the scheme.

The second presentation in this workshop was *An Action Research Inquiry Into The Potential Role Of A Medical Social Worker For Tuberculosis Patients In An Acute Hospital Outpatient Setting* given by Donna Stapleton from St James's Hospital, Dublin. She described how a multi-disciplinary team comprising consultant respiratory physicians, registrar, public health doctors and nurses, senior pharmacist, tuberculosis (TB) nurse manager and administration staff worked together to meet patient needs.

The project was initiated as the hospital TB team felt the service would benefit from an outpatient Medical Social Worker (MSW). With this in mind, funding from Trinity College 'Med Day' initiative allowed a MSW to work with the team for ten months. This study aimed to reach a greater understanding of the social needs of TB patients and determine how a social work role might complement TB patient care.

The service trial indicated that TB patients have needs which might require MSW support or assistance; however, referrals from the TB team were low. Review of specific cases yielded inconsistencies in the documentation of social history and indications that patients might have benefit from an MSW-led intervention/contributions to their care.

A focus group confirmed these benefits to allied professionals, and also highlighted a lack of shared understanding around the role and responsibilities of MSWs. Direct observations showed that MSW involvement in regular meetings with the TB team improved communications between team and

MSW, allowing each professional to focus on their particular role, as the emotional needs of the patient are met by the MSW.

The third presentation was by Drs Gopal Oliver and Rebekah Wilmington from the University of Nottingham and Health Education East Midlands, UK. Entitled *Generating Student Insight Into Interprofessional Communication Through A Simulated Patient Workshop* they described the design of an interprofessional workshop focusing on communication in the acute medical setting.

Such a workshop in an interprofessional format, is entirely novel to the University of Nottingham curriculum for both medical and nursing students. The workshop used simulated patients preceded by an introductory talk and accompanying video. The workshop aimed to improve handover skills during patient admission. Student nurses would triage the patients and hand them over to medical students who would then assess the patient. Following this, the medical plan, and any specific nursing instructions, would be fed back to the student nurses. Facilitators would then supervise a discussion about the clinical case and highlight the importance of how both collaboration and communication results in improved patient care.

Through patient interaction, each cohort observed the communications approach of the other. Particular scenarios facilitated learning; in particular, aspects of care which involved interaction with other professionals on the care team. There was widespread support among participants including confirmation of increased insight regarding the role of colleagues, learning experience overall, and communication. There was earlier access to simulated patients than nursing students would otherwise have experienced. Both cohorts confirmed they would like more teaching on Situation-Background-Assessment-Recommendation (SBAR) handover techniques.

Afternoon Workshop 4 - Interprofessional Learning for Collaborative Practice: Overcoming challenges and barriers

The first presentation, *Benefits and Challenges of Interprofessional Education in an Acute Hospital: Occupational Therapy and Physiotherapy Perspectives*, was by Valery Flattery of Galway University Hospital. She described how, since 2011, occupational therapy and physiotherapy Practice Tutors have collaborated to deliver interprofessional education sessions (IPE) to students on clinical placement within their departments.

Historically there had been a commitment to facilitating shadowing interdepartmentally and attending multidisciplinary team meetings as part of IPE. It was considered beneficial to attempt to expand students' experience. IPE has been facilitated on an ongoing basis but the presentation reflected on the development, implementation and evaluation of an IPE programme for students in 2013.

Although not novel in design, IPE has proved challenging to implement in the acute setting within existing resources, hence there is value in looking at it from a practice perspective in order to promote its benefits and share learning. The purpose included;

- role clarification,
- professional socialisation,
- IPL to increase knowledge and competence, collaboration and conflict resolution.

Clear outcomes were judged to be enhanced communication, increased levels of collaboration and increase in knowledge, both profession-specific and interprofessional.

The second presentation was by Doris Corkin of Queen's University Belfast. *Integrating Elements Of Undergraduate Curriculum Learning* described how rapidly advancing practice and recognition of nursing, midwifery and medicine as a vital interrelated workforce provides a variety of curricula opportunities.

This project addressed the challenge for healthcare educators to widen student engagement and participation through interprofessional education by creating learning environments whereby student interactions foster the desire to develop situational awareness, independent learning and contribution to patient advocacy. The aim of the project was to develop a student-led, IPL approach to support the development of advanced knowledge and understanding of feeding and nutrition in infants and children as a response to a low uptake of breast-feeding in Northern Ireland. This interprofessional student-led workshop was initially implemented in 2006-07 in collaboration with the Centre for Excellence in IPE, within the curricula of medical and nursing programmes.

Supported by the development of a student resource pack, this project has been offered to Learning Disability Nursing and Midwifery students since September 2014. The outcome was described as a positive experience for students in supporting relationship building, and the approach will be embedded into undergraduate medical and nursing curricula.

Afternoon Plenary Panel Session 1 - System, Structure and Psyche
Christine Braithwaite

The first plenary speaker of the afternoon was Christine Braithwaite, Director of Standards and Policy at the UK Professional Standards Authority for Health and Social Care. She stressed the need for improved communication among healthcare workers to support better patient outcomes, and, echoing Margaret Murphy's point, emphasised the need to take into account the whole human being rather than just aiming to treat the disease.

She stressed the need to take into account the psyche not only in patients, but particularly in healthcare professionals, arguing that disengaged professionals are likely to provide a poorer standard of care. She told the meeting that examination of Fitness to Practise cases had had allowed them to postulate three categories of healthcare professionals. She offered characteristics of:

- adventurers, who exploit holes in whatever system they were working in to their own ends,
- drifters who are disengaged, and
- strugglers who have difficulty in meeting appropriate standards of competence.

She described the hierarchy within the health and social care system as deriving from a medieval model in which each profession carves out its own niche. She explored the influence of the psyche of the health and social care professionals on patient care, describing the psyche as a potential danger to patients. She explained that professionals may be more influenced by their peers than by regulators and that problems with psyche might develop during student days and be carried forward to the work environment. She questioned whether professional identity is of relevance to patients and their care.

Different professions were described as having diverse cultures; thus, she asserted, research suggests nurses are more likely than doctors to speak out about problems, whereas doctors may often regard medicine as an exact science and apply denial and distancing in the face of problems. She described evidence of doctors and anaesthetists regarding dangerous situations as normal with the result that they did not discuss these situations, and hence no change or improvement was made. She concluded by stressing the need to take human psychology and the psyche of health and social care professionals into account in patient care.

Afternoon Plenary Panel Session 2 - Learning together to work together
Dr Siobhan Ní Mhaolrúnaigh

The second plenary speaker was Dr Siobhan Ní Mhaolrúnaigh, Director of Research in Nursing at IT Tralee. Reflecting the views of other speakers, Dr Ní Mhaolrúnaigh started her presentation with the assertion that collaboration can only take place within a conducive environment in educational and practice arenas, and that IPL through collaboration must result in better services for patients, clients and service users.

She described the dilemmas and barriers involved in developing a collaborative approach to learning as including:

- command and control culture,
- competition versus collaboration
- tribalism versus togetherness,
- interagency communication breakdown,
- preparation,
- resources,
- complexity of structures, and
- the fragility of collaborative planning.

She described the requirements for change as including:

- collaborative interactive learning
- appreciative inquiry within learning organisations
- mutual trust
- visionary, and innovative collective leadership, and
- champions who act to create a culture of change.

Thus future directions should include: strategic planning and decision-making, policy development and implementation, collaborative networks, open dialogue, replication of good practices not duplication of effort, knowledge networks and knowledge transfer, champions and leaders of change, and evaluation and research.

She used the example of the aviation industry as a sector that works collaboratively to develop crew resource management through safety training. Health and social care organisations must embrace a Black Box approach to policy implementation and improvement. She argued that in the current economic uplift it is important that the rising tide of opportunity, through interprofessional networking in Ireland, be seized to evolve teaching, learning and collegiality for high quality inclusive care for the public.

Closing Address
Ginny Hanrahan, CEO, Health and Social Care Professionals Council (CORU)

The Closing Address was given by Ms Ginny Hanrahan, CEO of the Health and Social Care Professionals Council (CORU), who concluded from the presentations that IPL was alive and well in Ireland and, importantly, was improving. She stressed that in accreditation processes all regulators expect to find evidence of providers embracing interprofessional education and learning in their disciplines. She acknowledged that problems do arise from poor teamwork and poor communication and was pleased that the conference had addressed such issues. She summed up the main themes of the conference as:

1) emphasising that it is the role of the healthcare worker to care for the patient as well as to treat the medical problem,

2) stressing that students need to be aware of the roles of other health and social care and related workers caring for patients, and

3) that health and social care professionals and workers should always think about how they work and how it relates to the standard of patient care.

Overall she stressed the need for compassionate health and social services.

Ms Hanrahan reported that over the course of the conference, it had become clear to her that these themes will require a fundamental change in approach to the future education and training of health and social care professionals with the aim of providing a holistic approach to patient care, in an era of severely restricted healthcare funding.

For an IPL approach to be fully successful it is likely to require early exposure of students to peers in other health and social care professions which in turn will require governmental direction. A piecemeal approach is unlikely to be effective, but it will represent a considerable cultural challenge to change entrenched hierarchical attitudes.

Concluding, the closing speaker drew on an analogy: the change required can be likened as going about into the wind in a sailing boat; it is essential that a decisive move is made– a half-hearted move of the tiller will cause the sails to lose the wind and the boat to lose momentum. The conference agreed that it favoured a full sail ahead approach and looked forward to learning of continued developments in the area.

Outcomes

The inaugural Health and Social Care Interprofessional Learning Conference facilitated the theme of IPL amongst health and social care professions to be discussed at a national level in a dedicated forum for the first time.

It is hoped that the platform that the conference provided shall encourage ongoing initiatives and research into IPL activities. It is anticipated that as integrative principles become more embedded in professional education and training programmes, multi-agency perspectives will increasingly inform models of health and social care practice, supporting the prominence and practice of IPL across the professions.

Poster Presentations

During the conference, delegates had the opportunity to view 10 poster presentations:

- Interprofessional education in Brazilian primary healthcare – *Heloise Agreli (University of São Paulo)*
- Establishing a CPD system for pharmacists which supports interprofessional collaboration in the interests of enhancing patient care – *Dr Catriona Bradley (Irish Institute of Pharmacy)*
- Influences on, and relationship between, clinical autonomy and nurse/physician collaboration among emergency nurses – *Patrick Cotter (University College Cork)*
- Equipping practitioners to deal with child protection and welfare: an interdisciplinary model for delivering blended learning – *Dr Michaela Davies (University College Dublin)*
- Preparedness of undergraduate students for interprofessional learning – *Frances Horgan (Royal College of Surgeons in Ireland)*
- ePrePP: An electronic Preparation for Professional Practice – *Dr Henry Smithson & Eileen O'Leary (University College Cork)*
- Developing early IPE initiatives at RCSI – *Dr Judith Strawbridge (Royal College of Surgeons in Ireland)*
- A cross-faculty IPL experience – *Dr Ann Taylor (University of Limerick)*
- Interprofessional collaborative practice in the clinical setting – *Emer Thompson & Ann Stout (Bantry General Hospital)*
- Practical prescribing: the use of postgraduate research to inform undergraduate curriculum design – *Dr Elaine Walsh (University College Cork)*

Resources

The full conference programme, speaker biographies, presentations and videos of plenary addresses from the day are available on the conference website www.iplconference.org.

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Finally, the organisers thank all the speakers and delegates for their support in attending. In showing their commitment, interprofessional learning is steadily brought to the forefront as an essential aspect of health and social care education, training and continuing professional development.

Contact

Should you wish to contact the organising committee about any aspect of the IPL Dublin 2015 conference, you can do so by email to iplconference@psi.ie.