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Doctorate Studies

The HEIPS framework: Scaffolding interprofessional education starts with health professional educators

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ABSTRACT

The link between interprofessional collaboration and interprofessional education has been at the centre of discourse for some time. To understand some of the challenges of interprofessional collaboration, a research study was undertaken. The study investigated the interprofessional socialisation experiences of health professional educators, across five higher education faculties in Perth, Western Australia (WA). An interpretive phenomenological framework was utilised to explore the phenomena of interprofessional socialisation. Twenty-six professional educators were interviewed from a variety of health-related disciplines and qualitative content analysis was undertaken with the aid of NVivo 10 software. Examination of the data discovered a range of barriers that were potentially preventing professionals from working together effectively, within education. Overcoming some of these obstacles were identified, such as, professional language, organizational support, time and workload and the proximity of professionals. The research also recommended a framework that would support health educators. Currently, there are conceptual frameworks that guide the professional and interprofessional socialisation of healthcare graduates within education. Whereas, there is very little guidance or frameworks to support professional educators interprofessional experiences. The heath educators' interprofessional socialisation (HEIPS) framework is presented within this paper, and is a four-step process to encourage the interprofessional socialisation of educators within universities.

1. Background

IPE has been recognised as a vital phase in preparing healthcare graduates to work collaboratively within clinical environments. The reason for this important component in healthcare activity, is that interprofessional collaboration has been cited as being successful in achieving safe patient health outcomes as well as, providing improved student learning experiences (Centre for the Advancement of interprofessional Education, 2002; World Health Organisation, 2010).

Interprofessional collaboration is also acknowledged as an important factor whether working within healthcare or education and the delivery of optimal patient centred care requires healthcare professionals to effectively communicate, cooperate and collaborate with each other. Evidence has also shown that collaboration and having a shared purpose to pursue quality improvement provides a framework for interprofessional practice success (Reeves, 2012).

Interprofessional socialisation is an important first step in scaffolding interprofessional relationships, as it provides the opportunity for interprofessional collaboration. However, although interprofessional socialisation appears to be important, there are claims that profession-specific socialisation may be deterring the development of interprofessional relationships. Cameron (2011) extends this discussion by adding that there are opponents to interprofessional socialisation, especially because some professionals perceive the activity of interprofessional socialisation and collaboration as the, potential loss of professional identity and the erosion of professional boundaries. Khalili et al. (2013) adds that although professional barriers do exist they can be overcome, if, interprofessional collaboration and interprofessional education were supported by strategic planning with higher education institutions.

Over the past 30 years there have been quality improvement initiatives which have introduced health service changes, and the way in which health professionals work together (Grol et al., 2007). The Australian health care system has undergone major reviews due to the Government's endeavours to modernise healthcare. These changes have been supported by the World Health Organisation (World Health Organisation, 2010) and this is evidenced by the introduction of initiatives such as, the Department of Health's 'Framework for Action on Interprofessional Education and Collaborative Practice' within the United Kingdom and the Review of Australian Government Health Workforce Programs' (Department of Health, 2010; Department of Health, Australia, 2013). In addition, there are also the political drivers that have instigated, a global consultation on the healthcare agenda, which has aimed to strengthen interprofessional collaboration (Thistlethwaite, 2012). Thistlethwaite (2012. p.60) stated that a, "global workforce, building effective partnerships and fostering

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interprofessional collaboration" is the way forward if interprofessional education is to make progress.

The health care system and higher education institutions within Australia have undergone (and continue to undergo) a number of changes, especially in relation to interprofessional education initiatives and programs (Stanley, 2016). The changes have prompted an investigation into interprofessional education which have generated a variety of reports. One report in particular by Dunston (2014) undertook a study with the support of the Office of Learning and Teaching. The focus of this report was on the design, delivery and development of future pre-registration interprofessional education programs and activities in Western Australian (WA) universities.

Dunston's (2014) report builds upon Nicol's (2013) initial findings into the areas of interprofessional education, interprofessional learning and interprofessional practice from a WA perspective. The report confirmed that there were inconsistencies of interprofessional education activities across the universities and that key issues remained which included; the need for further funding to train and embed interprofessional education within the curricula and practice; discipline specific accreditation which included educator perspectives as well as there being a responsiveness to the changing requirements of healthcare delivery services. These findings were viewed as being central to the future of interprofessional education, with the sustainability and direction of interprofessional education relying on consistency, continuity and alignment of these policy and contextual drivers (Nicol, 2013; Dunston, 2014; Stanley, 2016).

Nicol (2013) and Dunston (2014) also identified the need to appoint leaders that would 'champion' interprofessional education. In Nicol's (2013) report this was suggested to occur at a local level within organisations' whereas, Dunston (2014) recommended that this should happen at both local and national levels, with an additional annual leadership forum being established, to address the issues and initiatives in relation to interprofessional education across all institutions.

The purpose of the article is to share findings from a doctoral research study that was undertaken, to explore the interprofessional socialisation experiences of health professional educators within higher education. The data from the study enabled the creation of a theoretical framework which could enhance interprofessional collaboration within higher education institutions and support the success of interprofessional education.

The development of the interprofessional socialisation framework aims to support health professional educators, as it provides a scaffolding approach to interprofessional collaboration. The framework recognises the importance of professional and interprofessional socialisation, and how barriers between could be reduced. This could be achieved through the application of formal and informal strategies, which could ultimately lead to improved relationships between the professionals, which is important if interprofessional education is to be successful within faculties (Stanley et al., 2016).

The last five years has seen the development of frameworks designed to encourage interprofessional collaboration between students studying health sciences. Whereas, there are no frameworks to support the building of effective interprofessional relationships between professional educators within higher education. Cooperation and interprofessional collaboration would ensure the success of any interprofessional programs and also provide students with positive interprofessional role modelling behaviours, when they witnessed interprofessional teamwork (Watkins, 2016). Therefore, encouraging interprofessional socialisation in higher education could provide opportunities to collaborate interprofessionally and increase confidence and competence in implementing interprofessional education (Reeves, 2012; Khalili et al., 2013; Hall and Zierler, 2015).

2. Methods

A qualitative methodology was appropriate for this study because the aim was to uncover individual meaning and experience of interprofessional socialisation. An interpretative phenomenology design was utilised, because it was important to focus on understanding the participant's subjective and unique knowledge in describing the nature and phenomena of interprofessional socialisation (Smith et al., 2009).

3. Participants

Purposive sampling was used to select an accessible population of 26 health professional educators. The sample size was appropriate for the study as saturation of data was achieved. Data saturation in a qualitative study is a gold standard through which a purposive sample size is important (Creswell, 2012). The health educators were selected to ensure representation of the health professions within the five universities. The professionals interviewed were lecturers who either taught or provided research supervision for students. Some of the lecturers were involved in interprofessional education programs that were designed for undergraduate students, whilst others provided joint research supervision for postgraduate students. Participants were invited from five universities across Perth, WA. These were Curtin University, University of Western Australia, Murdoch University, Notre Dame, and Edith Cowan University. Participants were initially approached by e-mail with an information sheet outlining the aim and objectives of the study. Participants self-selected themselves by responding to the initial invitation, and arrangements were made to interview participants on their university campuses. All participants were employed by the universities.

4. Data collection

One-to-one semi-structured, face to face interviews were conducted, these were undertaken by the primary researcher who asked the major questions followed by additional questions that arose from the participants responses. The interviews were audio-recorded and further transcribed verbatim. Note-taking was also undertaken in order to uncover the meaning beyond the surface level of the data. This allowed for interpretation and generation of meaning from the participants experiences Smith et al. (2009). The data was collected between March to December 2014, and the interviews were ceased once data saturation was reached. Written consent was obtained at the beginning of the interview, following clarification of the aim and objectives of the study. All of the interviews were undertaken by the same researcher.

5. Ethical considerations

Ethical issues were taken into consideration. Participants were provided with verbal and written information regarding the purpose of the study. Informed consent was confirmed before obtaining data. A choice of venue and duration for the interview was given. The participants' autonomy and anonymity were protected. Ethical approval was sought and secured for the study from the Human Research Ethics Committee of Curtin University, Perth, WA, before data collection activities commenced. Protocol approval: EDU-140-13.

6. Data analysis

The data collected from the one-to-one interviews were coded by breaking down, examining, comparing, conceptualising, and categorising the data. This was achieved by reading and re-reading interview data and initial noting of the keywords and phrases. This then led to the development of the categories and sub-categories. The categories and sub-categories were analysed inductively with the aid of NVivo10 software (QSR International, 2014). This was followed by identifying the connections across the categories, which ultimately led to the development of the five themes (Creswell, 2012).

7. Quality issues

The application of Yardley's (2008) criteria, ensured that the principles of trustworthiness and authenticity were guaranteed. These were demonstrated through the framework of interpretive phenomenological analysis, which included; consistency, validity, and quality. Elements such as sensitivity to context takes into account how the researcher interacted appropriately and respectfully with the participants, by conducting an effective interview; commitment and rigour were addressed through careful selection of participants and ensuring and that there was no interviewer bias; transparency and coherence ensured that the analytical processes were free from ambiguity and contradiction. Authenticity was maintained by ensuring that the interview questions asked were a true reflection of the interprofessional agenda within the Faculty and University. Ultimately the application of the Yardley's (2008) criteria contributed to the richness of the phenomena that was being explored within the study (Smith et al., 2009).

8. Findings

Data was analysed from the 26 participants and was followed by coding and categorising the themes. Five themes emerged and these were: 1) *working with other professionals in higher education; 2) qualities and attributes of interprofessional socialisation; 3) advantages and benefits of interprofessional socialisation; 4) barriers and disadvantages of interprofessional socialisation and 5) interprofessional socialisation strategies within higher education.* These themes informed the development of the HEIPS framework and confirmed a number of factors already present within other established frameworks, such as Khalili et al. (2013). The factors will now be discussed in the following section and will explore the design of the HEIPS framework.

9. Discussion

The HEIPS framework evolved as a result of reviewing the existing literature available on socialisation, professional socialisation and interprofessional socialisation. The framework was also informed by the analysis of the data from the 26 participants within the qualitative study. The HEIPS framework has been created and developed by exploring previous examples of interprofessional frameworks from the literature, in particular Reising (2002), Kenny et al. (2004), O'Lynn, 2009, Simosi (2010) and Khalili et al, 2013.

Kenny et al. (2004) and Simosi (2010) both indicated that it was important to integrate individuals into new organisations by socialising them appropriately. Reising (2002) and O'Lynn (2009) go further by adding that it is not just about the socialisation process of orienting individuals to their new roles and surroundings. For some professionals it is also about learning about their group's particular norms, specific skills, values and roles that are significant in the development of their professional identities. Therefore, the relevance of professional socialisation is an essential factor for healthcare professionals. This is demonstrated within Khalili et al.'s (2013) professional socialisation framework see Fig. 1.

10. Professional socialisation

In Khalili et al.'s (2013), professional socialisation framework for healthcare students which can be seen in Fig. 1. Professional socialisation is demonstrated through a process that starts with an anticipatory socialisation phase which can be influenced by society, the media and the career that the student has chosen to pursue. There is an assumption that students may develop preconceptions due to these influences and that in turn, it may affect their career choices. These influences may also lead to further misunderstandings about other discipline groups. Therefore, the framework encourages students to collaborate with other professions, once they have formed their own professional identities. Their professional identity is created through uni-professional education and role learning. Role learning and education requires the students to trust and respect each other through the process of professional socialisation, with the conclusion that this process offers the students an opportunity to develop the skills they need, in order to work within interprofessional teams.

11. Interprofessional socialisation

Khalili et al. (2013) then went onto develop a framework that assisted healthcare students to move to the next stage in their socialisation journey which is interprofessional socialisation within higher education. This process is described in Fig. 2. This framework demonstrates how healthcare students could strengthen their relationships with other students from other disciplines. There are three stages; breaking down barriers; uniprofessional identity and interprofessional role-learning which is influenced by dual identity development. Again an atmosphere of trust, respect and equal status is required which encourages students to collaborate with a range of professionals, once they are confident about their own professional identities. This framework also includes the influences of systemic factors, these are; professional education programs, professional regulations and health care delivery models. In addition, personal factors were also considered as these would include the students' interprofessional beliefs, behaviours and previous experiences of interprofessional education (Khalili et al., 2013).

One of the differences between Khalili et al.'s (2013) two frameworks is the stage which is referred to as 'breaking down barriers' in Fig. 2. As this relates to the different roles that the students go through to achieve dual identity. Breaking down the barriers is an important step in ensuring that students develop confidence within their own abilities to socialise interprofessionally. Khalili et al. (2013) suggest that by following these stages students would work and collaborate more effectively within interprofessional teams both in clinical practice settings and educational environments. In addition, the process of integrating interprofessional collaboration into interprofessional practice and education would also reduce professional isolation (Stanley, 2016).

The two frameworks that have been presented so far, have illustrated how students can progress through the process of professional socialisation to become more interprofessionally focussed. There is even a suggestion that these frameworks could be embedded within curricula. However, there are limitations to the frameworks because, "at this point in time, the interprofessional socialisation framework has not been empirically tested" (Khalili et al., 2013, p.452). Therefore, the frameworks can only be viewed from an academic perspective. As previously stated, the purpose of the article is to share findings from a doctoral research study that was undertaken, to explore the interprofessional socialisation experiences of health professional educators within higher education. The main difference with regards to the frameworks already discussed is that Khalili et al.'s (2013) work purely focuses on healthcare students in higher education. Whereas, the data from this research study is aimed at health professional educators within higher education. This is significant because much of the literature is focussed on interprofessional education for students, with very little on how to support educators building effective interprofessional relationships with higher education (Stanley, 2016). The following discussion outlines the development of a framework that can support educators within higher education and assist them by enhancing their relationships with other health professionals. This will lead to improved research outputs, co-teaching of students and interprofessional collaboration within higher education institutions.

12. Health educators' interprofessional socialisation (HEIPS) framework

The health educators' interprofessional socialisation framework

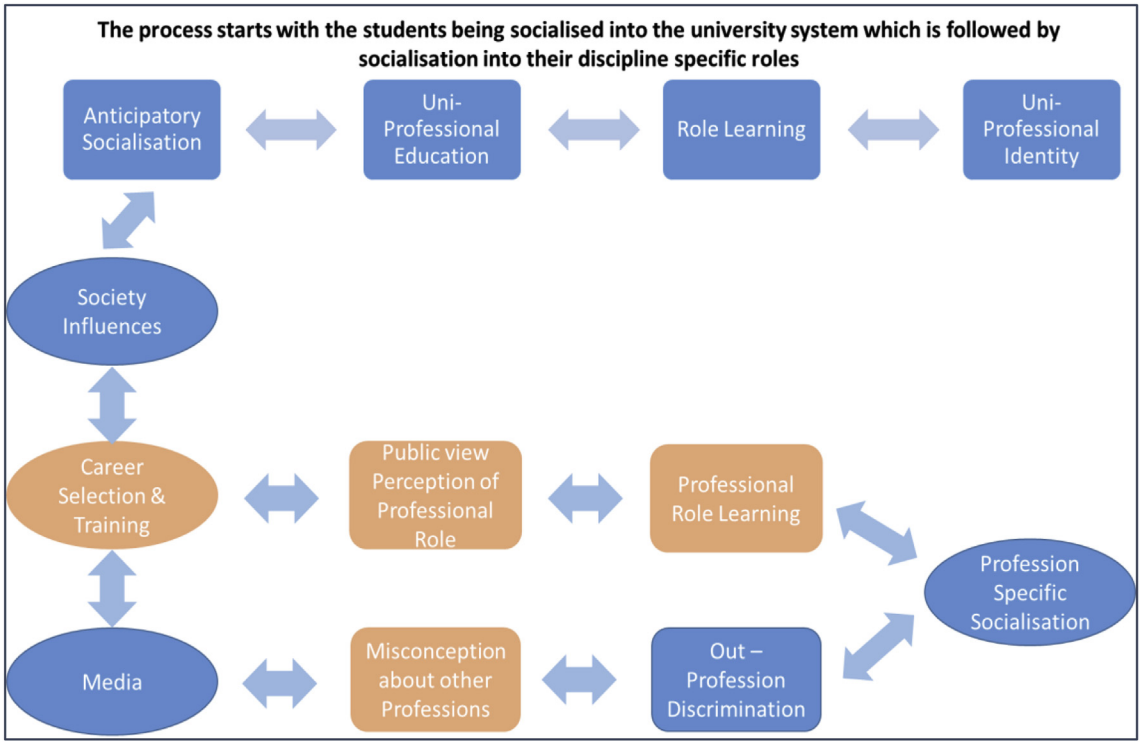

Fig. 1. Professional Socialisation process.
Khalili et al. (2013, p. 450).

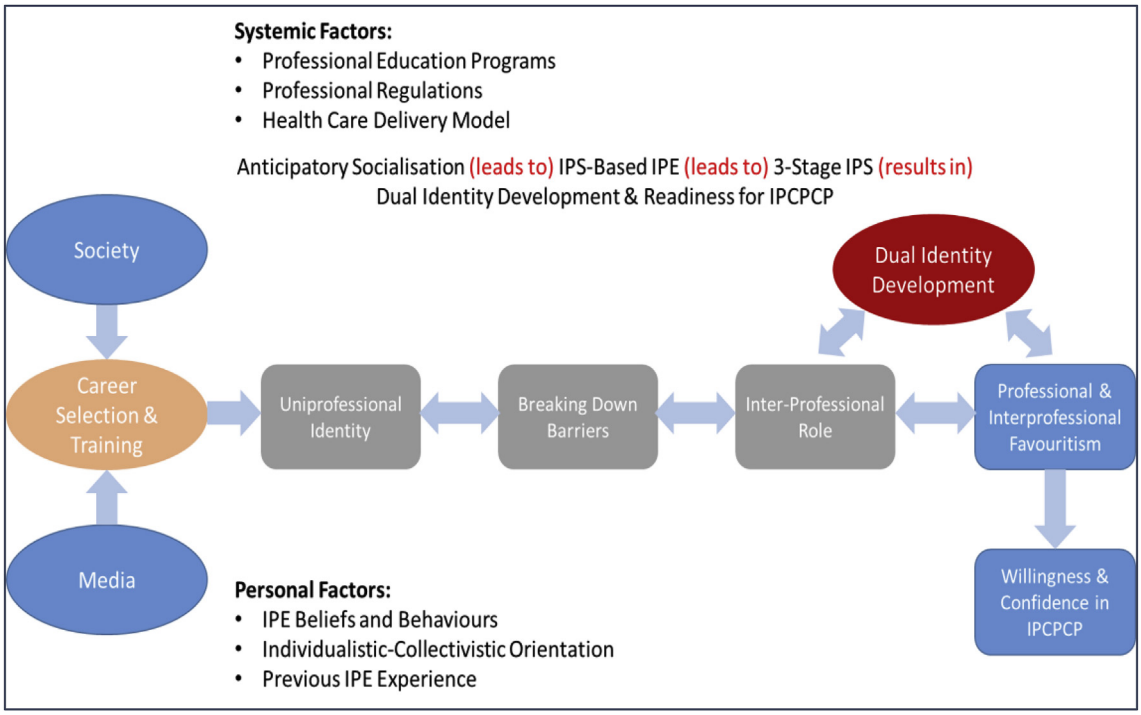

Fig. 2. Interprofessional Socialisation Framework.
Khalili et al. (2013, p.451).

(HEIPS) (Fig. 3) has been informed and developed through an examination of the literature in relation to socialisation models, and other interprofessional frameworks. In addition, it has been built upon the research that was undertaken with health professional educators described within this article. Some of the similarities between the HEIPS framework and that of Khalili et al.'s. (2013) framework (Fig. 2) is that both include important elements such as, the internal and external factors and an acknowledgement of professional socialisation processes and breaking down of the barriers. However, the HEIPS framework adds another step, which is the inclusion of formal and informal socialisation strategies to support professional educators within higher education. Although the HEIPS framework design may follow four

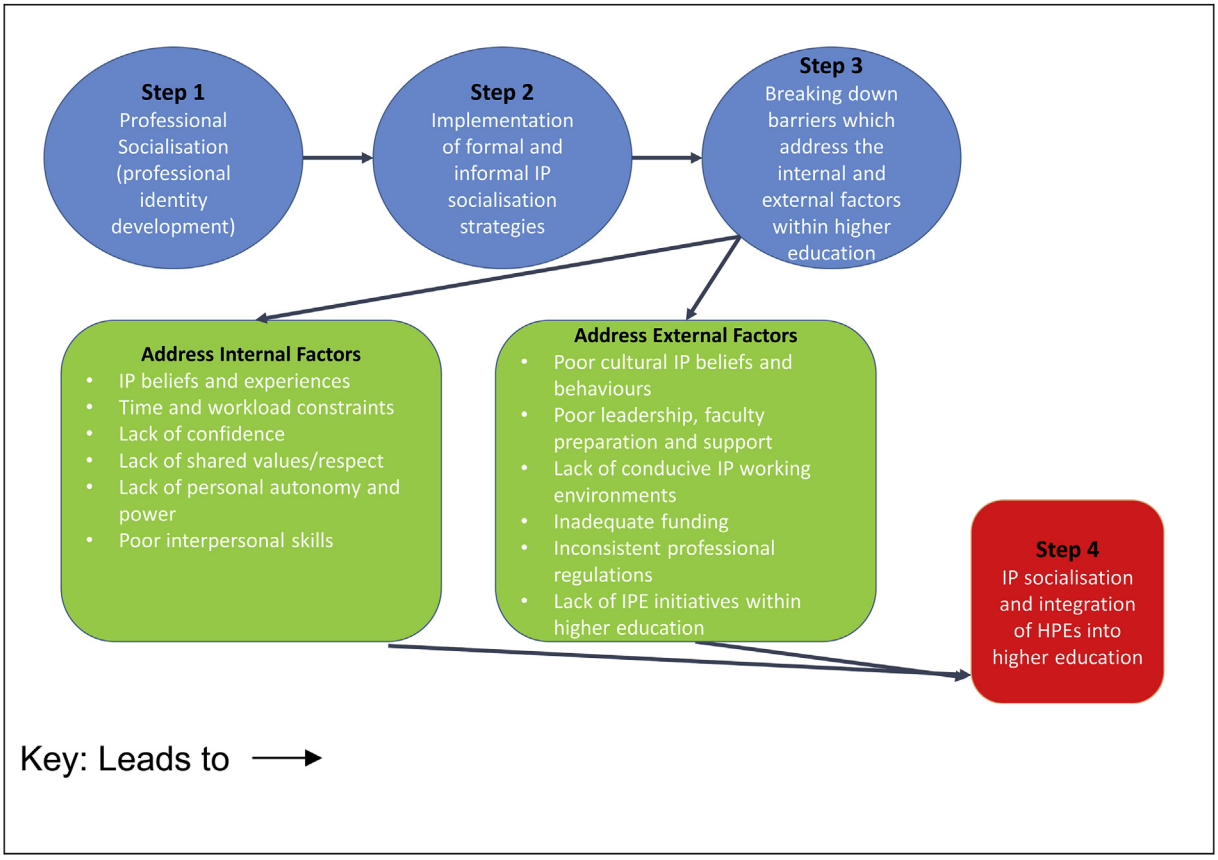

Fig. 3. HEIPS Framework.
Stanley (2016, p.160).

simple steps, its aim is a more pragmatic approach to interprofessional socialisation, with a focus on the professional educators and not the healthcare students. Therefore, it does incorporate some tangible strategies that can be put in place to reduce barriers and create opportunities to build interprofessional relationships (Stanley et al., 2016).

12.1. Step one: professional socialisation

The first stage of the HEIPS framework begins with professional socialisation. The interactive process of acquiring professional identity which is based on values and meanings. According to Alberto and Herth (2009) professionals appreciate having a set of values, as these provide standards that support the way in which, they interact with other disciplines. Values and meanings encourage the development of professional identity as the individual is required to accept the values and norms for that particular group. These standards assist with effective communication and teamwork, as it is important to use good interpersonal skills if professionals are to socialise effectively within all groups. Once this has been established, the professionals are then able to make the progression to building interprofessional relationships.

12.2. Step two: implementing IP socialisation strategies

According to Stanley et al. (2016) the implementation of formal and informal interprofessional socialisation strategies could reduce some of the barriers. This is because effective interprofessional socialisation strategies can provide opportunities for building interprofessional relationships and promote interprofessional collaboration. The range of formal and informal strategies identified by Dunston (2014) and Stanley et al. (2016) include; interprofessional co-teaching, interprofessional workshops, interprofessional research and interprofessional leaders, which are viewed as the main interprofessional socialisation strategies. Others include; interprofessional orientation/induction, joint curriculum planning and interprofessional mentors. The Centre for the advancement of interprofessional education (CAIPE, 2002), O'Lynn (2009), Thannhauser et al., 2010, Cameron (2011) and Dunston (2014) all acknowledge that interprofessional activity are associated with positive learning outcomes for students, this is because they are able to witness effective interprofessional teamwork and interprofessional role-modelling.

12.3. Step three: breaking down barriers

The need for cooperation between professionals can be achieved if they are working towards common goals. Although, barriers can be created if professionals do not cooperate with each other or, if the institution does not support the goals and needs of the professionals (Rice et al., 2011; Rutherford-Hemmimg, 2018). Leadership and culture are also viewed as having a significant impact on the way in which interprofessional socialisation is supported within higher education (Nicol, 2013; Dunston, 2014; Hall and Zierler, 2015; Stanley, 2017). One of the challenges for interprofessional socialisation is the management of those professionals who are currently working within their own professions 'comfort zones'. Therefore, it is important to be sensitive and understanding of the socialisation processes, as Price et al. (2014, p.107) note that, "promoting a culture of interprofessional respect and collaboration during early socialisation must extend to educational and practice environments". So, although there may be recognition that interprofessional collaboration has a number of benefits for individuals as well as organisations, the way in which professional educators are supported is vital if interprofessional socialisation is to be successful (Ho, 2006). Therefore, finding ways to break down those barriers can

be a challenge and may require patience and understanding by all of the professionals involved.

13. Internal and external factors

Both internal and external factors can impact on how the barriers can be reduced. Therefore, exploring these factors may give insight into how these challenges could be overcome.

14. Internal factors

The internal factors listed below relate to how professionals' view their experiences of interprofessional socialisation within higher education.

14.1. Interprofessional beliefs and experiences

Within this current study the health professional educators provided a list of qualities and attributes they believed, were important in building interprofessional relationships (Stanley, 2016). These qualities and attributes were relevant because they had shaped their beliefs and experiences and had contributed to scaffolding their own interprofessional education. This factor was also confirmed within Khalili et al.'s. (2013) interprofessional socialisation framework for healthcare students.

14.2. Time and workload constraints

The educators cited time constraints as one of the major factors that prevented them from collaborating with other disciplines. Workload issues was a significant concern because they were frustrated with high workloads which prevented them from working interprofessionally. Time constraints is also acknowledged by Alberto and Herth (2009) and Stanley (2016, p.163), who suggested that it can be "assumed that time and workloads are interconnected. These issues could be viewed as external factors, because 'time' to some extent is not always controlled by the professional."

14.3. Lack of confidence

Some educators voiced their concerns about interprofessional credibility and how this had created a lack of confidence which had led to personal challenges. Scarvell and Stone (2010) discuss their evidence of interprofessional competition and interprofessional opposition and suggested that this indeed did create barriers to interprofessional collaboration, as well as, stopping professionals getting involved in interprofessional socialisation activities.

14.4. Lack of shared values and respect

Hollenberg and Bourgeault (2011) referred to the interactional determinants that were required for interprofessional collaboration. They believed it was important that professionals share ideas and best practice, although this necessitates professionals to communicate with each other, demonstrate mutual respect and be prepared to learn from one another. These interactional determinants are ways in which professionals could work together interprofessionally and are therefore constructive internal factors.

14.5. Lack of personal autonomy and power

Being independent with regards to building interprofessional relationships enables the professional to control what interprofessional socialisation activities they become involved in. However, Cameron (2011) and Karim (2011) claim that if power is used negatively in terms of another professional assuming superiority, this would have the opposite effect on the development of these relationships.

14.6. Poor interpersonal skills

Effective and constructive interprofessional communication is an essential part in the building of relationships. It is also an important internal factor because it is beneficial for cooperative and collaborative relationships. Communication can have a positive effect and impact, on interprofessional teams, whereas poor communication has negative consequences (Foronda et al., 2016). Baxter and Markle-Reid (2009) and Clark (2011) all agree that having effective interpersonal skills had the ability to engage professionals in collaborative educational activities, which are important if students are motivated to learn within supportive interprofessional learning environments.

Suter et al. (2009) supports the view that competent collaboration is necessary in providing patient centred care and discusses core competencies in the context of "what it takes to be a good collaborator". Core competencies such as trust, respect, effective communication, shared knowledge and understanding were qualities identified by Suter et al. (2009), who asserted that there was a need for these qualities, in order to build effective interprofessional relationships. Competency frameworks have also been viewed as a way in which to identify and promote interprofessional competencies. A competency framework designed by Bainbridge et al. (2010) assessed interprofessional competencies required for specific groups of professionals. Deficits could then be identified within interprofessional groups and educational programs developed to assist with addressing shortfalls, to improve collaborative practice. Reeves (2012) agrees that this type of framework could be beneficial in standardising elements needed to promote and create environments for interprofessional collaboration. Although the reliability and validity of assessing and measuring interprofessional collaboration within different environments are not definitive.

Another element in relation to communication is the specific terminology which professionals use to describe health practices or apply healthcare principles. The importance of using a common language that all professionals understand ensures that errors were minimised. This is because if the language is significantly different, there is the potential for confusion which may create barriers between professionals. Therefore, sharing a common language can assist with building effective interprofessional relationships (Foronda et al., 2016).

15. External factors

The external factors listed below relate to challenges which are outside the professional's immediate control, but could impact on the opportunities to build interprofessional relationships across the faculties.

15.1. Poor cultural interprofessional education beliefs and behaviours

According to Hall (2005) the values, beliefs, attitudes and behaviours of individuals within an organisation or community defines their culture. Therefore, the process of interprofessional socialisation would need to take into account the changes that may be required in an individual's awareness, behaviour and attitude to other disciplines. Each health discipline has its own professional culture that shapes their educational experience, values, attitudes and philosophy. Pecukonis et al. (2008) indicate that there are groups that promote a culture of 'professional centrism' this is where professionals are only concerned about their own discipline.

Karim (2011) notes that any change in culture within the health industry needs to start within education. This could be achieved by creating "enduring inter-disciplinary cultures that facilitate dialogue regarding teaching and learning among faculty" (Karim, 2011, p. 41). Hall (2005) and Stanley (2017) both point out that culture should be viewed positively, as it could be a source of stability within any

organisation. This is because significant structures and systems influence the way in which individuals work, and shape an organisation's culture and should be facilitated in a way which identifies both positive and negative aspects of that environment.

15.2. Leadership and faculty support

Leaders are viewed as those who influence an organisation's culture and assist with the creation of a vision, values and philosophy that support the direction of an organisation. Nicol (2013), Dunston (2014) and Hall and Zierler (2015) agree that leaders are needed who can champion interprofessional activity and support the changes needed within an organisations culture. They also point out that these leaders can support interprofessional development from a faculty perspective. However, leaders need to be respectful of professional differences, as well as have the ability to manage discussions between disciplines with regards to interprofessional activity. Stanley (2017) confirms that leaders could become 'champions of culture' and also be effective 'role-models'. In essence, supportive leadership as well as the demonstration by faculty to promote and commit to interprofessional socialisation, needs to be evidenced by the inclusion of interprofessional socialisation strategies, within their strategic objectives for the faculty or school (Rutherford-Hemmimg, 2018).

15.3. Conducive interprofessional working environments

Another external factor relates to the environments in which professionals' work. The opportunity to collaborate with others professionals could be precluded by the separation of staff into other buildings within the University. This would prevent the opportunity for incidental meetings and conversations and was evidenced by the literature, as well as the participants within the study (Stanley, 2016). Xyrichis and Lowton (2008) confirm that greater interprofessional co-operation was evident when groups worked with in close proximity of each other. Sharing buildings, offices or a common room helped to facilitate informal conversations and led to a breakdown of many professional barriers.

15.4. Inadequate funding

Without monetary support professionals found that it was challenging to try and establish interprofessional relationships outside of their own schools, unless it was part of their role and workload (Stanley, 2016). The literature agrees that the lack of funding and other resources was creating barriers. Therefore, faculties and universities needed to provide dedicated time for professionals to engage in interprofessional socialisation activities (Rutherford-Hemmimg, 2018).

15.5. Inconsistent professional regulations

In Australia, the majority of the health professions are regulated by APHRA. The systems of discipline specific regulation currently promote uni-professional patterns of practice. However, although each discipline group has their own regulatory codes of practice and guidelines, these do not necessarily correspond to each other. There are also differences between the standards of practice and accountability that is contributing, to the siloed effect, which is creating divisions between the professions (Cameron, 2011; Khalili et al., 2013; Stanley, 2016).

15.6. Interprofessional education initiatives within higher education

There are also other external and systematic factors that may influence interprofessional socialisation. These include the educational initiatives associated with interprofessional education as they are dependent on the institutions interprofessional education agenda. However, healthcare students undertaking cross-professional learning within education could create opportunities for interprofessional collaboration for themselves, by building relationships with other students from different professions (Stanley, 2016). Although there are political drivers that aim to strengthen interprofessional collaboration, the evidence is not consistent with regards to interprofessional education activity across all higher education institutions within WA (Thistlethwaite, 2012; Nicol, 2013; Dunston, 2014; Stanley, 2016). Therefore, universities that do not have a robust agenda in relation to interprofessional education may miss the opportunity for their staff to collaborate on interprofessional activities. Ho (2006) and Watkins (2016) suggest that developing faculty members who valued interprofessional collaboration were critical to the success of interprofessional education initiatives within higher education. Rutherford-Hemmimg (2018) adds that there is a need for more for research into interprofessional interventions which could be undertaken by the professionals involved in interprofessional activities.

15.7. Step four: interprofessional socialisation and integration of HPEs within higher education

The final stage in the HIEPS framework is the fulfilment of the interprofessional socialisation process, as well as the integration of health professional educators within higher education. According to Alberto and Herth (2009) and Watkins (2016) the preparation and support of educators appears to be the key to ongoing working relationships and effective collaboration within education. This is because it can assist with the reduction of barriers. Alberto and Herth's (2009) review of the literature stated that healthcare professionals could not work together effectively if they did not have the educational background and experiences that, "nurture, support and grow collaboration" (2009, p. 2). They go on to discuss the importance of collaboration and teamwork and also the need to share the same vision and purpose. Once a common vision, values and purpose has been established, interprofessional teams could begin to examine their individual practice together, because they now shared the same philosophical grounding. The benefits of interprofessional socialisation for health professional educators, "is that it would build interprofessional teamwork behaviours and integrate the knowledge and expertise needed" (Stanley, 2016. p.170). This would then contribute to the healthcare students learning experiences within higher education, as well as the positive impact it would have on patient health outcomes within clinical environments.

The significance of this study is that the research adds to the body of knowledge in relation to the interprofessional socialisation of health professional educators within higher education. The outcome of the research study was the development of a new framework to support educators and strengthen interprofessional education. The participant's experiences were valuable in providing insights into the challenges they had in commencing and maintaining interprofessional relationships within the Universities they were employed in. The four step framework that has been presented (see Fig. 3) provides a structure that can be used to support improved interprofessional communication and collaboration within higher education institutions. By utilising the steps and understanding the challenges that participants have shared, could assist professionals in formulating their own ideas or plans in how they can overcome some of the barriers in working together more effectively.

16. Recommendations

Early interprofesssional socialisation initiatives could be one way in which, to overcome some of the barriers to interprofessional collaboration (Price et al., 2014). This could be achieved by implementing formal and informal interprofessional socialisation strategies that would support and provide opportunities to enhance capacity for early interprofessional socialisation. The introduction of a framework such as HEIPs into the faculty's interprofessional strategy and agenda could scaffold and enhance interprofessional relationships which in turn

could strengthen interprofessional education initiatives. Universities and their faculties need to create clear strategic objectives and interprofessional agendas to support interprofessional collaboration and share this with their staff.

Health Science Faculties could demonstrate support for their educators by including time allocation and resources for interprofessional socialisation activities within their workload plans for the staff. Activities could be accessed through the individuals' annual performance review. Health Science Faculties could also create a centralised register of staff interested in collaborative activities as this would be an effective approach to connecting professionals who were interested in undertaking research or projects.

17. Conclusion

The aim of this paper was to present the findings of a doctoral research study that focussed on developing a theoretical framework to support interprofessional socialisation of health professional educators. It was not the author's intention to present data that informed the socialisation strategies as this was captured in a previous article, "Twelve possible strategies for enhancing inter-professional socialisation within higher education" (Stanley et al., 2016), therefore no participant comments have been added. In addition, this paper makes a distinction between the interprofessional socialisation of health educators and interprofessional education for students. Interprofessional education was viewed as one of the outcomes of increased interprofessional collaboration but it was not the overall focus. As previously stated the HEIPS framework (Fig. 3) may appear simplistic in its design. However, it differs from previous models and frameworks such as Khalili et al.'s (2013) framework (Fig. 2) because the focus is on the professional educators who would be facilitating healthcare students' interprofessional educational experiences. The framework also acknowledges and respects that professional educators need to be autonomous, because they may already have strategies that assist them with building their own interprofessional relationships and networks. The four steps described within the HEIPS framework are believed to be workable in practice, as they provide strategies that would contribute to the fulfilment of interprofessional socialisation and help start the process of interprofessional team working from the commencement of a health professionals learning journey.

There are a number of positive outcomes that can be achieved by implementing the HEIPS framework within faculties. These are opportunities to create; 1) increased research outcomes and grant application success; 2) improved student satisfaction in terms of learning and teaching experiences, as well as improved patient health outcomes; 3) increased connections within industry that create opportunities for individual professional development, as well as the potential for student employability; 4) improved interprofessional collaboration.

The inconsistency of interprofessional education activities across universities has highlighted a need to provide a framework such as HEIPS. The HEIPS framework could be used to formulate an interprofessional socialisation plan, aimed at identifying appropriate interprofessional socialisation activities that are aligned with the faculties' strategic interprofessional objectives and interprofessional agenda. This could be tailored to meet the requirements of the cultural diversity of the professionals involved in teaching, research and those arranging interprofessional practice placements, and ultimately lead to effective and successful interprofessional relationships starting at the beginning of health professionals, educational journey, within higher education. The translation of this research into practice supports health professional educators in their pursuit of establishing and maintaining co-operative and collaborative interprofessional relationships within higher education. This is because it provides steps for overcoming barriers to some of the challenges that may exist, so that collaboration between professionals is enhanced, thereby providing opportunities for inspiration and creativity.

Interprofessional education requires professionals who are innovative and committed. Positive professional relationships are the key to improved learning outcomes for students as well as, healthcare outcomes for patients.

18. Limitations of the study

Limitations included the sample being limited to Perth, WA, which may not reflect the views and experiences of health professionals within other universities across the rest of Australia and internationally. Additionally, participants self-selected themselves therefore acquiring a balance of professional representation was a challenge. The methodology was limited as it only provided participant experiences, therefore it could not be generalised to a wider population. The sample size would not have been appropriate for a quantitative study, which would have required a larger sample.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.nepr.2018.11.004.

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