

Creating a collaborative practice environment which encourages sustainable interprofessional leadership, education and practice

Final Report

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http://healthsciences.curtin.edu.au/faculty/leadership_programme.cfm

Support for the production of this report has been provided by the Australian Government Office for Learning and Teaching. The views expressed in this report do not necessarily reflect the views of the Australian Government Office for Learning and Teaching.



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2014

ISBN 978-1-74361-962-9 [PDF]
ISBN 978-1-74361-963-6 [DOCX]

Acknowledgements

The project team would like to thank the participants of the programme pilots at Curtin and Charles Sturt Universities for their contribution and their willingness to become champions for interprofessional education and practice. Without their involvement and generous feedback on the pilots, the project would not have been possible. Curtin University's pilot participants included health professional staff from the South Metropolitan Health Service and the interprofessional education team from Curtin University's Faculty of Health Sciences. Staff from Curtin University's interprofessional education team also generously shared stories of student interprofessional leadership, which are included as part of the project materials. At Charles Sturt University, Albury Wodonga Health staff participated along with academic staff from the Schools of Community Health and Nursing, Midwifery and Indigenous Health.

Key team members at Curtin University include Mandy Miller, the project's instructional designer, and Cassandra Doherty, who provided (as always) excellent administrative support. At Charles Sturt University, the interprofessional project officer, Isabel Paton, provided essential organisational and administrative support. Sincere thanks go to Michelle Donaldson, who took over the project manager role mid-2013. Michelle has demonstrated outstanding collaborative team skills, generosity, patience and exceptional organisational abilities, and has been crucial to the project's successful completion.

The University of Toronto's Centre for Interprofessional Education was essential in shaping the programme that was developed as part of this project. In particular, Dr Ivy Oandasan and Lynne Sinclair were instrumental to the creation of the Interprofessional Education and Practice: Creating Leaders and Opportunities for Clinical Learning programme, which is based on their work in leadership development over the past decade. They truly demonstrated collaborative practice in their willingness to share and support us in developing this programme for Australia.

Thanks also goes to the Expert Reference Group members for their insight and support of the project: Professor Hugh Barr, Maria Tassone and Professor Gary Rogers. Professor Dawn Forman was a project team member initially, but she returned to England before the project was finished. Professor Forman then became part of the project's Expert Reference Group, providing guidance and feedback.

The project team gratefully acknowledges the Office for Learning and Teaching for funding this project.

List of abbreviations used

AWH	Albury Wodonga Health
CQI	Continuous Quality Improvement
CSU	Charles Sturt University
Curtin	Curtin University
DVD	Digital video disc
ehpic™	Educating Health Professionals in Interprofessional Care (programme developed by the University of Toronto's Centre for Interprofessional Education)
IPE	Interprofessional education
IPP	Interprofessional practice
IP-COMPASS®	Interprofessional Collaborative Organization Map and Preparedness Assessment (tool developed by the University of Toronto's Centre for Interprofessional Education)
L-TIPP, A	Learning and Teaching for Interprofessional Practice, Australia from the project: <i>Developing interprofessional learning and practice capabilities within the Australian health workforce – a proposal for building capacity within the higher education sector</i>
OLT	Office for Learning and Teaching
SMHS	South Metropolitan Health Service
WHO	World Health Organization

Executive summary

This two-year Office for Learning and Teaching funded project aimed to support the expansion of interprofessional clinical placement learning opportunities for students through creating an interprofessional change leadership programme for health academic and clinical staff.

Currently, pockets of successful interprofessional education and practice exist, largely the result of individual champions. For students to expand their interprofessional practice capabilities—and be ready to meet future workplace demands—more sustainable interprofessional clinical fieldwork learning opportunities are required so students can integrate the theory of interprofessional collaboration into their practice.

Through close collaboration with the University of Toronto's Centre for Interprofessional Education, this project has resulted in the creation of a change leadership programme suitable for adaption to local health and university contexts. The programme, created for Australia, is based on the Canadian best practice model and was piloted three times in two different locations with participants who had differing levels of knowledge and understanding of interprofessional education and practice. The change leadership programme, which incorporates an action learning plan, has demonstrated potential to support an increase in understanding and knowledge of interprofessional education and practice as well as interprofessional clinical placement opportunities through developing change leadership capacity. Several pilot participants successfully implemented their action plans, which are resulting in increased interprofessional practice in the project health industry partners, South Metropolitan Health Service in Perth and Albury Wodonga Health in NSW.

For example, prior to the initial Perth pilot, one of the health facility teams had begun to work on developing a client-centred approach to goal-setting within their rehabilitation service. At the time of their participation in the programme considerable work was still to be done on this initiative. According to one member of this team the professional development provided a positive and energising environment that reaffirmed they were on the right track in focusing on the introduction of client-centred goals. Participation also provided a name for what they were doing—interprofessional collaboration—as well as consolidating that they were adopting best practice. Having the opportunity to hear from international leaders in interprofessional education and practice had been rewarding and motivating, and the programme worked as a catalyst for several meetings to progress the development of the client-centred goal-setting document. Other reported benefits included networking and getting to know team members from the same health facility better. The introduction of the client goal-setting document has resulted in a shift in language use and practice at the rehabilitation service, as well as improved communication across teams at that health facility, because health professionals are beginning to change focus from their point-of-view to the client's.

Similarly, the project has facilitated increased collaborative partnerships—with a focus on interprofessional education—between the project partner universities and their local health service providers. These outcomes suggest the potential of the project to affect student learning through the creation of more interprofessional clinical placement opportunities.

Creating sustainable change for interprofessional education and practice is challenging because of professional territoriality and the hierarchies that exist between different health professions. Further, interprofessional education requires one to reimagine health education traditions. One of the important learnings from the project has been the identification of Appreciative Inquiry as a mechanism to energise and inspire change leaders through identifying existing practices that can be modified and built on to create interprofessional education and practice opportunities. This strengths-based approach, combined with a strong message that a leader is anyone who identifies the need for change and chooses to do something about it, is highly productive and has supported the

development of a community of leaders for interprofessional education and practice at Curtin and Charles Sturt Universities and their health industry partners.

However, some participants reported significant barriers to their proposed plans, with a lack of senior health management buy-in frequently highlighted. Such challenges raise the importance of fully engaging with senior executive within the organisations involved as well as providing ongoing coaching and support for participants beyond the programme. This in turn raises resourcing issues related to providing this ongoing support.

Key outcomes from the project include strong collaborative relationships with international leaders for interprofessional education and practice, the best practice change leadership programme to support interprofessional education and practice, and an expansive range of materials and resources to support the facilitation of the programme to local contexts and cultures. An important element of successfully delivering the programme is ensuring that the facilitator has the right mix of skills, abilities and knowledge, as well as the capacity to model the values that underpin interprofessional collaborative practice. To support potential facilitator(s), the project materials include a detailed guide and a facilitator reflection tool.

Project products

Several products have been produced as part of the project, including:

- LE12-2161 project final report: *Creating a Collaborative Practice Environment Which Encourages Sustainable Interprofessional Leadership, Education and Practice*;
- project dissemination website
<http://healthsciences.curtin.edu.au/faculty/leadership_programme.cfm>;
- the Interprofessional Education and Practice: Creating Leaders and Opportunities for Clinical Practice programme—seven modules with capacity for adaption to local contexts;
- a guide to assist in the implementation of the change leadership programme: *Facilitating and Coordinating the 'Interprofessional Education and Practice: Creating Leaders and Opportunities for Clinical Learning' Programme*;
- a full suite of programme materials including PowerPoints[®], handouts, worksheets, resources to support interprofessional collaboration and an advertising flyer for the programme;
- a facilitator self-reflection tool;
- an interactive cartoon resource on interprofessional practice;
- a short video, *Collaborate for Better Health*, for use in the programme and to promote client-centred care;
- two iLectures by international leader of interprofessional education and practice Dr Joshua Tepper;
- a short video by Dr Joshua Tepper on the need for change leadership for interprofessional education and practice; and
- five stories of successful interprofessional education initiatives from Curtin University.

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A note on terminology

Many different terms are used in the field of interprofessional education and practice. As a result it is important to establish a shared understanding of the key terms used in this project: interprofessional practice, collaboration and education. The table below provides a list of terms used in this document. For the purposes of this project, and the associated leadership programme, *interprofessional education* is the umbrella term for ‘when two or more professions learn with, from and about each other to improve collaboration and the quality of care’ (Freeth, Hammick, Reeves, Koppel & Barr, 2005, p. xv), and it occurs in both tertiary and clinical settings. *Interprofessional practice* is used interchangeably with *collaborative practice* throughout this project, and both are defined by the World Health Organization’s definition for collaborative practice: ‘when multiple health workers from different backgrounds work together with patients, families, carers and communities to deliver the highest quality care’ (World Health Organization, 2010, p. 7). It is important to note that interprofessional practice is not limited to health professionals or workers and should incorporate the multitude of people working in health, education, communities, businesses, charities and public services who play a role in supporting improved health outcomes. Health in this context is therefore everybody’s responsibility and demands many partnerships (Barr, Koppel, Reeves, Hammick & Freeth, 2005), hence the emphasis on collaboration and a focus on the client.

Definitions

Appreciative Inquiry	A strengths-based process that, rather than focusing on the problems or barriers to change, examines what is already working well to build on that success
Client-centred	A client refers to the individual, family or community that is the focus of the health or social service/care. ‘Client-centred’ is therefore an approach focused on the client’s needs and goals; the client is valued as an important partner in planning and implementing services/care.
Clinical placement	Generic term used to describe clinical fieldwork and practicum experiences during which students apply and develop their learning in the workplace
Coordinator	The person responsible for the administration of the leadership programme
Collaborative practice	‘When multiple health workers from different backgrounds work together with patients, families, carers and communities to deliver the highest quality care’ (World Health Organization, 2010, p. 7)
Facilitator(s)	Those responsible for facilitating the leadership programme
Interprofessional education	‘When two or more professions learn with, from and about each other to improve collaboration and the quality of care’ (Freeth et al., 2005, p. xv); occurs in both tertiary and clinical settings
Interprofessional practice	Adopted from the World Health Organization’s definition for <i>collaborative practice</i> —‘when multiple health workers from different backgrounds work together with patients, families, carers and communities to deliver the highest quality care’ (World Health Organization, 2010, p. 7)
Leadership	Distributed in nature, implying that regardless of one’s formal leadership role (or lack thereof), there is the potential to lead change for interprofessional education and practice. For the purposes of this project and programme, leadership is conceptualised as collaborative; collaborative leaders bring people together with different viewpoints to attempt openly and supportively to solve a larger problem or achieve a broader goal.
Work-integrated-learning (WIL)	An umbrella term used for a range of approaches and strategies that integrate theory with the practice of work within a purposefully designed curriculum, including planned, assessed (credit-bearing) activities

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Desiring better health: building on strengths

In 2011, a 14-year-old mother with an intellectual disability and her five-week-old baby, Catriona, born as a result of a rape, found their way to the Child and Parent Centre at a primary school in Perth, Western Australia. Curtin University's Faculty of Health Sciences has been in partnership with this school since 2011. Health science students, under the supervision of qualified health professionals, provide a free interprofessional health service to the local community within the school grounds. The mother of Catriona had almost no support in place because her own mother has an intellectual disability and her father lives interstate. The recommendation had been made for Catriona to be taken from her mother's care. The team of Curtin University's health science students met with the mother in the hope that by providing a highly integrated client-centred service they would support her to develop her parenting skills and increase her confidence to advocate for, and meet, her baby's needs. Their concern was heightened when at the first meeting Catriona slipped from her mother's arms and was caught by a physiotherapy student. When Catriona cried, her mother tried to feed her pieces of a hamburger. The students from speech pathology, dietetics, occupational therapy, physiotherapy and nursing worked collaboratively with each other and Catriona's mother over a three-month period. They taught the mother how to prepare food and feed Catriona safely, basic hygiene and how to stimulate her development. The activities were practised multiple times with continual constructive feedback. Sessions began at the mother's 'safe place' (a local park) until she trusted the students enough to attend sessions at the school. In view of the mother's very low literacy level information was provided through picture books and therapy sessions videoed on the mother's mobile phone so that she could view these at any time. How does this story end? Catriona is now a thriving baby who remains in her mother's care, and both mother and baby continue to attend the parenting centre at the primary school.

The above story demonstrates that interprofessional practice has the potential to affect health and social care outcomes positively. In fact, many reviews of the health care system in Australia (Australian Government Department of Health and Ageing, 2011; Department of Health, 2010; Garling, 2008) point to the need for interprofessional health care. These reports, mirroring those of the World Health Organization (2008, 2010), argue that service must be both integrated and interprofessional if the challenges of health service delivery into the future are to be met.

'Interprofessional practice capabilities have been identified as essential for delivering health services that are safer, more effective, more patient centred and more sustainable. They are the building blocks of effective team-based practice and assist health professionals to make the best use of their professional knowledge and skills in a team environment and to understand and work with other health professionals to deliver better care. Accordingly, the graduation of health professional students who have well developed interprofessional practice and interprofessional learning capabilities is now identified as an urgent national workforce development task to be addressed by the higher education sector.' (Learning and Teaching for Interprofessional Practice, Australia, 2009, p. 7).

As a consequence—and to be able to educate the interprofessional practitioners of the future to meet these new challenges—innovative approaches to health education are required. According to the World Health Organization (2010), 'interprofessional education occurs when students from two or more professions learn about, from and with each other to improve health outcomes' (p. 3). Health education thus needs to move beyond educating

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in disciplinary silos to bring students together from different professions and support them to develop the communication and collaborative practice capabilities required for client-centred care. To be competitive in the employment market, future health graduates will be required to demonstrate an understanding of both the theory and the practice of interprofessional collaboration and have high levels of skill in communication and teamwork.

For health graduates to develop interprofessional practice capabilities, a philosophical change to educational norms and traditions is required. This relates to both education settings (universities) and practice settings (where fieldwork learning occurs). Currently, in Australia, there tend to be small pockets of successful innovative interprofessional education initiatives across the sector (usually the result of local champions). This situation is neither sustainable nor able to respond to education or workforce needs (Learning and Teaching for Interprofessional Practice, Australia, 2009; Meads et al., 2009). As Lawlis, Anson and Greenfield (2014) have identified, enablers of interprofessional education are required at more than just the individual level; they are also required at institutional, government and professional levels. Strong leadership encompassing a complex set of skills to ensure safe, high-quality client-centred care while transforming the model of service delivery and supporting student learning is urgently required. However, leadership and change leadership capacity do not develop naturally. Consequently, to enable sustainable change to interprofessional education and practice, health academics and clinicians need support and training to build crucial leadership capabilities including: knowledge of interprofessional education and practice, high emotional intelligence and collaborative abilities, knowledge of change management, the ability to network, creativity and resilience. Further, interprofessional practice and leadership require an understanding of professional hierarchies, the power assigned to different professions and the reflective, emotional and communication skills to negotiate changes to entrenched practices that engender discipline-focused professional identities and privilege. Successful change agents must therefore have sophisticated capabilities to lead and sustain interprofessional change.

The aim of this two-year project was to design and pilot a change leadership programme with the goal of building the capacity of health industry and academic staff to lead interprofessional education and practice.

Curtin and Charles Sturt Universities were the partner institutions for the project and worked with their local health care organisations—South Metropolitan Health Service and Albury Wodonga Health respectively—to pilot and shape the programme. Collaboration with the University of Toronto’s Centre for Interprofessional Education has been essential to the project’s success and played a pivotal role in the programme’s design. Figure 1 (below) provides an overview of the key stages of the project.

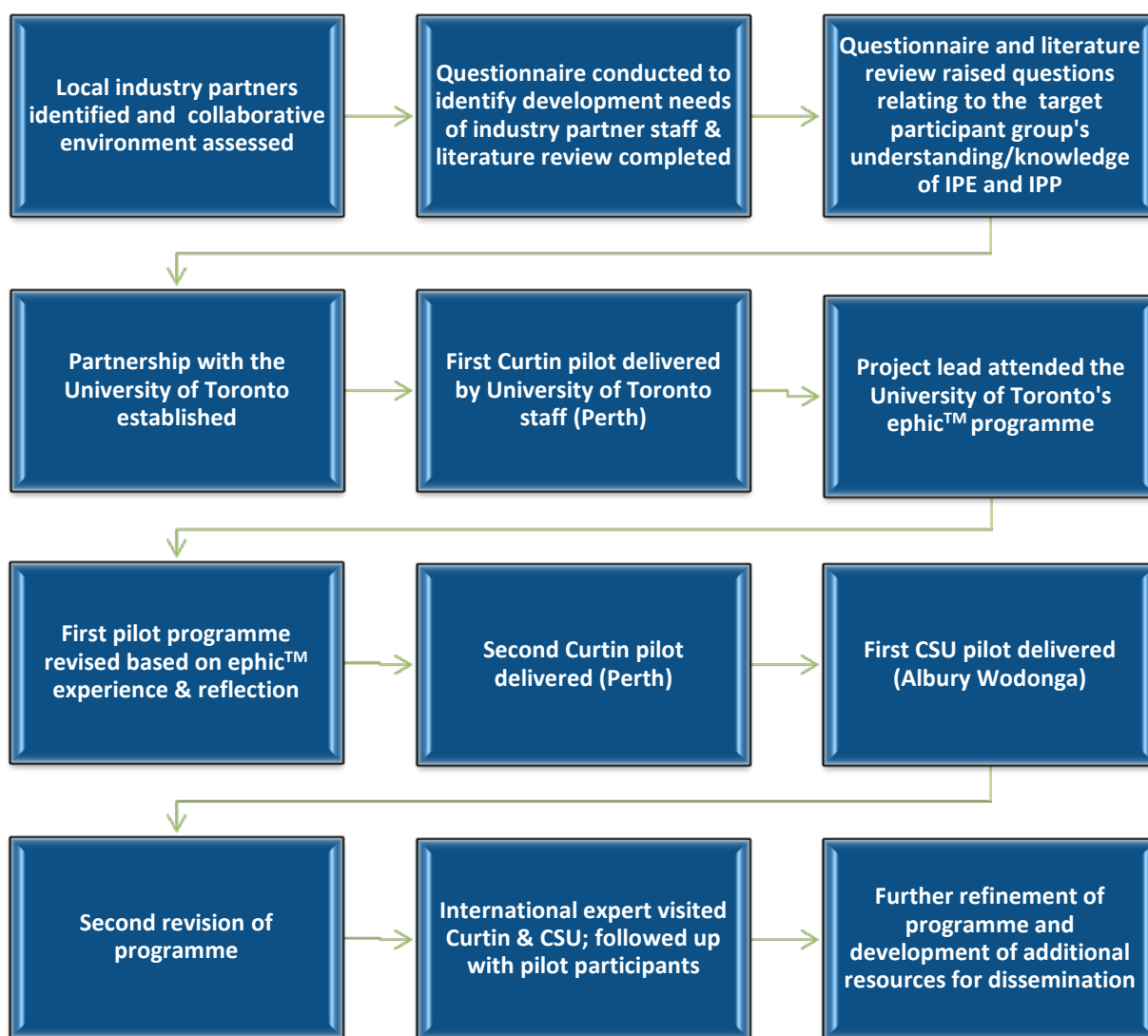


Figure 1: Major project stages

Change leadership for interprofessional education and practice

As outlined above, to transform health service delivery, there is a need to facilitate change in the clinical education environment to support student learning and foster opportunities for students to develop interprofessional practice capabilities. Leading change is often challenging because people are typically most comfortable continuing to do things as they have in the past. Resistance to change is therefore normal and so should be expected. In the interprofessional space, change leadership can be particularly challenging because interprofessional collaboration implies reimagining oneself and one's professional identity (for health staff, academics and students). The power and privilege associated with certain disciplines and professions are contested in collaborative practice, in which all individuals equally bring their knowledge, skills and abilities to assist clients—who are also part of the care team—to achieve better health. Many perceive that professional territories are at risk in interprofessional collaboration—heightening resistance—and many assume that simply working with different professions constitutes interprofessional practice. These and other issues, such as scheduling, resourcing and structural barriers, often result in difficulty imagining and sustaining interprofessional change (Axelsson & Axelsson, 2009). Specific approaches to managing change within this context have been identified as part of this project and are incorporated into the change leadership programme that has been

developed.

Learning philosophy and conceptual framework

Curtin University's Interprofessional Capability Framework (Brewer & Jones, 2013) is used explicitly in the programme, and also informs the approach to facilitation and delivery. Specifically, the underlying emphasis on the client's needs (which in the case of the programme is the participant group) remains central, as illustrated in Figure 2. Overall, the programme aims to model the interprofessional capabilities through its design, facilitation and coordination.



Figure 2: Curtin University's Interprofessional Capability Framework (Brewer & Jones, 2013)

To enable interprofessional practice, change leadership must be distributed (Jones, Harvey, Lefoe & Ryland, 2014) because it cannot be achieved through formal leadership roles alone. Thus, in the context of this project, leaders are defined as 'anyone who sees an issue or opportunity and chooses to do something about it' (Wheatley, 2009, p.144). The participants' action learning plans were thus built on the premise that anyone can take on the role of leader.

Figure 3 below illustrates the components that make up the conceptual framework of the programme which are then described in detail. As discussed above, the framework incorporates key elements of Curtin University's Interprofessional Capability Framework (Brewer & Jones, 2013).



Figure 3: The programme's conceptual framework

Client-centred: The participants are seen as the programme's clients and thus are members of the project team. Hence, they have a key role in the design of the programme. An important component in involving them in the programme design is the participant needs assessment questionnaire. The results of this are used by the facilitator(s) to adapt the programme by emphasising and de-emphasising particular modules. The second key element of the client-centred approach is the collection of local examples of interprofessional education and/or practice in action to ensure relevance. Where these are limited or non-existent, the examples provided in this programme package can be shared with participants to highlight what is possible. The third key element of a client-centred approach is the focus on scenarios throughout the programme to ensure a high level of interactivity and engagement for participants.

Safe and high quality: The facilitators undertake self-reflection prior to the programme, and are self-reflective throughout the process to ensure they have an awareness of their effect on the participants, can deal with difference and conflict, understand and manage group process and relationships, and provide a safe environment where all opinions are sought and valued. They also take a professionally neutral stance by ensuring they resist using profession-specific jargon and their professional identity is secondary to the participants' needs. They acknowledge that power and status exist within health, often associated with stereotypes, and work with the group to flatten those hierarchies that divide participants.

Collaborative: Anyone considering facilitating this programme is advised to seek co-facilitator(s) from different professional background(s) to model effective interprofessional collaborative practice for participants. A significant portion of the programme focuses on exploring collaborative practice capabilities and how these inform the design, implementation and evaluation of both interprofessional education and interprofessional practice. These capabilities link inextricably with collaborative leadership (discussed below).

Leadership models: Although leadership is conceptualised as distributed in nature (Jones et al., 2014), the term collaborative leadership is used to describe the leadership style employed throughout the programme and illustrated through facilitation. Collaborative leadership has been defined as follows:

'Collaborative leadership embraces a process in which people with differing views and perspectives come together, put aside their narrow self-interests, and discuss issues openly and supportively in an attempt to solve a larger problem or achieve a broader goal.'
(Leadership Development National Excellence Collaborative, 2012)

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There are six key principles of collaborative leadership (Leadership Development National Excellence Collaborative, 2012), which underpin the facilitation of the programme:

1. *Assessing the environment for collaboration: Understanding the context for change before you act*
2. *Developing clarity through visioning and mobilizing: Defining shared values and engaging people in positive action*
3. *Developing trust and creating safety: Creating safe places for developing shared purpose and action*
4. *Sharing power and influence: Developing the synergy of people, organizations, and communities to accomplish more*
5. *Developing people through mentoring and coaching: Committing to the development of people to maximize learning experiences*
6. *Self-reflection and personal Continuous Quality Improvement (CQI): Understanding one's own leadership attributes, pursuing one's personal CQI, and engaging others.* (<http://www.collaborativeleadership.org/pages/faq.html>)

In keeping with the client-centred approach of the programme, a number of leadership models are discussed in Module 6 allowing participants to select those that they feel most align with their own values and leadership style. The models highlighted are Kotter's (1996) eight steps of change, Scharmer's (2008) Theory U and Bolman and Deal's (1997) leadership frames.

Kotter's (1996) eight steps are often cited in the business literature. Kotter proposes that most change fails because organisations generally do not take the sort of holistic approach that is required to see the change through. The eight steps are:

1. Establish a Sense of Urgency: Help others see the need for change so they are convinced of the importance of acting immediately.
2. Create the Guiding Coalition: Assemble a group with enough power to lead the change and encourage the group to work as a team.
3. Develop a Change Vision: Create a vision to help direct the change along with strategies for achieving this vision.
4. Communicate the Vision for Buy-in: Make sure as many stakeholders as possible understand and accept the vision and the strategy.
5. Empower Broad-Based Action: Remove obstacles to change, change systems or structures that seriously undermine the vision. Encourage risk-taking and non-traditional ideas, activities and actions.
6. Generate Short-Term Wins: Plan for achievements that can easily be made visible, follow through with these, recognise and reward those who were involved.
7. Never Let Up: Hire, promote and develop staff who can implement the vision, and continue to reinvigorate the process with new projects, themes and change agents.
8. Incorporate Changes into the Culture: Articulate the connections between the new behaviours and organisational success; develop the means to ensure leadership development and succession.

Scharmer's (2008) change model is less about the 'what' of leadership (as described by Kotter) and more about the 'how'. It is the source that guides the leader who is focused on sensing or 'presencing'. This approach is well suited to this programme because it is a collective leadership model designed to meet the challenges of change in an intentional and strategic manner. The journey through the Theory U develops seven essential leadership capacities.

1. **Holding the space for listening**: The foundational capacity of the Theory U is listening to others and to oneself; effective listening involves being open to what others can contribute to the collective/group.

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2. Observing: The capacity to suspend the ‘voice of judgement’, to be able to move from projection to observation.
3. Sensing: In preparation for presencing, the leader needs to have an open mind, open heart and open will. This is an active process of ‘sensing’ together as a group.
4. Presencing: The capacity to connect to the deepest source of self allows the future to emerge from the whole group rather than from a smaller part or special interest group.
5. Crystallising: When the group commits to the purpose and outcomes of a project, the power of their intention creates an energy field that attracts people, opportunities and resources that make things happen.
6. Prototyping: The group needs to deal with the resistance of thought, emotion and will, and to integrate thinking, feeling and will in the context of practical applications and learning by doing.
7. Performing: Organisations need to perform at a macro level, convening the right stakeholders and engaging them to shift from debating to co-creating a new future.

Bolman and Deal’s (1997) four leadership frames—each with its own image of reality—are provided as a means to make sense of organisations. The first, the structural frame, focuses on rules, roles, goals, policies, technology and the environment. The leadership role is one of social architecture matching structure to task, technology and the environment. The second, the human resource frame, focuses on needs, skills and relationships. The leadership role is one of empowerment aligning organisational and human needs. The third, the political frame, focuses on power, conflict, competition and organisational politics. The leadership role is one of advocacy developing agenda and a power base. The fourth, the symbolic frame, focuses on culture, meaning, metaphor, ritual, ceremony, stories and heroes. The leadership role is one of inspiration creating faith, beauty and meaning. Effective leaders need to view the world through all four frames.

Table 1: The leadership models highlighted in the programme

Leadership theories	Focus
Kotter’s 8 steps of change	<ol style="list-style-type: none"> 1. Create a sense of urgency 2. Form a powerful guiding coalition 3. Create a vision 4. Communicate the vision 5. Empower others to act on the vision 6. Plan for and create short-term wins 7. Consolidate improvements and produce more change 8. Institutionalise new approaches—Embed into organisation’s culture
Scharmer’s Theory U Seven leadership capabilities	<ol style="list-style-type: none"> 1. Holding the space of listening 2. Observing 3. Sensing 4. Presencing 5. Crystallising 6. Prototyping 7. Performing
Bolman & Deal’s four frames	<ol style="list-style-type: none"> 1. Structural 2. Human resource

3. Political

4. Symbolic

Appreciative Inquiry: The key underlying philosophy adopted in this project is Appreciative Inquiry because it has been shown to be an effective accelerator of change (Cooperrider, Whitney & Stavros, 2008). Appreciative Inquiry aims to highlight the positive aspects of current practice to better understand the factors contributing to success and how to build and capitalise on them (Ghaye et al., 2008). It is underpinned by collaborative learning and appreciating diverse ways of knowing and doing with a focus on action. An appreciative approach to leadership and change avoids negative, deficit-based discourses while maintaining a critical perspective (Kemmis, 2005). Momentum for change is generated through developing respectful professional relationships and generating a shared discourse. The use of Appreciative Inquiry's four 'D' cycle (Discover–Dream–Design–Destiny) (Cooperrider et al., 2008, p. 5) shown below engages participants from all organisational levels to ensure effective, positive change by discovering and elevating what is good and working well. For example, how might examples of multiprofessional practice be transformed into interprofessional practice? The four underlying propositions of Appreciative Inquiry make this an effective approach to sustainable change:

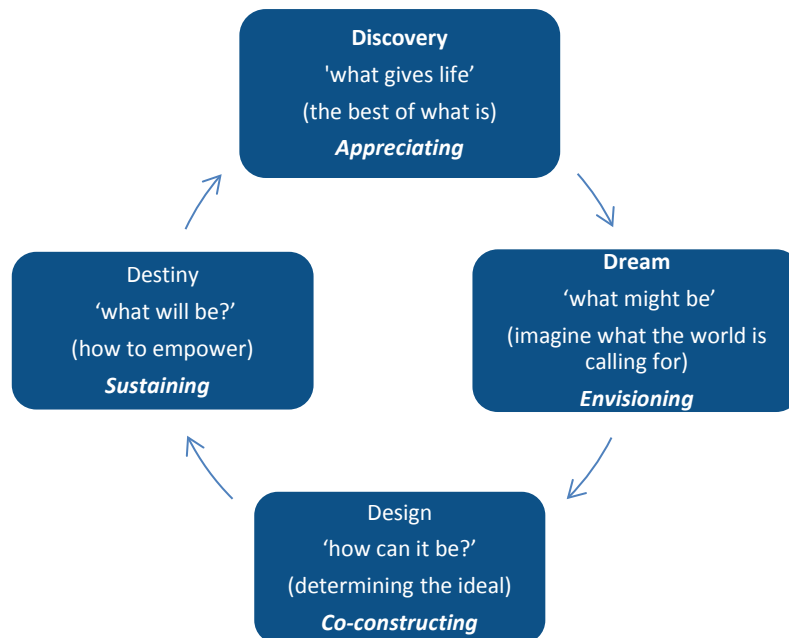


Figure 4: The Appreciative Inquiry Four 'D' Cycle (Cooperrider et al., 2008, p.5)

This appreciative, strengths-based approach allows the facilitator(s) to harness the power and wisdom of the group to achieve the programme's outcomes. In keeping with Appreciative Inquiry, this report has been structured utilising the four 'D' cycle, as shown below in Table 2.

Table 2: Structure of this report reflecting the four ‘D’ cycle of Appreciative Inquiry

Discover	This section sets the scene by providing an overview of the local, national and international contexts as well as the results of the review of the literature on leadership for interprofessional education and practice and the results from the initial needs assessment of one local industry partner organisation. It demonstrates a need for change leadership capacity to achieve the desired outcomes for health and social care promised by interprofessional collaboration.
Dream	Explores what a leadership programme for interprofessional change leadership might look like for an Australian context and how such a programme could support interprofessional education and practice and enable future graduates to develop the capabilities needed for client-centred care. It also describes the collaborative partnership with the University of Toronto’s Centre for Interprofessional Education that informed the development of the initial programme for Australia.
Design	The programme pilots, their design and overall participant feedback are outlined. This section also describes what was learnt from the pilot process and the revision of the pilot programme into the final programme for dissemination.
Destiny	Here the final collaborative change leadership programme for interprofessional education and practice is outlined including the learning outcomes, project materials, dissemination strategy and the lessons learnt through the project. Local, national and international project outcomes are also described.

Discovery: appreciate the best of what is

The discovery process aims to highlight what is worth valuing (Cooperrider et al., 2008), in other words, to appreciate what is already being done in interprofessional education and practice as a basis to extend those initiatives and identify what has contributed to their success: the leadership, processes, structures, relationships and technologies. Within the context of this report and the associated project, this discovery phase involved several phases as outlined previously in Figure 1. The first was the identification of the contexts within which the project team were planning to implement the programme to explore what work had already been undertaken locally (in Perth and Albury Wodonga, where the project partner institutions are located), nationally and internationally. The information in this section aims not only to set the scene but also to engage you in a dialogue and meaning-making process whereby stories of interprofessional education and practice are shared; the same approach utilising stories is adopted in the programme with participants.

Local context

Curtin University (Curtin), Perth, Western Australia

Curtin's Faculty of Health Sciences is the largest educator of health professionals in Western Australia with approximately 11,000 students from 22 professions organised within seven schools: Biomedical Science, Nursing & Midwifery, Occupational Therapy & Social Work, Pharmacy, Physiotherapy, Psychology & Speech Pathology, and Public Health. The main campus of Curtin is located in metropolitan Perth. Additional campuses are located at three regional centres and six offshore partner institutions. Interprofessional education was introduced in Curtin's Faculty of Health Sciences several years ago. This journey began when a small number of champions of this educational approach developed local initiatives. Some of these were on a small scale such as the collaboration between the clinical programme leads of speech pathology and dietetics that resulted in joint education workshops on the management of dysphagia (swallowing disorders) for their students (Brewer & Snell, 2012). Other initiatives were larger scale, for example, interprofessional workshops for students on medication errors, the management of chronic conditions (e.g. stroke and dementia) and palliative care (Brewer, Tucker, Irving & Franklin, 2014). Another key initiative was the expansion of an international service learning programme for occupational therapy students, 'OT Abroad', to an interprofessional, international service learning programme called '[Go Global](#)'. This programme provides international, interprofessional clinical fieldwork learning experiences for students from physiotherapy, occupational therapy, speech pathology, pharmacy, nursing and dietetics (Gribble, Dender, Lawrence & Manning, 2014).

In 2008, Curtin established a full-time position to oversee the implementation of Curtin's vision to be international leaders in interprofessional education (Brewer & Jones, 2014). The creation of this dedicated leadership position—the director of interprofessional practice—resulted in a significant increase in the range of case-based interprofessional workshops available to students (Brewer et al., 2014), the introduction of the Interprofessional Practice Programme (Brewer & Jones, 2014) including the student placement programme at Brightwater Care Group (Brewer, Franklin & Lawrence, 2011; Marles, Lawrence, Brewer, Saunders & Lake, 2012), the development of the first iteration of Curtin's assessment tool for interprofessional practice capabilities (Brewer, Gribble, Robinson, Lloyd & White, 2011), the creation of an Interprofessional Capability Framework (Brewer & Jones, 2013), and the establishment of the first student training ward in the Southern Hemisphere (Brewer & Stewart-Wynne, 2013). Curtin's reputation as a leader of interprofessional education has been established via multiple conference presentations and publications ([refer to IPE website](#)). Curtin has the largest-scale interprofessional curriculum within Australia, with approximately 3,300 first year students from 23 professions enrolled in the interprofessional first year curriculum, over 1,100 students involved in the case-based workshops annually, and over 15,500 hours of interprofessional clinical placements per annum being completed

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(Brewer, 2012). The director of interprofessional practice has provided professional development and training on interprofessional education and practice to hundreds of academic and industry staff. These initiatives, along with others, are highlighted at Curtin's annual Health Interprofessional Education conference (Curtin University, 2012).

The success of Curtin's interprofessional education initiatives has been recognised nationally through Office for Learning and Teaching (OLT) Awards for Programmes that Enhance Learning for Go Global (2010), and the Interprofessional Practice Programme (2012). In 2012, the interprofessional education programme also received international recognition through winning first place in the Best Practice Competition at the World Business Capability Congress held in New Zealand. As described by Brewer and Jones (2014), a number of factors contributed to these successes, including the creation of the discrete interprofessional leadership position, the leadership approach adopted, the structures and process that facilitated collaboration across professions, and the use of various technologies to aid communication and collaboration.

Although students at Curtin engage in a range of university-based interprofessional education experiences, insufficient fieldwork placement opportunities are available to facilitate students transferring their interprofessional knowledge to practice contexts. Close partnerships with its fieldwork placement providers are required to develop additional interprofessional practice learning opportunities. Curtin University is located within the catchment of the South Metropolitan Health Service (SMHS), the fastest-growing health service in Western Australia, covering over 5,000 square kilometres and a population of almost 840,000 (Government of Western Australia, 2013). The SMHS is currently undergoing unprecedented reform of its clinical services and infrastructure, including the opening of a new hospital in September 2014. Their vision is to provide seamless access to innovative, safe, high-quality health care by developing collaborative networks and partnerships and having an integrated approach across professions, sites and services, sharing knowledge and expertise, and recognising and building on strengths. The close alignment of Curtin's local health service's vision with the university's interprofessional education vision has facilitated collaboration between health education and practice. The programme developed through this project was designed to assist Curtin's industry partners, including the SMHS, to develop further their capacity to lead interprofessional education and ultimately increase interprofessional placement opportunities for students.

Charles Sturt University, Albury Wodonga, New South Wales

Similarly to Curtin, Charles Sturt University (CSU) is uniquely positioned to provide interprofessional learning experiences because of the multiple health disciplines studied at the university. Currently, 19 health discipline courses are offered. The university consists of multiple campuses geographically placed in regional New South Wales, and graduates contribute substantially to building the rural and regional workforce of New South Wales.

CSU has been developing its capability to deliver interprofessional education over several years, largely driven by champions in the School of Community Health. This project has involved the school, which has over 700 students studying podiatry, occupational therapy, physiotherapy and speech pathology. The School of Community Health is substantially located in Albury Wodonga, and physiotherapy is also offered on the Orange campus. The School of Community Health has a close affiliation with the School of Nursing, Midwifery and Indigenous Health, co-located on the Albury Wodonga campus.

A reliance on champions to progress interprofessional education reflects the experience at Curtin. The result has been pockets of interprofessional education rather than a systematic embedding of interprofessional education capability development. For example, the School of Community Health has a foundational first year subject taken by students from all disciplines, which has been operating for a number of years, as a basis for students to develop interprofessional practice capabilities. A particular area of focus for the university has been the inclusion of interprofessional learning experiences in the on-campus clinic. Creating a collaborative practice environment which encourages sustainable interprofessional leadership, education and practice

based at Albury. In this clinic, podiatry, physiotherapy and occupational therapy students work collaboratively to deliver client-centred care. The university's involvement in this OLT project has supported further enhancement of interprofessional learning experiences.

In parallel with this, a project officer position was established to support the embedding of interprofessional education, which demonstrates senior leaders' support of interprofessional practice capabilities as key learning outcomes. The new position is supporting the development of collaborative learning activities around topics such as palliative care, an expansion of interprofessional learning in the clinics, and a systematic identification of interprofessional education opportunities in curricula. A key focus has been a review of existing interprofessional frameworks to guide and monitor the development of interprofessional capabilities. Significantly, the School of Community Health is located in Albury Wodonga and has developed important collaborative relationships with the local health service, Albury Wodonga Health (AWH). This includes collaborative projects as well as placement opportunities. During these interactions, staff from AWH expressed a desire to see changes in the capacity for interprofessional education and practice in their organisation. This made them an ideal partner organisation for this project.

AWH was founded in 2009 as a result of a bringing together of the Albury Hospital (est. 1850) and Wodonga Hospital (est. 1954). It is located on two sites, one in Albury, New South Wales (formerly Albury Base Hospital), and the other in Wodonga, Victoria (formerly Wodonga Regional Health Service). The cities of Albury and Wodonga are situated on the Murray River, at the border of New South Wales and Victoria. Together, the cities are home to over 90,000 people, which is one of the largest inland populations in Australia. The health service has a catchment population of over 250,000 people (AWH, 2002–2014). The amalgamation of health services from Victoria and New South Wales has provided numerous and ongoing challenges for the health service as disparities in process across the jurisdictions have had to be negotiated. The health service has now worked through many of these challenges and is in a position of seeking to develop and advance its practice as a unified service.

Significantly, the two industry project partners—Curtin's large and primarily urban health service (SMHS) and CSU's smaller rural health service (AWH)—provided two contrasting contexts in which to pilot the programme. The differences between the two health industry partners have been highly beneficial to the project, and the experience of delivering the programme to the two sites has informed the final package for dissemination.

National context

Interprofessional education has been successfully introduced in many Australian universities, as described in two national OLT projects: Learning and Teaching for Interprofessional Practice from the project: *Developing interprofessional learning and practice capabilities within the Australian health workforce – a proposal for building capacity within the higher education sector* (2009) and Curriculum Renewal for Interprofessional Education in Health from the project: *Curriculum renewal and interprofessional health education: establishing capabilities, outcomes and standards* (2014). Several other interprofessional projects have also been undertaken, such as those led by OLT fellows Maree O'Keefe (Office for Learning and Teaching, 2013), Cobie Rudd and Amanda Henderson (Henderson & Alexander, 2010) and, more recently, the work-based assessment of teamwork project led by Jill Thistlethwaite. Currently, two Australian capability frameworks exist (Brewer & Jones, 2013; Gum et al., 2013) that assist universities to establish the learning outcomes for their interprofessional curriculum. Several health organisations are committed to interprofessional education and practice. The most well-known of these is ACT Health, which has a specific policy on interprofessional learning, education and practice (ACT Health, 2011). Leadership groups have emerged at local levels, for example, the Clinical Placements and Interprofessional Education Committee led by The University of Melbourne's Faculty of Medicine, Dentistry and Health Sciences staff, and the

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student-led Interprofessional Education and Practice Student Council. Supported by the L-TIPP project, a national leadership group, the Australasian Interprofessional Practice and Education Network (AIPPEN) started to emerge in 2006 (Nisbet et al., 2007) and launched its website in 2009. AIPPEN continues to be active today; its most recent meeting was held at the international interprofessional conference “All Together Better Health VII” held in Pittsburgh in June 2014 (World Interprofessional Education and Collaborative Practice Coordinating Committee, 2014). Other informal networks to advance interprofessional education and practice also exist, such as the Australasian Community of Interprofessional Collaborative Practice (Ritchie et al., 2013).

The project team from *Curriculum renewal and interprofessional health education: establishing capabilities, outcomes and standards* completed a recent review of interprofessional education in 26 Australian universities which resulted in a number of key recommendations (Interprofessional Curriculum Renewal Consortium Australia, 2013), including the need for national leadership and coordination across higher education, health and government. A national forum was held in Sydney in April 2014 to launch the report from that OLT project and the interprofessional education curriculum that was developed. A key outcome of the forum was the letter sent to the federal ministers of education and health requesting that they engage in a dialogue with universities and accreditation bodies to facilitate, mandate and resource action to develop, deliver and evaluate further interprofessional education in Australian universities.

International context

Interprofessional practice has a long history internationally; Baldwin (1996) traces it to interprofessional health care teams in India prior to 1900. The idea of educating health professionals together emerged somewhat later. An early example of this was at the University of British Columbia, where, in 1961, the dean of medicine established the ‘Coordinating Committee for Health Sciences’ (Charles, Bainbridge & Gilbert, 2010). The dean went on to describe the interprofessional education approach in the literature: ‘All of these diverse members of the health team should be brought together during their undergraduate years, taught by the same teachers, in the same classrooms and on the same patients’ (McCreary, 1964, p. 1220). National networks began to emerge in the 1980s; the Centre for the Advancement of Interprofessional Education was established in the UK in 1987 and its key publication, the *Journal of Interprofessional Care*, was launched in 1992. Others soon followed, including the European Interprofessional Practice and Education Network in 2000, the Nordic Interprofessional Network in 2001, the Canadian Interprofessional Health Collaborative in 2006, the Japanese Interprofessional Working and Education Network in 2008, and the American Interprofessional Health Collaborative in 2009. Many of these networks also established conferences to disseminate their work and the work of others. These include the European Interprofessional Practice and Education Network conference, the Collaborating Across Borders conference (a US and Canadian collaboration) and the international All Together Better Health conference held biennially. A number of well-known interprofessional education initiatives have emerged since the 1960s, including the Health Care Team Challenge simulation developed by the University of British Columbia (Charles et al., 2010), the Leicester model (Anderson & Lennox, 2009) and the student training ward (Brewer & Stewart-Wynne, 2013). Perhaps the most significant recent initiative was the establishment of the National Centre for Interprofessional Education and Practice in the US in 2013 with \$12.6 million in funding. This centre is designed to ‘provide leadership, scholarship, evidence, coordination and national visibility to advance interprofessional education and practice as a viable and efficient healthcare delivery model’ (Brandt, 2014, p. 3). The centre is focusing on what they refer to as the ‘nexus’, bringing education and health together (Brandt, 2014, p. 5).

Initial needs assessment and literature review

In the project's initial proposal, an online questionnaire for health industry partner staff from the SMHS in Perth (Curtin's industry partner) and AWH (CSU's industry partner) was planned to inform the change leadership programme design. The questionnaire was initially conducted with SMHS staff with the aim of identifying their interprofessional leadership development needs. During this phase of the project, a parallel review of the literature on leadership in interprofessional education and practice was under way, raising several important issues for consideration:

1. There appears to be some confusion regarding the definitions and understanding of interprofessional collaborative practice and leadership, and when leadership is discussed, it is frequently not theorised nor is the broader leadership literature cited.
2. When used, the leadership terms employed in the literature include collaborative, servant, transformational (v. transactional), empowered, interorganisational and charismatic.
3. Rather than broad leadership skills, the focus tends to be on those identified as crucial to facilitating change into an interprofessional practice environment: role clarification, critical reflective practice, emotional intelligence, negotiation and conflict resolution skills, self-efficacy, change management, networking, communication and assertiveness training (for professions dominated by women such as nursing).
4. Many health professionals lack a basic understanding of interprofessional education and practice. In other words, one of the fundamental roles of professional development will be to clarify what interprofessional collaborative practice is as well as developing capacity to lead change and interprofessional educational initiatives.
5. There is an essential need for leadership development to be highly experiential and relevant to the context of individual participants.

As a consequence of the initial literature review, it became apparent that the questionnaire was not the most effective method to determine the programme design because many health professionals were not familiar with interprofessional practice and, in essence, did not know what they did not know (Newton, Wood & Nasmith, 2012). This lack of awareness was largely due to their own siloed education as health professionals and the current approaches to health care.

However, the questionnaire was piloted in Perth and was useful in some respects because it confirmed the findings of the literature review. Forty-nine respondents from 16 professions from Curtin University's industry partner, SMHS, began the questionnaire and 36 (73.5 per cent) completed this in full. The online survey captured qualitative and quantitative data and requested information on the level of understanding of interprofessional education and practice (questionnaire participants, colleagues and their organisation). The response rate and completion rate are likely to be an indication of the time constraints of SMHS staff and the extensive detail included in the survey, despite two gift vouchers being offered as prize draws for those who participated. Significantly, as reported above, their feedback was consistent with the literature identifying that health professionals at SMHS sought practical knowledge to expand their understanding of, and capacity to support, interprofessional education and practice within their health service. Similarly, as reflected in the literature, it appears that the majority of respondents did not value developing broad leadership skills but rather those relating specifically to interprofessional collaboration and change (team facilitation, conflict management, role clarification, communication and managing change). As a consequence of the issues raised by the literature review, it was decided not to survey staff from CSU's partner health service as was initially planned. A different plan to inform the design of the programme was required.

Dream: identify what might be

Given that interprofessional collaboration requires us to reimagine traditional health education and practice, the change leadership capabilities of academics and health professionals are crucial to achieving sustainable interprofessional collaborative practice outcomes. Following this premise, the next step is to imagine how leadership capacity for sustained interprofessional education and practice might be achieved. What, for example, might a leadership programme for interprofessional change look like? What are the essential components of leadership development aimed at providing more interprofessional clinical placement opportunities to support health graduates to achieve interprofessional practice capabilities? What can be learnt from what has been done elsewhere?

The work undertaken for this project builds on the project team's knowledge and insight gathered through their professional and personal experiences including:

- designing and facilitating academic leadership development;
- designing and facilitating interprofessional education workshops;
- designing, facilitating and evaluating leadership programmes in large teaching hospitals;
- research experience in, and knowledge of the literature on, interprofessional education, clinical education, change theories and practice transformation;
- experience in higher education and knowledge of health education traditions;
- experience as fieldwork coordinators and partnering with health industries;
- leadership experience managing interprofessional change;
- experience as health professionals; and
- experience as clients, or family members, accessing traditional health care services.

As discussed earlier, one of the important developments for the project was the collaboration with the University of Toronto, which has over a decade's experience developing and delivering leadership for interprofessional education and practice. From the project team's perspective, it made sense to capitalise on what they were doing that was working well—consistent with an appreciative stance—and adapt it to an Australian context.

Collaboration with the University of Toronto's Centre for Interprofessional Education

Initially, a dialogue with the University of Toronto's Centre for Interprofessional Education began to establish how they had determined the design of their *epic*TM programme (Educating Health Professionals in Interprofessional Care, Advancing the Future of Healthcare through Interprofessional Learning). *epic*TM is 'a [five-day] certificate course for health professionals, educators and leaders and is designed to equip leaders with the knowledge, skills and attitudes to teach learners and fellow colleagues the art and science of working collaboratively for patient-centred care' (Centre for Interprofessional Education, 2014). This course has been nominated for the Canadian Society for Teaching and Learning in Higher Education's Alan Blizzard Award, which recognises exemplary collaboration in university teaching that enhances student learning (2014). The centre also delivers other interprofessional development programmes, such as the Collaborative Change Leadership Program. As a result of the dialogue with the centre, and based on their experience conducting leadership development for interprofessional education and practice, it was decided to enter into a partnership to deliver the first programme pilot.

The development of the pilot with the centre was highly collaborative and interactive, and utilised an Appreciative Inquiry methodology (Cooperrider & Whitney, 1999), an approach consistent with the literature review carried out that indicated that an important aspect of designing leadership development for interprofessional change management had to be

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highly contextualised, responsive to participants' local needs and build on their existing strengths. For example, if health services and universities were very new to interprofessional education and practice, it would be important to spend more time establishing the basic foundations before moving on to change leadership. However, if the participant group already had an understanding of the basics of interprofessional education and practice, the programme could focus more on change leadership. To ensure this successful tailoring process, a number of conversations took place via telephone and email between the project team and the staff from Toronto. These focused on comparison of the goals of this project and their *epic*TM programme; examination of their participant self-assessment tool; exploration of the ideal participant selection process, including factors such as total number and mix of professions; discussion on the local context, including the participants' likely level of knowledge of interprofessional education and practice; and the vision and objectives of the partner organisations SMHS and AWH. Key resources were exchanged, including Australian reports on interprofessional education to assist with scene setting and key publications from Curtin such as their Interprofessional Capability Framework. Based on these negotiations with the University of Toronto, modifications were made to the original project to accommodate their experiences. While the Appreciative Inquiry approach was retained along with reference to Bolman and Deal's (1997) leadership frames, Vilkinas and Cartan's (2001, 2006) integrated competing values framework was removed and replaced with Scharmer's (2008) Theory U and Kotter's (1996) eight steps of change. This decision was initially based on the Toronto team's use of these two leadership models. Later, however, the project team realised that a key focus of this programme needed to be change leadership rather than various leadership roles per se.

To ensure that an outcome of this collaboration was the capacity for the project team to deliver the programme independently, a train-the-trainer approach was adopted for the initial pilot hosted by Curtin and attended by Charles Sturt project members. The project lead opened the workshop with an overview of Curtin's interprofessional education curriculum and shared local examples and success stories throughout the two-day workshop. Through the collaborative partnership, the Centre for Interprofessional Education staff effectively became the project's expert reference group, guiding the initial programme design and subsequent pilot programme.

Based on the dialogue with the Centre for Interprofessional Education, the literature review, an understanding of Australian health services and the aims of the project, the key elements of the interprofessional leadership programme were identified as:

- Establish a shared understanding of interprofessional education and practice.
- Utilise a strengths-based approach (Appreciative Inquiry) to garner enthusiasm and build on existing clinical learning opportunities to achieve interprofessional clinical learning.
- Incorporate change management theory as well as the drivers for interprofessional change.
- Include an action learning plan to achieve sustainable change.
- Model collaborative practice through facilitation and coordination, invoking the 'flattened' hierarchies implied by interprofessional collaboration, including a client-centred approach (in this case, the programme participants were viewed as the clients).
- Bring health academics and health professionals together and establish a shared responsibility for interprofessional health education.

The next section of the report discusses the design of the three pilots conducted in Australia (two in Perth and one in Albury Wodonga) and provides information on:

- tailoring the pilot programme/s in response to participant needs;
- an overview of three pilots including overall participant feedback;
- activities undertaken to engage senior health service management in

- interprofessional education and practice; and
• key lessons learnt from the pilots.

Design: co-construct the future design

'I feel this has been one of the most informative and interactive education programmes on interprofessional education.'

'Change Leadership—so inspiring!'

(participant comments, second Perth pilot)

The first Curtin University pilot

Held on 30 April and 1 May 2013, the two-day leadership programme was delivered to 33 targeted staff from the SMHS by Dr Ivy Oandasan and Lynne Sinclair from the University of Toronto's Centre for Interprofessional Education. Funding for Dr Ivy Oandasan and Lynne Sinclair to facilitate the pilot and share their resources and knowledge was provided by a parallel Curtin project undertaken for Health Workforce Australia. An agreement was signed between the University of Toronto and Curtin that enabled the adaption of resources for use and dissemination as part of this OLT project.

Consultations were also undertaken with SMHS staff responsible for professional development and training. Although the centre's *epic*TM programme runs for five days, the decision to deliver this revised, compact version was based on advice from SMHS staff and the project team's knowledge of Australian health services resources and the ability of participants to be away from work for an extended period. In fact, the commitment of SMHS staff to take two days from normal duties to attend was a significant achievement and was the result of working closely with senior leaders at SMHS, who were asked to identify staff well-primed to adopt interprofessional education and practice. The attraction of spending two days with international leaders from the University of Toronto's Centre for Interprofessional Education functioned as an additional enticement to attend.

Participants selected for the first pilot included SMHS staff from different local metropolitan services (who were already working to some degree in an interprofessional manner and looking to make improvements), staff appointed to a major new teaching hospital (Fiona Stanley) who hold senior project leader roles in education and training, and senior leaders in staff development. Participants were from a range of health professions, including nursing, podiatry, dietetics, physiotherapy, occupational therapy, social work and speech pathology. Only one medical doctor, an early adopter of interprofessional education, attended.

The learning outcomes identified for the pilot included:

1. Understand interprofessional education and practice as well as the drivers for change.
2. Apply change management theory and strategies to embed interprofessional education in clinical settings.
3. Understand approaches to interprofessional education that build on existing clinical learning opportunities.
4. Develop an action plan to facilitate/support interprofessional education for students in clinical settings.

These learning outcomes were threaded throughout the two-day programme.

Table 3: Pilot programme topics

Day	Topics
1	Overview of the programme and participants Overview/theory and evidence Collaborative practice capabilities Opportunities in clinical settings
2	IPE in practice settings Facilitation and IPE facilitation Collaborative change leadership IP-COMPASS [®] tool Change leadership theories Sustainability and next steps

In keeping with the train-the-trainer approach outlined earlier, the project team members from CSU participated in the dialogues with Curtin and the University of Toronto to plan the first pilot and travelled to Perth to participate.

Prior to the workshop, the participants were required to complete a questionnaire that asked them to rate their knowledge and understanding of interprofessional education and practice, collaborative practice skills, facilitating interprofessional education, and change leadership. A five-point Likert scale was used: expert, intermediate expert, intermediate novice, novice and unsure. The findings from this self-assessment were used to shape the pilot programme.

Day 1 of the programme focused on developing a shared understanding of interprofessional education and practice and how to facilitate these in practice settings, and Day 2 focused on change leadership and organisational readiness for interprofessional education and practice. This readiness was assessed using the University of Toronto's IP-COMPASS[®] tool (Parker et al., 2012). On the basis of the information covered over the two days, participants then began work on an action plan to be implemented in their local setting.

Feedback from participants at the end of Day 1 was very good, with strong positive responses on all aspects of the programme. For example, on Day 1, there was 100 per cent agreement (n = 31) that 'the workshop enabled me to achieve the stated objectives', and 90 per cent agreement that the 'material presented encourages me to make changes to my practice'. Feedback from the first day (e.g. what could be improved) was incorporated into Day 2, thus modelling a client-centred approach.

Qualitative feedback for Day 1 was focused on the enthusiasm and quality of the facilitators. Other aspects of Day 1 were also mentioned, including the opportunity to meet and engage with different professionals, the frameworks provided and the DVD interprofessional scenarios (resources developed by the University of Toronto) and how they were used:

The enthusiasm of the facilitators—can't help but get caught up in their energy/passion. Thank you. Group discussions/debrief (whole class). DVD scenarios and mix of professions on each table.

Other qualitative comments from Day 1 focused on implementing interprofessional education and practice along with tools and support that might further this implementation:

Working towards implementing IPP in our workplaces with our current clinical workforce across WA, acknowledging that our workforce moves between sites, metropolitan and rural; as do our consumers.

The following comment is indicative of participants' realisation that interprofessional education and practice was already occurring in their team/organisation and that they could then build on it. These comments highlight the value of the Appreciative Inquiry approach, Creating a collaborative practice environment which encourages sustainable interprofessional leadership, education and practice

which begins by first asking what is being done well or works well in an organisation:

Highlights areas in which we are already working in an interprofessional way and ways we can improve and expand.

The evaluation conducted at the end of Day 2 asked the participants to repeat the pre-workshop self-rating of their knowledge and understanding of interprofessional education and practice, and change management. Results indicated that the programme had a positive effect on all of the questionnaire's subscales including background and knowledge, collaborative practice, facilitating interprofessional education and change leadership.

Feedback for the facilitators across the two days was outstanding, with 19 per cent of participants rating the facilitators as 'good' and 81 per cent rating them as 'outstanding' on a five-point Likert scale.

Qualitative feedback on Day 2 indicated that participants enjoyed the opportunity to problem-solve, brainstorm and collaborate in teams as well as the practical application of Day 2, which focused on developing an action learning plan:

Action oriented, practical and forced us to use the theory to form a plan, instead of putting everything back into the nice file, putting it on a shelf and forgetting all about it. I have never been on a course that did this.

A number of benefits were frequently mentioned in the qualitative feedback, including the resources, tools and skills gained that equipped attendees to become change agents and interprofessional practice advocates. The operationalisation of this for some participants is described below.

Action learning plans review from the first Curtin University pilot

On 31 July 2013, two project team members from Curtin University organised to meet with staff from SMHS who had participated in the first pilot. The agenda for this meeting, set by participants, was to review the action plans developed during Day 2 of the programme. Eight staff attended the meeting at their health service. Prior to the meeting, one of the teams advised that no progress had been made on their action learning plan because of significant organisational changes occurring within their unit. Another team's action plan aimed to introduce client-driven interprofessional goals into service provision. This team asked to brainstorm ideas to accelerate this plan. They reported that, although there was a lot of change taking place in their organisation, it was a good time to introduce new ideas because things were not set in stone. They also reported that staff were generally feeling positive about the client goal-setting process but that it was difficult to implement throughout the clients' journey through the service, that is, from the inpatient unit right through to the therapy in the home service. The majority of the meeting was spent discussing issues around setting client-driven goals, implementation strategies and overcoming barriers to achieve this plan. This follow-up meeting also provided an opportunity for the project team members to provide additional resources, including useful journal articles.

In line with the client-centred approach, a separate meeting was held at the Fiona Stanley Hospital on 4 August 2013, to follow up with three staff members from this site who had also participated in the first pilot. It was very pleasing to learn that, following the programme, they had completed the IP-COMPASS[®] tool to assess their hospital's readiness for interprofessional education and practice. The pilot participants reported the use of the terms interprofessional education and practice in key documents and that these were included in the engagement agreement for staff. The key issue raised was the lack of understanding by executive staff of the difference between multiprofessional (multidisciplinary) practice and interprofessional practice. This lack of understanding was
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identified as a critical barrier to their plan to moving the hospital from merely documenting an interprofessional approach to implementation. This meeting also provided an opportunity for the project lead to provide additional resources, including links to useful YouTube clips and a TED talk that could be employed within their staff engagement strategy.

Critical reflections at this point

At this point, the project team paused to reflect on the key learnings from the first pilot. Two critical concerns were identified. First, the lack of executive understanding of interprofessional education and practice was having a negative effect on the participants' ability to progress their action plans. Second, as demonstrated by the evaluation results, the University of Toronto staff had successfully reduced and tailored their five-day epic™ programme to a two-day programme in another country. However, based on her experience with interprofessional education and practice, the project lead felt that to ensure the success of the subsequent pilot, it would be highly beneficial to complete the full epic™ programme in Canada, which she subsequently did.

As a result of the project lead participating in epic™ along with the opportunity to reflect on her previous experience in delivering professional development in interprofessional education and practice, a number of changes to the first pilot was made. The key changes included: streamlining topics and the links between these (e.g. collaborative change leadership and change leadership theories were combined); ensuring consistent use of terminology (i.e. 'interprofessional practice' was adopted to replace alternatives such as 'collaborative practice' and 'interprofessional care'); addition of client stories to enhance participants' motivation for change; making the links between education and practice more explicit with examples of these threaded throughout; addition of a session on assessment and evaluation; explicit activities exploring the difference between multiprofessional, interprofessional and transprofessional education/practice were incorporated; global networks were included to provide a background to interprofessional education as an international movement; and a model for developing interprofessional practice opportunities for students was also included (Barr & Brewer, 2012).

Second Curtin University pilot

Participants for the second Curtin University pilot were recruited from the list of SMHS staff who had indicated an interest in the programme but were not accommodated in the first pilot. This list was generated early in the project through promotion in the SMHS electronic newsletter and via project team networks.

Thirty-five participants from a broad range of health professions initially enrolled for the programme held on 24 and 25 October 2013; however, a few were unable to attend, which left a total of 28 participants over the two days. Participants were from nine different local health service providers plus three of Curtin's interprofessional education team staff (who coordinate and supervise Curtin's interprofessional student placements) and two academic staff members from Curtin's Faculty of Health Sciences. The SMHS participants included an acting director of Allied Health Services, Workforce Development and Safety and Quality managers, heads of department from social work, occupational therapy and physiotherapy, staff development educators, registered nurses, speech pathologists, physiotherapists, a dietician and project officers employed by Medicare Local. Participants were provided with a comprehensive folder containing practical resources to embed interprofessional education and practice.

Both days were facilitated by the project lead, Margo Brewer, the Director of Practice and Interprofessional Education at Curtin.

This second pilot was a valuable and worthwhile experience, and the evaluation feedback for the two days mirrored the evaluation for the initial pilot delivered by the University of

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Toronto staff. For example, there was 95 per cent agreement that the programme achieved the stated objectives, and 94 per cent agreement that the programme encouraged the participants to make changes in their practice (n = 27). Similar improvements in participants' self-rating of their knowledge and understanding post the programme were recorded, with increases in all the questionnaire subscales, including background and knowledge, collaborative practice, facilitating interprofessional education and change leadership. The same responsive approach was adopted in the second pilot, with feedback from the first day's evaluation being incorporated in the second day.

Overall ratings of the quality of the facilitation were 100 (n = 27) per cent agreement:

Margo, this was terrific. You are a very knowledgeable and passionate presenter. I learned a lot from you and was captivated all day. To listen and engage. Thank you, love this opportunity.

Participant qualitative feedback indicated that participants felt reinvigorated to engage in interprofessional initiatives, enjoyed networking opportunities, change management content and the collaborative aspects of the programme activities:

Getting opportunity to use IP compass tool as a way of facilitating discussion within the team which allowed me to develop possible actions/quick runs for me to implement when I get back to work.

These results suggest that the train-the-trainer approach, supplemented by completion of the five-day change leadership programme run by the University of Toronto, was a successful model for building local capacity to adapt and deliver this programme.

Action learning plans from the second Curtin University pilot

As part of the second day (and consistent with the first pilot), participants worked with the University of Toronto's IP-COMPASS[®] tool to assess their organisation or area's alignment with, and capacity for, interprofessional education and practice. Following this, they identified actions to support interprofessional education and practice, which they recorded on a specially designed postcard. These were posted to the group at the end of December 2013 to serve as a reminder of their commitment to action.

The project team at Curtin undertook a number of follow-up initiatives with the participants to support the implementation of their action plans. For example, one action plan identified the development of a student training ward at Armadale Health Service as its goal. In December 2013, a presentation on the evidence for such wards as an effective clinical training programme was provided to their executive and other interested staff. Several meetings were held with senior leaders at Fiona Stanley Hospital to progress embedding interprofessional education for staff and students in their organisation.

A focus group with eight participants from both Perth pilots was conducted in March 2014 to determine the effect of the programme and how their action plans had progressed. Results indicated that, for many, structural barriers and getting senior staff on board had been challenging and continued to limit their progress. However, overall, the participants stated that the programme had strongly affected their personal clinical practice. For example, one reported that she had moved from setting the goals for her patients to working collaboratively with them to set their own goals. She was also discussing patient goals with the other members of the patient's team to ensure some coherence in their management plans. Another participant reported that she had learnt the value of influence and that she now regularly influences upwards with her senior executive. Several participants described the sense of feeling 'less isolated' in the drive to embed interprofessional education and practice in their organisation. The message of 'leading from where you stand' and the Appreciative Inquiry approach had clearly influenced some participants' thinking.

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Third pilot facilitated by Charles Sturt University

Participants for CSU's pilot were recruited through project team contacts at AWH. This was held at Wodonga Hospital on 14–15 November 2013. Twenty-five participants attended, comprising 14 AWH staff and 11 from CSU. The programme was delivered by Associate Professor Megan Smith, Associate Professor Franziska Trede and Margo Brewer, with input from Isabel Patton (CSU's project manager for interprofessional education). Margo Brewer, Michelle Donaldson and Linley Lord from Curtin were also present as observers and as part of the formative evaluation process.

Three key local considerations resulted in modifications from the second Perth pilot. First, the CSU project team was faced with a different mix of participants, comprising almost equal numbers of industry and university staff. Second, the extent to which interprofessional education had been embedded at CSU was different from that at Curtin, and as yet, they had not created a dedicated position to lead this innovation. Third, they felt that two full days for the programme was not achievable in their context so they decided to reduce the hours from seven to five hours per day. In view of these issues, modification of the programme was undertaken, which, although covering all the content, resulted in decreased time spent engaged in activities. Some group activities were omitted and less time was available for discussion, particularly the IP-COMPASS[®] assessment, critiquing the DVDs and developing an action plan. A reduction in the focus on change leadership was also made.

Participant feedback again was very good: 96 per cent agreement that the workshop enabled the achievement of the objectives and 96 per cent agreement that the programme encouraged them to make changes to their practice (n = 21). Overall satisfaction for the facilitation was 100 per cent agreement. Again, an overall improvement in the self-rated knowledge and understanding subscales in the pre- and post-questionnaire was registered. Qualitative feedback indicated that participants enjoyed the networking opportunity, valued the knowledge and resources provided and the facilitation:

Variety of activities relevance and high quality information

Interactive exercises that promoted reflection and identified areas of improvement. Networking opportunities.

Start to become a leader of change and activity draw in those around me that also have a passion to collectively drive change in this area.

Change in structure of team meetings and greater focus on facilitation—it is a small change that I feel will be easily supported by management.

During the formal debrief meeting held at the conclusion of the third pilot the team considered that, although this pilot received positive feedback, maintaining the full two days for the programme would have enabled the facilitators to develop the change leadership content more fully. It is recommended that, where possible, the programme be delivered in a way that is consistent with the recommendations made in the programme guide to facilitation and coordination.

Action learning plans from the Charles Sturt University pilot

As in the first two pilots, the participants in the AWH pilot were asked to identify an action learning plan. The organisational commitments from the participants to interprofessional education resulted in ongoing collaborative activities as an action outcome. A direct outcome following the programme was a meeting with AWH regarding interprofessional collaboration with CSU. This led to the establishment of the Hume Collaborative Alliance, with representation from the aforementioned organisations plus the Hume Medicare Local.

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Other smaller-scale changes made included: the establishment of regular collaborative meetings between two different departments at Charles Sturt University; a new interprofessional orientation package being developed for students from allied health; and, nursing and radiography students joining physiotherapy and podiatry students at CSU's interprofessional clinic. A number of professional development sessions for AWH and CSU health staff was conducted in 2014. University staff also progressed incorporating interprofessional education in curricula with the School of Community Health having established an interprofessional education group that is now embedded in the School Learning and Teaching Committee. Post the initial pilot, Lynne Sinclair was invited to run a further collaborative workshop for CSU and AWH staff. This was not part of the OLT project but recognised the common desire to progress change with an emphasis on practical outcomes.

What was learnt from the three pilots

The collaboration with the Centre for Interprofessional Education at the University of Toronto was highly productive because it enabled the project team to build on the centre's experience, knowledge and resources, thus saving considerable time and allowing access to excellent resources such as the IP-COMPASS[®] tool. The collaboration also enabled the project to deliver three pilots (an additional pilot from the two initially proposed) to a total of 86 participants. Delivering the programme to different health services in different locations assisted to shape the final programme and associated resources, and has contributed to the robust nature of the package developed for dissemination because the programme has been tested three times with three different cohorts.

Table 4: Participants and their professional profiles

Pilot	Participants	Professions	Total
Perth, April/May 2013	31 staff from SMHS 2 Curtin staff including the manager of the on-site clinic	7 different health professions	33
Perth, Oct 2013	21 staff from SMHS 7 Curtin staff	7 different health professions	28
Albury Wodonga, Nov 2013	14 clinicians from AWH 11 CSU staff		25
Total			86

Although feedback for all three pilots was very good and suggests a considerable increase in participant knowledge, understanding and skills to progress interprofessional initiatives, we would recommend not reducing the contact hours of the programme or the focus on the change leadership component. This change leadership capability is essential to assist in embedding interprofessional collaboration. It is important when engaging people in interprofessional education and practice that they are provided with the foundational knowledge, and that they are also given the leadership tools to advance interprofessional education and practice.

Another key lesson was the need to adapt the programme to the stage of interprofessional development at the facility. It became apparent that the key differences for the two partner universities were not related to their contrasting locations (urban and rural) but more related to the level of progress that these organisations were at on the journey to embedding interprofessional education. The differences were addressed by the inclusion of relevant exemplars as part of the final programme package. For example, at the Albury Wodonga pilot, exemplars from Curtin were used to provide participants with stories about what is possible (the Dream phase in Appreciative Inquiry), which in turn facilitates their understanding of what interprofessional education and practice are.

Further, it became increasingly apparent through delivering the programme that facilitators must have significant knowledge and experience in both interprofessional education and interprofessional practice. This is due to the health academic and clinical professional participant mix, as well as the varying degrees of organisational knowledge and advancement of interprofessional education and practice.

Feedback from programme evaluations and follow-up meetings raised another key lesson, which was that there was a need to engage senior health management staff to support interprofessional initiatives. As a consequence, Canadian Dr Joshua Tepper was brought to Perth and Albury Wodonga as part of the project. Dr Tepper is the vice-president of education at the Sunnybrook Health Sciences Centre. He is the former assistant deputy minister for the Ontario Ministry of Health and Long Term Health Human Resources Strategy Division. He is an internationally recognised leader of interprofessional practice and education, and his visit to Australia in March 2014 involved a very busy schedule. Dr Tepper spent two full days at CSU and AWH, meeting staff from all levels of the organisations, delivering public lectures and meeting with senior CSU health academics, including the executive dean of the Faculty of Science and AWH staff. He also spent three full days at Curtin delivering public lectures, and meeting with senior health managers and senior academic staff. As a medical doctor and change leader with experience in national policy development and health workforce planning, his visit was devised to support the expansion of interprofessional education initiatives. His two Curtin lectures were recorded and are available from the project dissemination website. Anecdotal evidence suggests his presentations were well received by both staff and students.

As a result of these pilot experiences, the guide to the programme is very detailed and provides information on both tips for success and potential pitfalls. The project website also houses a number of useful resources: a short video to highlight the need for a collaborative approach to health, lectures by Dr Joshua Tepper, and illustrations to highlight the difference between a multiprofessional and an interprofessional approach. In addition, the project has developed a facilitator's self-reflection tool to assist potential facilitators to gauge their knowledge and skills and then direct them to appropriate resources to build the skills and knowledge they require for successful facilitation.

At the time of writing this report, the action learning plans have not progressed as well as initially hoped. Structural and cultural issues have proved challenging to implementation of the plans. The most commonly cited challenge was a lack of buy-in from senior staff. In Albury Wodonga, the issues of time and competing demands in both the health service and the university were also highlighted. At the completion of the project, many action projects were still in progress and their outcomes unclear. Similarly to the development of interprofessional capabilities—developed over time and through experience—it is not realistic to expect substantial advances towards interprofessional collaboration through participation in a single two-day programme. Leadership development requires ongoing time and reflection (Ladyshewsky & Flavell, 2012), and interprofessional change leadership requires significant persistence, given the challenges it presents to health education traditions and professional identities. What the programme has delivered; however, is a substantial increase in knowledge, understanding and skills for interprofessional collaboration and change leadership across all three pilots. As some focus group participants identified—the programme functioned as an epiphany—and is resulting in individual changes to practice. In other words, participants have begun their journey towards becoming capable interprofessional leaders, but many are only at the start of this journey. Ideally, ongoing support of the participants should be given to advance their action plans and further facilitate the emergent community of interprofessional champions that the programme has ignited.

The next section of the report gives an overview of the final programme.

Destiny: sustain what gives life

The final programme developed in this project is titled Interprofessional Education and Practice: Creating Leaders and Opportunities for Clinical Learning. The programme has been packaged into seven modules to allow adaption to different contexts. The seven modules have their own learning outcomes, which are provided in Table 5.

Programme benefits and learning outcomes

The programme is designed to develop change leaders for interprofessional education and practice who have the knowledge, skills, attitudes and values to teach learners and fellow colleagues the art and science of working collaboratively for better health care.

Programme learning outcomes as outlined previously are:

- Understand interprofessional education and practice as well as the drivers for change.
- Apply change management theory and strategies to embed interprofessional education in clinical settings.
- Understand approaches to interprofessional education that build on existing clinical learning opportunities.
- Develop an action plan to facilitate/support interprofessional education for students in clinical settings.

These outcomes remained consistent over the life of the project, but in the final programme, in keeping with action research, modifications, including those described earlier, were made along the way. One key change was that the two-day programme was split into seven modules to allow for greater flexibility in delivery (see Table 5).

Table 5: Programme modules and their individual learning outcomes

Module	Title	Learning Outcomes
1.	Overview of programme and participants	<ul style="list-style-type: none"> • Understand the programme aims and structure • Understand the role of participants and facilitator/s
2.	Setting the scene	<ul style="list-style-type: none"> • Define both interprofessional education and practice • Demonstrate an understanding of the education/practice continuum • Examine the evidence for interprofessional education
3.	Practice education system	<ul style="list-style-type: none"> • Develop an understanding of the practice education system • Examine IPE programmes in Australia • Understand your role as a change agent
4.	Interprofessional practice capabilities, assessment and evaluation	<ul style="list-style-type: none"> • Critique the application of interprofessional practice capabilities in action • Understand some key principles of assessment and evaluation of interprofessional education and practice
5.	Delivering and implementing Interprofessional Education and Practice	<ul style="list-style-type: none"> • Identify the skills and abilities required to facilitate interprofessional education effectively
6.	Collaborative leadership	<ul style="list-style-type: none"> • Explore your organisation's readiness for interprofessional education and practice • Understand key approaches to collaborative change leadership

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7.	Sustainability	<ul style="list-style-type: none"> • Create and implement an action learning plan to lead change in your context • Consider the factors for sustainability of change
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A participant resource file has been developed to house the programme resources. Each module has a PowerPoint® presentation, handouts and worksheets related to the learning outcomes where appropriate. For more information on facilitation and coordination, see the detailed guide that has been developed and is available from the project website.

Project outcomes

Local project outcomes

The project outcomes at the partner universities—Curtin and Charles Sturt—are diverse and suggest increased interest in, and capacity for, interprofessional education and practice to support student interprofessional capability development. Improved relationships between industry partners and project universities have also been an outcome:

- Capacity building of the project team, particularly in the area of Appreciative Inquiry. It is now embedded into staff team meetings and quality improvement workshops at Curtin.
- Three pilots of the change leadership programme have been delivered (two in Perth and one in Albury Wodonga), and the final programme package has been refined based on participant feedback and the experience of conducting the pilots with different cohorts and in different settings.
- Relationships and collaborations between the partner universities and local health service organisations have been strengthened. For example, the project lead was invited to join the selection panel for new allied health education positions at Fiona Stanley Hospital, and was invited to present on behalf of one programme participant at an international conference. In Albury Wodonga, the 'Hume Collaborative Alliance' was created, which came about from the pilot conducted with CSU's industry partner AWH, and regular meetings of the community of practice have been held throughout 2014 to discuss topics related to interprofessional education and practice.
- Two participants of the Perth pilots have been employed as leaders of interprofessional education at Curtin.
- There is an emergent community of change agents for interprofessional education and practice at Perth and Albury Wodonga.
- At CSU more staff are expressing a commitment to interprofessional education, including embedding capabilities into curricula and increased involvement in interprofessional education projects.
- Four pilot participants presented their action learning plan projects at Curtin University's Health Interprofessional Education [HIPE] Conference (5 September 2014, Bentley, Western Australia).

National project outcomes

National outcomes from the project include:

- Links with other OLT projects:
 1. Curriculum Renewal for Interprofessional Education (2014)
 2. Work-Based Assessment of Teamwork: An Interprofessional Approach (2012).
- Negotiations are currently under way for the programme to be facilitated at Victoria University and the Western Regional Health Centre.

International project outcomes

International outcomes from the project include:

- A strong relationship was built with the University of Toronto's Centre for Interprofessional Education. A joint presentation was made at the All Together Better Health Conference in Pittsburgh, June 2014, and regular meetings via Skype are continuing to progress future research projects and joint publications.
- A strong relationship was built with Dr Joshua Tepper, and communication with him continues, to discuss interprofessional leadership in higher education and health.
- An international expert panel on interprofessional education and practice was captured through Google Hangout for use at Curtin's HIPE Conference. One panel member was from the University of Toronto and one was from the project's expert reference group.
- The University of Otago, New Zealand, has expressed interest in delivering the programme.

Project products

Several products have been produced as part of the project, including:

- LE12-2164 project final report: *Creating a Collaborative Practice Environment that Encourages Sustainable Interprofessional Leadership, Education and Practice*;
- project dissemination website;
- the Interprofessional Education and Practice: Creating Leaders and Opportunities for Clinical Practice programme—seven modules with capacity for adaption to local contexts;
- a guide to assist the implementation of the change leadership programme: *Facilitating and Coordinating the 'Interprofessional Education and Practice: Creating Leaders and Opportunities for Clinical Learning' Programme*;
- a full suite of programme materials, including PowerPoint[®] presentations, handouts, worksheets, resources to support interprofessional collaboration and an advertising flyer for the programme;
- a facilitator self-reflection tool;
- an interactive cartoon resource on interprofessional practice;
- a short video, *Collaborate for Better Health*, for use in the programme and to promote client-centred care;
- two iLectures by Dr Joshua Tepper on interprofessional education and practice;
- short video by Dr Joshua Tepper on the need for change leadership for interprofessional education and practice; and
- five stories of successful interprofessional education initiatives from Curtin.

Dissemination

Knowledge translation events

1. Sydney, 12 December 2014
2. Webinar, 11 February 2015
3. Perth, 25 February 2015

Oral paper presentations

1. 'Hand in Hand: Health and Education Working Together to Deliver Collaborative Practice Ready Graduates', Practice Based Education Summit (9–10 April 2014, Sydney, NSW)
2. 'Creating Leaders to Advance Interprofessional Learning and Interprofessional

- Practice in Australia and Canada—Two Countries One Vision’, All Together Better Health VII (6–8 June 2014, University of Pittsburgh, Pittsburgh). Presented in partnership with Ivy Oandasan and Lynne Sinclair from the University of Toronto
3. ‘How Do You Lead Interprofessional Education and Practice’, Curtin University’s HIPE Conference (5 September 2014, Bentley, Western Australia)
 4. forthcoming presentation, Teaching and Learning Forum (29–30 January 2015, University of Western Australia, Crawley, Western Australia)
 5. forthcoming presentation, Australian and New Zealand Association for Health Professional Educators (29 March–1 April, 2015, Newcastle City Hall, Newcastle)

Verbal promotion and flyer distribution

1. Singapore Rehabilitation Conference (April 2014, Singapore)
2. Curriculum renewal for interprofessional education in health national forum (1 May 2014, Sydney)
3. Western Australian Clinical Training Network workshop ‘Facilitating Interprofessional Education and Practice’ (7 May 2014, Perth)
4. The Australasian Community of Interprofessional Collaborative Practice (17 June 2014, via teleconference)

Short written reports

1. Websites: Curtin University, CSU’s Education for Practice Institute, the Australasian Interprofessional Practice and Education Network (AIPPEN).
2. Curtin and Charles Sturt University newsletters, South Metropolitan Health Service newsletter.

Refereed papers

Two refereed papers were in progress at the time of writing this report; the two papers address results from the pilots and programme design and a literature review of leadership in interprofessional education and practice. It is anticipated that both will be submitted for review by February 2015 at the latest.

Conclusion

This project has seen the creation of an Australian interprofessional change leadership programme for academic and health industry staff. The programme has been designed to expand interprofessional clinical learning opportunities to support students to develop their interprofessional practice capabilities and become work ready. The programme was created by Curtin and Charles Sturt Universities through collaboration with the University of Toronto's Centre for Interprofessional Education, a world leader in interprofessional leadership development programmes. This collaboration enabled the project team to learn from the centre's extensive experience. Due to their input, the initial development phase for the programme was shortcut, which made more time available to pilot the programme (the initial proposal identified two pilots; however, three pilots were conducted). The final programme for dissemination to the Australian higher education and health industry sectors has undergone multiple refinements following the three pilots.

Results from the pilots suggest that the programme has the potential to build participants' knowledge and understanding of interprofessional education and practice as well as support the creation of change leaders to expand interprofessional learning opportunities. The programme is underpinned by Appreciative Inquiry, which is designed to garner enthusiasm and energy for change through building on processes and practices already under way that have the capacity to become interprofessional.

The importance of the programme facilitator's skills, knowledge and abilities has been highlighted throughout the project. In particular, the facilitator must model interprofessional collaboration as well as have considerable experience and knowledge of interprofessional education and practice. In addition, the experience of delivering and evaluating the pilots revealed that, to maximise outcomes, participants require support beyond the programme to see the successful completion of their action plans. Assistance to maintain the emergent community of practice, that the programme seeds, is also highly recommended.

Finally, the project has seen the creation of not only the change leadership programme but also a range of materials and resources to enable the successful adaptation of the programme—and its facilitation—to varying local contexts and cultures.

Appendix A

Expert Reference Group

- Emeritus Professor Hugh Barr, president of the UK Centre for the Advancement of Interprofessional Education (CAIPE) and Honorary Fellow, University of Westminster
- Maria Tassone, director of the Centre for Interprofessional Education, University of Toronto
- Professor Gary Rogers, academic lead for the Doctor and the Patient theme and deputy head of school, School of Medicine, Griffith University
- Professor Dawn Forman, associate for the Higher Education Academy, the Leadership Foundation for Higher Education, and a senior associate of Ranmore Consulting

Dr Ivy Oandasan and Lynne Sinclair from the University of Toronto's Centre for Interprofessional Education played a significant role as an informal expert reference group. As already outlined in the project report, both made a considerable contribution to the project outcomes and helped shape the Australian change leadership programme. Professor Hugh Barr was also in regular contact with the project lead and provided crucial support and guidance.

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