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

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Key words: integrated facilitation, interprofessional care, work-based learning, Delphi survey, facilitation standards

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 is the workplace is a widely recognized 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, 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 to 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 ten 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 optimize performance. Further research could

evaluate the impact of skilled integrated facilitation on health and social care outcomes and the wellbeing of frontline interprofessional teams.

Keywords: integrated facilitation, interprofessional care, work-based learning, Delphi survey, facilitation standards, interprofessional facilitation

Introduction

Integration of health and social care forms part of health care policy in many countries worldwide in response to the changing population health and social care needs (Timmins & Ham 2013). The World Health Organization's (WHO) appeal for systems to manage the global epidemiologic transition advocates for provision of care that crosses boundaries between primary, community, hospital and social care (Rechel, Doyle, Grundy, McKee 2009). Epidemiological transition explains the changing patterns of population growth, age distribution, life expectancy and the different causes of death (McKeown 2009). Some countries such as United States of America and New Zealand have made incremental improvements in integrating health and social care while others like Scotland and Northern Ireland have opted for transformational changes (Grumbach, Bainbridge & Bodenheimer, 2012; Ham, Heenan, Longley & Steel, 2013). The international rise in chronic and degenerative health conditions necessitates concerted interprofessional working directed by a health and social care workforce that is adept to reduce disability and support independence (WHO, 2011). In integrated health and social care contexts, interprofessional teams like discharge, mental health services and enablement teams work collaboratively with an aim of providing seamless care across professional and organizational boundaries. However, interprofessional teams demonstrate unique

cultures related to professional identities that may inhibit vital collaborative working (Martin and Rogers 2004).

Using a systems perspective Manley, Martin, Jackson and Wright (2016) identified that successful transformations in health and social care delivery are more readily realized when structural, process and workforce strategies are considered in parallel. This enables consideration of workplace cultures that are influential in achieving and sustaining changes in health and social care delivery. Globally, there is emphasis on interprofessional education (IPE) as a strategy for enhancing communication and collaboration for improved health and social care outcomes (Barr 2015). Interprofessional education denotes occasions when members or students of two or more professions learn with, from and about each other to improve collaboration and the quality of care and services (Centre for the Advancement of Inter-professional Education (CAIPE) (2016). It is worth noting that learning is one aspect of development and improvement that can be acclaimed only when practitioners implement new skills and behaviours in the workplace (Mavin, Lee & Robson 2010). A review of key developments in IPE identified the need to grow skilled interprofessional facilitators to enhance collaboration and build effective partnerships in health and social care systems (Reeves, Tassone, Parker, Wagner & Simmons 2012).

Facilitating practice in the workplace is a widely recognized cornerstone for developments in the delivery of healthcare (Baskerville, Liddy, & Hogg, 2012; Grumbach et al., 2012; Mold et al., 2014; Lessard et al., 2016). Facilitators have the capacity to support critical reflection on practice and identify patterns that drive thinking and behaviors that require transformation (Thor et al., 2004). Skilled facilitators achieve this through collaborative and inclusive working relationships with frontline staff to promote person-centered values, develop new knowledge, skills and effective

workplace cultures (Watling 2015). Integrated facilitation focuses on enabling learning for action involving development and improvement. Learners including individual practitioners, teams and organisations are mutually active participants in their learning journey in the context of recognised need for improvement (Berta et al., 2015).

Integrated facilitation of learning, development and improvement in the workplace supports the integration remit across health and social care systems to meet the progression needs of interprofessional teams (Manley et al., 2016). We define integrated facilitation as bringing together different purposes (learning, development, improvement, knowledge translation, inquiry and innovation) of facilitation to achieve a holistic approach to person-centered care and improvement of health and social care outcomes. This definition embodies highly skilled facilitation practice that requires an eclectic knowledgebase to support partnership working across complex organizations and to develop understanding and responsibility in delivering person-centered safe and effective care. It is therefore essential that facilitators of interprofesional teams are primed effectively for the multifaceted and challenging role (Anderson, Cox &Thorpe 2009, Furness, Armitage & Pitt 2012).The purpose of this study was to develop standards for integrated facilitation to guide the growth of the skillset required to facilitate interprofessional teams.

Integrated facilitation for interprofessional teams offers common ground for basic values, a shared purpose and illuminates the contribution of interdependent partners. Skilled facilitators with expertise across all purposes for workplace facilitation are more likely to understand the context in which they work and provide continuity to individuals, teams and the organization (Blakey & Day 2012). Work-based learning, practice development and quality improvement are interrelated facilitation purposes, which may not independently lead to improved health and social care outcomes. The

common aspects that link the interaction between purposes of workplace facilitation are the essential skills and qualities that effectively enable those facilitated to achieve a shared purpose (Blakey & Day 2012).

Learning and development, quality improvement and research and innovation are often separate departments in health and social care organizations. This implies each department engages frontline staff independently causing preventable pressure on staff who have to respond to multiple requests from each of these departments. (Jenson et al., 2009; Watling, 2015). In the UK National Health Service (NHS) for example, an array of departments (learning and development, research and development, innovation and improvement, quality improvement and patient involvement) for ongoing learning, development and quality improvement prevail alongside each other in a confusing overlay of facilitation processes. Edgren and Barnard (2012) argue that better relationships and nonhierarchical approaches to improvement and development yield better outcomes in the management of integrated care.

While integrated learning offers opportunity for human creativity alongside knowledge translation (Fan, 2004), integrated facilitation improves patient outcomes, reduces waste of valuable resources and empowers individual learners (Bird, Norohnha & Sinnot, 2010). However, to date, no standards have been published to guide the quality and effectiveness of integrated facilitation. Existing standards are either uniprofessional or focus on specialized facilitation. For example, The Health Foundation (2013) standards are tailored to facilitating patient skills development with specific techniques as one of the components of integrated facilitation. The International Association of Facilitators (IAF) (2016) equips members with a range of skills, knowledge, and values to meet internationally recognized standards for effective

facilitation of group processes in a variety of contexts. Nonetheless, the IAF has a corporate focus, does not refer to the complexity of care delivery systems nor the workplace as a rich resource for learning and development. Our study aimed to identify elements to constitute a set of standards that can guide the quality and effectiveness of an integrated approach to workplace facilitation for interprofessional teams in health and social care.

Background

The standards for integrated facilitation that are the focus of this paper were identified in the original study (Manley et al., 2016) as a key enabler for transforming health and social care systems holistically. The original study used a multiple case design to identify gaps and 'pinch-points' in urgent care pathways to inform a workforce development plan for the delivery of high quality integrated urgent and emergency care across the patient pathway. This paper reports on key elements identified through a Delphi study to generate standards for an integrated approach to facilitation in the workplace.

Methods

A Delphi methodology (Heiko, 2012) was adopted to enable joint but anonymous engagement of experts in providing empirical evidence on workplace facilitation of transformations in health and social care. The Delphi technique was thought suitable for establishing a common knowledge base in making explicit what is required to facilitate an integrated approach to learning, development and improvement programs in the workplace and to identify indicators that would evidence the effectiveness of the process. The three rounds Delphi survey moved from broad principles to specific concepts to distill the fundamental components of standards for

integrated facilitation for interprofessional teams. The iteration process combined with collaborative provision of written feedback reduced non-constructive and potentially frustrating discussions (Heiko 2012). The current study is nestled within systems thinking that underpinned the original study (Manley et al., 2016) in mapping and understanding relationships to support a holistic approach to complex issues. As well as structural strategies, the realization of sustainable change in complex systems calls for attention to patterns that drive thinking and behaviors in the workplace. A two-stage approach to data collection was used to enhance rigor in developing the standards for integrated facilitation.

Data collection

Stage 1: literature review and expert identification. A scoping review was undertaken to highlight gaps in evidence and inform the Delphi survey and to identify a heterogeneous group of experts in the facilitation domain. MEDLINE and CINAHL databases were searched for literature published in English between 2000 and 2015. Using Boolean terms AND and OR, the key words used in the search were facilitation AND; practice development; skill development; workplace learning OR work-based learning; inquiry; innovation; improvement; knowledge translation OR evidence implementation; integration.

A sample of fifteen experts was identified through publications and snowball sampling. This was considered too small to achieve the objectives of the study. A call for expression of interest to participate in the study, issued through leads of international professional networks boosted the sampling frame to 42 experts in facilitating single or integrated purposes in health and social care contexts. Experts were invited to participate in the study if they met the following inclusion criteria: a

facilitator leading or researching a program of work linked to one or more of the facilitation purposes; and published on any of the areas of facilitation.

Thirty-five (35) experts fulfilled the screening criteria and they were all invited to participate in the Delphi study. Thirty-two (32) experts gave consent and confirmed their availability and commitment to participate in the survey.

Stage 2: The Delphi survey. The evidence about integrated facilitation was very scant but the literature on the concept of facilitation informed the development of the three rounds Delphi survey. The first round questionnaire included broad open-ended questions focusing on purpose, process, enablers, and evaluating outcome and impact of integrated facilitation. Manley and McCormack (2003) posit that the view of the world represented has implications for processes used, their facilitation methods and evaluation focus. These themes were therefore identified as essential for enhancing awareness of the relevance of facilitation and appreciation of the possible positive outcomes from its application.

Collated and summarized data from the first round questionnaire constituted the second questionnaire. Elements were presented in no particular order of frequency of appearance and experts were asked to rate the relevance and effectiveness of elements presented under each theme using Likert scales in Table 1. The second questionnaire also included statements derived from data that emerged from the first questionnaire. Questions were posed about the purpose of integrated facilitation, the intent of facilitating individuals and teams and the starting point of the process of facilitation. The expert panel was invited to agree or disagree with the statements and provide comments to support their responses. Based on the feedback from the second round, the Likert scales for assessing significance and effectiveness of

elements were expanded to include a fifth point. A sixth item ('I do not know' to imply 'not familiar with theory') was introduced on the scale for assessing the relevance of theories that would influence integrated facilitation practice.

Table 1. Likert scales used for the Delphi study

Theme	Likert scale	Items on the scale 2nd questionnaire	Items on the scale 3rd questionnaire
Purpose and Enablers	**4** point Likert scale to assess relevance	Essential Very important Unimportant Not at all important	Essential Very important Important Unimportant Not at all important I do not know (*for theoretical perspectives only*)
Process	**4** point Likert scale to assess effectiveness	Essentially effective Very effective Ineffective Not at all effective	Essentially effective Very effective Effective Ineffective Not at all effective
Evaluation of outcome and impact	**5** point Likert scale to assess agreement	Strongly agree Agree Neutral Disagree Strongly disagree	Strongly agree Agree Neutral Disagree Strongly disagree

Percentage scores accumulating from the rating of elements in the second questionnaire were presented in the third questionnaire, arranged in order of highest to the lowest scored elements. New and modified elements were italicized to enable experts identify changes made to the third questionnaire. Some of the feedback that influenced the changes was included in the third questionnaire. This gave the expert panel the opportunity to comment on modifications, change their responses and clarify their views or stick with their original decisions. Questionnaires for all rounds were piloted with local facilitators of learning to make sure that the questions were clear and that they collected information relevant to the study. The feedback received was used to refine questionnaires before they were emailed individually to each participating expert.

Data analysis

All questionnaires completed in the first round were imported into NVivo version 10- a qualitative data analysis computer software package. Data were thematically analyzed (Braun & Clarke 2006) to develop sub themes around purpose, process, enablers, and evaluating outcome and impact of integrated facilitation. The researchers read the raw data again to ascertain shared understanding of the content, the sub themes developed and to make sure that all data were included.

Data from the second questionnaire were analyzed statistically using the Statistical Package for Social Scientists (SPSS Version 21) to obtain percentage scores of ratings for the summarized items. Qualitative comments were used to modify elements considered and to add new elements relating to specified categories. The third round data were also analyzed statistically using SPSS 21 version software. The aim was to determine consensus, its strength and convergence of views using criteria in Table 2. Two experts on the panel did not complete the final round questionnaire and the incomplete data were eliminated during analysis. See Appendix 1 (available as online supplementary materials) which illustrates the process of developing the standards for integrated facilitation.

Criteria for determining consensus

Consensus represented general agreement on the elements that were considered fundamental to constitute standards for integrated facilitation. Consensus was obtained if an element matched at least two of the descriptive statistics presented in Table 2. It was significant to complement the analysis of the majority view with the distribution of data on the ordinal scales used. Analysis across the descriptive statistics enhanced the rigor in exploring the data and contained the extension of the number of items on the Likert scales used in the third round of the Delphi survey.

Table 2. Criteria used to determine consensus

Criterion	Score
1. A composite score (CS) on the top 2 items on the scale	$CS \geq 75\%$
2. A standard deviation (SD)	$SD \leq 1$
3. A mean score (μ_x)	$\mu_x < 3$
4. An interquartile range (IQR)	$IQR \leq 1$

The interquartile range indicated the difference between the third quartile and the first quartile to identify the position of the middle half of the scores in the distribution. The standard deviation was useful for ordering items that achieved equal composite scores (top two items) on the scales used. For example, an item with a lower standard deviation ranked higher in priority than that with a similar score but with a higher standard deviation. Mean scores were scrutinized to identify the mass distribution of data on the ordinal scales, specifically for elements that obtained an IQR =1 and a $\mu_x \approx 3$.

Ethical considerations

The study obtained ethical clearance from the University Ethics Committee (Ref: 15/H&W/CL114) and all experts consented to participating in the study.

Results

Literature review

The literature about integrated facilitation is very limited. The review was a deliberate approach to understand how the literature presents the concept of facilitation and inform the Delphi survey. Practice improvement interventions constructed upon clear concepts enhance practitioners' awareness of the relevance

of the concept and appreciation of likely positive outcomes from its application (Bousso, Poles & Cruz, 2014). The review included a broad range of evidence from research that appraised the concept of facilitation; reported on interventions accelerated by facilitation support; and or examined the role, purpose, enablers or effectiveness of facilitation. Four overarching themes resulted from the review including purpose, enablers, facilitation process and evaluation of outcome and impact.

Purpose

The literature highlighted that facilitating learning, improvement and development in the workplace is embodied in the purpose, the defining characteristics and the theoretical perspective that influence means of achieving the purpose. Facilitation is an enabling process built on clear indication of the need for support (preparedness), mutual respect, working within clear values and reciprocal learning (Kinley et al., 2014). Facilitation is a multifaceted role usually conceptualised and applied according to purpose ranging from providing support to achieve an explicit task like skills development to holistic processes of enabling individuals, teams and organisations to implement change (Berta et al., 2015). The purpose of facilitation influences the style, process and the underlying theoretical perspective the facilitator espouses to perform the facilitation role effectively (Dogherty, Harrison & Graham 2010).

Process

The process of facilitation involves enabling individuals and teams without taking the reign (Bergin 2015). Emphasis is on interaction between the facilitator and participants; individual empowerment and development; as well as dialogue aimed to

develop shared values and improve mutual understanding. The underlying notion of a skilled facilitator is the ability to work flexibly across roles and structural boundaries and to recognise the needs of a given context at different stages of any intervention (Hardy, Jackson, Webster & Manley, 2013). The complex nature of facilitation and a lack of consistency in definition make it difficult to draw meaningful conclusions about strategies or a blend of strategies effective for different settings (Bidassie 2015). Various purposes and contexts may require interventions of varying intensity of facilitation support (Rycroft- Malone 2002).

Enablers

The review identified that factors that enable effective facilitation are universal and adaptable to integrated facilitation. The drive to grow, develop, and achieve the highest levels of functioning influence participation of individuals, teams and organisations in the facilitation process (Wayne, Grzywacz, Carlson & Kacmar, 2007). While context and other variables may influence the facilitation process, skill in facilitation enables collaborative work with individuals, teams and the wider system to influence contextual factors and support stakeholders in managing change (Kitson 2009). Factors such as co-production of interventions to mirror real conditions in the workplace, organisational leadership support and a safe environment are essential for the spread and progress of the facilitation process (Bergin 2015; Berta 2015).

Evaluating outcome and impact

The extent to which the purpose of facilitation is achieved suggests the effectiveness of the process, irrespective of professional or organizational boundaries. Facilitation is a catalyst that enables others within a system to work collaboratively through reciprocity (Tollyfield, 2014). It is thus significant to evaluate intended and

unintended consequences at all levels of the systems including individual, teams and the organisation (Hawe, Sheill, &Riley, 2009). Documenting evidence of facilitation outcomes is beneficial to practice and validation of facilitation processes (Bergin, 2015). Effective facilitation is witnessed in practitioners' proactive accountable behaviours as they logically convey similar empowering principles towards improved health and social care outcomes (Gibbs 2011).

The Delphi survey

Analysis focused on obtaining consensus about the priority elements around the purpose, process, enablers and evaluation of the effectiveness of integrated facilitation of interprofessional teams. Consensus was determined in the final round following an iteration process that involved fine-tuning elements to validate content. Thirty-two (32) experts completed the first round questionnaire, 28 completed the second round questionnaire and 26 experts completed the third round questionnaire. The Delphi survey engaged experts from 10 countries including England (50%), Australia (13%), Northern Ireland (10%), Scotland (9%), Canada (3%), Denmark (3%), Netherlands (3%), Sri Lanka (3%), Switzerland (3%) and Wales (3%). Most of the participants (50%) had expertise of facilitating more than one purpose. The distribution of expertise of other facilitation purposes comprised inquiry (19%), innovation (16%), work-based learning (12%) and knowledge translation (3%). There was no eligible representation for exclusive facilitation of skills development nor service improvement.

Elements that obtained consensus (97 out of 200) constitute the standards for integrated facilitation (Appendix 2). Elements that did not meet the criteria for

determining consensus, italicized in the results tables, may still be of critical significance to specific or single purposes of facilitation. The results of the Delphi survey are presented according to the four overarching themes (purpose, enablers, facilitation process and evaluation of outcome and impact) considered in designing the Delphi study and the sub themes that emerged from the data.

Purpose

Experts agreed that an integrated approach to facilitation focuses on what matters to individuals and teams in the context of their work and workplace to achieve person centered cultures and improved service user outcomes (80.1% agreed). Through this process, individuals achieve psychological and structural empowerment, self-awareness and self-efficacy. Consensus was established that when facilitating teams, the intent is to achieve shared workplace and practice development goals through realizing a sense of security, belonging and significance (80.1%agreed). There was strong agreement that there is interdependence between the purpose of facilitating individuals, teams and the organization and the ultimate purpose of improving care for the people (96.3%).

Experts suggested and deliberated the common end purposes of facilitating interprofessional practice for the organization and its beneficiaries. Work-based learning (in and from practice) (92% agreed), practice development (91.7% agreed) and improvement and development (88% agreed) emerged as priority end purposes. Consensus was also obtained on developing and implementing new ideas (innovation) ($IQR \leq 1$ & $\mu_x < 3$). Knowledge translation, skills development and inquiry did not achieve consensus.

Theories underpinning integrated facilitation.

There was consensus that the purpose and theoretical disposition underpinning the facilitation approach will have an impact on the processes used (96.2% agreed). Out of 73 theoretical perspectives considered, 14 achieved consensus as most relevant for the integrated approach to workplace facilitation of interprofessional teams (Table 3). Five theoretical perspectives met all criteria for determining consensus and these were related to experiential learning (80.8%), action learning (76.9%), action research (76.9%), work-based learning (76.9%) and reflective models of practice (76.9%). The majority (81%) of theoretical perspectives considered did not achieve consensus (Supplementary file 3).

Table 3. Theoretical perspectives for integrated facilitation

Theoretical	CS essential & very important	SD	IQR	μ_x
Experiential learning (Kolb 1984; Boud & Miller, 1996)	80.80	1.158	1	1.69
Action learning (Revans, 1991)	76.9	.981	1	1.81
Action research (Lewin, 1946)	76.9	1.050	1	1.69
Work based learning (Flanagan, Baldwin, & Clarke, 2000)	76.9	1.201	1	1.81
Reflective models of practice (Schön 1983)	76.9	1.440	1	1.92
Principles of practice development (McCormack, Manley, &Walsh, 2008)	76.9	1.804	1	2.15
Effective workplace culture (Manley, Sanders, Cardiff & Webster, 2011)	69.3	1.555	1	2.54
Organisational learning (Senge, 2006)	65.4	1.158	1	2.31
Emotional intelligence (Goleman, 1998)	61.6	1.093	1	2.35
Group dynamics (Yalom & Leszcz; 2005)	57.7	1.272	1	2.46
Situated learning (Lave & Wenger, 1991)	57.7	1.573	1	2.65
Appreciative inquiry (Cooperrider, Barret & Srivasta 1995)	53.9	1.273	1	2.50
Participative leadership (Likert, 1967)	53.8	1.600	1	2.81
A six-category intervention analysis (Heron, 1976)	50	1.336	1	2.77

Enablers

External and internal enablers. The expert panel considered factors surrounding the facilitator that are essential for integrated facilitation for interprofessional teams to happen (external enablers). Experts agreed that it is essential to obtain time and active support from the wider organizations (92.3% agreed) and to develop a safe environment and learning culture (84.6% agreed).

The panel agreed on a number of values that guide actions and decisions in the moment and following facilitation practice (internal enablers). These were person centeredness (88.3%agreed), participation, inclusion and collaboration with humility (84.7% agreed), reciprocal learning relationships (87.1% agreed) and flexibility and responsiveness to the individual's style of learning (76.9% agreed).

Qualities and skills

Experts deliberated various skills and qualities considered essential to manage the integrated facilitation process effectively in health and social care contexts. Results in Table 4 show qualities listed 1-7 obtained strong agreement. All experts (100%) agreed that a skilled facilitator for interprofessional teams should be participative, inclusive and have the ability to work across learning styles and professional boundaries. This entails connecting with complexity to make facilitation a transparent process to support individuals and interprofessional teams in the workplace without taking the reign.

Facilitation process

The expert panel agreed that facilitators are confident to begin the facilitation journey at different starting points, depending on where individuals and teams are (100% agreed).

Table 4. Qualities and skills identified for skilled integrated facilitation

Qualities	CS Essential & very important	SD	IQR	μ_x
Understanding the requirements of working at different levels - individuals teams and organizations	92.3	.629	1	1.35
Empathy, realism/pragmatism and continuing to be person centered	92.3	.761	1	1.54
Inspiring, enthusiastic, a sense of humor with attributes of a transformational leader[1]	92	.651	1	1.56
Working with uncertainty and being reflexive to the needs of the group /individual and context (including political)	88.5	.652	0	1.23
Credibility, practical knowledge and understanding of theory underpinning facilitation approach used	84.7	.710	1	1.77
Courage and resilience, integrity and the ability to develop a safe environment	84.6	.895	1	1.81
Critical thinking and reflexivity	84.6	.977	1	1.65
An eclectic broad knowledge base and skills such as identified in the theoretical influences	73.1	.938	2	2.00
Articulate and engaging	*73*	*1.280*	*2*	*1.96*
Accessible through different media (e.g. face to face, virtual and remote)	*46*	*1.336*	*2*	*2.88*
Being participative, inclusive and working across learning styles, boundaries and connecting with complexity	100	.272	0	1.08
Knowing self, emotional intelligence, being reflective, continuing to learn and grow	96.1	.533	1	1.27
Enabling experiential learning by helping others to explore, reflect and review	92.3	.761	1	1.46
Active listening, skilled questioning and observing	88.5	.697	1	1.38
Identifying and challenging assumptions	88.4	.703	1	1.58
Providing high support and high challenge, and	84.7	.827	1	1.73
Giving and receiving feedback	84.7	.827	1	1.73
Identifying political drivers, risks and consequences; influencing, negotiation and networking to make positive connections within the organization	84.7	1.021	1	1.81
Celebrating and recognizing achievement	77	.999	2	2.04
Reflective inquiry, problem solving and critique with others	77	1.230	2	2.08
Using ethical principles in facilitation practice	76	1.256	2	1.92
Skill in mentorship and critical companionship	*57.7*	*1.137*	*2*	*2.42*
Systematic and analytical approaches to implementation and evaluation using different sources of evidence and observation	*60*	*1.186*	*2*	*2.64*
Using creative approaches to enable creative thinking and thinking outside the box	*50*	*1.185*	*2*	*2.73*

Italicised elements did not achieve consensus.

Experts identified that the most common and relevant starting points of a facilitation journey Include: exploring specific culture and contexts collaboratively and holistically taking into account stakeholders' perspectives and priorities; what matters to the people who are supported through facilitation by starting where they are; developing a shared understanding and purpose or agreed focus through clarifying

values and beliefs; and identifying the inquiry focus around implementing changes/ evidence/ innovations. The panel distinguished significant and effective processes for creating a safe learning environment as: building relationships to provide reciprocity, high support high challenge and recognizing others' expertise and agreeing on ways of working, clear boundaries and responsibilities.

Strategies for effective integrated facilitation

The expert panel recommended strategies for effective integrated facilitation of interprofessional health and social care teams (Table 5).

Table 5. Strategies for effective integrated facilitation

Strategies	**CS Essentially effective & very effective**	**SD**	**IQR**	μ_x
Establishing effective relationships for reciprocal and negotiated learning	96.3	.852	1	1.38
Enabling experimentation and informed and supported risk taking	96.1	.860	1	1.50
Using available time effectively	92.3	.629	1	1.35
Enabling participation, open communication and offering practical support and encouragement	84.6	.859	1	1.54
Creating a reflective space, enabling self-reflection, sense making and reflective reviews	80	1.003	1	1.56
Developing and sustaining effective ways of working	79.2	.897	1	1.75
Knowing when to stop and review working with principles of what works well	76.9	.936	1	1.65
Enhancing individual and group independence and autonomy	76.9	1.041	0	2.27
Giving and receiving high challenge and high support	76.9	.845	2	1.92
Supporting practice, observation and self-assessment	76	1.190	1	2.20
Recognizing and praising effort using real time feedback to develop learning in a deliberate way	73.1	.796	2	1.92
Analyzing and reporting on the processes of inquiry, allowing specific detail of the change to emerge over time and in response to the local environment	72	1.028	1	2.16
Attending to the process and the goal rather than being outcome orientated i.e. learning to learn	65.4	.948	1	2.46
Strengthening capabilities and skill set to match goals, practice frameworks, policy and vision	65.4	1.030	1	2.50
Critiquing practical and theoretical knowledge and drawing on a variety of sources of evidence, experiences and perspectives	53.9	.945	1	2.58
Using creative methods	48	1.036	1	2.64
Motivating by focusing on small steps and small wins then ever advancing cycles of development and evolution	*73.1*	*1.038*	*2*	*2.04*
Using humor and storytelling	*69.3*	*1.116*	*2*	*2.27*
Using qualitative 360 degree feedback to achieve individual and team role clarity	*23*	*1.164*	*1*	*3.35*

Italicized elements did not achieve consensus

The majority of strategies recommended (1-16) obtained consensus but the top priority elements identified were establishing effective relationships for reciprocal and negotiated learning (96.3% agreed), enabling experimentation and informed supported risk taking (96.1% agreed) and using available time effectively (92.3% agreed).

Monitoring and maintaining effectiveness of integrated facilitation

The expert panel considered a number of ways of monitoring the effectiveness of integrated facilitation based on the assumption that this hinges around the context and purpose. Elements that obtained consensus were deemed the most successful in monitoring and maintaining effectiveness of integrated facilitation for interprofessional teams. Experts largely agreed on critical reflection in the moment of and following facilitation practice (96.1% agreed), obtaining formal or informal stakeholder feedback (92.4% agreed) and reviewing the safety of the learning environment (76.9% agreed). Other elements that obtained consensus include reviewing the safety and learning environment (IQR =1 & μ_x = 2.4); reviewing field notes and preparatory work (IQR=1 & μ_x = 2.52); and reviewing the level of support and challenge experienced (IQR=1 & μ_x = 2.54). There was no agreement on external peer review, reviewing whether facilitator values were held nor requests from others to provide facilitation being successful ways of monitoring and maintaining the effectiveness of integrated facilitation of interprofessional teams. The Delphi expert panel agreed that effective integrated facilitation would generate process outcomes outlined below for individuals and interprofessional teams, taking into account the purpose of facilitation and emphasis. Specifically there was agreement on the following: increased reflexivity, self-awareness & self-efficacy; effective ways of working demonstrated by engagement, autonomous learners, self-directing leaders and goal achievement; role

clarity and skills that enable others to be effective (growing capacity); evidence of personal and professional development (including formal/ accredited learning); and evidence of improved team effectiveness.

Evaluation of outcome[2] and impact[3]

Indicators of outcomes. Experts unanimously agreed that motivated, engaged, self-directing individuals who know how to learn would indicate effectiveness of support through integrated facilitation in both the short term and long term. Individuals would evidence this through increased effectiveness, action initiated leadership and development (100% agreed). Table 6 shows indicators of outcome and impact that would arise from an integrated approach to facilitating interprofessional teams in health and social care contexts.

Table 6. Indicators of outcome and impact of integrated facilitation

Indicators of outcome	**% CS Strongly agree & Agree**	**SD**	**IQR**	μ_x
Motivated, engaged self-directing individuals who know how to learn evidenced by increased effectiveness, action initiated leadership and development	100	.332	0	1.12
Measureable progress/ development that can be evidenced e.g. Improvement in patient care, tangible development and/or new insights	93.5	.765	1	1.77
Achievement of agreed goals and facilitation purpose	92.3	.648	1	1.50
Flourishing individuals & sense of wellbeing	73.1	.999	2	2.04
Individuals become more aware of organizational direction and goals	69.2	.898	1	2.38
Publications and other disseminated outputs	*23.1*	*1.055*	*1*	*3.08*
Better use of evidence in the context of work and the workplace	*69.2*	*1.306*	*2*	*2.23*
Indicators of impact				
Motivated, engaged self-directing teams	100	.402	0	1.19
Flourishing curious individuals	90.2	1.113	1	1.96
Effective workplace cultures and learning cultures	88.5	1.123	1	1.69
Professional competence and team skill set development	76	1.201	2	1.88
Achievement of systems/ organizational change	61.5	1.029	1	2.54
Achievement of service and organizational key performance indicators	50	.906	1	2.50
Ongoing employment and career progression for individuals	*38.5*	*1.183*	*2*	*2.96*
Academic accreditation of learning	*23*	*1.093*	*2*	*3.35*

Italicized statements did not obtain consensus

Strategies for identifying the impact of integrated facilitation

The expert panel considered four strategies for identifying the impact of integrated facilitation in health and social care contexts. Three strategies attained consensus and these were: reviewing agreed goals and records about interventions and process outcomes at different levels (92.3% agreed); reviewing learning processes or strategies and new insights (84.4% agreed); and using different approaches to stakeholder evaluation (76.9% agreed). There was no consensus on using broad frameworks to identify what has changed and what helped the change in the short, medium and long term.

Discussion

There is growing awareness that health and social care for the ageing population and long-term illnesses require reorientation towards integration to avoid duplication and optimize flow and continuity across organizational boundaries (Imison & Bohmer 2013). Nonetheless, service integration is not sufficient for collaborative practice without active, positive and collaborative engagement of practitioners in supporting the implementation of policies in practice. Interprofessional education is an internationally endorsed approach to improved interprofessional collaborative practice but countries worldwide have experienced uneven progress (Barr, 2015). Evidence of the long-term impact of IPE on practice is scant and patchy (Reeves et al., 2013).

Workplace integrated facilitation for interprofessional teams focuses on learning for ongoing development and improvement. This establishes flexible interprofessional teams that work collaboratively to deliver quality care and services for the constantly changing health and social care needs of the people (Porter-O'Grady, 2009). The prevailing workforce crises in health care (Global Workforce

Alliance, 2013) call for flexible and effective ways of developing the workforce using the workplace as the main resource for learning. This study established key elements that constitute standards to guide the growth of skilled workplace facilitators of learning, improvement and development to enable collaborative working in health and social care settings and support a holistic approach to enhancing the quality of care. Workplace facilitation of learning, improvement and development in interprofessional teams creates opportunities for shared learning and knowledge exchange and enables understanding of the contribution of individual roles to the effectiveness of health and social care pathways (Macfarlane et al., 2011; Reeves et al., 2012). Integrated facilitation reduces the strain on highly pressurized staff, avoids duplication of effort and costly handoffs between different departments. Stakeholders across health and social care organizations to use reflective and provocative questions consistently to develop understanding and personal responsibility in delivering organizational outcomes (Manley et al., 2016).

The expert panel provided greater emphasis on clarity of the purpose of integrated facilitation, making explicit the purpose of facilitating practice for individuals, interprofessional teams and organizations. Results about the common end purposes of integrated facilitation for the organization and its beneficiaries provide more insight into the overlap in the processes of facilitating the different purposes and hence the importance of effective use of valuable resources. There was no consensus on inquiry and knowledge translation as common end purposes, which reflects the contingent and complex interplay between the generation of knowledge and the implementation of knowledge into practice (Rycroft-Malone et al., 2004). Integrated facilitation promotes working within different contexts to enable interprofessional teams

appreciate the broader system in which they work, articulate issues and develop strategies that allow for successful implementation of evidence based models of care.

Theoretical influences for integrated facilitation that obtained consensus demonstrate the significance of effective and supportive relationships in collaborative work-based learning underpinned by practice and everyday experiences of acting, negotiating and skilled resolution of issues within teams and organizations. Whilst the art of skilled facilitation lies in the intuitive knowing of when to use specific strategies and theoretical underpinning (Raelin, 2006), organizational leadership support and a safe environment enable the facilitator to manage multifaceted processes in complex systems and support interprofessional teams' progress in implementing and sustaining transformations in the way care is delivered. A safe environment offers access to work-based leaning because it conveys psychological safety, promotes individual contributions, gives a sense of being valued and entails mutual respect (Shaw et al., 2008). The range of skills and qualities agreed on in this study enable holistic facilitation that recognizes requirements of a given context and flexible adaptation of the supportive role and strategies used at any stage of the intervention. The outcome competence focuses on achieving high quality practice, ascertains value on investment and validates the process.

Elements that were recommended and considered by the expert panel but did not achieve consensus to be part of the standards for integrated facilitation may be relevant to single purposes of facilitation and may inform facilitation practices. The standards for integrated facilitation provide a framework for guiding the development of holistic, person-centered and relational skills of new and developing facilitators for interprofessional teams to make a difference within their sphere of service delivery. These standards endorse an integrated facilitation approach to all the activities

required for supporting ongoing learning, development and improvement in the workplace across health and social care settings.

This study has limitations. There was unequal representation of expertise selected for each of the facilitation purposes, which presents potential selection bias. There was no eligible expertise identified for facilitating skills development nor quality improvement. This shortfall may limit the generalizability of results to integrated facilitation. The selection bias is mitigated by the expert representation (50%) of facilitating practice development in and about the workplace. This expertise involves facilitating more than one of the facilitation purposes that encompass learning, development, improvement, inquiry, innovation and knowledge translation.

Concluding comments

Findings of this study helped to identify elements included in the resulting standards for integrated facilitation in the workplace (Appendix 2*)* that will enable the growth of skilled facilitators for supporting individual practitioners, interprofessional teams and organizations to flourish and optimize performance in the delivery of changing models of care. Integrated facilitation for interprofessional teams aligns the health and social care workforce across boundaries of practice to enable the realization of transformations in health and social care services. The standards provide assurance that workplace learning and development would be skillfully supported to enable interprofessional teams to work collaboratively and develop core skills required to confidently provide care focused on service user needs.

Further research would be useful to understand firstly, how effective the standards are in guiding the development of competent and confident workplace facilitators for interprofessional teams. Secondly, future research could evaluate the

impact of skilled integrated facilitation for interprofessional teams on health and social care outcomes and the wellbeing of interprofessional teams.

Notes

1. Transformational leadership – enabling, challenging and stimulating, celebrating, building trust, and inspiring a shared vision.
2. Immediate changes in the people facilitated, their contexts and systems.
3. Deeper, longer term changes in the people facilitated, their contexts and systems.

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Declaration of interest

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

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Appendix 2: Standards for an Integrated Approach to Workplace Facilitation of Learning, Development and Improvement

STANDARD 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

Performance Indicators:

Overall purpose:

1.1. Model an integrated (holistic) approach to facilitation that focuses on what matters to individuals, teams and organisations

1.2. Work with the individual/team, their work and workplace context

1.3. Relate the endpoint of facilitation practice as developing person centred cultures and ultimately improved health outcomes

Individual Purpose:

1.4. Enable a systematic and informed approach to personal and professional judgement to foster psychological and structural empowerment, enhance self-awareness and self-efficacy

Team Purpose

1.5. Work towards achieving shared workplace and practice development goals through realising a sense of security, belonging and significance

Organisational Purpose:

1.6. Recognise and articulate the common end purposes of facilitation practice for the organisation and its beneficiaries:

- Work based learning – in and from practice
- Practice development
- Improvement and development through growing leaders and facilitators of learning as well as positively impacting on workplace culture
- Innovation - developing and implementing new ideas

1.7. Accommodate less prominent purposes relevant

to the organisation:

- Knowledge translation- implement new knowledge or theory in practice
- Skills development– developing new skills, confidence and competence
- Inquiry- explore meanings and develop understanding

1.8. Articulate the interdependence between effective facilitation of individuals, teams and the organisation and improving care for people

STANDARD 2: Optimise the external enablers and values necessary for successful facilitation practice

Performance Indicators:

External enablers:

2.1. Obtain time and active support from the wider organisation/ employer for facilitation activity

2.2. Develop a safe environment and learning culture for and with individuals and teams through:

- Agreeing ways of working, clear boundaries and responsibilities
- Building relationship that provide *reciprocity, high support & high challenge* and recognising others' expertise

Facilitator values:

2.3. Embrace a person centred approach that models integrity mutual respect is open and non-judgmental

2.4. Is participative, inclusive and collaborative with humility

2.5. Demonstrate reciprocal learning relationships; sharing information, vulnerability, celebrations and understanding

2.6. Is adaptable, flexible and responsive to individuals' style of learning and motivation

STANDARD 3: Draw on the qualities necessary to build effective relationships for facilitation practice

Performance Indicators:

3.1. Understand the requirements of working at different levels - individual's teams and organisations

3.2. Use empathy, realism/pragmatism being person centred

3.3. Inspire, be enthusiastic, use humour with the attributes of a transformational leader[1]

3.4. Work with uncertainty being reflexive to the needs of the group /individual and context (including political)

3.5. Has credibility, practical knowledge and understanding of theory underpinning facilitation approach used

3.6. Is courageous and resilient with integrity to develop a safe environment

3.7. Use critical thinking and reflexivity

STANDARD 4: Demonstrate the skills required for integrated facilitation practice in health & social care

Performance Indicators:

4.1. Be participative, inclusive and work across different learning styles, boundaries, connecting with complexity

4.2. Know self, emotional intelligence, being reflective, continuing to learn and grow

4.3. Demonstrate active listening, skilled questioning and observing

4.4. Enable experiential learning by helping others to explore, reflect and review

4.5. Provide high support and high challenge, give and receive feedback

4.6. Use reflective inquiry, problem solving and critique with others

[1] Transformational leadership- enabling, challenging and stimulating, celebrating, building trust and inspiring a shared vision

4.7. Use ethical principles in facilitation practice
4.8. Identify political drivers, risks and consequences, influencing, negotiating and networking to make positive connections within the organisation
4.9. Celebrate and recognise achievement

STANDARD 5: Commence the facilitation journey with confidence at different starting points depending on where individuals and teams are at

Performance Indicators:

5.1. Explore specific culture and contexts collaboratively and holistically taking into account stakeholders' perspectives and priorities
5.2. Identify what matters to the people who are being supported through facilitation by starting where they are at
5.3. Develop a shared understanding and purpose or agreed focus through for example; clarifying values and beliefs
5.4. Identify the inquiry focus around implementing changes/ evidence/ innovations

STANDARD 6: Use common strategies appropriately for effective facilitation practice

Performance Indicators:

6.1 Establish effective relationships for reciprocal and negotiated learning
6.2 Enable experimentation and informed and supported risk taking
6.3 Enable participation, open communication and offering practical support and encouragement
6.4 Create a reflective space, enabling self-reflection, sense making and reflective reviews
6.5 Develop and sustain effective ways of working knowing when to stop and review working with principles of what works well
6.6 Enhance individual and group independence and autonomy
6.7 Give and receive high challenge and high support
6.8 Support practice, observation and self-assessment
6.9 Recognise and praise effort using real time feedback to develop learning in a deliberate way
6.10 Analyse and report on the processes of inquiry, allowing specific detail of the change to emerge over time and in response to the local environment
6.11 Attend to the process and the goal rather than being outcome orientated i.e. learning to learn
6.12 Strengthen capabilities and skill set to match goals, practice frameworks, policy and vision
6.13 Critique practical and theoretical knowledge drawing on a variety of sources of evidence, experiences and perspectives
6.14 Use creative methods
6.15 Use different theoretical dispositions to impact on facilitation processes used (See knowledge and understanding)
6.16 Use available time effectively

STANDARD 7: Monitor and maintain effective facilitation practice using a range of methods

Performance Indicators:

7.1. Critically reflect in the moment and following facilitation practice
7.2. Obtain formal or informal individual/ group and/ or stakeholder feedback
7.3. Review the safety of the learning environment/ culture
7.4. Review field notes and preparatory work
7.5. Review group's perceptions/self-assessment of group functioning (e.g. hierarchy, co-operation or autonomy)
7.6. Review the level of support and challenge experienced
7.7. Demonstrate reciprocal learning relationships; sharing information, vulnerability, celebrations and understanding
7.8. Is adaptable, flexible and responsive to individuals' style of learning and motivation

STANDARD 8: Evaluate and evidence process outcomes, intermediate outcomes and impact that individuals or teams may experience using a range of approaches

Performance Indicators:

8.1. Recognise and evidence a range of process outcomes that individuals or teams may experience e.g.:
- Increased reflexivity, self-awareness & self-efficacy
- Effective ways of working demonstrated by engagement, autonomous learners, self-directing leaders and goal achievement
- Role clarity and skills that enable others to be effective (growing capacity)
- Evidence of personal and professional development (including formal/accredited learning)
- Evidence of improved team effectiveness

8.2. Enable others to use and recognise indicators of outcome e.g.:
- Motivated, engaged self-directing individuals who know how to learn evidenced by increased effectiveness, action initiated leadership and development
- Measureable progress/ development that can be evidenced e.g. Improvement in patient care, tangible development and/or new insights
- Achievement of agreed goals and facilitation purpose
- Flourishing individuals & sense of wellbeing
- Individuals become more aware of organisational direction and goals

8.3. Use a range of strategies for identifying the impact of facilitation through:
- Review of agreed goals and records about interventions and process outcomes at different levels
- Review of learning processes/ strategies used and new insights
- Stakeholder feedback (e.g. using different approaches to stakeholder evaluation)

8.4. Recognise and evidence the impact of facilitation practice through:
- Motivated, engaged self-directing teams

- Flourishing curious individuals
- Effective workplace cultures and learning cultures e.g. staff retention
- Professional competence and team skill set development
- Achievement of systems/ *organisational* change
- Achievement of service and organisational KPIs e.g. improved patient outcomes and experience, saving money and time