Using participatory, practice development, Delphi and realist research approaches to understand how front line teams can use the workplace to integrate learning, development, improvement and innovation

Professor Kim Manley

Carolyn Jackson

England Centre for Practice Development

Canterbury Christ Church University

Acknowledgements

- Christine McKenzie, Royal College of Nursing
- Dr Toni Wright, Principal Research Fellow
- Anne Martin, Research Fellow
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Health Education Kent, Surrey and Sussex

Key RCN Research Conference themes

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Research symposium addresses

- Workforce development and emerging new roles
- Supporting learning in practice
- Partnership working and collaboration

Symposium Aims

- Approaches, theoretical insights and findings from three key research studies
- Reflection on contribution to body of knowledge on person centered safe and effective care in the workplace
- Synthesis of findings into new theoretical framework- **Venus** model for person centered sustainable transformation in health & social care
- Discussion and reflection with symposium participants

Paper 1
Safety Culture, Quality Improvement, Realist Evaluation (SCQIRE)

Project Team

Professor Kim Manley; Carrie Jackson, Anne Martin

Christine McKenzie, Dr Toni Wright,

Aim of Evaluation

- What is the impact of the Patient Safety Collaborative (PSC) initiative on patient safety culture, quality improvement capability and leadership?

- To understand what works for whom and why:
  - when working with frontline teams in acute NHS Trusts to embed a safety culture
  - when enabling facilitators to work with the PSC initiative with frontline teams

SUPPORT PROVIDED TO FOUR ACUTE TRUSTS

ACTION LEARNING for ORGANISATIONAL FACILITATION TEAMS

TEXAS CULTURE TOOL/Other

HUDDLES/LEEDS EXPERIENCES

Ten independent frontline teams across four case studies (acute NHS Trusts)

Case Study 1:: Overall project lead with clinical leads/managers for each of **three teams:**

- Antenatal and post-natal ward
- Respiratory ward
- Clinical decision unit/urgent care

Case Study 2: One ward team previously experiencing a high fall rate & invested with intensive facilitation support, facilitator left leaving reminder members of facilitation team comprising clinical Lead for safety and organisational lead for safety. Organisational lead for safety took over immediate support role for ward.

Case Study 3: One overall project lead, with senior clinical lead for each of **two teams:**

- Midwifery Delivery Suite
- Emergency Department

Case Study 4: Four senior clinical leaders each facilitating one of **four teams**:

- Frailty ward and safe discharge
- Renal ward and sepsis
- A &E and patient transfer to wards
- Ambulatory Care – safety huddle

Research approach

- **Realist evaluation** assumes both social systems and structures are real because they have real effects and human actors respond differently in different circumstances
  - Interaction between context (C) & mechanisms (M) produces outcome (O) i.e. C+M=O
  - Programmes (complex interventions) occur in different contexts and trigger different mechanisms so can't just be replicated
  - Theoretical understanding about what works and why can be transferred to different contexts

- **Practice development methodology** because of:
  - **Values**: person centred, safe and effective care and effective workplace cultures at the microsystems level and context
  - **Enabling stakeholder engagement** and the use of tools that focus on what matters

Methods & Analysis (1)

Interrogation of the literature

- Patient safety
- Safety culture , QI and leadership capacity building

Output

Identify enablers, attributes and consequences at individual, team and organisational level

Generation of 16 tentative CMO relationships

Appendix 2: What works, why it works and for whom it works – insights from the literature

Context	Mechanism -why	Outcome	For whom
Frontline teams and safety culture			
L1. Contexts where individuals (clinical leaders & team members) have specific personal characteristics and values and beliefs that intentionally guide their actions	L1a • Use compassionate presence • Are committed to engagement with others • Truly listen to others communicating without discrimination	• Establish and maintain caring responsive trusting therapeutic relations • Enable staff to speak up • Advocacy for patients	Patients Staff
	L1b • Address and sign up to safety values; • Comply with safety policies, protocols and processes; • Follow up corrective action; • Challenge established norms, power structures and decisions with safety implications • Collaborate across the system	• Increased accountability for own practice • Improved compliance, • increased safety awareness • Staff speaking up • Promote learning across system	Staff Patients Organisation and system
	L1c • recognise own assumptions to develop awareness of own interventions, • participate in practice based learning and show a readiness to change	• increased accountability for own practice; • continuous learning and creative problem solving; • behaviour change based on learning,	Staff Patients
L2 Team contexts that value patient participation, engagement and person centredness	• Use approaches that share and communicate information with patients, families and staff, • Encourage and engage patients in care as equal partners	• Achieve staff and patient empowerment	Staff Patients
L3 Teams that hold values about clinical and practical expertise, staff autonomy and involvement in safety and quality improvement	• Use approaches that engage and involve staff to create ownership for safe practice	• Achieve high level/improved staff engagement, • improved staff morale, satisfactions and staff outcomes	Staff Patients

Specific INDIVIDUAL values, beliefs & characteristics for contributing to safety culture (Literature analysis)

Personal characteristics:

- **Person-centred, compassionate and caring**
- **Authentic, open, honest and trusting with integrity**
- **Supportive, valuing and empathetic**
- **Motivated , showing perseverance, resilience**
- **Are active and adaptive to the work system**
- **Creative, passion with drive and self-efficacy**
- **Enthusiastic and optimistic**
- **Vision and systems thinking**

Personal values and beliefs:

- **Respectful and ethical**
- **Accountable, responsible and take pride in one's work**
- **Self and safety aware, reflective**
- **A commitment to safety, quality, learning and a blame free approach to incident reporting**
- **Positive commitment to adopting & implementing safe, ethical practice**
- **Courage to speak up assertively**

Methods & Analysis (2)

Unit of analysis = group processes within each frontline team towards collective action

- **Self assessment data from facilitators**
- **Qualitative 360 degree analysis**
- **Emotional Touchpoints with facilitators** – focusing on what matters in relation to the QI skill set (Health Foundation)
- **Texas/other tool**
- **Collaborative Observations of practice teams**
- **Claims, concerns and issues** with stakeholders including:
  - Frontline teams
  - Facilitators
  - Governance teams

Output

CMO Relationships for each team and case study

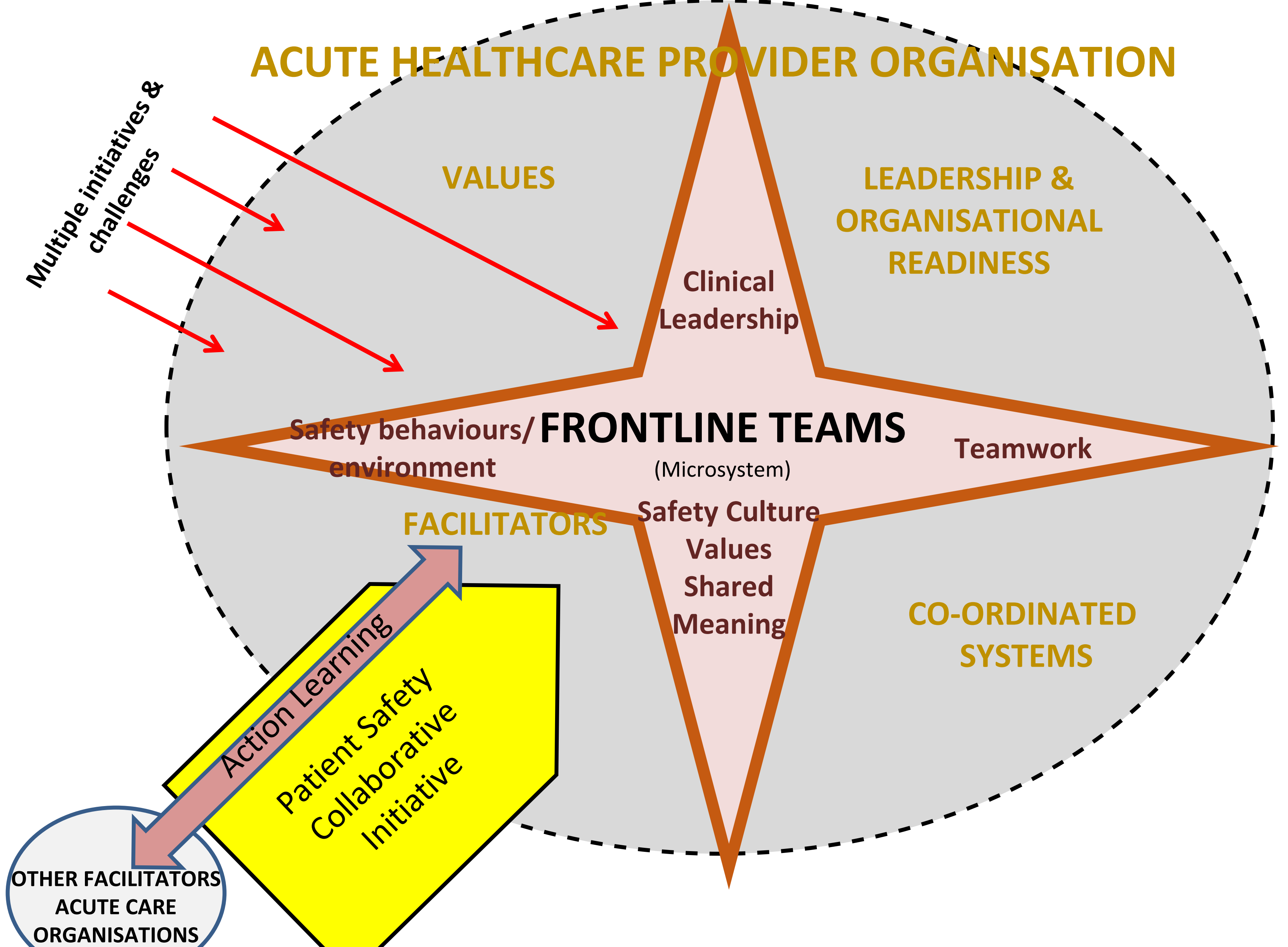
Synthesised across all case studies to generate statements of what works , why it works and for whom it works refining CMO relationships from the literature interrogation

Focus of Findings

What works, why and for whom when:

- ❑ **developing a safety culture in frontline teams**
- ❑ **senior facilitators** work with frontline teams to embed safety culture, QI in frontline teams
- ❑ **the Patient Safety Collaborative initiative** is used by facilitators and frontline teams
- ❑ using the patient safety collaborative initiative within **acute hospital Trusts**

SYNTHESIS FRAMEWORK - KEY INTERDEPENDENT THEMES



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What Works	Why (Mechanisms)	For who does it work	S1	S2	S3	S4	Literature Theme
Context: Frontline teams and safety culture							
1. Clinical leadership in frontline teams that models respectful relationships, person centred values and actively listens to and values patient and service user expertise	Consistently enables and endorses person centred respectful relationships between all staff members and with service users with a 'can-do' attitude, and attention given to both patient and staff wellbeing. Service users and staff feel heard and listened to and become empowered	All staff groups in clinical setting - their wellbeing and safety Service users & stakeholders present in clinical setting as focus is on the person Improvement in service users experiences & safety Team priorities	S1.1	S2.2 S2.4	S3a.2	S4.P1.3 S4.P2.2 S4.P3.1 S4.P3.3 S4.P4.1 S4.P4.2	L1a L2 L4
2. Team working with consistent good leadership and team members willingness to engage and collaborate for improvement	Team members have shared purpose and plan, work to same purpose collaborate and help each other and share responsibilities High support high challenge for effective team behaviours to enable everyone to flourish Team dynamics have an impact on patient outcomes	Team members and their beneficiaries i.e. service users and other teams benefit from clear expectations and role clarity Focused team priorities and plan are achieved	S1.1 S1.2	S2.1 S2.18	S3a.1	S4.P1.1 S4.P1.2 S4.P2.1 S4.P2.2 S4.P3.1 S4.P3.3 S4.P4.2	L1a L2 L3 L9

Developing a safety culture in frontline teams. Theme 1: Clinical leadership

What works?

Clinical leaders (ward managers, clinical leads, team leads, shift leads) who:

- ✓ Model respectful relationships and person- centred values
- ✓ Are approachable, actively listens to and values patient and service user expertise, engagement and participation
- ✓ Pay attention to both patient and staff wellbeing
- ✓ Support teams with patient safety/improvement
- ✓ Are clinically credible, model self-awareness, reflection and learning.
- ✓ Creates shared vision/direction and embeds this
- ✓ Connects everyone for the patient, encourages innovation
- ✓ Possess personal attributes and qualities, and are transformational leaders

Why does it work?

Consistently endorses and enables:

- Service users and staff to feel heard and listened to, to become empowered and this improves experiences
- Person centred respectful relationships between all staff members and with service users, so people feel valued and respected
- Impacts on a collaborative approach to developing workplace culture

360 Degree feedback illustrating qualities and values in action

- ✓ **From different members of role set**
- ✓ **Endorses the qualities, values and beliefs experienced of effective clinical leaders and facilitators**

"You have very clear standards for the delivery of care and I have never known you to compromise these standards. This sends a clear message to staff, encourages and inspires similar standards."

"You have a welcoming and enthusiastic personality that makes you easy to approach, ask questions and suggest solutions. This makes it easy for staff to report adverse incidents and support further learning and enhances safety."

"You always make the time to listen and explain; this is a great trait in a manager and has been a great support."

"Positive support and leadership to staff and listen to concerns"

"Always seeks to develop service and involves teams in actions"

"You involve staff in discussion and decision making about changes"

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Facilitator insights

What Works	Why (Mechanisms)	For who does it work	S1	S2	S3	S4	Lit
Context: Senior facilitators/leaders working with frontline teams to embed safety culture, QI in frontline teams							
5. Facilitators using Observations of practice and enabling others to do so, enable collective learning, growth of confidence and staff engagement around safety culture and human factors through celebrations, recognising patterns and dissonances that support discussions around shared meaning and role clarity	Using Observations of Practice provides a structured approach to helping teams celebrate what is going well, understand their priorities and direction of travel for improvement Provides small bits of information about relationships Provides information about bigger patterns about micro-interactions and the environment Enables dissonance about shared meanings or between values and behaviour to be identified to clarify expectations	Organisation Governance teams Divisional leads Facilitators Front line teams Service users and patients		S2.19	S3a10	S4.P2.5 S4.P3.9	

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TheAHSNNetwork

Safety Culture, Quality Improvement, Realist Evaluation (SCQIRE)

Evidence shows that improving patient safety is a complex business. You need to focus on a range of issues, and to make a lasting impact, improving the culture in teams and organisations has to be a priority.

Good safety culture is where staff have consistently positive experiences of teamwork and leadership, where staff feel comfortable discussing errors, where leaders and frontline staff take shared responsibility for delivering safer care.

In 2016 KSS PSC developed an initiative to facilitate safety culture, improvement and grow leadership and quality improvement capacity and capability across four acute NHS hospitals in South East England.

Culture is "the way we do things around here", it's what you do when nobody's watching.

Specifically, the aim was to identify which strategies are effective in supporting frontline teams to sustain bottom up change and quality improvement driven by the needs of patients and practitioners.

The England Centre for Practice Development (ECPD) was commissioned to evaluate the initiative, using a realist evaluation approach, to understand what works for whom, when and why.

Tony Kelly, Clinical Lead for Leadership, Culture & Capability at KSS PSC, said:

"Our approach builds in capability and capacity for teams to run the project themselves, and this research shows that teams can be empowered to tackle their own safety culture."

ECPD Co-Director Professor Kim Manley said: *"The SCQIRE project endorses the importance of health care organisations investing in quality clinical leadership for safety cultures in frontline teams; organising facilitation support to embrace the values and diverse skillsets needed to make a difference through building on what works; and adding to our understanding about achieving culture change."*

A range of clinicians and specialities was included in the study, from renal, urgent care, ED and obstetrics to frailty and respiratory wards.

The project tested a range of practical tools, including Claims Concerns and Issues, Texas Culture survey, safety huddles and action learning sets. These were found to contribute to and nurture an effective workplace culture and inclusive transformational leadership, but could only work in a sustained way if the managers at Matron, Directorate and Board level were supporting and empowering front line clinicians.

For more information about the project, including the full research paper, implementation toolkit and background information, visit **www.kssahsn.net/scqire** **www.canterbury.ac.uk/ecpd** or **email psc@kssahsn.net**

Kent Surrey Sussex

Patient Safety Collaborative

Key messages

- Clinical leaders and front line teams, working where care is provided and experienced, are the most essential focus for achieving and sustaining safe, person-centred and effective cultures.
- Investment in the role, skills and support of organisational facilitators to enable frontline teams to be effective, as well as growing collective and collaborative capacity for facilitation at all levels of the organisation, can help achieve the learning, development, improvement and innovation needed to keep patients safe.
- A wide range of skills is needed for this, but the most essential is enabling participation and unpacking the 'why' as well as the 'what' of patient safety with frontline teams and their managers.
- Success depends on providing role models committed to authentic transformational leadership, engagement with front line teams and ability to influence connected quality improvements at all levels to promote effective 'bottom up' change for safety initiatives.

England Centre for Practice Development (2017)

Quality Standards Realist Evaluation for evaluators & peer reviewers (Wong et al, 2017)

Theoretical outputs

Standard 3

Led to the development of a refined theory for person-centred culture change in frontline teams

Standard 5

Use of practice development approach and methods e.g. Observations of Practice and Claims, Concerns and Issues led to wider uptake and application in participating teams not previously exposed to them

- Standard 1: Evaluation Purpose
- Standard 2: Understanding and applying the realist principle of generative causation in realist evaluations
- Standard 3: Constructing and refining a realist programme theory or theories
- Standard 4:Evaluation design
- Standard 5: Data collection methods
- Standard 6:Sample recruitment strategy
- Standard 7: Data analysis
- Standard 8: Reporting

Limitations

- Application for ethical clearance coincided with the launch of the awarding body- the NHS Health Research Authority- which resulted in a time lag of three months

- There was a lack of PSC initiative guiding principles and a common approach across case study sites for participating organisations and teams which made clarity of purpose more difficult.

- Not all sites used the Teamwork Safety Climate Survey making comparison difficult

- Engagement of frontline teams varied due to three factors, i) the busyness of the areas; ii) the timeliness of the data collection; and iii) the relationships influencing the frontline teams.

- Minimizing the burden on frontline staff required the research team to be as flexible and sensitive as possible in collecting data

- Training the facilitators in how to use Observations of Practice and Emotional Touchpoints would have strengthened confidence in the usefulness of the tools in some sites

Paper 2
Developing integrated facilitation standards to embrace the facilitation of learning in the workplace using an e-delphi

Project Team

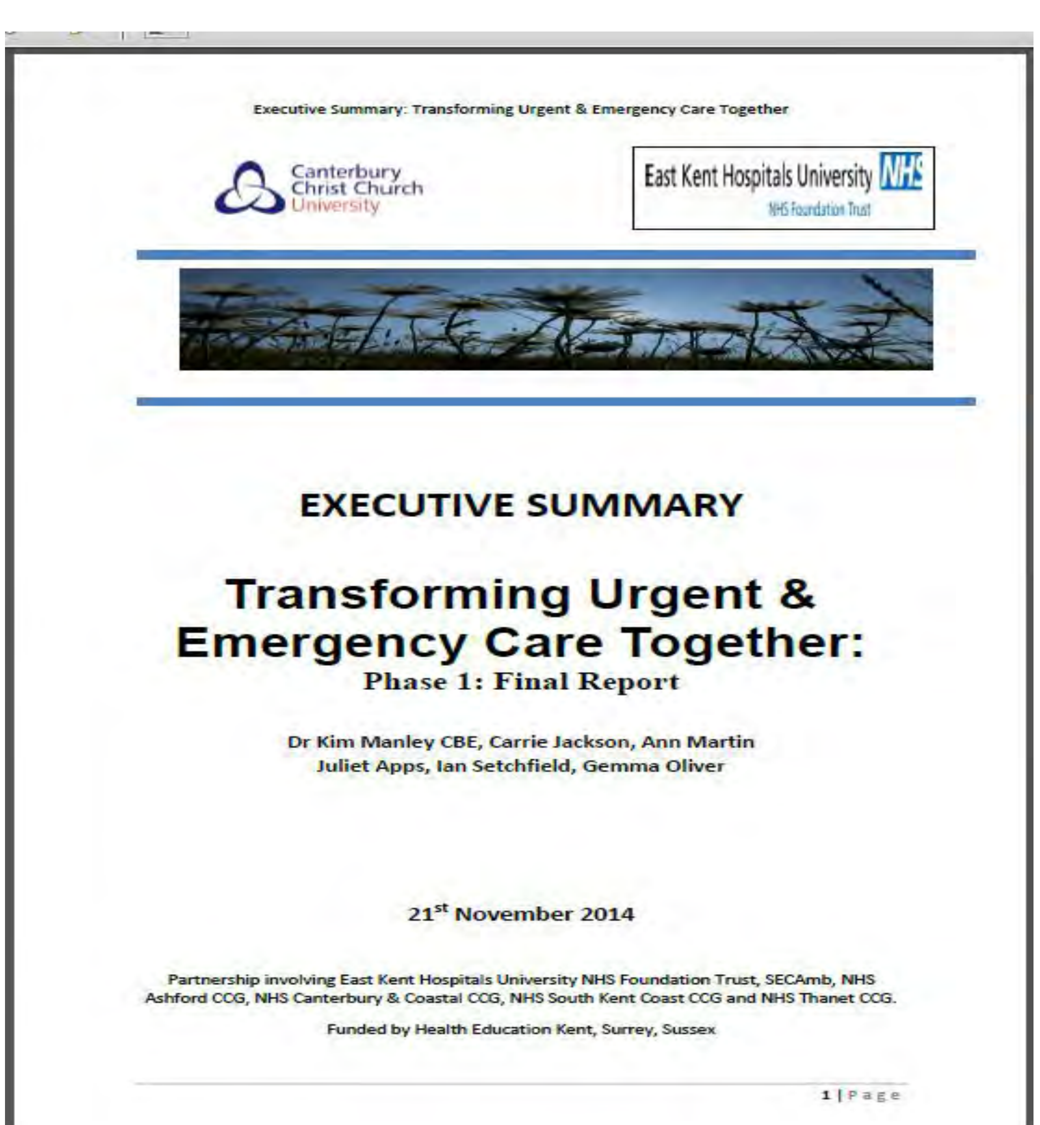
Prof Kim Manley, Anne Martin

Health Education Kent, Surrey and Sussex

Aim of Presentation

- Context
- The PD processes and research methods
- The three key actions for enabling workforce transformation
- The process and outcomes of developing the standards
- Implications for practice

Transforming the workforce across the health economy



Executive Summary: Transforming Urgent & Emergency Care Together

Canterbury Christ Church University

East Kent Hospitals University NHS Foundation Trust

EXECUTIVE SUMMARY

Transforming Urgent & Emergency Care Together: Phase 1: Final Report

Dr Kim Manley CBE, Carrie Jackson, Ann Martin
Juliet Apps, Ian Setchfield, Gemma Oliver

21st November 2014

Partnership involving East Kent Hospitals University NHS Foundation Trust, SECAmb, NHS Ashford CCG, NHS Canterbury & Coastal CCG, NHS South Kent Coast CCG and NHS Thanet CCG.

Funded by Health Education Kent, Surrey, Sussex

1 | Page

Manley et al. BMC Health Services Research (2016) 16:368
DOI 10.1186/s12913-016-1616-y

BMC Health Services Research

RESEARCH ARTICLE Open Access

Using systems thinking to identify workforce enablers for a whole systems approach to urgent and emergency care delivery: a multiple case study

Kim Manley, Anne Martin*, Carolyn Jackson and Toni Wright

Abstract

Background: Overcrowding in emergency departments is a global issue, which places pressure on the shrinking workforce and threatens the future of high quality, safe and effective care. Healthcare reforms aimed at tackling this crisis have focused primarily on structural changes, which alone do not deliver anticipated improvements in quality and performance. The purpose of this study was to identify workforce enablers for achieving whole systems urgent and emergency care delivery.

Methods: A multiple case study design framed around systems thinking was conducted in South East England across one Trust consisting of five hospitals, one community healthcare trust and one ambulance trust. Data sources included 14 clinical settings where upstream or downstream pinch points are likely to occur including discharge planning and rapid response teams; ten regional stakeholder events (n = 102); a qualitative survey (n = 48); and a review of literature and analysis of policy documents including care pathways and protocols.

Results: The key workforce enablers for whole systems urgent and emergency care delivery identified were: clinical systems leadership, a single integrated career and competence framework and skilled facilitation of work based learning.

Conclusions: In this study, participants agreed that whole systems urgent and emergency care allows for the design and implementation of care delivery models that meet complexity of population healthcare needs, reduce duplication and waste and improve healthcare outcomes and patients' experiences. For this to be achieved emphasis needs to be placed on holistic changes in structures, processes and patterns of the urgent and emergency care system. Often overlooked, patterns that drive the thinking and behavior in the workplace directly impact on staff recruitment and retention and the overall effectiveness of the organization. These also need to be attended to for transformational change to be achieved and sustained. Research to refine and validate a single integrated career and competence framework and to develop standards for an integrated approach to workplace facilitation to grow the capacity of facilitators that can use the workplace as a resource for learning is needed.

Keywords: Urgent and emergency care, Whole systems working, Leadership, Workforce development, Multiple case study, Facilitation, Work based learning, Integrated competence framework

* Correspondence: anne.martin@canterbury.ac.uk
England Centre for Practice Development, Faculty of Health and Wellbeing, Canterbury Christ Church University, North Holmes Road CT1 1QU, Canterbury, UK

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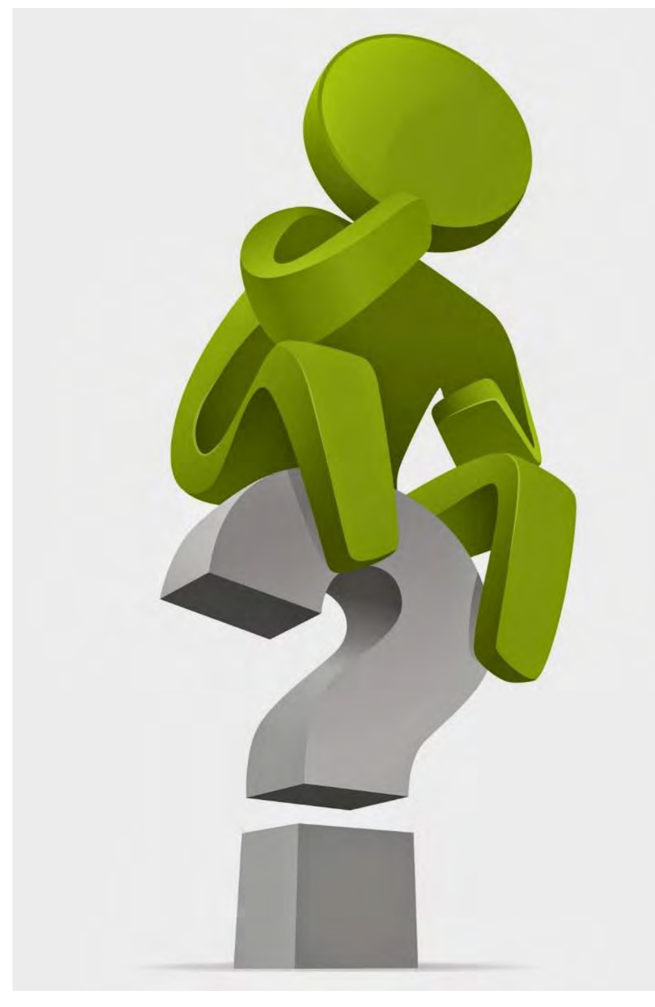
Context



- How do we solve the current workforce crisis in emergency departments creatively to promote sustainable transformational change?
- What does the future workforce look like?

Systems perspective to transformation:

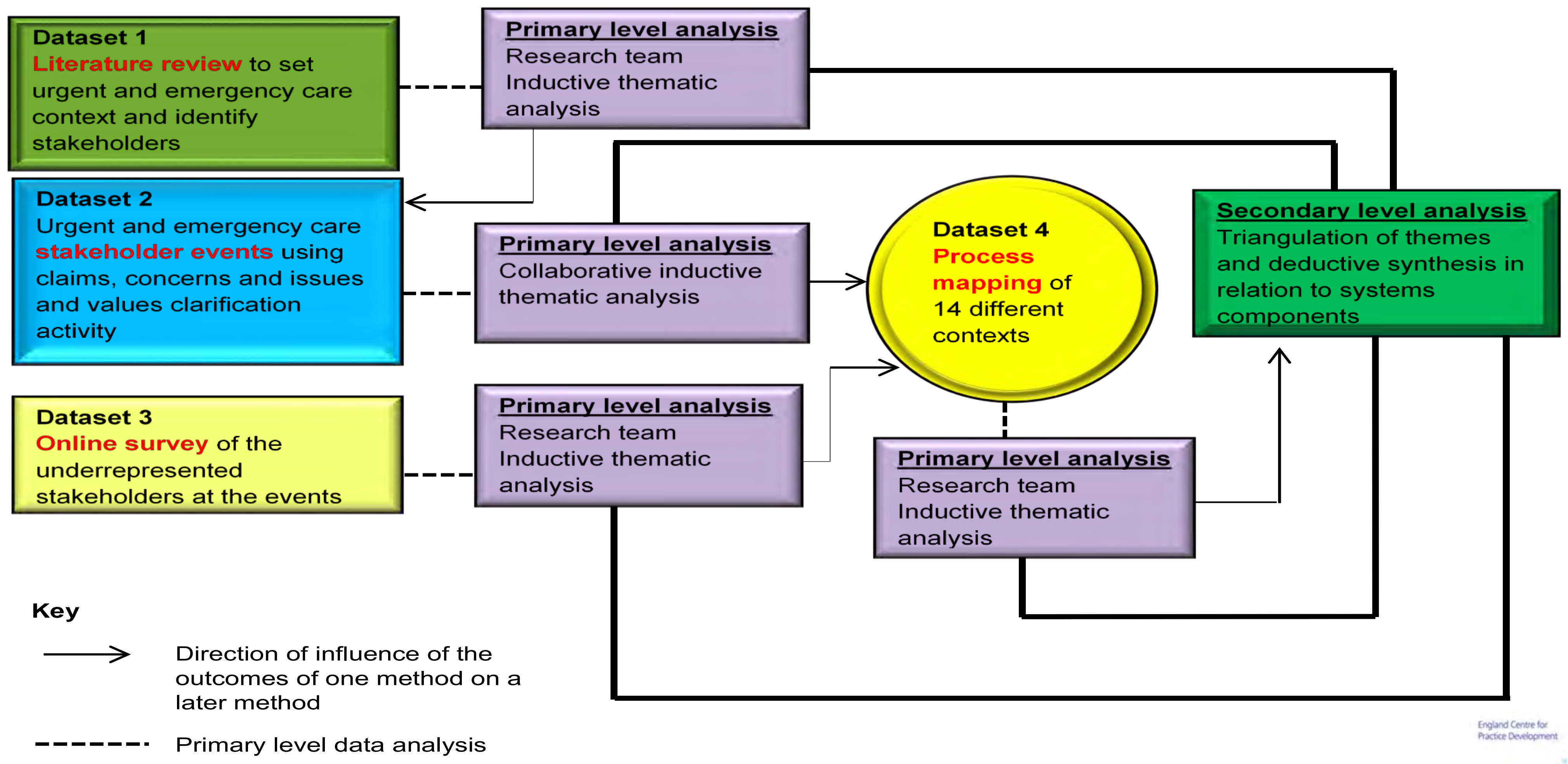
- Structures

- Processes

- Patterns e.g. values, trust, how various groups communicate with one another, etc.

(Plsek 2003)

Synthesising a framework for transforming urgent and emergency care workforce



Framework for achieving whole systems urgent and emergency care across health economy

Inputs

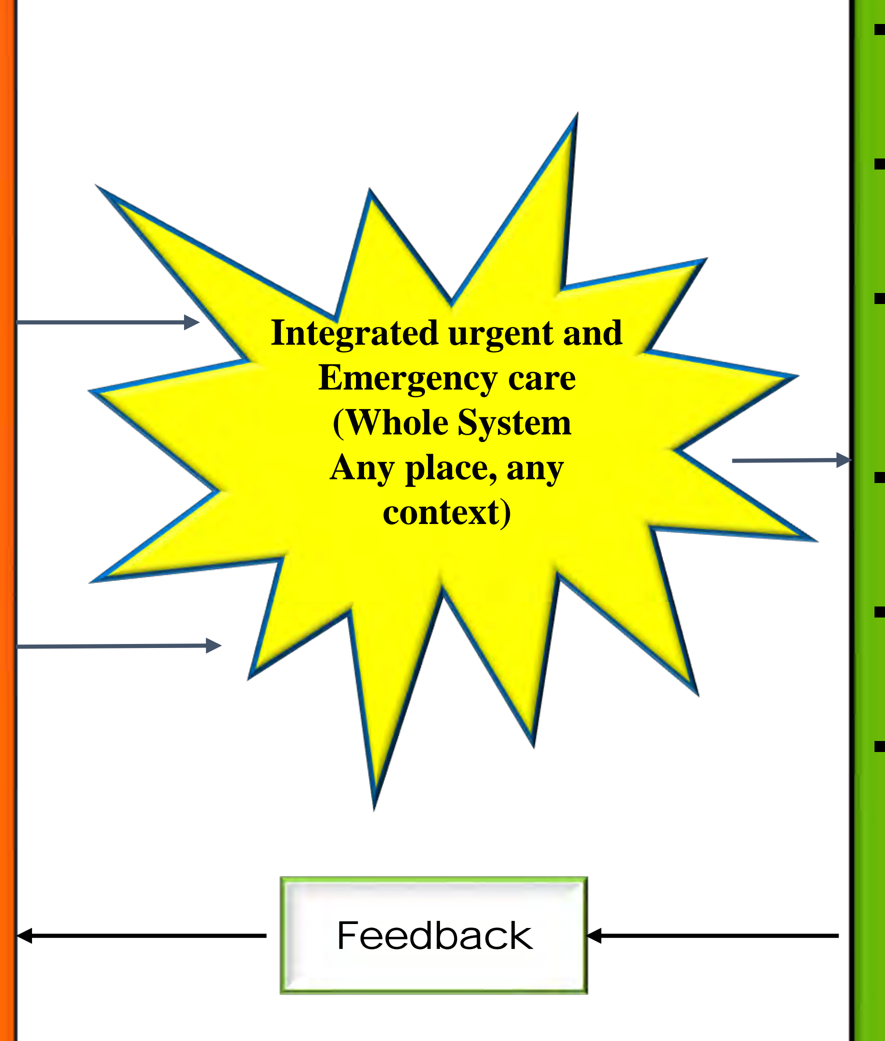
Outputs

System Enablers

- Whole pathway commissioning- integrated information & funding systems
- Interdependent partners across primary, secondary & tertiary care
- **Leadership, expertise and collaborative ways of working**
- **Staff recruitment and retention**
- **Strategies that attend to competence, role clarity, empowerment and support**
- Public information for navigating the system

Specific Workforce Enablers

- ✓ **Clinical systems leadership**
- ✓ **Single career & competence framework (Assess Treat SORT)**
- ✓ **Work based facilitators of learning, development & improvement**
- ✓ Curriculum content for High Education Institutions and Further Education Colleges



Feedback

Outcomes

- Timely care at time of crisis in the right place
- Urgent and high dependency care prevents loss of life or on-going illness
- Consistent approach to care delivery experienced across regional communities and population
- Positive work based culture enables person-centred, safe and effective care
- Improvements in mortality and quality outcomes
- Effective use of financial resources through reducing duplication of effort

Facilitation in and about the workplace – a Delphi Study

Aim

- To develop a set of standards that could be used to guide an integrated approach to facilitation in and about the workplace

Assumptions

- Learning, improvement and knowledge translation duplicate similar processes and to be consistent with the whole system approach should be integrated
- Previous standards tend to be uni-professional or focus on one of the processes or purposes
- Need to pay attention to evaluating effectiveness and impact

Process of developing the standards

Literature review to highlight gaps

Three e-Delphi rounds

Consensus based on preset criteria

Criterion	Score
1. A composite score (CS) on the top 2 items on the scale	CS ≥ 75%
2. A standard deviation (SD)	SD ≤ 1
3. A mean score	Mean < 3
4. An interquartile range (IQR)	IQR ≤ 1

Developing the standards for integrated facilitation

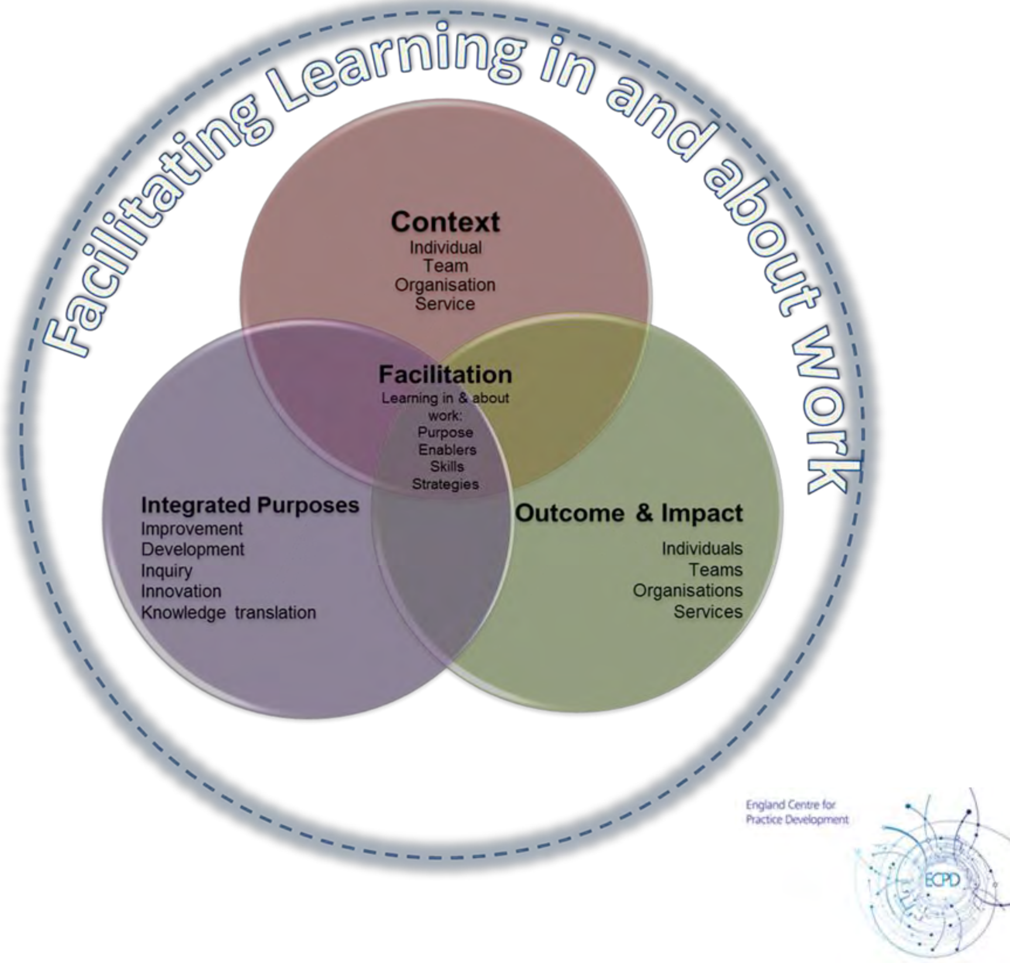
What is integrated facilitation?

‘Bringing together different purposes (learning, development, improvement, knowledge translation, inquiry and innovation) … to achieve a holistic approach to person centred care and improving public health outcomes’.

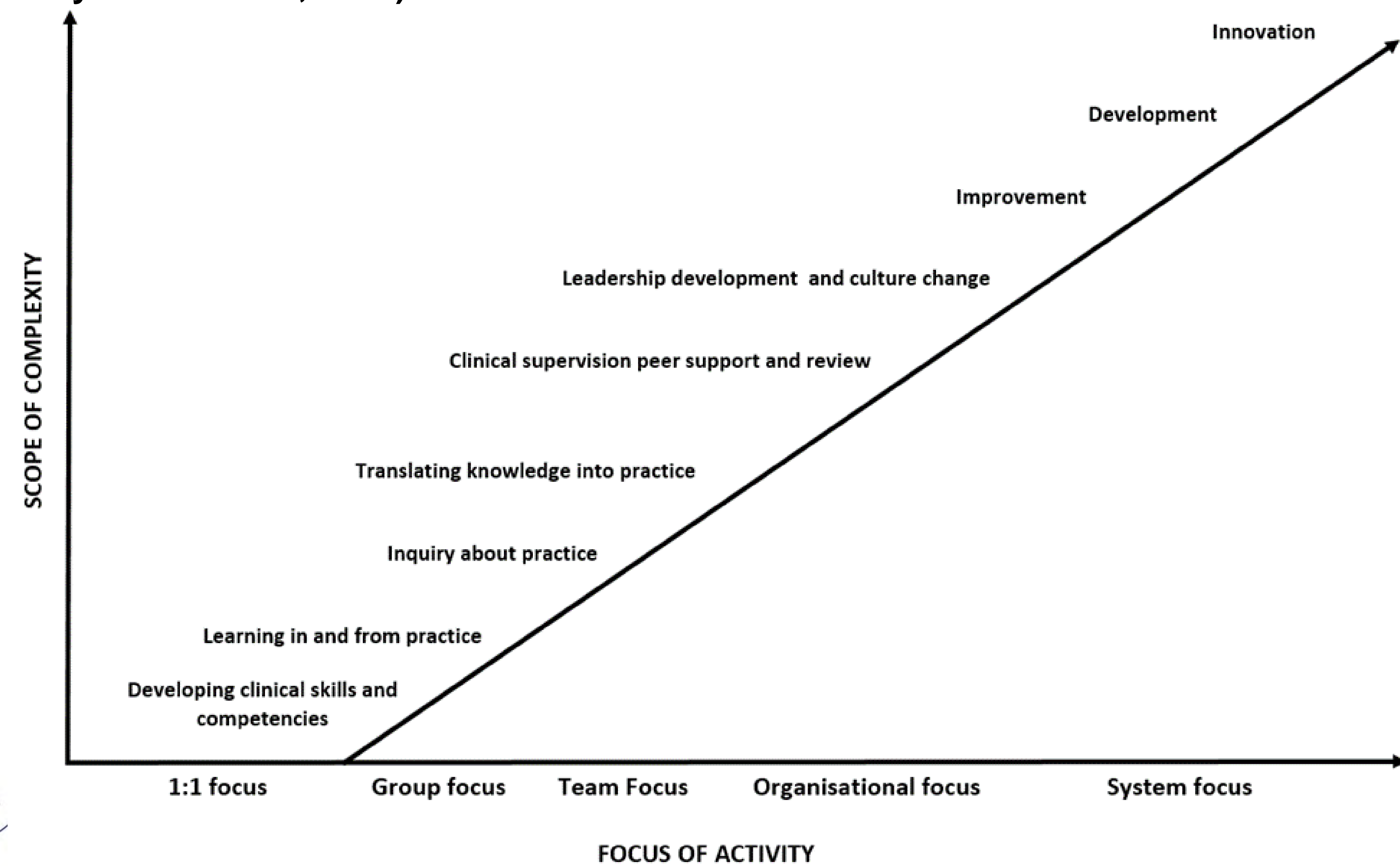
Three key foci to achieve higher order learning in and about the workplace :

- **Purpose**
- **Context**
- **Effectiveness (outcome & impact)**

Components of an Integrated Facilitation Approach in and about Work



Facilitation is increasingly recognised as a complex skill set essential to helping people achieve effectiveness in and across different situations and contexts with regard to different aims or purposes (Manley and Titchen, 2016)



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Standards for integrated facilitation in and about the workplace

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1. **Negotiate, agree and sustain clarity of purpose** for facilitation activity at the individual, team or organisational level in the context of developing person-centre cultures and improved health outcomes
2. **Optimise external enablers and values** necessary for successful facilitation practice
3. **Draw on qualities necessary to build effective relationships** for facilitation practice
4. **Demonstrate skills required for integrated** facilitation practice in health and social care
5. **Commence facilitation journey with confidence at different starting points** depending on where individuals and teams are at
6. **Use common strategies appropriately** for effective facilitation practice
7. **Monitor and maintain effective facilitation** practice using a range of methods
8. **Evaluate and evidence process outcomes, intermediate outcomes and impact** that individuals or teams may experience using a range of approaches

How can the standards be used?

- To guide the content and processes of workplace and education programmes that focus on facilitation practice for multiple purposes

- To provide individuals with a framework for developing portfolios of evidence to support professional revalidation , career progression and academic accreditation.

- To support clinical leaders, clinical educators and clinical systems leaders with the skills required to enable others to be effective.

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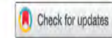
ORIGINAL ARTICLE



Developing standards for an integrated approach to workplace facilitation for interprofessional teams in health and social care contexts: a Delphi study

Anne Martin and Kim Manley

England Centre for Practice Development, Faculty of Health and Wellbeing, Canterbury Christ Church University, Canterbury, UK

ABSTRACT

Integration of health and social care forms part of health and social care policy in many countries worldwide in response to changing health and social care needs. The World Health Organization's appeal for systems to manage the global epidemiologic transition advocates for provision of care that crosses boundaries between primary, community, hospital, and social care. However, the focus on structural and process changes has not yielded the full benefit of expected advances in care delivery. Facilitating practice in the workplace is a widely recognised cornerstone for developments in the delivery of health and social care as collaborative and inclusive relationships enable frontline staff to develop effective workplace cultures that influence whether transformational change is achieved and maintained. Workplace facilitation embraces a number of different purposes which may not independently lead to better quality of care or improved patient outcomes. Holistic workplace facilitation of learning, development, and improvement supports the integration remit across health and social care systems and avoids duplication of effort and waste of valuable resources. To date, no standards to guide the quality and effectiveness of integrated facilitation have been published. This study aimed to identify key elements constitute standards for an integrated approach to facilitating work-based learning, development, improvement, inquiry, knowledge translation, and innovation in health and social care contexts using a three rounds Delphi survey of facilitation experts from 10 countries. Consensus about priority elements was determined in the final round, following an iteration process that involved modifications to validate content. The findings helped to identify key qualities and skills facilitators need to support interprofessional teams to flourish and optimise performance. Further research could evaluate the impact of skilled integrated facilitation on health and social care outcomes and the well-being of frontline interprofessional teams.

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KEYWORDS
Integrated facilitation; interprofessional care; work-based learning; Delphi survey; facilitation standards; interprofessional facilitation

Paper 3
Developing indicators of Continuous Professional Development based on theoretical insights using realist evaluation

Project Team

Carolyn Jackson, Prof Kim Manley, Anne Martin, Dr Toni Wright

Study Aim and Working Definitions

Study Aim

- To devise and test a CPD outcomes tool that identified mechanisms for measuring impact of learning on individual, team and organisational effectiveness in relation to improvements in quality of care and patient experience outcomes in the workplace

Working Definition

- *CPD is the systematic maintenance, improvement and continuous acquisition and/or reinforcement of the life-long knowledge, skills and competences of health professionals. It is pivotal to meeting patient, health service delivery and individual professional learning needs. The term acknowledges not only the wide ranging competences needed to practise high quality care delivery but also the multi-disciplinary context of patient care (*Executive Agency for Health Consumers *EAHC report 2013: 6)*

Research Questions

The research questions were mapped to the domains of the Health Education England (HEE) Education Outcomes Framework (EOF) to articulate their intention.

1. Which indicators are useful for providing information on individual and team effectiveness in relation to improvements in quality of care and patient experience in the workplace? (EOF Domain 1, 2, 3, 5).

2. How can these impact indicators be synthesized to develop a tool to measure individual and team effectiveness in the workplace? (EOF Domain1,2, 3, 5).

3. What are the indicators of organisational effectiveness appropriate to include in a CPD impact tool? (EOF Domain 1-5).

Study Design

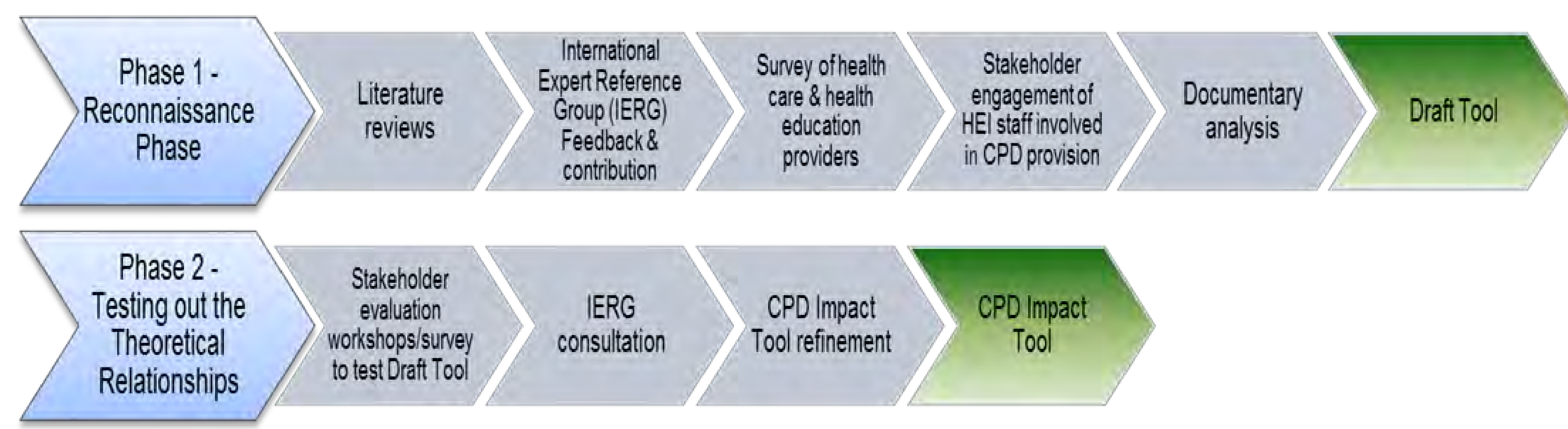
Multiple case study design to enable development and refinement of a tool for evaluating impact of CPD in the workplace across the healthcare system (whole systems approach)

Data collection and synthesis underpinned by realist synthesis, a theory driven process that enables understanding of **what works for whom, how and under what circumstances** (Greenhalgh et al 2011)

Realist synthesis fits well with the case design –focus on ‘how’ and ‘why’ questions and enable use of multiple sources of data to holistically understand phenomena in real life situations (Rycroft-Malone 2010)

Methodology and Methods

Realist synthesis and evaluation (Pawson and Tilley 2004)



Key questions guiding the literature review

What CPD is and why it is important

- How do we define CPD?
- Who provides CPD currently and where does it happen?
- What are the current drivers for CPD?

Purpose and impact of CPD

- What are the main purposes of CPD?
- What impact does CPD have on patient /user experiences?
- What impact does CPD have on health professionals and their career development?
- What impact does CPD have on services and providing organisations?

Facilitating and Judging the Effectiveness of CPD

- What are the enablers and processes by which CPD learning occurs?
- How are these related to educational theory and philosophy?
- What methodology and methods have been used to evaluate and measure the impact of CPD?
- What does current evidence tell us about gaps in measuring impact and why?
- Why is a whole systems approach to CPD at individual team and organisational level?

Project Outcomes

- The overarching framework for understanding effective CPD
- Four transformation theories
- Impact indicators useful for determining the impact of CPD
- A range of ways to evaluate achievement of CPD impact

Conceptual framework for effective CPD

- Four ancillary CPD purposes that focus on individual and team journeys of transformation in their work and workplace, -transformation of:
  - The individual's professional practice
  - Skills to meet a continually changing context
  - Knowledge, so that it is used and blended with other knowledge in practice through knowledge translation approaches
  - The workplace culture

Table 11: The Relationship Between Context, Mechanisms and Outcome that Describe and Explain the Transformation of Individual Professional Practice Through CPD

Mechanism	Context	Outcomes
M1 Facilitated support and reflection M2 Developing skill in reflection and self-awareness M3 Self-assessment M4 Learning that is self-driven	**Workplace context:** C1 Opportunities for CPD that are work based C2 Culture of inquiry, learning, application and implementation **Organisational context:** C3 Enabling organisations that value work based learning & development	**Person/individual related:** O1 Increase self-awareness O2 Increase self-confidence, and increased perceived self-efficacy[7] O3 Transformational learning, new knowledge, & continuing motivation to learn O4 Empowerment, self-sufficiency and self-directing **Role related:** O5. Person centred safe & compassionate practice experienced by service users O6. Role clarity & opportunities for role innovation and development O7. Career development & progression O8. Meaningful positive engagement with change

Both the workplace and organisation are key influencers on whether the outcomes of CPD are achieved for the individual because both the workplace and the organisation can negatively or positively impact on:

- What content is considered important to focus on in terms of learning and development.
- Whether the workplace is valued and used as a resource for learning and development; and,
- How the workplace is used to enable learning and development

Theory 1: Transformation of individual's professional practice through CPD

CPD that is work based and provides facilitated support and reflection and include 360 degree feedback will increase self confidence and self awareness and role clarity

Theory 2: Transformation of skills through CPD to meet society's changing healthcare needs

Table 12: The Relationship Between Context, Mechanism and Outcome that Describe and Explain the Transformation of Skills to Meet Society's Changing Healthcare Needs Through CPD

Mechanism	Context	Outcomes
M5 Assessment of systems and team skills and competences M6 Identifying systems & service needs/gaps M7 Expanding & maintaining skills and competences through a range of different ways M8 Developing team effectiveness	**Workplace context:** C4 A focus on team competences and effectiveness rather than just the individual **Organisational context:** C5 Value for money in the use of human resources and investment **Healthcare context:** C8 The need for staff in contemporary healthcare to be adaptable and flexible responding to ever changing healthcare needs	**Outcomes for service users:** O9 Improved continuity and consistency experienced by service users **Outcomes for staff/team:** O10 Better and sustained employability O11 Career progression O12 An effective cohesive team/ increased team effectiveness **Outcomes for organisation/system** O13 Better integration of services O14 Better partnerships with services and agencies O15 Better value for money from human resources through substitution and reduced duplication

- CPD that focuses on expanding skills to meet a changing service will be reflected in outcomes around better integration of service provision

Theory 3: Transformation of knowledge through CPD to enable knowledge translation

Table 13: The Relationship Between Context, Mechanism and Outcome that Describe and Explain the Transformation of Knowledge Enabling Knowledge Translation Through CPD

Mechanism	Context	Outcomes
M9 Helping people to reflect on the quality and range of knowledge they use in practice M10 Blending and melding different types of knowledge to guide practice M11–Facilitating dialogue[8] about how to use knowledge in practice M12 Facilitating active inquiry and evaluation of own and collective practice and learning M13 Developing practical and theoretical knowledge of leadership, facilitation evaluation and cultural aspects influencing knowledge translation in practice	**Workplace context:** C7 Engaging with and using different types of knowledge in everyday practice C8 Active sharing of knowledge in the workplace	**Workplace/Team outcomes:** O16 Knowledge used in and developed from practice O17 A knowledge-rich culture **Team & Organisational outcomes** O18–Active contribution to practice development/inquiry O19 Innovation & creativity

- CPD that focuses on providing up to date knowledge about effective, safe practice will achieve knowledge translation if participants are supported to address their leadership and workplace contexts and cultures

Theory 4: Transformation of workplace culture through CPD to implement workplace and organisational values and purpose

Table 14: The Relationship Between Context, Mechanism and Outcome that Describe and Explain the Transformation Workplace Culture to Implement Workplace and Organisational Values and Purpose Relating to Person Centred, Safe and Effective Care Through CPD

Mechanism	Context	Outcomes
M14 Developing shared values and a shared purpose M15 Facilitating the implementation of shared values through feedback, critical reflection, peer support and challenge M16 Evaluating experiences of shared values relating to person centred, safe and effective care from both service users and staff M17 Creating a culture that enables individual personal growth, effective relationships and team work M18 Developing leadership behaviours	C5 Context has explicit shared values and purposes C6 Organisational readiness to change	**Service users:** O20 Improved service user and provider experiences, outcomes and impact **Staff/team:** O21 Sustained person centred, safe and effective workplace culture O12 An effective cohesive team/ increased team effectiveness **Organisational:** O22 Increased employee commitment to work and learning O23 Organisational leadership and human behaviours O24 Increased organisational effectiveness

- CPD that focuses on living organisational values across different boundaries will increase team effectiveness and organisational effectiveness

Key Messages

- Positioning CPD within the transformation agenda
- Focusing on workplace as main resource for learning context of CPD
- Needs facilitators of whole systems integrated learning development, improvement inquiry and innovation.

Paper 4

Developing theoretical insights into sustainable transformation in front line teams
The Venus model

Prof Kim Manley
Carolyn Jackson
in collaboration with International Fellows of ECPD

Context

- Need to have greater insight into how we address the current health agendas in the workplace
- Key elements and linked concepts (and relationships) needed to support front line teams (micro-systems) in health and social care
- Skill sets required to transform practice through interprofessional learning, development, improvement and innovation in the workplace
- Essential organisational and systems factors required to enable transformation

Coordinating Principles for the Venus Model

Embedding and sustaining person centered systems

Informed by 5 theories (**3 new**, 2 existing):

1. Theory of person-centred culture change (Manley et al 2017, adapted from Manley et al, 2011)
2. Theory of transformational leadership and the impact this has on team effectiveness in the workplace (Manley and Jackson 2014)
3. The theory of integrated facilitation using the workplace as the main resource for learning, developing, improving, innovation and knowledge translation (Manley et al 2016, Jackson et al 2015)

4. Systems theory (how organisations overcome barriers to transformed through five patterns of behaviour in relation to relationships, power, conflict, decision-making and learning) (Plesk 2001)
5. Theory on how to Promote Action on Research implementation in Health Settings (PARiHS) (Rycroft-Malone et al 2013)

England Centre for Practice Development

ECPD

Venus Stems

- Venus model has 5 integrated stems representing the essential 'know how' required of any healthcare professional when planning sustainable changes in practice or wishing to develop, innovate or improve the quality of services. This 'know how' consists of:

  1. **leadership,**
  2. **facilitation,**
  3. **culture change,**
  4. **practice development and evidence implementation;**
  5. **improvement skills** (Manley and Jackson 2018)

VENUS MODEL OF PERSON CENTERED SUSTAINABLE TRANSFORMATION

Facilitation

Practice development + evidence implementation

Improvement

Person Centered
Sustainable Transformation

Culture Change

Leadership

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Facilitation

- Underlying principle holistic facilitation
- Crucial for embedding and sustaining transformation (growing critical mass)
- Draws on transformation theories CPD project
- Picks up facilitation standards (e-Delphi)
- Individual and systems level (SCQIRE)
- Facilitating complexity

Senior facilitators work with frontline teams to embed safety culture, QI in frontline teams (SCQIRE Manley et al 2017)

What works?

- Confident **transformational leaders** who:
  - ✓ role model values, active listening & engagement
  - ✓ Inspire and stimulate improvement
  - ✓ challenge & address safety issues/barriers
  - ✓ use varied improvement approaches
- **Personal attributes: Are approachable, visible, present, self aware, compassionate and fair**
- **Place service user at heart** for improvement
- **Welcome feedback from stakeholders and act on this**
- **Support frontline teams with local knowledge and skills to:**
  - ✓ Build relationships
  - ✓ Engage teams in co-creating shared meaning, reflection, change
  - ✓ Integrate with activities already happening
  - ✓ Create a learning and safety culture
  - ✓ Use QI tools systematically to ensure going in the right direction
  - ✓ Use observations of practice to celebrate and identify dissonances
- **Embedded in practice, provide staff development**
- **Integrate new developments/ideas**

FACILITATORS

Need time & support in their role to be effective at organisational level to support frontline teams to be successful in sustaining QIs

Why does it work?

- **Staff feel supported** because:
  - ✓ given time & listened to
  - ✓ Its easy to ask questions and report adverse events
  - ✓ Feel trusted & valued – removes micro-management – increases accountability
- **Staff are engaged, enabled & empowered to:**
  - ✓ **participate in collaborative change**
  - ✓ **know what is best practice,**
  - ✓ **have clarity of role & expectations and shared meaning about what is expected**

Through:

- ✓ Creating safe spaces for conversations and reflections and thinking about how things can be improved
- ✓ Good relationships and shared meanings enable challenge, new ideas and embedding of values
- ✓ Service user feedback drives improvement
- ✓ Clarity of purpose
- ✓ Positivity – what works

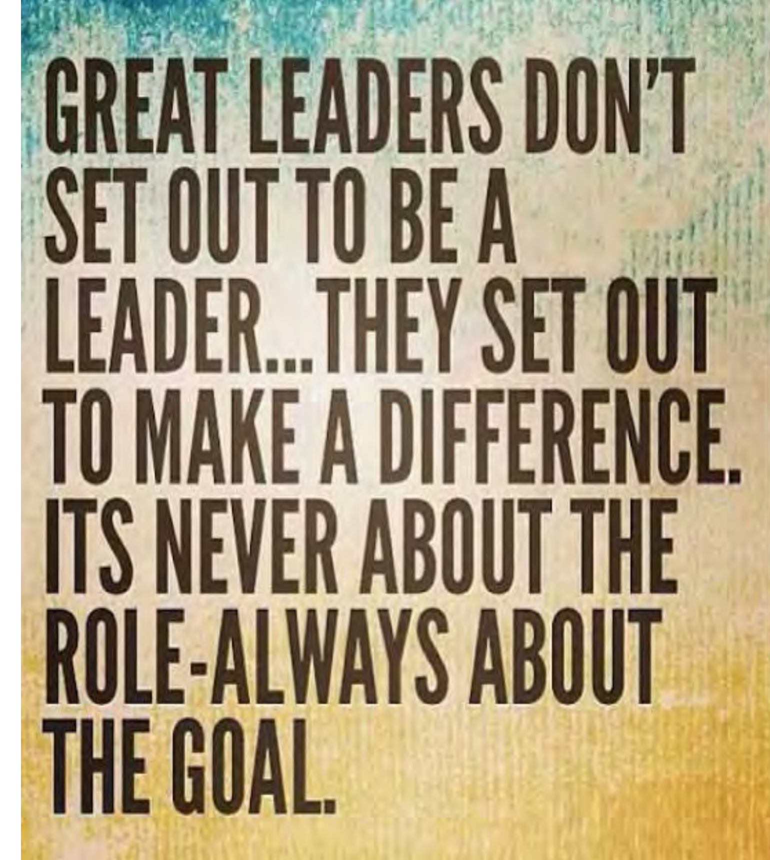
- **All the above enhances safety and enables learning**

Leadership

- Clinical and clinical systems leadership
- Underpinning principles of transformational and collective leadership
- Skill set required for systems leaders (manifested through CP roles and HEKSS U & E work)

Transformational leadership

Model the way
Inspire a shared vision
Challenge the process
Enable others to act
Encourage the heart
(Kouzes & Posner 2012)



Clinical systems leadership

What is it?

"*the leadership approach that drives integration across boundaries based on specialized clinical credibility working with shared purposes to break down silos and deliver person-centered, safe and effective care with continuity*" (Manley et al. 2016).

Draws on different expertise from across partners to work together towards a shared purpose and create a culture that values and retains staff.

Why is clinical systems leadership important?

- Achieve integrated ways of working and effective teamwork across partner organisations
- disseminate expertise to as many people across the system THROUGH ADVANCED consultancy approaches
- Create a learning culture
  - Uses the workplace as the main resource for learning, development, improvement and develops competences in others through rotation of learning opportunities
- Evaluate effectiveness and fosters inquiry
  - Developing, improving and evaluating person centred care
  - Research, Inquiry and practice based evaluation of effectiveness

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Practice Development
• "a continuous process by which person-centred cultures for the delivery of safe, effective care are developed by skilled facilitators who engage authentically with both the interprofessional team and individuals within it to promote effective transformations in the workplace" (Manley et al., 2008)

9 Principles of Practice Development (Manley et al 2008; Manley and Titchen, 2016)

1. Develop person-centred, evidence based care demonstrated by human flourishing and a healthy workplace culture which is effective
2. Focus on relationships at the micro-systems level where care is provided and experienced at the front line of practice by patients and care professionals
3. Facilitate active learning and formal systems learning processes to enable real-time learning and care transformation in the workplace
4. Enable the use of evidence generated in, through and from practice to transform and improve care delivery and outcomes
5. Promote the importance of free thinking by blending creativity (heart, mind, soul) with more formal learning approaches to promote human flourishing (referred to as critical creativity)
6. Select from a range of practice development methods in an intentional and systematic way to help people learn, change and develop their practice in a sustainable, effective way
7. Ensure that these methods accord with the methodological principles used and the stated objectives of the endeavour
8. Use processes (including skilled facilitation) which can be translated into the specific skill-sets required for any context
9. Integrate evaluation approaches which are collaborative, inclusive and participative (CIP principles)

Quality Improvement

- QI Pyramid (Health Foundation)
- SCQIRE feedback from emotional touchpoints making engagement, meaning of concepts, having conversations to complement technical skills

Culture change

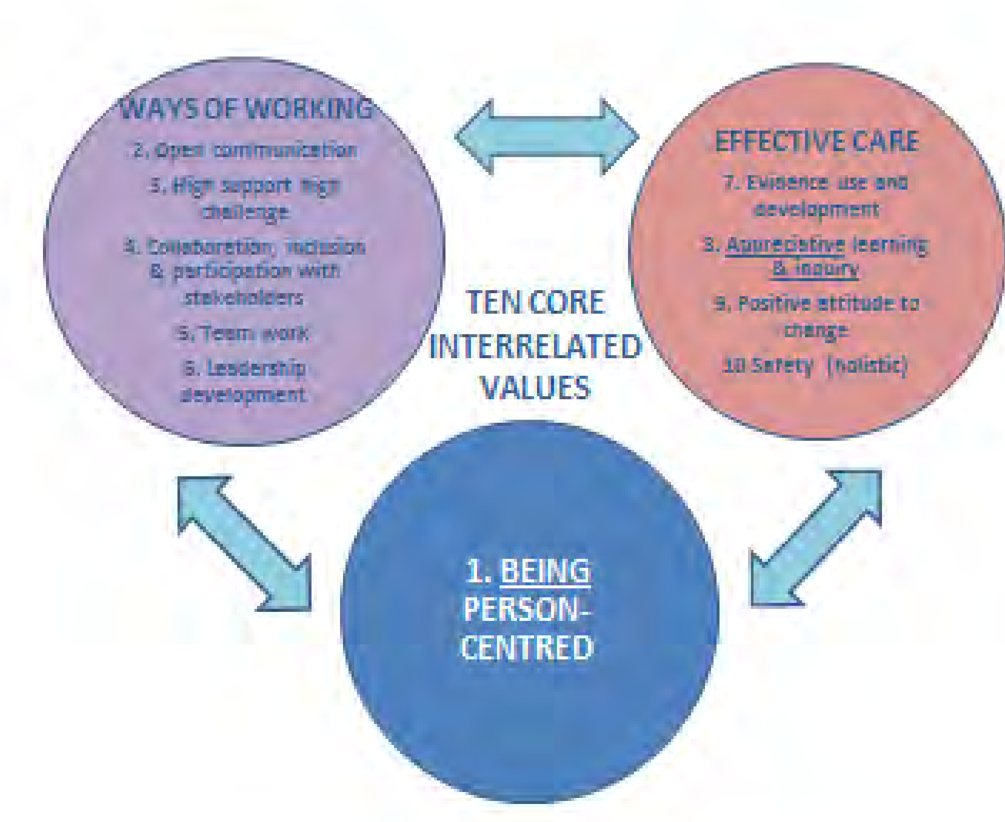
- Underpinned by principles of EWC
- Insights about how to change culture
- Organisational systems enablers that need to be optimised
- Implications for governance, infrastructure, critical mass of facilitators

Theory of Person-Centred Culture Change in Frontline Teams

Manley, Jackson, McKenzie, Martin, Wright,(2017). Theory derived from: Effective workplace culture (Manley, Sanders, Cardiff, Webster 2011), tested and refined through the Safety Culture, Quality Improvement, Realist Evaluation (SCQIRE) Project

EMBEDDING TEN core values associated with:

- being person-centred,
- ways of working
- effective care



Understanding the culture change journey

(Manley 2014)

Relationships

Agreeing shared values, purpose & ways of working together

Talking about purpose & values

(values espoused)

Challenging and supporting each other to LIVE the shared values & purpose

(values lived)

Embedding shared purpose & values in systems

('Form follows function')

Enabling factors: an effective workplace culture

Manley K; Sanders K; Cardiff S; Webster (2011) refined from SCQIRE Project (Manley et al, 2017)

Individual

- **Transformational leadership**
- **Skilled facilitation that engages staff in co-creating meaning and shared purpose**
- **Role clarity**

Organisational

- **Collaborative and authentic senior leadership;**
- **Focus on supporting bottom-up change;** organisational readiness; and human resource management's role **in recruiting for shared values**
- **Embedding values** in organisational systems for learning, development, and improvement, based on appreciation of what works, and growing organisational; capacity and capability in leadership and facilitation

Indicators for Recognising Person-centred, Safe & Effective Workplace Cultures

Manley, Jackson, McKenzie, Martin, Wright,(2017). Theory derived from: Effective workplace culture (Manley, Sanders, Cardiff, Webster 2011), tested and refined through the Safety Culture, Quality Improvement, Realist Evaluation (SCQIRE) Project

Framework for Organisational Transformation

(1) Organisational Transformation recognised by:
- Radical changes in patterns of behaviour across organisation
- Presence of integrated support systems
- Flourishing staff and patients
- Organisational reputation for excellence in person-centred,
 timely, safe, effective, equitable & efficient care
- Financial integrity

Organisational systems (3) to:
- Support & implement learning, development and improvement about what works
- Embrace & support innovation & solutions towards transformation
- Develop workforce as leaders, critical companions and coaches with the skills required

Leadership for microsystems (2) & team effectiveness

(2)'*…small functional, front-line units that provide most healthcare to most people. They are the essential building blocks of large organisations. They are the place where patients & providers meet. The quality and value of care produced by a large health system can be no better than the services generated by the small systems of which it is composed'* (Nelson et al., 2002, p 472).

Organisational Transformation (1)

Skills and competence framework for transformation
- Collaboration, inclusion, participation
- Improvement
- Learning
- Leadership
- Inquiry and innovation

Patterns that drive thinking & behaviour

Relationships - generate energy and innovation
Decision-making is timely, rapid & based on knowledge
Power towards collective purpose
Conflict embraced as opportunities for new ways of working
Learning – curiosity & learning about what might be better

(Plesk, 2001)

(3) Formal Systems Model (Checkland & Scholes, 1990)
- A system has a purpose (or purposes), it exists for a reason & achieves some change, or 'transformation'
- Its performance can be measured, and it can be shown to be more, or less efficient
- There is a mechanism for control – a decision-making process
- It has components - which can themselves be taken to be systems
- Its components are related, and interact
- It exists as part of a wider system or systems - its environment, with which it must interact
- It has a boundary - which defines what is, and what is not part of the system
- It has its own resources
- It has an expectation of continuity, and can be expected to adapt to, or recover from disturbances

KManley 12 10 17

Connect with us at:

Twitter:

- @ECP4PD, @kimmanley8, @ECPDCarolyn

Website:

- www.canterbury.ac.uk/englandcentreforpracticedevelopment

Email:

- Kim.manley@nhs.net kim.manley1@canterbury.ac.uk
- carolyn.jackson@canterbury.ac.uk

Facebook:

- www.facebook.com/groups/ecpd1