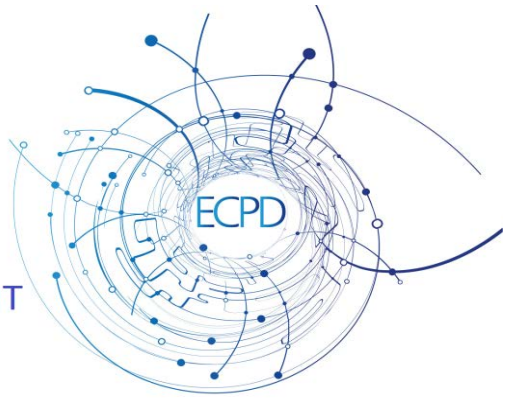
Canterbury Christ Church University

East Kent Hospitals University NHS
NHS Foundation Trust

ENGLAND CENTRE for PRACTICE DEVELOPMENT



Transforming Urgent & Emergency Care Together

Phase 2 Report: Developing Standards for Integrated Facilitation in and About the Workplace

December 2015

Kim Manley, Anne Martin, Carrie Jackson, Toni Wright

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

ISBN: 978-1-909067-54-7

Contents

Figures

Tables

Acknowledgements

The Project Team gratefully acknowledge the members of the Delphi Panel, who with sincere devotion gave freely of their time to contribute, evaluate and validate the information included in the standards for integrated facilitation.

We are grateful to the Leads of International and National Professional Networks for their support in raising awareness of the study.

Special thanks to our critical reviewers Famke Van Lieshout and Angie Titchen for their valuable feedback and insights.

List of Abbreviations

Composite score	CS
Department of Health	DoH
Expression of Interest	EOI
Higher Education Institutions	HEIs
Interquartile Range	IQR
Knowledge Resource Nomination Worksheet	KRNW
National Health Service	NHS
Standard Deviation	SD
The Health Foundation	THF
The National Institute for Health and Care Excellence	NICE
United Kingdom	UK
Quartile	Q
Department of Health Social Services and Public Safety	DHSSPS

Executive Summary

Introduction

Integration of health and social care systems and processes features distinctively in policy aspirations of the UK with a vision to overcome service duplication and to optimise flow and continuity across organisational boundaries. Integration offers the potential for better outcomes for people using services, makes limited resources go further and improves people's experience of health, care and support. Integrated models of care need to be complemented with an integrated approach to facilitating urgent and emergency care workforce transformation. This would bring together multiple programmes for learning, development and improvement that exert insurmountable pressure on staff who already feel time poor particularly in the presence of increasing demand for patient care.

An integrated approach to facilitation necessitates comprehensive standards to influence the consistency in quality and effectiveness of this role. This report presents results of an electronic Delphi (e-Delphi) study carried out between June and August 2015 as part of the Health Education Kent, Surrey and Sussex urgent and emergency care workforce development project. The aim of the e-Delphi study was to gather expert knowledge on facilitation across a range of purposes (learning, development, improvement, knowledge translation, inquiry and innovation) to enable the development of standards required for workplace integrated facilitation.

Literature Review

It is important that programmes aimed to improve practice are developed based on clear concepts. The literature review was a deliberate strategy to examine how the concept of facilitation is articulated in the literature and to identify gaps to inform the Delphi study. The literature review focuses on:

- Purpose of facilitation
- Facilitation process
- Enablers of facilitation
- Outcome and impact of facilitation at the individual, team, organisational (and service) levels

Methodology

The electronic Delphi was selected for this study to allow a significantly large number of experts to participate, jointly but anonymously in giving empirical information on facilitation. Three e-Delphi rounds involved participants from ten countries with expertise in facilitating either one or more of the purposes in work and/ or about the workplace. The selection of experts was based on two criteria: i) leading and or researching a programme of work linked to one or more of the purposes identified and ii) published on any of the identified purposes of facilitation.

32 experts completed round one by answering broad open ended questions analysed through importing into NVivo; 28 completed round two which involved rating the relevance of items arising from round one; and 26 completed round three which aimed to achieve

consensus. Rounds 2 and 3 results were analysed statistically using SPSS. Consensus criteria were set before data collection and determined using a combination of measures.

Results

Four themes arising from the literature review- purpose, enablers, process and evaluation of impact and outcome were used to structure the results with items presented in order of the level of strength of consensus achieved.

Purpose

'*The intent of an integrated approach to facilitation is to focus on what matters to individuals and teams in the context of their work and the workplace with the endpoint being person centred cultures and improved health outcomes'*. There was a strong consensus about the interdependence between the purpose of facilitating individuals, teams and the organisation.

End points were identified more specifically at the individual, team and organisational levels. The most influential and essential theories underpinning an integrated approach to facilitation practice were identified, as were less common theories associated with specific purposes.

Enablers

The two most important external enablers identified included: *obtaining time and active support from the wider organisation/ employer; and developing a safe environment and learning culture*. Internal enablers focused on specific values about person centredness, collaboration, inclusion and participation, the ability to build reciprocal learning relationships and adaptability and flexibility to individual styles.

Facilitation Process

Qualities and skills for effective practice were identified and complemented the statement with 100% consensus - '*facilitators are confident to begin the journey at different starting points depending on where individuals and teams are at.'*

Other features in the facilitation process identified of importance included; *the ability to work from different starting points; the processes for creating a safe environment; the use of common strategies appropriately; and ongoing monitoring of facilitation effectiveness using process outcomes*.

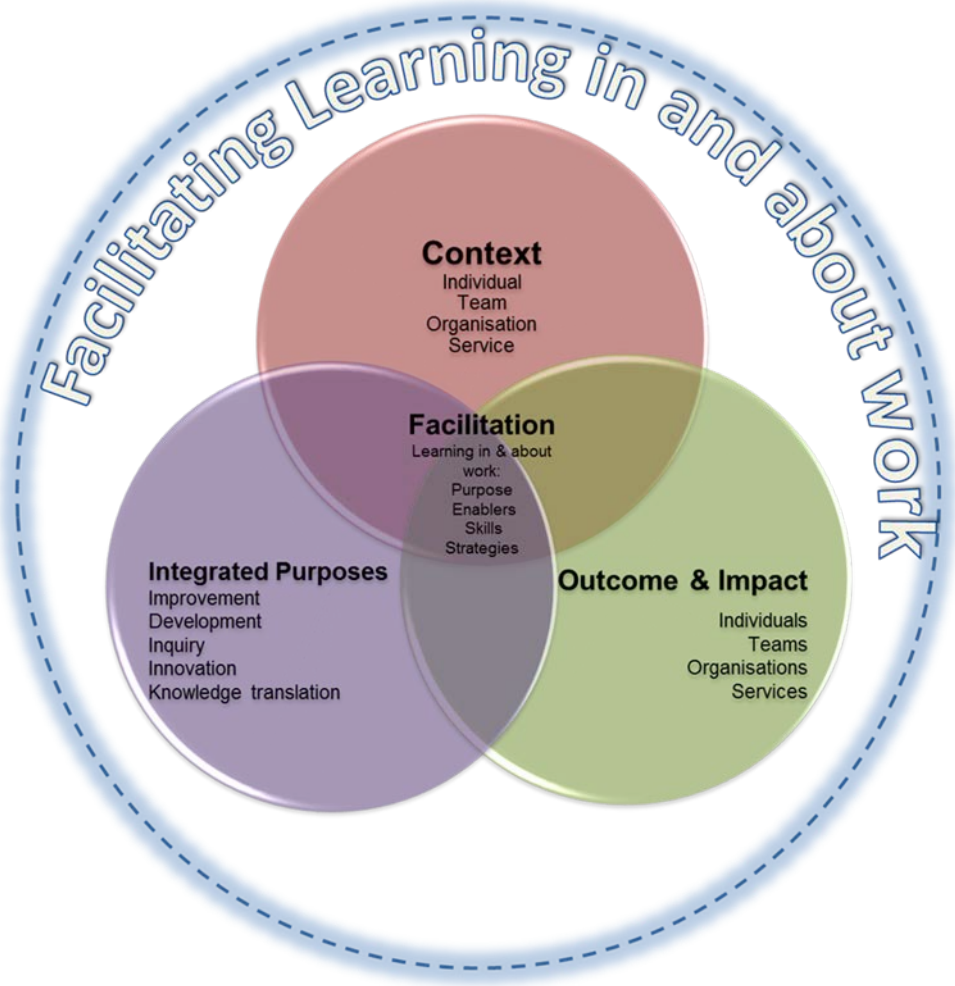
Evaluation of Outcome and Impact

Indicators of outcome and specific indicators of impact as well as a number of strategies for evidencing the impact of facilitation were identified.

An Emerging Framework: Components of an Integrated Facilitation Approach in and about Work

Figure 4 illustrates the three key components that facilitators need to attend to when supporting individuals, teams, organisations and services to achieve higher order learning in and about the workplace to positively impact on person centred cultures and ultimately health outcomes.

Figure 4 An Emerging Framework: Components of an Integrated Facilitation Approach in and about Work



Eight standards have been developed based on the findings, to operationalise the emerging framework for an integrated approach to facilitation in the workplace.

Limitations

It is possible that the electronic platform used for the study excluded qualifying participants with limited or no access to information technology.

The study involved representation from the majority of facilitation purposes but for skills development and quality improvement. This shortfall may limit the generalisability to integrated purposes which include skills development and quality improvement.

Conclusions

The UK population healthcare needs are constantly changing and systems and processes are devised to cope with the changes within constrained resources. Whole systems integrated urgent and emergency care requires to be matched with whole systems learning for development and improvement not only to reap the benefits that accrue to integrated models (Ham and Curry 2011) but also to develop a workforce that can flexibly keep pace with the rapidly changing practice needs and contexts. The standards for integrated

facilitation would enable the workforce to grow and facilitators to support the achievement of this vision.

Recommendations

Recommendations for Commissioners of Learning, Development and Improvement

- Commissioning of learning and development needs to embrace facilitation preparation, quality and opportunities for an integrated approach in order to add value to the service and use resources effectively.

Recommendations for Higher Education Institutes

- Postgraduate modules in facilitation aimed at practice based programmes, developing competence and workplace facilitator preparation need to take an integrated approach, draw on the standards and the theoretical influences to inform curriculum content.
- Higher Education Institutes should support facilitators and supervisors in practice to develop the full range of skills required to deliver on an integrated approach to facilitation rather than just skills development. For example; Facilitators supporting Physician Associates and Advanced Practice programmes.
- Higher Education Institutes are encouraged to adopt the standards to guide the structure and content of portfolios of evidence of new and developing facilitators through assessment strategies.
- Programmes for developing clinical systems leaders should integrate the standards as this is a core component of the expertise expected from these roles.
- Development of future professional programmes of learning leading to registration need to have an element of facilitation theory and practice embedded so mentors at the point of registration are capable of facilitating learning in the workplace.
- The facilitation standards provide a framework for self-assessment suitable for CPD and postgraduate professional programmes as a means of assessment that can be built into teaching, learning and assessment strategies within curricula. This adds value to the portfolio of professional education because it will enable HEIs to demonstrate impact in and on the workplace.
- The facilitation standards as a self-assessment tool provide a valuable framework for professional revalidation portfolios.

Recommendations for Healthcare Providers

- The integrated facilitation standards provide the opportunity for healthcare providers to attend to key organisational functions in a joined up way by attending to the quality of their practice supervisors and facilitators enabling them to develop a broad range of skills required to integrate the learning for improvement and development.
- The standards provide a framework for accrediting facilitators and building a sophisticate network of support for organisations that focus on growing key staff and practice leaders.
- Healthcare providers need to consider how departments/ functions such as quality improvement, practice development, inquiry etc. can work in a more integrated way to enable higher order learning for faster safer and better services as there is much more in common in these functions than is different. This would enhance the use of scarce resources and avoid duplication of effort.

Recommendations for the economy:

- Development of the facilitation capacity of whole systems clinical leaders is vital to manage the pace and complexity of change and challenges us to think about what integration truly means laterally.

Next steps

Phase 3 of this work aims to identify gaps and risks across the current system against the integrated career and competence framework developed – the first output from Phase 2 of Transforming the Urgent and Emergency Care workforce project. The facilitation standards are pivotal to growing quality facilitators to support the workforce in the workplace and across professional boundaries. The integrated facilitation standards could be developed into an interactive learning resource to strengthen facilitation capacity in the region.

1. Introduction and Context

Integration of health and social care systems and processes features distinctively in policy aspirations of the UK with a vision to overcome service duplication and to optimise flow and continuity across organisational boundaries. Integration is defined as 'to put together separate parts to make as a whole' (Oxford English Dictionary 1989). In integrated systems care is coordinated between health and social care to treat the person as a whole to respond to their needs rather than the presenting medical condition (McCormack et al 2008). Integration offers the potential for better outcomes for people using services makes limited resources go further and improves people's experience of health, care and support (Humphries & Curry 2011).

One of the models of care cited in the Five Year Forward View (NHS England 2014) involves integrating accident and emergency departments, General Practice's out-of-hours services, urgent care centres, NHS 111, and ambulance services. Integration is facilitated by whole systems working, which recognises the contribution of all partners to delivering high quality care (DoH 2003). Whole system working defies restrictive service boundaries and requires health and social care professionals for various interventions to work together across systems (Alderwick et al 2015).The current NHS austerity budgets call for effective ways of achieving this. Manley et al (2014) found that a whole system approach to care requires whole systems learning for development and improvement. Manley et al recommend key enablers for developing the workforce from a whole systems perspective:

- A single competence and career framework for all across all interdependent partners in the system. A single career and competence framework for a whole system approach demonstrates how interdependent partners across the NHS Career framework provide complementary competences in different contexts and drives career development and progression (horizontally and vertically), not just for clinicians but also for support staff including administrators and volunteers.
- Clinical systems leadership. Clinical systems leadership draws on expertise from across different areas to facilitate contributing partners to work together towards a shared purpose. The expertise encompasses: clinical expertise and credibility; leadership for culture change; developing improving and evaluating person centred care; and creating a learning culture that uses the workplace as the main resource for learning.
- An integrated approach to facilitation, drawing on the workplace as the main resource for this. An integrated approach to facilitation/ integrated facilitation in this study is defined as '***bringing together different purposes (learning, development, improvement, knowledge translation, inquiry and innovation) of facilitation to achieve a holistic approach to person centred care and improving public health outcomes'***.

The need for an integrated approach to facilitation

Existing NHS learning, development and improvement activities appear to operate in silos resulting in potential overlap in facilitation processes. Edgren (2012) argues that better outcomes are achieved through better relationships and breakdown of hierarchical approaches to improvement and development. Nonetheless distinct NHS departments or roles for practice development, learning and development, research and development,

service improvement, quality improvement, patient improvement, lean methodology and workforce skills and competence development prevail alongside each other. Watling (2015) contends that multiple programmes for development and improvement exert insurmountable pressure on staff who already feel time poor particularly in the presence of increasing demand for patient care.

Developing an integrated approach to service delivery necessitates a workforce supported to integrate not just service delivery across the health economy, but also, those activities that enable ongoing learning, development, improvement, inquiry, knowledge translation and innovation (Manley et al 2014). Facilitation is widely recognised as a cornerstone for integrated developments in the delivery of healthcare (Kitson 2009; Harvey et al 2002; Rycroft- Malone et al 2002 and 2004; Titchen, 2000; Shaw et al., 2008; Lieshout, 2013; Mold 2014; Watling 2015). Integrated facilitation plays a major role in supporting competence development using the workplace as the main resource for learning (Solman and Fitzgerald 2008). Skilled facilitators have the capacity to enable the integration of the whole systems agenda to facilitate learning, development and improvement in the workplace (DHSSPS 2012). This is achieved through a collaborative working relationship with frontline staff to enable critical reflection on practice and identify behaviours, systems and processes that require transformation to conform to person centred values; and to develop new knowledge, skills and effective workplace cultures (Watling 2015).

The need for integrated facilitation standards

While the importance of facilitation is resounded, there are no comprehensive standards for integrated facilitation to influence consistency in quality and effectiveness of this role. Standards are concise sets of prioritised statements designed to drive measurable quality improvements within a particular area of health or care (NICE). There are standards for facilitating practice development but these implicitly focus on integrated activity that aims to develop person centred cultures in the workplace (Manley et al 2011). The Health Foundation standards for facilitation (2013) are tailored to facilitating patient skills development with specific techniques that are simply a component of the strategies required for integrated facilitation. The Royal College of Nursing (Manley & Webster 2006) facilitation standards include an outcome element but exclude indicators of outcome and impact and ways of monitoring these.

The current study aimed to develop facilitation standards that make explicit what is required to facilitate an integrated approach to learning, development and improvement programmes in the workplace and also evidence outcomes that would reflect effective facilitation.

1.1. Study Purpose

To identify the standards required for integrated facilitation in and about the workplace.

1.2. Study Assumptions

- Whilst a substantial amount of work has been published on the concept of facilitation in practice development, work based learning and knowledge translation in health and social care, there are also a number of related areas that require similar facilitation approaches e.g. quality improvement, service improvement and

innovation.

- Taking an integrated approach to facilitation in the workplace is a more efficient use of resources and reduces duplication as there is overlap in the processes of facilitation.
- There are different levels of facilitation expertise required to support developmental and collaborative opportunities within a career framework across all purposes and disciplines.
- The full range of facilitation expertise would be expected to be a component skill set for clinical systems (informal and formal) leaders and other facilitators in practice.

2. Literature Review

There are still questions about facilitation structures and process that need to be in place to maintain practice change (Berta et al 2015). Bousso et al (2014) argue that work aimed at improving practice needs to be constructed upon a clear concept to enhance practitioners' awareness of the relevance of the concept and appreciation of possible positive outcomes from its application. This literature review was a deliberate approach to examine how the concept of facilitation is articulated in the literature and identify gaps to inform a Delphi study for developing standards for integrated facilitation in and about the workplace.

2.2. Search strategy

The intent of the literature review was to cover a broad range of literature including research that appraised the concept of facilitation; reported on interventions accelerated by facilitation support; and/ or examined the role, purpose, enablers and/ or effectiveness of facilitation. For the purpose of this study the search was undertaken using two databases (MEDLINE and CINHAL) for literature published in English between 2000 and 2015 relating to facilitation in health and social care. The search terms used were: facilit* and practice develop, skill develop, workplace learn or work based learn, inquiry, innovation, quality improve, knowledge translat* or evidence implement, integrat*. The search terms were truncated to widen the base of items returned with those terms. 66 Items (including articles and books) constituted the review about the concept of facilitation.

The review was influenced by the practice development methodology (Manley and McCormack 2003), which is underpinned by critical science principles of enabling practitioner enlightenment (self-awareness), empowerment (motivation to act) and emancipation (taking action freed from habits and assumptions) that enable transformation of practice (Fay 1987). The practice development methodology posits that the view of the world represented has implications for processes used, their facilitation methods and evaluation focus. The literature review is therefore framed around the **purpose**, **process** and **evaluation of outcome and impact** of facilitation.

2.3. The purpose of facilitation

Several studies have reviewed the concept of facilitation to clarify defining attributes (Cross 1996; Burrows 1997 and Kitson 1998) or add to the concept's maturity by augmenting the existing body of knowledge (Harvey et al 2002; Simmons 2004; Stetler et al 2006; Shaw et al

2008; Dogherty et al 2010). Facilitation is multifaceted usually applied and conceptualised according to purpose (Harvey 2002; Stelter 2006). Manley and McCormack (2003) argue that clarifying the purpose and means is fundamental to tangible and meaningful understanding of complex concepts. Definitions of the construct of facilitation in table 1 illustrate how precision of purpose and means may articulate views represented about a concept.

Table 1 Table 1 Defining Facilitation

Definition	Purpose	Means
A goal oriented dynamic process in which participants work together in an atmosphere of genuine mutual respect in order to learn through critical reflection (Burrows 1997).	Learning	• Critical reflection • Working together • Genuine mutual respect
Facilitation is a deliberate and valued process of interactive problem solving and support that occurs in the context of a recognised need for improvement and a supportive interpersonal relationship (Settler 2006).	Improvement	• Interactive problem solving and support • Supportive and interpersonal relationship
A technique by which one person makes things easier for others (Kitson et al 1998).	Make easy	• Providing the support needed
A helping relationship, essentially one of enabling others and consequently self, through transitions to achieve growth/development and ultimately self-actualisation (Shaw et al 2008).	Growth/ development and self-actualisation	• Helping relationship • Enabling others and self
Facilitation is a goal-oriented, context-dependent social process for implementing new knowledge into practice or organizational routines....involves individuals learning together in the context of a recognised need for improvement and supportive relationships. Effective communication and interactive problem solving are key process components (Berta et al 2015).	Implementing new knowledge into practice or organizational routines	• Learning together • Effective communication • Interactive problem solving

The definitions above demonstrate that facilitation embodies a wide range of purposes varying from support to achieve an explicit task such as skills development (Kitson et al 1998) to a holistic process of enabling individuals, teams and organisations to change (Settler 2006; Berta 2015). Facilitation is a distinctive appointed role for change agents who may be internal or external to the organisation or combined internal-external (hybrid) (Harvey et al 2002). The Oxford model of facilitation (Fullard 1994) is the most commonly quoted example of a task orientated approach while Titchen's (2001) framework of critical companionship exemplifies holistic facilitation (Rycroft- Malone et al 2002; Harvey 2002). Interventions with a purpose relating to cultural change in organisations are associated with the hybrid facilitation model with an aim to grow, empower and/ or emancipate internal facilitators to continue the change process (McCormack & Wright 1999). While the external facilitator offers expertise in change approaches and or external critique (Bidassie 2015;

Hughes 2004) the internal facilitator has a better sense of an entity's political organisation and history (Tollyfied 2014). With relative effectiveness, the external facilitation model is often regarded as superfluous and the model is challenged by practice norms, issues of trust and acceptability of tools for change and sustainability beyond external intervention (Kitson 1998; Manley et al 2013; Raelin 2006; Hughes 2004; Laferriere et al 2012; Kinley et al 2014; Bergin 2015).

There is significant evidence to indicate that the purpose of facilitation influences the style, process and the underlying theoretical perspective espoused by the facilitator to effectively perform the role (Manley and McCormack 2003; Harvey et al 2002; Rycroft Malone 2002; Dogherty et al 2010). However Berta et al (2015) grounded conceptualisation of facilitation within the organisational theoretical perspective – a reductionist approach in a context of eclectic purposes of facilitating knowledge translation and improving health outcomes. Raelin (2006) argues that the art of facilitation is the intuitive knowing of when to use specific strategies and theoretical underpinnings. Table 2 lists some of the theoretical frameworks that influence facilitation of different purposes.

Table 2 Theoretical Perspectives that Influence Facilitation Purposes

Purpose	Theoretical underpinnings	Reference
Implementation of evidence/ Knowledge translation	▪ PARIHS framework: Rycroft- Malone et al (2002) ▪ Critical companionship: Titchen (2004) ▪ Experiential leaning: Kolb (1984) ▪ Reflection models: Paul Freire (1972, 1987) ▪ Organisational learning theory: Argyris (2003)	Stetler et al (2006) Ellis et al (2005) Kitson (2009) Westerngreen (2012) Berta et al (2015)
Work based learning	▪ Heron (1995) ▪ Action learning Alto and Davies- Black- (1999) ▪ Organisational learning: Argris and Schőn (1974, 1996) ▪ Freire (1970) ▪ Appreciative intelligence: Thatchenkery (2009) ▪ Situated learning: Lave and Wenger (1991)	Raeline (2006) Cohen (2013) Hughes (2004)
Quality improvement	▪ Experiential leaning: Kolb (1984) ▪ Organisational learning: Argyris and Schőn (1996)	Thor et (2004)
Practice Development	▪ Critical companionship: Titchen (2004) ▪ Person centredness: McCormack (2004) ▪ Heron's 6 dimensions of facilitation styles (1989) ▪ Active learning: Dewey (2004)	Shaw et al (2008) Harvey et al (2002) Bergin (2015)
Implementation of standards	▪ Critical reflection ▪ Action learning, High challenge high support: McGill and Brockbank (2004)	Kinley et al (2014)
Participatory development	▪ Organisational learning: Senge (1990), Argyris and Schön (1992) ▪ Soft systems methodology: Checkland (1989) ▪ Communicative action: Habermas (1984)	Groot and Maarleveld (2000)

Manley (2001) suggests that identifying the characteristics of a concept- in this case facilitation provides a concise way of understanding the concept. Harvey et al (2002) distinguished five characteristics of facilitation:

- It is an appointed role as opposed to other agents who influence change through their own personal reputation.
- The facilitator may be internal, external or both internal and external approach to the organisation in which the change is being implemented.
- The role is about helping and enabling rather than telling or persuading.
- Facilitation can encompass a range of help from technical as an expert authority figure to using methods to enable individuals become aware of and free from presupposed aspects of their practice and the organisational systems constraining them.
- A wide range of roles accrue to facilitation with corresponding skills and attributes needed to fulfil the role effectively.

Characteristics of facilitation identified in literature that occur across the various purposes included partnership learning, enabling, mutual respect, a process and authenticity. These can be compounded in three constituent elements of facilitation:

- A process of enabling

Definitions of the concept of facilitation allude to enabling or providing support for a process to progress with salient components comprising a clear indication of the need for support (preparedness), a shared purpose and the autonomy of the group (Kinley et al 2014). As a process a series of steps are taken that involve getting to know people, the organisation and their culture and how the facilitator develops a neutral ground to perform the role (Kirk & Broussine 2000). Learners are likely to follow progression of scientific inquiry and learning skills embracing critical thinking, creative thinking, communicating and collaborating (Burrows 1997).

- Partnership/ collaborative learning

Kitson (2009) contends that improvement in systems is most effective when it involves key stakeholders in personal development; control of the immediate physical resources and context and increased autonomy over the external environment. Collaborative workplace learning is underpinned by practice and embedded in everyday experiences of acting, negotiation and applying problem solving skills within teams and organisations (Cohen 2013). The process involves the co-production of knowledge through critical reflection, and dialogue between the learner and skilled facilitator (Titchen 2000; Groot and Maarleveld 2000).

- Working with clear values

Manley and McCormack (2003) assert that identifying explicit workplace values and beliefs helps to achieve greater clarity about strategies used in a process and their effectiveness. There are often differences between espoused values and those seen in practice (Manley 2001). Clarifying values is therefore crucial, especially for effective group facilitation as change and innovation are directly and indirectly linked to assumptions and beliefs about self and other people and these influence working relationships and social norms (Manley 2003;

McCormark et al 2002; Wales et al 2013; Kirk and Broussine 2000). The facilitator enables self and practitioners to engage in critical dialogue and reflect on how values are lived in their workplace (Van Lieshout and Cardiff 2015).

Facilitator values that inspire effective processes mostly alluded to in literature include awareness of self (Berry 1993; Wales et al 2013; Kirk and Broussine 2000; Shaw et al 2008), empathy (Cross 1996; Kitson 1998) respect embodying person centredness (Cross 1996; Burrows 1997; Shaw et al 2008), authenticity (Kitson 1998; Harvey 2002; Raelin 2006; Shaw et al 2008) and humility (Kirk and Broussine 2005). Bergin (2015) found that neutrality improves the effectiveness of facilitation. Bergin suggests that neutrality about issues, decisions and outcomes enables the facilitator to guide individuals and groups towards increased engagement and ownership of outcomes.

The world view of the concept of facilitation is represented in the purpose of the role, the defining characteristics and the theoretical perspective that influences the means of achieving the purpose.

2.4. The Facilitation Process

The facilitation process involves enabling individuals and teams without taking the reign (Bergin 2015). Making facilitation a more transparent process also requires acknowledging differences in style and competences and understanding their consequences for the learning process (Groot and Maarleveld 2000). Van Lieshout and Cardiff (2015) maintain that knowing self is essential for person centred facilitation, required for sustaining reciprocity during the process. Berry (1993) suggests that effective learning and transfer of what is learned in the workplace is a result of an interactive blend of preparedness and style of the learner with facilitator skills and sensitivity to the context. Table 3 lists just some of the skills identified in literature as being necessary for expert facilitation.

Table 3 Some of the Skills Identified for Skilled Facilitation

Skills	References
Communication	Bidassie (2015); Stetler (2006); Lafferriere (2012); Kinley (2014); Rhydderch (2006); Tollyfield (2014); Kumagai (2008)
Relationship building	Bidassie (2015); Stelter (2006); Bylund et (2009); Hughes (2004)
Listening questioning clarifying and summarising in a way that promotes group/ individual involvement and commitment	Berry (1993), Titchen (2003); Rhydderch (2006); Tollyfield (2014)
Different strategies and underpinning theories	Bidassie (2015); Kinley (2014); Lafferriere (2012)
Monitoring performance	Bidassie (2015); Lafferriere (2012); Kumagai (2008)
Ability to acknowledge own limitations and be willing to share process with others	Ttichen (2003); Bidassie (2015); Kirk and Broussine (2000); Kumagai (2008)
Listening and attending to the process	Berry (1993); Raelin (2006); Bidassie (2015)
Clarifying goals, agenda, norms	Raelin (2006); Bylund et (2009)
Promoting airing of problems from diverse viewpoints	Raelin (2006)
Giving and soliciting critical feedback in a non-defensive	Raelin (2006); Bylund et (2009); Lafferriere

Skills	References
way	(2012)
Encouraging autonomy (group to take ownership of their learning	Bidassie (2015); Raelin (2006); Chen (2013); Kumagai (2008)
Looking at underlying assumptions operating in a context	Raelin (2006)
Reflexivity	Kirk and Broussine (2000); Crisp & Wilson (2011); Kumagai (2008)
Use different kinds of evidence	Titchen 2000; Ellis et al (2005);
Organisation and planning	Lafferriere (2012)
Knowledge of context	Lafferriere (2012); Berry (1993)
Handling group dynamics	Rhydderch (2006)

Facilitators embrace a range of skills required to function appropriately in different and demanding learning contexts. There is considerable evidence to suggest that the bedrock for a competent facilitator are the skills and attributes that enable the facilitator to build relationships and manage the process in different contexts and for individual's or teams' needs (Titchen 2003; Bidassie 2015; Stetler 2006; Wales 2013; Raelin 2006). Rhydderch et al's (2006) facilitation model highlights a matrix of skills necessary for good practice to promote organisational development. Although the overarching skills (structuring the session, obtaining consensus, handling group dynamics and enabling team learning) are important to the facilitation process, the model gives an impression that facilitation interventions are orderly and predictable- potentially stifling the flexibility and creativity necessary for the facilitator to manage complex processes.

Facilitation is a key construct in many initiatives but its complex nature and lack of consistency in definition make it difficult to articulate strategies or combinations of strategies effective under different settings (Lombarts 2005; Bidassie 2015; Stetler 2006). Various purposes and contexts may require different interventions of varying intensity- making it difficult to draw meaningful conclusions about effective strategies (Rycroft- Malone 2002; Harvey et al 2002). Groot & Maarleveld (2000) contend that the purpose of facilitation determines who should be learning as well as techniques used and that the process unfolds overtime to develop and strengthen individual or group learning abilities.

The process of facilitation focuses on interaction amongst the facilitator and participants, empowerment, autonomy, personal development and dialogue to share values and improve mutual understanding and agreement.

2.5. Enablers for Facilitation

Enablers are factors that encourage facilitation to be implemented successfully. Kitson (2009) posits that effective facilitation is enabled by skilled facilitators who collaboratively work with individuals, teams and the wider system in order to influence contextual factors and support individuals and/ or teams in managing change. While context and other variables are important for successful implementation of innovations, skilled facilitation is vitally essential in influencing the desired goal (Ellis et al 2005; Crisp & Wilson 2011; Dewing 2010; Kitson 2009). Skilled facilitators have the potential to work with individuals and teams to convey issues that arise from interactions of various variables and enable the development and implementation of strategies that accommodate these factors (Rycroft-

Malone et al 2004). Bylund et al (2009) suggest that some facilitation skills appear to be more easily acquired than others and that key skills should be prioritised in training of novice facilitators. Crisp and Wilson (2011) outline three stages of developing expertise in facilitation comprising: the preliminary, progressive and propositional. Crisp and Wilson posit that at the propositional stage, the facilitator develops knowledge, skills, theoretical complexity and an integrated sense of self defined by flexibility of thought and action. Bergin (2015) identified that the key to becoming a skilled facilitator is having access to mentorship, a role model and the opportunity to apply learned skills. The underlying notion of a skilled facilitator is the ability to work flexibly across roles and structural boundaries and to recognise the requirements of a given context and adjust their role and style appropriately, even at different stages of the intervention (Macneil 2001; Rycroft-Malone et al 2002; Harvey et al 2002; Hardy et al 2013).

Conversely role clarity and intended purpose are vital as are the skills, knowledge, and style of the facilitator. Clarifying the purpose and roles of the facilitator and the individual or group in the process helps to define boundaries and strengthen facilitation effectiveness (Kirk and Broussine 2000; Kitson 1998).

Berry (1993) argues that coproduction of interventions/ learning programmes mirror the conditions that practitioners face in their work setting in terms of task and process - promoting a shared responsibility for the process. Groot and Maarleveld (2000) endorse this view and add that the greatest effects in participatory interventions are realised when teams are engaged from the beginning.

An environment that supports facilitation presents prospects for effectual collaborative relationships for the facilitator and learners to identify and espouse ways of delivering person centred and evidence based care (Manley et al 2009). A supportive environment is characterised as one that is safe for learning, conveys psychological safety, promotes individual contributions, gives a sense of being valued, entails mutual respect and offers access to work based leaning (Cross 1996; Simmons 2004; Kitson 1998; Shaw et al 2008). Additionally, a supportive learning environment is welcoming, feels relaxed and is physically clean and comfortable (Tollyfied 2014).

Stetler et al (2006) and Munten (2012) emphasise organisational leadership support in relation to protected time and recognising the importance of facilitation being essential to the spread of implementation and progress. Effective partnerships between employers, individuals and facilitators of learning provide positive support, and flexibility contributing to higher order learning (Bergin 2015; Berta 2015). Based on integrated facilitation of different actors in a whole system, Groot and Maarleveld (2000) argue that critical peer assessment and active networking largely compliment leadership support.

Facilitators promote open learning climates in which ideas are challenged supportively but voluntary participation and involvement precede optimal change (Burrows 1997; Kitson 1998; shaw et al 2008). Premised on the resource gain development perspective, Wayne et al (2007) posit that individuals' participation is influenced by their innate drive to grow, develop, and achieve the highest levels of functioning for themselves and the systems in which they participate including organisations. Adaptive learners are advantageous to organisations where there is a lot of change, particularly in healthcare that requires a lot of adaptive learning potential (Berta 2015).

Evidence in the literature identifies skilled facilitators, co-production of interventions, role clarity, a safe learning environment, organisational leadership support and voluntary participation and involvement of individuals and teams being significant for enabling effective facilitation. The factors are universal and adaptable to facilitation of integrated purposes which is not explicitly addressed in the literature.

2.6. Evaluating the Outcome and Impact of Facilitation

Stakeholders evaluate facilitation outcomes in terms of what they expect to be able to do after undertaking the intervention. The rationale is that the success of the intervention is assessed by looking at the extent to which expectations have been met (Marvin et al 2010). Process and impact evaluations mutually aim to determine the effectiveness of facilitation. However, process evaluation focuses on the activities, strategies and external factors to determine whether the intervention was delivered as intended (Moore et al 2015). Facilitation is a catalyst that enables others to understand processes and work well together through reciprocity and mutuality (Tollyfield 2014, Titchen 2003) and thus it is important to consider outcomes at all levels when evaluating changes in systems in order to capture individual, team, service and organisational intended and unintended consequences (Hawe et al 2009).

2.6.1. Process outcomes

Bergin (2015) found that documenting evidence of facilitation outcomes is beneficial to practice and validation of facilitation processes. Process outcomes include immediate and intermediate consequences. Immediate consequences are directly attributable to the intervention's outputs for example an increase in awareness. Israel (2010) suggests that answering key questions about practitioners' acquisition of new skills, aspirations to do something as a result of the intervention and attitude toward a specific behaviour change reflect the immediate changes following facilitation. Where participation is voluntary Harty (2006) posits that immediate effects can also be reflected in the number of participants, the intensity of participation and participants' satisfaction with the facilitation. Intermediate outcomes on the other hand are expected to logically occur once one or more immediate outcomes have been achieved, for example a change in patterns of behaviour that is consistent with that promoted by the intervention and adoption of the changes (Bennett & Rockwell 2003).

2.6.2. Impact

Whereas process evaluation is useful for measuring immediate and intermediate changes, impact evaluation centres on long-term changes. Impact evaluation is an assessment of the contribution of the intervention to capture both intended and unintended consequences (Bennett & Rockwell2003).

2.6.2.1. Impact of facilitation at the individual level

Evidence suggests that effective facilitation can only be acclaimed if the skills and behaviours are applied in the workplace (Marvin et al 2010; Manley et al 2009). Gibbs (2011) argues that demonstrating effectiveness of facilitation ensures that proactive accountable behaviour forms part of what the practitioner is, and then logically that they impart the same empowering principles to service users towards improved health outcomes. Kumagai et al (2008) found that facilitating small group discussions in practice fostered reflective approaches to patients and acted as a source of fulfilment and renewal among facilitators.

Manley and Titchen (2012) suggest that the impact of facilitation can be demonstrated through active learners acquiring facilitation skills to inquire into own practice to develop own effectiveness and thereafter colleagues' in their teams. Seligman and Csikszentmihalyi (2000) refer to this outcome as flourishing individuals who draw on their strengths and dedicate time to something greater to create an upward spiral of enthusiasm for learning and contributing.

2.6.2.2. Impact of facilitation at the team level

Effective facilitation at the team level is demonstrated by evidence of collaboration; communication based on mutual respect; increased learner confidence; and shared innovative team responsibilities for service and practice improvement (Manley et al 2009). As a result of facilitation, individuals' new skills and perspectives, self-esteem and confidence are reflected within their interactions that illustrate team cohesion and perceived team effectiveness (Wayne et al 2007).

2.6.2.3. Impact of facilitation at organisational level

At the organisational level effective facilitation is illustrated by greater focus on person-centred processes, supportive environments, integrated working, achievement of best practice, changes in workplace culture and strategic influence from practice on the strategic agenda (Howarth et al 2006; Manley et al 2009).

2.6.3. Evaluating the effectiveness of integrated facilitation

Boomer and McCormack (2010) highlight the importance of establishing the worth of any programmes designed to change practice. Where effectiveness documents the achievement of the desired result, effective facilitation for integrated purposes is demonstrated by the extent to which the purpose is achieved irrespective of professional or organisational boundaries. Interventions that promote shared purposes and integrated working are very seldom evaluated and evidence for their effectiveness is limited (Legare et al (2012). Nonetheless Bird et al (2010) established that effective facilitation of integrated purposes reduces waste, empowers individual learners and improves patient outcomes. Bird et al evaluated a patient focused integrated care facilitation model and found that individuals were empowered to self-manage their conditions, there was a reduction in utilisation of acute health care facilities and improved clinical outcomes.

In summary, the literature has identified general insights about facilitation as a concept, but only scanty literature on integrated facilitation. The need for greater understanding of the concept of integrated facilitation is therefore supported to enable integrated ways of working in the workplace.

3. Methodology

This section of the report presents the methodological approach to the study and methods used to systematically gather expert knowledge to enable the development of standards for integrated facilitation in and about work.

3.1 The Electronic Delphi Technique

The electronic Delphi was selected for this study to allow a significantly large number of experts to participate, jointly but anonymously in giving empirical information on facilitation. The method conforms to Mitroff & Turoff's (1975) supposition, who maintain that precision is experiential, derived inductively, and based on sufficient widespread agreement by a group of experts.

The e-Delphi technique is an electronic survey method used to facilitate an efficient group dynamic process (Heiko 2012). The Delphi technique involves an iteration process that comprise a sequence of qualitative and/ or quantitative questionnaires interspersed with summarised information and controlled feedback of opinions derived from earlier responses with an aim to achieve the most reliable consensus of opinion (Dalkey and Helmer 1963). The iteration process combined with collaborative provision of written feedback reduces non-constructive and potentially frustrating discussions (Heiko 2012). Developing integrated facilitation standards required involvement of skilled facilitators of single or integrated purposes with heterogeneous backgrounds to discuss and justify content in a psychologically safe environment. The process also involved mutual learning and established a common knowledge base (Gordon 1994).

3.1.2. Identifying and selecting the Expert Panel

The expert panel was purposively selected using a Knowledge Resource Nomination Worksheet (KRNW) (Okoli & Pawlowski 2004). Three domains were devised for the KRNW which enabled plausible experts to be identified. Table 4 illustrates the framework used to populate the sampling frame.

Table 4 Knowledge Resource Nomination Worksheet for Populating the Sampling Frame

Relevant Domains	Category	Means of identifying experts
Identified facilitation purposes	Practitioners	Direct contact of experts known to the research team Snowballing (asked experts to nominate others)
Professional networks	Education institutions National Health Services (NHS) Social Care Institutions	Electronic search Direct contact Call for Expression of Interest Snowballing (asked experts to nominate others)
Publications and other disseminated materials	Academic journals Practice journals Blogs	Electronic search for literature and direct contact Snowballing

Experts were identified based on the distinguished purposes of facilitation. Contacts for some experts in facilitation practice were generated by the Project Lead who is an expert facilitator of integrated purposes. This strategy was supplemented by an internet search for names and contacts of members of professional networks and authors of disseminated literature on facilitation practice. The findings of the search were used to populate the Knowledge Resource Nomination Worksheet.

Identified experts were contacted electronically (by e-mail), received a brief about the study and were informed of the possible inclusion if they expressed interest to participate and matched the sample selection criteria. Experts identified were also asked to nominate others in their field for inclusion on the sampling frame. The aim was to get as many representatives from each of the facilitation purposes as possible. This stage yielded a sampling frame of 15 possible participants, which was considered too small to achieve the objectives of the study.

A call for Expression of Interest (EOI) to participate in the study to was then issued to professional Network Leads in Higher Education institutes and disseminated internationally to their respective Networks. The EOI called for experts in facilitation, leading/researching a programme of work linked to one or more of the facilitation purposes and those who have published on any of the areas of facilitation. This was the **criteria used to select the panel of experts in facilitation** to participate in the study. Responses to the call for EOI boosted the sampling frame to 42 experts in facilitation purposes in health and social care.

35 subjects fulfilled the selection criteria and they were all invited to participate in the e-Delphi study. The electronic invitations contained details about the study including the purpose, procedures and commitment required. 32 participants confirmed their availability and commitment to the e-Delphi study and these formed the expert panel for the e- Delphi survey to develop integrated facilitation standards. Table 5 shows the response rate for the three rounds of the e-Delphi study.

Table 5 The Response Rate for the Delphi Study

Rounds		Response rate
Round 1	32 experts fully completed questionnaire	100 %
Round 2	28 experts fully completed questionnaire	87.5%
Round 3	- 26 fully completed questionnaire - 2 experts half-filled in the questionnaire and these data were removed during analysis	81.2%

Overall, the study response rate was good in each of the three rounds. Two of the experts recruited did not fully complete the final round questionnaire and the incomplete data were eliminated during analysis. This reduced the number of participants who completed the third round to 26. Experts engaged in the study were from ten countries (figure 1) and constituted skilled facilitators of different purposes (figure 2). There was no eligible representation for quality improvement or skills development.

Figure 1 Country representation of the e-Delphi study

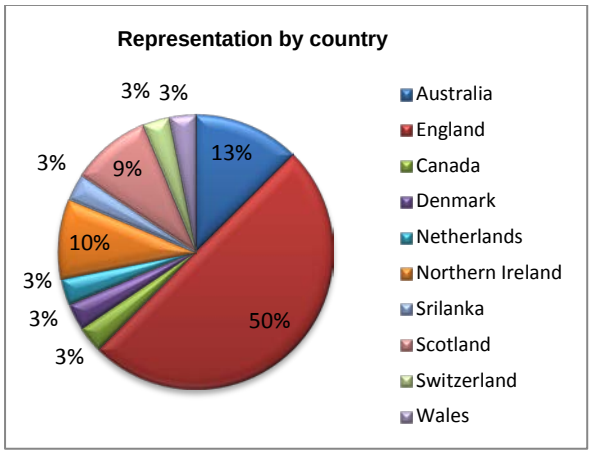
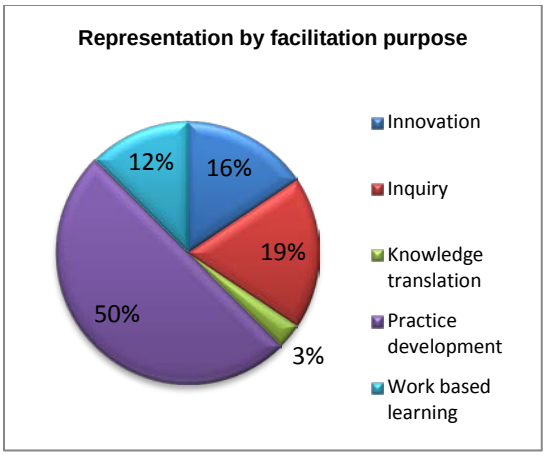


Figure 2 representation by facilitation Purpose



3.2. Questionnaire Design and Data Analysis

The first round questionnaire included broad open ended questions to enable the expert panel to provide as much detail as possible. The questionnaire was prepared based on gaps identified in literature about facilitation. The questions focused on facilitating individuals and/ or groups in relation to their work activity in and about the workplace either for a single purpose or multiple purposes. Work in this context embraced health and social care and other practical activities that take place in a workplace or about work. Questions were framed around four themes:

- Purpose
- Process
- Enablers
- Evaluating outcome and impact

Questionnaires for all rounds were piloted with colleagues in the Centre for Work Based Learning and Continuing Development at Canterbury Christ Church University in order to make sure that the questions were clear and that they collected information relevant to the study. The feedback received was used to refine the questionnaires before they were emailed to the e-Delphi panellists- referred to as participants from hereon. Individual emails were sent out for all exchanges between the research team and the participants to maintain anonymity.

3.2.1. Analysis of Responses from the First Questionnaire

All completed questionnaires were imported into NVivo version 10- a qualitative data analysis computer software package. Data were thematically analysed (Braun & Clarke 2006) to develop sub themes under the original themes around which questions were developed. The raw data were read again by the researchers to ascertain a shared understanding of the content, the sub themes that were developed and to make sure that all data were included. The collated and summarised data were used to formulate the second questionnaire.

3.2.2. Formulation of the Second Questionnaire

Collated and summarised data were presented in no particular order of frequency of responses. Participants were asked to rate the relevance of items about purpose and enablers, effectiveness relating to process and give their views on items relating to the outcome and impact of effective facilitation using Likert scales (table 6). The second questionnaire also included statements posed about the purpose of facilitation, intent of facilitating groups and individuals and the start point of the process. Participants were invited to agree or disagree and provide comments to support their responses.

Table 6 Likert Scales Used for the Study

Theme	Likert scale	Items on the scale 2nd questionnaire	Items on the scale- 3rd questionnaire
Purpose & Enablers	**4** point Likert scale to assess relevance	**1**- Essential **2**- Very important **3**- Unimportant **4**- Not at all important	**1**- Essential **2**- Very important **3**- Important **4**- Unimportant **5-** Not at all important **6**- I do not know (*for theoretical underpinnings only*)
Process	**4** point Likert scale to assess effectiveness	**1-** Essentially effective **2**- Very effective **3-** Ineffective **4-** Not at all effective	**1**- Essentially effective **2**- Very effective **3-** Effective **4-** Ineffective **5**- Not at all effective
Evaluation of outcome and impact	**5** point Likert scale to assess agreement	**1**-Strongly agree **2-**Agree **3-**Neutral **4**-Disagree **5-**Strongly disagree	**1**-Strongly agree **2**-Agree **3**-Neutral **4**-Disagree **5**-Strongly disagree

3.2.3. Analysis of the Responses from the Second Questionnaire and Formulation of the Third Questionnaire

Data from the second questionnaire were analysed statistically using the Statistical Package for Social Scientists (SPSS Version 21) to obtain percentage scores of ratings for the summarised items. Qualitative comments were used to modify items and to add new items relating to specified categories.

Based on the feedback from the second round the Likert scales for assessing significance and effectiveness of items were expanded to include a fifth point (Table 6). A sixth item ('I do not know'- implying '**not familiar with theory'**) was introduced on the scale for assessing the relevance of theories that influence integrated facilitation practice.

Percentage scores accumulating from the rating of items in the second questionnaire were provided and items were presented in order of their scores – from the highest to the lowest. Items modified and additions were presented in italics to enable participants to identify changes made in the third questionnaire. Some of the feedback that influenced the changes was included in the questionnaire. This was the final opportunity for participants to comment on modifications, change their responses and clarify their views or stick with their original decisions.

3.2.4. Analysis of the Third Round Responses

Data from the third round questionnaire were analysed statistically using SPSS 21 version software. The aim was to determine consensus, its strength and convergence of views using criteria predetermined before the data collection process. Descriptive statistical measures used included the central tendency (mean), dispersion (interquartile range, standard deviation) and level of agreement (essential/strongly agree and very important/effective/

agree). Agreement about items to be included in the key standards for integrated facilitation was determined in the final round following the iteration process that involved modifications and fine tuning of items to validate content.

3.3. Criteria Set for Determining Consensus

The criteria for determining consensus on items to be included in the standards for integrated facilitation were set prior to collecting data. Consensus was obtained if an item matched at least two of the predetermined criteria presented in table 7.

Table 7 Criteria for determining consensus

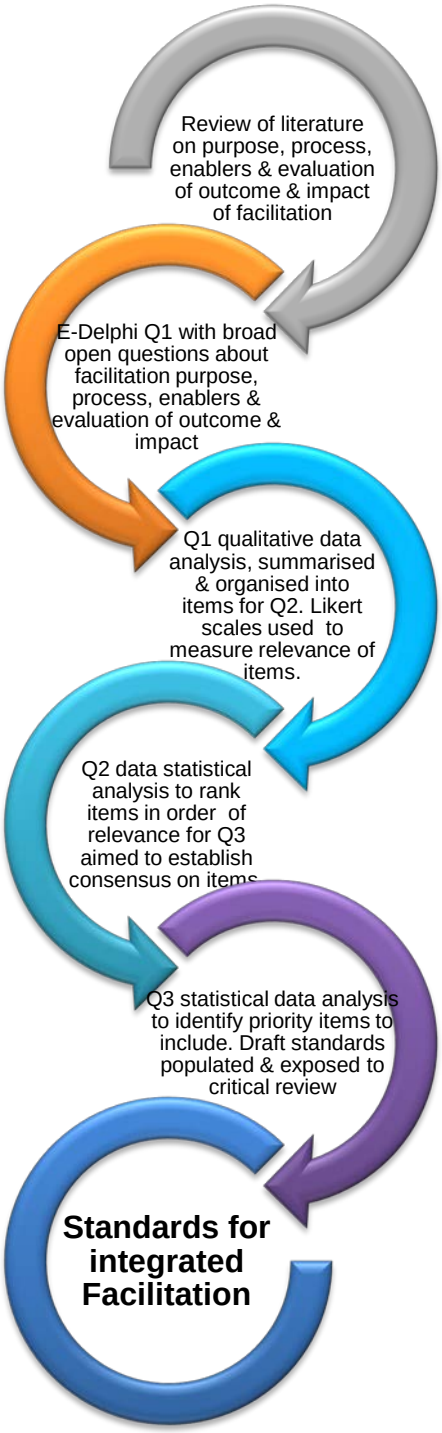
Criterion	Score	References
1. A composite score (CS) on the top 2 items on the scale	CS ≥ 75%	Diamond et al 2014
2. A standard deviation (SD)	SD ≤ 1	Heiko (2012)
3. A mean score	Mean < 3	
4. An interquartile range (IQR)	IQR ≤ 1	

The range was a useful measure for assessing items with either critical high or low (or both) thresholds that should not be crossed. The interquartile range describes the difference between the third quartile (Q3) and the first quartile (Q1), identifying the range of the middle half of the scores in the distribution.

The standard deviation was also useful in ordering items that achieved equal composite scores on the top two items of the scales used. An Item with a lower standard deviation ranked higher than the item with a similar score but with a higher standard deviation. Mean scores were scrutinised to identify the mass distribution of data, specifically for items that obtained an IQR = 1 but a mean ≥ 3.

Figure 3 presents an overview of the methods used to develop the standards for integrated facilitation.

Figure 3 Process of Developing the Standards for Integrated Facilitation



4. Results

This section presents the main results from the e-Delphi survey. The results are presented in the order of the four themes devised for the study- purpose, enablers, process and evaluation of impact and outcome. Items in tables are presented in order of the level of strength of consensus achieved on the top two items on the Likert scales used.

4.1. Theme 1: The Purpose of Integrated Facilitation

4.1.1. The intent of Integrated Facilitation

The intent of an integrated approach to facilitation is to focus on what matters to individuals and teams in the context of their work and the workplace with the endpoint being person centred cultures and improved health outcomes	Agree	Disagree
	80.08	19.2

Strong consensus (80.08%) was achieved on the intent for the integrated approach to facilitation. The final statement was embellished using qualitative comments from the third questionnaire to encompass the ultimate aim for facilitating integrated purposes.

4.1.2. The Intent When Facilitating INDIVIDUALS

Table 8 Individual Achievements that May Result from Effective Facilitation Practice

	Individual achievements	CS Essential & very important	SD	IQR	Mean
1	Psychological and structural empowerment (by systematically informing personal and professional judgement)	88	.821	1	1.44
2	Self-awareness and self-efficacy	61.5	.919	1	2.27
3	Enhanced autonomy/ independence/ self-determination	73.1	1.113	2	2.04
4	The start to a journey to maximise their potential	50.0	1.373	2	2.73
5	Wellbeing	48.0	1.344	2	2.84

Items 3-5 did not obtain the required score to determine inclusion in the standards for integrated facilitation. Qualitative comments highlighted an overlap of these items with 'psychological and structural empowerment', which achieved the strongest agreement (88%) on individual achievements resultant from effective facilitation. Self-awareness and self-efficacy matched the consensus criteria on SD ≤ 1, IQR ≤ 1 and mean score < 3.

4.1.3. The Intent When Facilitating TEAMS

The intent when facilitating teams is to achieve shared workplace and practice development goals through realising a sense of security, belonging and significance	Agree	Disagree
	80.8	19.2

80% of the participants agreed on the statement relating to the intent when facilitating teams. The final statement was fine-tuned based on the qualitative feedback from the final round to eliminate complex constructs that limited its applicability.

4.1.4. The End Purpose of Facilitation for the ORGANISATION and its Beneficiaries

Table 9 Common End Purposes of Facilitation Practice for the Organisation and its Beneficiaries

Common end purposes		CS Essential & very important	SD	IQR	Mean
1	Work based learning –in and from practice	92.0	.866	0	1.40
2	Practice development	91.7	.875	0	1.38
3	Improvement and development through growing leaders and facilitators of learning as well as positively impacting on workplace culture	88.0	1.118	1	1.60
4	Innovation- developing and implementing new ideas	58.3	1.213	1	2.42
5	Knowledge translation- implement new knowledge or theory in practice	64.0	1.241	2	2.04
6	Skills development – developing new skills, confidence and competence	60.0	1.389	2	2.74
7	Inquiry - explore meanings and develop understanding	60.0	1.414	3	2.40

Four items obtained consensus on the significance of common end purposes of facilitation for the organisation and its beneficiaries. Work based learning, practice development and improvement and development achieved the highest CS (92%, 91.7% and 88% respectively) on the top 2 items of the scale of relevance. Innovation obtained a score 58.3% <75% but achieved an IQR =1 indicating a fair distribution of responses on the positive side of the relevance scale.

4.1.5. The Purpose of Facilitating of Facilitating Individuals Teams and the Organisation

There is interdependence between the purpose of facilitating individuals, teams and the organisation and the ultimate purpose of improving care for people	Agree	Disagree
	96.3	3.7

The statement posed in round two of the survey achieved stronger agreement (96.3%) than the modified statement in the third questionnaire (85.5%). Qualitative comments in the third questionnaire pointed to the importance of emphasising facilitation practice rather than the organisation's responsibility. The original statement was therefore reinstated.

4.1.6. Theories Underpinning Integrated Facilitation Practice

In the first questionnaire participants were asked about theoretical perspectives that influence their facilitation practice. A number of theoretical underpinnings emerged and were listed under three categories based on the percentage scores of the ratings for the relevance of theories to facilitation.

4.1.6.1. Most Relevant for an Integrated Approach to Facilitation

Table 10 presents theories that matched the criteria pre-set to determine consensus on items under specified categories. These were considered to be the most relevant theories that would influence integrated facilitation.

Table 10 Theories Most Relevant for Integrated Facilitation

Most relevant for integrated facilitation		CS Essential & very important	SD	IQR	Mean
1	Experiential learning (e.g. Kolb, Lewin, Dewey, Schon, Boud and Miller)	80.80	1.158	1	1.69
2	Action learning (e.g. Revans)	76.9	.981	1	1.81
3	Action research (e.g. Lewin)	76.9	1.050	1	1.69
4	Work based learning (e.g. Kolb, Falnagan et al)	76.9	1.201	1	1.81
5	Reflective models of practice (e.g. Gibbs', Burton)	76.9	1.440	1	1.92
6	Principles of practice development (e.g. McCormack et al)	76.9	1.804	1	2.15
7	Effective workplace culture (e.g. Manley et al)	69.3	1.555	1	2.54
8	Organisational learning (e.g. Peter Senge)	65.4	1.158	1	2.31
9	Emotional intelligence (e.g. Goleman)	61.6	1.093	1	2.35
10	Group dynamics (e.g. Yalom, Lewin)	57.7	1.272	1	2.46
11	Situated learning (e.g. Lave and Wenger)	57.7	1.573	1	2.65
12	Appreciative inquiry (Srivastva & Cooperrider)	53.9	1.273	1	2.50
13	Participative leadership (e.g. Lewin, Likert)	53.8	1.600	1	2.81
14	Active learning (e.g. Dewey)	50	1.267	1	2.62
15	A six-category intervention analysis (Heron)	50	1.336	1	2.77

Experiential learning obtained the strongest agreement (80%) of participants followed by action learning (76.9%). Items 7-15 achieved composite scores (*CS*) <75% but matched the criteria for determining consensus. That is: IQR ≤ 1 and a mean score < 3, indicating that participants' responses were more inclined to the positive side of the relevance scale.

4.1.6.2. Specific to Single Purposes of Facilitation

The theories in table 11 are categorised as specific to single purposes of facilitation due to the relative importance reflected in the scores on the 6 item scale of relevance.

Table 11 Theories Specific to Single Purposes of Facilitation

Specific to single facilitation purposes		CS Essential & very important	SD	IQR	Mean
1	Humanism (e.g. Maslow, Rogers, Heron)	73.1	1.071	2	2.12
2	Leadership (e.g. McCormack & McCance; Cardiff)	65.4	1.490	2	2.31
3	Personal and professional development (e.g. Melton et al)	65.4	1.223	2	2.15
4	Adult learning theory (E.g. Knowles)	65.4	1.347	2	2.15
5	Transformative learning (e.g. Cranton & Taylor)	65.4	1.903	2	2.50
6	Evidence based practice (E.g. Eddy)	61.6	1.263	2	2.35
7	Critical reflexivity (e.g. Josephsen, Giddens, Bourdieu)	57.7	1.573	2	2.65
8	Person centeredness (e.g. Berwick, Rogers)	57.7	1.577	3	2.38
9	Critical social science theory (e.g. Fays)	57.7	1.832	3	2.65
10	Transformational leadership (E.g. Kouzes and Posner,	56.8	1.203	2	2.38

Specific to single facilitation purposes		CS Essential & very important	SD	IQR	Mean
	Bass)				
11	Learning styles (e.g. Kolb)	50.0	1.238	2	2.58
12	Communicative action (e.g. Habermas)	46.2	1.583	2	2.88
13	Theory of groups (Burnside)	46.1	1.483	2	2.96
14	Organisational development (Porras & Silvers)	42.3	1.143	2	2.88

The items in table 11 obtained a mean score <3 but a SD >1.00 and thus did not meet the criteria for obtaining consensus to be part of the key standards as significant theoretical perspectives that influence integrated facilitation in health and social care.

4.1.6.3. Might Inform Facilitation Purposes

Many of the theoretical underpinnings listed in table 12 below obtained significant percentage scores (23.1-69.2) % on the 'I do not know' option the scale, indicating that participants were largely not familiar with the theory. The 'I do not know' option was introduced in the third round of the questionnaire following missing data for non-rated items and comments alluding to being unfamiliar with theories. An inclusive approach to knowledge was adopted and the less commonly applied theoretical perspectives were categorised as 'might inform facilitation practices' but did not meet the criteria for consensus to be part of the facilitation standards.

Table 12 Theories that Might Inform Facilitation Purposes

Might inform facilitation purposes		CS Essential & very important	SD	IQR	Mean
1	Social constructivism (e.g. Vygotsky)	50	1.768	3	3.38
2	Knowledge translation and utilisation- PARIHS framework (e.g. Rycroft-Malone)	50	1.736	3	3.15
3	The skilled facilitator approach(e.g. Schwartz)	50	2.000	4	3.19
4	Support and challenge (e.g. Daloz, Sanford)	46.2	2.015	5	3.31
5	Quality improvement (Demming)	42.3	1.599	3	3.55
6	Critical companionship (e.g. Titchen)	41.8	1.677	4	3.58
7	Pedagogy of the oppressed (e.g. Freire)	38.5	1.499	3	3.38
8	Phenomenology (e.g. Scutz, Habermas)	38.4	1.327	3	3.19
9	Social cognitive theory (e.g. Bandura)	38.4	1.529	3	3.46
10	Humanity, Power and knowledge (e.g. Foucault)	36.0	1.9000	4	4.12
11	Grounded theory (e.g. Glaser & Strauss)	34.6	1.538	3	3.73
12	Hermeneutics (e.g. Walsh and Andersen, Schleiermacher, Dilthey)	34.6	1.599	3	3.35
13	Critical Creativity (Titchen & McCormack)	34.6	1.679	3	3.54
14	Power and empowerment (e.g. Bachrach & Botwinick	34.6	1.733	4	3.73
15	Emergent leadership (Northouse)	34.6	1.738	3	3.69
16	The social self (e.g. Mead)	30.8	1.606	3	3.54
17	Social identity (Tajfel & Turner)	30.8	1.657	4	3.88
18	Co-production (e.g. Trinh et al)	30.8	1.679	4	3.50
19	Postmodernism (Anderson)	26.9	1.608	3	3.77

Might inform facilitation purposes		CS Essential & very important	SD	IQR	Mean
20	Vocational knowledge (Young)	26.9	1.637	3	4.04
21	Improving quality together/100 lives (framework for core skills developed for NHS Wales staff)	26.9	1.898	4	3.81
22	Systems theory and methodology (e.g. Checkland, Ackoff, Senge, Goldratt)	23.1	1.532	3	3.88
23	Critical Realism (Archer)	23.1	1.701	3	3.42
24	Scholarly evidence (McWilliams et al)	23.0	1.674	3	3.81
25	Scholarship typologies (Boyer, Benner, Gray)	19.2	1.558	3	4.12
26	Metacognition (Flavell)	19.2	1.655	3	4.50
27	Theatre of the oppressed (e.g. Boal)	15.4	1.554	3	4.42
28	Theory of leadership (e.g. House)	15.4	1.569	3	4.31
29	Solution focused (e.g. McKergow)	15.4	1.661	3	4.04
30	Adaptive leadership(Heifetz, Grashow & Linsky)	15.4	1.698	3	4.19
31	Relational theories (e.g. Cunliffe & Eriksen ; Uhl-Bien)	15.4	1.794	3	4.54
32	Cultural anthropology (Mead)	15.3	1.505	2	4.12
33	Curriculum pedagogy and educational research (e.g. Stenhouse)	11.5	1.395	2	4.12
34	Positive psychology principles (e.g. Bion)	11.5	1.529	3	4.46
35	Complex Adaptive Systems (Holland)	11.5	1.549	2	4.00
36	Transdisciplinary (Hardon)	11.5	1.606	3	4.50
37	The circle of trust approach (e.g. Palmer)	7.7	1.341	2	4.96
38	Power and systems (e.g. Oshry)	7.7	1.440	2	4.92
39	Psychoanalysis (Freud)	7.7	1.485	2	4.27
40	Soft systems methodology (Checkland)	7.7	1.577	3	4.38
41	Balance & synchronicity (*Van Lieshout*)	7.7	1.650	3	4.81
42	Coaching with the Brain in Mind (Rock & Page)	7.6	1.483	2	4.96
43	Prochaska stages of change	7.6	1.505	3	4.77
44	Ethical literacy (Lunt, Friedman)	7.6	1.648	3	4.65

Items presented in table 12 did not match any of the consensus criteria established for the study. The majority of items obtained mean scores > 3 indicating that responses were more inclined to the negative side of the relevance scale.

4.1.7. Purpose and Theoretical Disposition Influencing the Facilitation Approach

The statement below relates to the purpose and theoretical disposition underpinning the facilitation approach.

	Agree	Disagree
The purpose and theoretical disposition underpinning the facilitation approach will have an impact on the processes used.	**96.2**	**3.8**

Modifications were made to the statement presented in the third questionnaire to accommodate participants' qualitative comments led to weaker strength (76.9%) of agreement than that obtained in the second questionnaire (96.2%). The original statement about the purpose and theoretical disposition influencing the facilitation approach was therefore maintained.

4.2. Theme 2: Enablers for Integrated Facilitation

This section presents factors that encourage effective facilitation. These comprise external and internal enablers, facilitator qualities and skills.

4.2.1 External Enablers and Internal Enablers

External enablers are factors that surround the facilitator but are considered essential for facilitation to happen while internal enablers are values held by the facilitator that guide actions and decisions in the moment and following facilitation practice.

4.2.1.1 External Enablers

Table 13 External Enablers

External enablers		CS Essential & very important	SD	IQR	MEAN
1	Obtaining time and active support from the wider organisation/ employer	92.3	.902	1	1.42
2	Developing a safe environment and learning culture	84.6	.761	1	1.46
3	Participants who choose to be actively present	69.2	1.183	2	1.96
4	An organisation culture that learns to understand and value facilitation	61.5	1.421	3	2.54
5	Political drivers	43.3	1.443	2	2.91
6	Strong evidence base	43.3	1.443	2	2.91

Obtaining time and active support from the wider organisation/ employer received strongest agreement (92.3%) on the CS of the top two items on the relevance scale followed by developing a safe environment and learning culture (84.6%). Items 3-6 did not meet the criteria pre-set for determining consensus.

4.2.1.2 Internal Enablers

Table 14 Internal Enablers

Internal enablers		CS Essential & very important	SD	IQR	Mean
Facilitator values that embrace and demonstrate:					
1	Person centeredness (for service users and staff), integrity, non-judgmental, openness, and mutual respect	88.3	.679	0	1.31
2	Participation, inclusion and collaboration with humility	84.7	.951	1	1.77
3	Reciprocal learning relationships; sharing information, vulnerability, celebrations and understanding	80.8	1.011	1	1.69
4	Adaptability/ flexibility and responsiveness to the individual's style of learning and motivation	76.9	1.243	3	1.88
5	Using work and the workplace as a resource for	73.1	1.509	2	2.04

Internal enablers		CS Essential & very important	SD	IQR	Mean
	active learning including the moment of practice				

The majority of external enablers achieved agreement on the significance of their existence preceding effective integrated facilitation. The term reliability was removed from item 4 based on feedback about the overlap with integrity in item 1. Consensus was not achieved on 'using work and the workplace as a resource for active learning'.

4.2.2 Qualities for an Integrated Approach to Facilitation

Table 15 Qualities for Integrated Facilitation

Qualities		CS Essential & very important	SD	IQR	Mean
1	Understanding the requirements of working at different levels - individuals teams and organisations	92.3	.629	1	1.35
2	Empathy, realism/pragmatism and continuing to be person centred	92.3	.761	1	1.54
3	Inspiring, enthusiastic, a sense of humour with attributes of a transformational leader[1]	92	.651	1	1.56
4	Working with uncertainty and being reflexive to the needs of the group /individual and context (including political)	88.5	.652	0	1.23
5	Credibility, practical knowledge and understanding of theory underpinning facilitation approach used	84.7	.710	1	1.77
6	Courage and resilience, integrity and the ability to develop a safe environment	84.6	.895	1	1.81
7	Critical thinking and reflexivity	84.6	.977	1	1.65
8	An eclectic broad knowledge base and skills such as identified in the theoretical influences	73.1	.938	2	2.00
9	Articulate and engaging	73	1.280	2	1.96
10	Accessible through different media (e.g. face to face, virtual and remote)	46	1.336	2	2.88

Table 15 indicates qualities required for effective integrated facilitation. Items 1-7 attained strong consensus demonstrated by the CS on the top two items on the relevance scale. Item 8 obtained a CS <75% and an IQR >1 but a SD< 1 and a mean score < 3, implying an insignificant divergence from the average rating of the item (2-very important). It was hence considered that consensus was achieved on 'an eclectic broad knowledge base and skills such as identified in the theoretical influences' being an essential quality for effective facilitation.

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

4.2.3. Skills for an Integrated Approach to Facilitation

Table 16 Skills for Integrated Facilitation

Skills		CS Essential & very important	SD	IQR	Mean
1	Being participative, inclusive and working across learning styles, boundaries and connecting with complexity	100	.272	0	1.08
2	Knowing self, emotional intelligence, being reflective, continuing to learn and grow	96.1	.533	1	1.27
3	Enabling experiential learning by helping others to explore, reflect and review	92.3	.761	1	1.46
4	Active listening, skilled questioning and observing	88.5	.697	1	1.38
5	Identifying and challenging assumptions	88.4	.703	1	1.58
6	Providing high support and high challenge, and	84.7	.827	1	1.73
7	Giving and receiving feedback	84.7	.827	1	1.73
8	Identifying political drivers, risks and consequences; influencing, negotiation and networking to make positive connections within the organisation	84.7	1.021	1	1.81
9	Celebrating and recognising achievement	77	.999	2	2.04
10	Reflective inquiry, problem solving and critique with others	77	1.230	2	2.08
11	Using ethical principles in facilitation practice	76	1.256	2	1.92
12	Skill in mentorship and critical companionship	57.7	1.137	2	2.42
13	Systematic and analytical approaches to implementation and evaluation using different sources of evidence and observation	60	1.186	2	2.64
14	Using creative approaches to enable creative thinking and thinking outside the box	50	1.185	2	2.73

100% of the participants agreed that 'being participative, inclusive and working across learning styles, boundaries and connecting with complexity' is an essential skill for integrated facilitation. Items 2-4 also obtained very strong consensus, scoring highly on the CS of the top 2 items of the scale of relevance. Items 10 & 11 achieved IQR >1 and SD > 1 but CS >75% and mean scores<3, matching the criteria for determining consensus on priority items to be included in the standards.

4.3. Theme 3: The Facilitation Process

This theme illustrates aspects involved in the facilitation process encompassing the start point of the facilitation journey, the process for creating a safe environment, common strategies used in facilitation, ways of monitoring the effectiveness of facilitation and the process outcomes.

4.3.1. The Beginning of a facilitation Journey

The following statement conveys the point where facilitators begin the facilitation journey. The statement was modified in the third questionnaire to incorporate the confidence of a skilled facilitator and individuals' and/ or teams' differing needs. 100% of the participants agreed on the starting point of the facilitation journey.

	Agree	Disagree
Facilitators are confident to begin the journey at different starting points depending on where individuals and teams are at	100	-

4.3.2. Starting Points of a Facilitation Journey

The first round questionnaire generated different start points of the facilitation journey. Participants were asked to rate the most relevant starting points that would improve outcomes for integrated facilitation. Table 17 below illustrates the different starting points of the journey of the facilitation process.

Table 17 Starting Points of a Facilitation Journey

Starting points		CS Essential & very important	SD	IQR	Mean
1	Exploring specific culture and contexts collaboratively and holistically taking into account stakeholders' perspectives and priorities	92.3	.629	1	1.35
2	What matters to the people who are being supported through facilitation by starting where they are at	92.3	.846	0	1.35
3	Developing a shared understanding and purpose or agreed focus through clarifying values and beliefs	80.7	1.132	1	1.81
4	Identifying the inquiry focus around implementing changes/ evidence/ innovations	76.9	1.017	1	1.92

All items relating to starting points of a facilitation journey attained consensus and thus qualified to be included in the standards for integrated facilitation.

4.3.2.1. Processes for Creating a Safe Environment

The first questionnaire initiated a high frequency on 'creating a safe environment' as a starting point of a facilitation journey and processes of doing this. Creating a safe environment was in turn presented separately to capture the most effective processes for achieving this.

Table 18 Processes for Creating a Safe Environment

Processes		CS Essentially effective & very effective	SD	IQR	Mean
1	Build relationship to provide reciprocity, high support & high challenge and recognising others'	96.1	.533	0	1.27

Processes		CS Essentially effective & very effective	SD	IQR	Mean
	expertise				
2	Agreeing ways of working, clear boundaries and responsibilities	92.3	.587	0	1.23
3	Continuous evaluation of ground rules	69.3	1.038	2	2.04

Items 1 and 2 achieved consensus as the most effective processes for creating a safe environment. Continuous evaluation of ground rules did not match the criteria for establishing consensus.

4.3.3. Common Strategies Used in Facilitation Practice

Table 19 Common strategies used in facilitation practice

Strategies		CS Essentially effective & very effective	SD	IQR	Mean
1	Establishing effective relationships for reciprocal and negotiated learning	96.3	.852	1	1.38
2	Enabling experimentation and informed and supported risk taking	96.1	.860	1	1.50
3	Using available time effectively	92.3	.629	1	1.35
4	Enabling participation, open communication and offering practical support and encouragement	84.6	.859	1	1.54
5	Creating a reflective space, enabling self-reflection, sense making and reflective reviews	80	1.003	1	1.56
6	Developing and sustaining effective ways of working	79.2	.897	1	1.75
7	Knowing when to stop and review working with principles of what works well	76.9	.936	1	1.65
8	Enhancing individual and group independence and autonomy	76.9	1.041	0	2.27
9	Giving and receiving high challenge and high support	76.9	.845	2	1.92
10	Supporting practice, observation and self-assessment	76	1.190	1	2.20
11	Recognising and praising effort using real time feedback to develop learning in a deliberate way	73.1	.796	2	1.92
12	Analysing 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
13	Attending to the process and the goal rather than being outcome orientated i.e. learning to learn	65.4	.948	1	2.46
14	Strengthening capabilities and skill set to match goals, practice frameworks, policy and vision	65.4	1.030	1	2.50

Strategies		CS Essentially effective & very effective	SD	IQR	Mean
15	Critiquing practical and theoretical knowledge and drawing on a variety of sources of evidence, experiences and perspectives	53.9	.945	1	2.58
16	Using creative methods	48	1.036	1	2.64
17	Motivating by focusing on small steps and small wins then ever advancing cycles of development and evolution	73.1	1.038	2	2.04
18	Using humour and storytelling	69.3	1.116	2	2.27
19	Using qualitative 360 degree feedback to achieve individual and team role clarity	23	1.164	1	3.35

The majority of items (1-16) participants identified as common strategies used in facilitation practice to keep learners and facilitators motivated and engaged to achieve a shared purpose obtained consensus. Establishing effective relationships for reciprocal and negotiated learning; enabling experimentation and informed and supported risk taking; and using available time effectively ranked highest with very high (>90%) composite scores on the top 2 items of the scale for effectiveness. Item 16 obtained a significantly low score 48% < 75% but achieved an IQR ≤ 1 and mean score <3, matching the criteria for establishing consensus on priority items to be included in the integrated standards for facilitation. Items 17 – 19 did not fit the pre-set criteria.

4.3.4. Common Ways of Monitoring and Maintaining Effectiveness of Facilitation

Table 20 lists common ways of monitoring and maintaining effectiveness of the facilitation role depending on the situation/ context or purpose.

Table 20 Common Ways of Monitoring and Maintaining Effectiveness of Facilitation

Ways of monitoring and maintaining effectiveness of facilitation		% CS Essentially effective & very effective	SD	IQR	Mean
1	Critical reflection in the moment of and following facilitation practice	96.1	.578	1	1.42
2	Obtaining formal (e.g. using claims concerns and issues), or informal individual/ group and/ or stakeholder feedback	92.4	.884	1	1.69
3	Reviewing the safety of the learning environment/ culture	76.9	.993	1	1.88
4	Reviewing field notes and preparatory work	64	1.118	1	2.40
5	Reviewing group's perceptions/self-assessment of group functioning (i.e. hierarchy, co-operation or autonomy)	60	1.159	1	2.52
6	Reviewing the level of support and challenge experienced	57.7	1.067	1	2.54

Ways of monitoring and maintaining effectiveness of facilitation		% CS Essentially effective & very effective	SD	IQR	Mean
7	External peer review, critical dialogue (reflection & critique) supervision and observation– against the pre stated outcomes/ purpose	73.1	1.055	2	1.92
8	Reviewing whether own values were upheld	69.3	1.177	2	2.12
9	Requests from others to provide facilitation through reputation	30.7	1.327	2	3

Items 1-3 matched all four measures pre-set for determining consensus on items presented in the study. 'Critical reflection in the moment of and following facilitation practice' coupled with 'obtaining formal or informal stakeholder feedback' achieved the strongest agreement on the CS of the top two items of the effectiveness scale. Items 4-6 achieved CS $<$ 75% but matched the IQR $\leq$ 1, and mean $<$ 3. There was no agreement on the effectiveness of items 7-9 to be part of the standards for integrated facilitation.

4.3.5. Process Outcomes

Table 21 illustrates process outcomes that individuals or teams MAY experience as a result of effective facilitation depending on the facilitation purpose and emphasis.

Table 21 Process Outcomes that Individuals or Teams MAY Experience

Process outcomes		% CS Strongly agree and Agree	SD	IQR	Mean
1	Increased reflexivity, self-awareness & self-efficacy	96.1	.827	0	1.27
2	Effective ways of working demonstrated by engagement, autonomous learners, self-directing leaders and goal achievement	92.3	.990	1	1.5
3	Role clarity and skills that enable others to be effective (growing capacity)	88.5	.797	1	1.65
4	Evidence of personal and professional development (including formal/accredited learning)	88.5	1.018	1	1.65
5	Evidence of improved team effectiveness	80	.957	1	1.8

Participants strongly agreed on all process outcomes that individuals and/ or team may experience as result of effective facilitation. The strength of agreement is reflected in the matching scores on all measures pre-set for determining consensus.

4.4. Theme 4: Evaluation of Outcome[2] and Impact[3]

This section presents findings about the evaluation of evidence of integrated facilitation. This covers indicators of outcome, strategies for identifying the impact of facilitation and indicators of impact of facilitation.

4.4.1 Indicators of Outcome

Table 22 lists indicators of immediate changes in the people facilitated their contexts and systems and resultant aligned to the pre-set consensus criteria.

Table 22 Indicators of Outcome

Indicators of outcome		% CS Strongly agree and Agree	SD	IQR	Mean
1	Motivated, engaged self-directing individuals who know how to learn evidenced by increased effectiveness, action initiated leadership and development	100	.332	0	1.12
2	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
3	Achievement of agreed goals and facilitation purpose	92.3	.648	1	1.50
4	Flourishing individuals & sense of wellbeing	73.1	.999	2	2.04
5	Individuals become more aware of organisational direction and goals	69.2	.898	1	2.38
6	Publications and other disseminated outputs	23.1	1.055	1	3.08
7	Better use of evidence in the context of work and the workplace	69.2	1.306	2	2.23

The overwhelming majority (100%) of participants agreed on item 1 being the highest priority indicator of outcome for facilitation practice in health and social care. Items 2 and 3 also achieved strong composite scores on the top two items of the opinion scale. Item 5 matched the consensus criteria on SD and mean scores. The mean score for item 6 (≥ 3) indicates an inclination of responses to the negative side of the opinion scale and thus did not match the pre-set criteria for establishing consensus.

4.4.2 Strategies for Identifying the Impact of Facilitation

Participants were asked their opinion on strategies distinguished for identifying the impact of facilitation. Table 23 lists items presented in the third questionnaire and their scores on the measures for determining consensus.

[2] immediate changes in the people facilitated, their contexts and systems
[3] deeper, longer term changes in the people facilitated, their contexts and systems

Table 23 Strategies for Identifying the Impact of Facilitation

Strategies		% CS Strongly agree and Agree	SD	IQR	Mean
1	Reviewing agreed goals and records about interventions and process outcomes at different levels	92.3	.648	1	1.50
2	Reviewing learning processes/ strategies used and new insights	88.4	.811	1	1.54
3	Stakeholder feedback (e.g. using different approaches to stakeholder evaluation)	76.9	.720	2	1.96
4	Using broad frameworks (e.g. PARIHS and the senses framework) to identify what has changed and what helped the change in the short, medium and long term	68	1.137	2	2.28

Reviewing agreed goals and records about interventions and process outcomes at different levels achieved the strongest consensus (92%) followed by 'reviewing learning processes/ strategies used and new insights (88.4%). Item 3 was slightly modified to address the qualitative feedback about the perceived bias on the approach suggested to obtain stakeholder feedback. Item 4 did not match the pre-set criteria for establishing consensus on priority items to include in the integrated facilitation standards.

4.4.3. Indicators of the Impact of Facilitation

Table 24 illustrates results on the measures for determining consensus on the deeper longer term changes that people facilitated, their contexts and systems may experience as a result of effective facilitation.

Table 24 Indicators of the Impact of Facilitation

Indicators		% CS Strongly agree and Agree	SD	IQR	Mean
1	Motivated, engaged self-directing teams	100	.402	0	1.19
2	Flourishing curious individuals	90.2	1.113	1	1.96
3	Effective workplace cultures and learning cultures e.g. staff retention	88.5	1.123	1	1.69
4	Professional competence and team skill set development	76	1.201	2	1.88
5	Achievement of systems/ organisational change	61.5	1.029	1	2.54
6	Achievement of service and organisational KPIs e.g. improved patient outcomes and experience, saving money and time	50	.906	1	2.50
7	Ongoing employment and career progression for individuals	38.5	1.183	2	2.96
8	Academic accreditation of learning	23	1.093	2	3.35

Motivated, engaged self-directing teams attained the strongest agreement on indicators of impact of facilitation, with a CS of 100% on the top two items on the opinion scale. Items 7 and 8 did not match the pre-set criteria for determining consensus.

4.5. Standards for Integrated Facilitation

The e-Delphi technique successfully involved a panel of professional, devoted and committed experts in facilitation. All items that matched the predetermined measures for establishing consensus were considered being priority items for inclusion in the integrated facilitation standards (table 25). All data received were carefully analysed and presented to the panel for assessment. The ranking and prioritising process was deliberately geared towards obtaining consensus on the most relevant items relating to the different themes. 48.5% (97) of items assessed (200) achieved consensus. This implies that items that did not meet the criteria for determining consensus may be of critical significance for specific purposes and/ or contexts.

Table 25 Standards for Integrated Facilitation

STANDARD	Performance Indicators
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	**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

STANDARD	Performance Indicators
	• 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
2. Optimise the external enablers and values necessary for successful facilitation practice	External enablers 2 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
3. Draws on the qualities necessary to build effective relationships for facilitation practice	3.1 Understand the requirements of working at different levels - individuals 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[4] 3.4 Work with uncertainty being reflexive to the needs of the group /individual and context (including political)

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

STANDARD	Performance Indicators
	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
4. Demonstrate the skills required for integrated facilitation practice in health and social care	4.2 Be participative, inclusive and work across different learning styles, boundaries, connecting with complexity 4.3 Know self, emotional intelligence, being reflective, continuing to learn and grow 4.4 Demonstrate active listening, skilled questioning and observing 4.5 Enable experiential learning by helping others to explore, reflect and review 4.6 Provide high support and high challenge, give and receive feedback 4.7 Use reflective inquiry, problem solving and critique with others 4.8 Use ethical principles in facilitation practice 4.9 Identify political drivers, risks and consequences, influencing, negotiating and networking to make positive connections within the organisation 4.10 Celebrate and recognise achievement
5. Commence the facilitation journey with confidence at different starting points depending on where individuals and teams are at	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
6. Use common strategies appropriately for effective facilitation practice	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 6.6 knowing when to stop and review working with principles of what works well 6.7 Enhance individual and group independence and

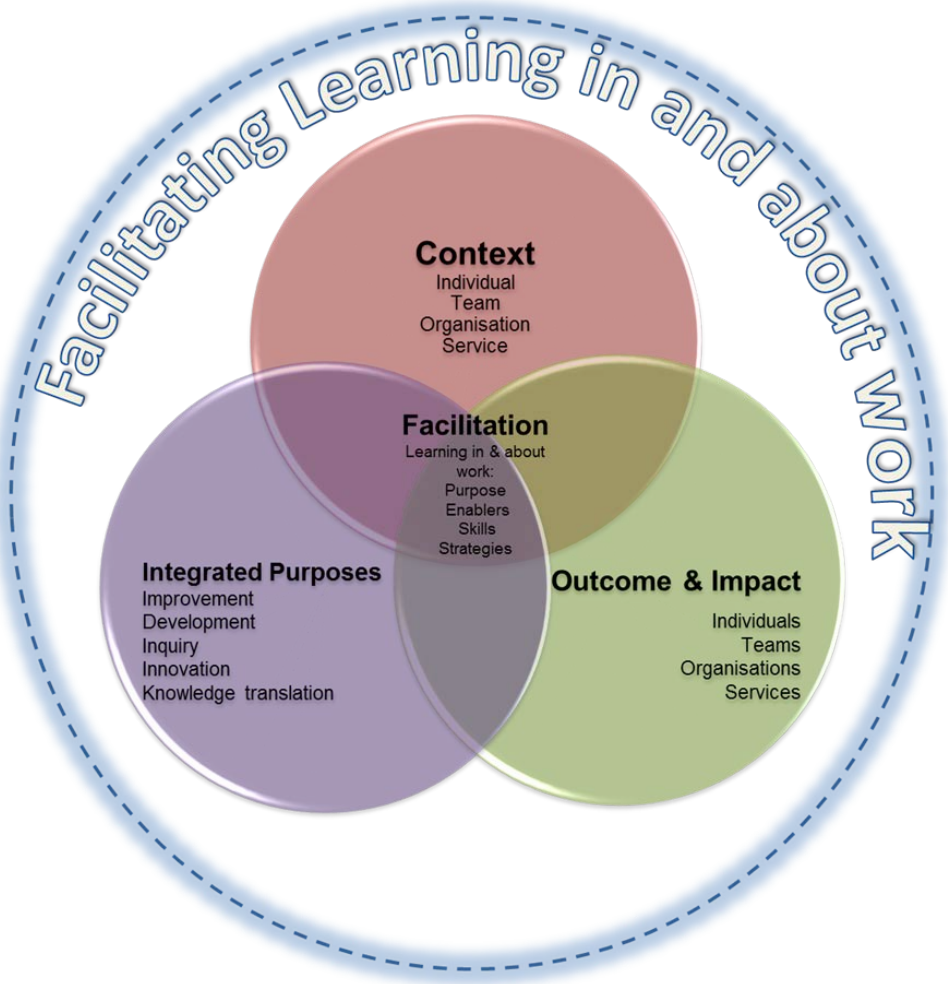
STANDARD	Performance Indicators
	autonomy 6.8 Give and receive high challenge and high support 6.9 Support practice, observation and self-assessment 6.10 Recognise and praise effort using real time feedback to develop learning in a deliberate way 6.11 Analyse and report on the processes of inquiry, allowing specific detail of the change to emerge over time and in response to the local environment 6.12 Attend to the process and the goal rather than being outcome orientated i.e. learning to learn 6.13 Strengthen capabilities and skill set to match goals, practice frameworks, policy and vision 6.14 Critique practical and theoretical knowledge drawing on a variety of sources of evidence, experiences and perspectives 6.15 Use creative methods 6.16 Use different theoretical dispositions to impact on facilitation processes used (See knowledge and understanding) 6.17 Use available time effectively
7. Monitor and maintain effective facilitation practice using a range of methods	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
8. Evaluate and evidence process outcomes, intermediate outcomes and impact that individuals or teams may experience using a range of approaches	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

STANDARD	Performance Indicators
	• 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

4.5.1. An Emerging Framework: Components of an Integrated Facilitation Approach in and about work

Figure 4 illustrates the three key components that facilitators need to attend to when supporting individuals, teams, organisations and services to achieve higher order learning in and about the workplace to positively impact on person centred cultures and ultimately health outcomes. Working within different contexts and helping staff appreciate the broader contexts in which they work is a key part of the facilitator's role. These contexts impact on both facilitator and staff purposes within and across each context. The second component includes the purposes that an integrated approach to facilitation would aim to support, namely: improvement, development, inquiry, innovation and knowledge translation. The enablers, skills and strategies to achieve these purposes in an integrated way are identified through the standards that have been developed. Finally, the third component that the facilitator needs to attend to includes the evaluation of outcome and impact in the given context whilst keeping focused on constantly refining the processes that are effective.

Figure 4 An Emerging Framework: Components of an Integrated Facilitation Approach in and about work



Limitations

Although the internet is highly accessible in this era, it is possible that the electronic platform used for the study excluded qualifying participants with limited or no access to information technology. This shortcoming is offset by the set criteria for selecting experts that called for researchers and/ or programme leaders and experts who have published widely on the concept under study.

The study involved representation form the majority of facilitation purposes for but for skills development and quality improvement. This shortfall may limit the generalisability to integrated purposes which include skills development and quality improvement.

5. Conclusions

The UK population healthcare needs are constantly changing and systems and processes are devised to cope with the changes within constrained resources. Whole systems integrated urgent and emergency care requires to be matched with whole systems learning for development and improvement not only to reap the benefits that accrue to integrated

models (Ham and Curry 2011), but also develop a workforce that can flexibly keep pace with the rapidly changing practice needs and contexts. The standards for integrated facilitation would enable the workforce to grow and facilitators to support the achievement of this vision.

6. Recommendations

6.1. Recommendations for Commissioners of Learning, Development and Improvement

- Commissioning of learning and development needs to embrace facilitation preparation, quality and opportunities for an integrated approach in order to add value to the service and use resources effectively.

6.2. Recommendations for Higher Education Institutes

- Postgraduate modules in facilitation aimed at practice based programmes and competences and workplace facilitator preparation need to take an integrated approach, draw on the standards and theoretical influences should inform curriculum content.
- Higher Education Institutes should support facilitators and supervisors in practice to develop the full range of skills required to deliver on an integrated approach rather than just skills development. For example Physician Associates and Advanced Practice programmes for all programmes.
- Higher Education Institutes are encouraged to adopt the standards to guide the structure and content of portfolios of evidence of new and developing facilitators
- Programmes for developing clinical systems leaders should integrate the standards as this is a component of the expertise expected from these roles.
- Development of future professional programmes of learning leading to registration need to have an element of facilitation theory and practice embedded so mentors at the point of registration are capable of facilitating learning in the workplace.
- The facilitation standards provide a framework for self-assessment suitable for continuing professional development and postgraduate professional programmes as a means of assessment that can be built into teaching, learning and assessment strategies within curricula. This adds value to the portfolio of professional education because it will enable HEIs to demonstrate impact in and on the workplace.
- The facilitation standards as a self-assessment tool provide a valuable framework for professional revalidation portfolios.

6.3. Recommendations for Healthcare Providers

- The integrated facilitation standards provide the opportunity for healthcare providers to attend to address key organisational functions in a joined up way by attending to the quality of their practice supervisors and facilitators to enable them to develop a broad range of skills required to integrate the learning for improvement and development.

- The standards provide a framework for accrediting facilitators and building a sophisticated network of support for organisations that focus on growing all staff.
- Healthcare providers need to consider how departments/ functions such as quality improvement, practice development, inquiry etc. can work in a more integrated way to enable higher order learning for faster safer and better services as there is much more common in these functions than is difference. This would enhance the use of scarce resources and avoid duplication of effort.

6.4. Recommendations for the Economy:

- Development of the facilitation capacity of whole systems leaders is vital to managing the pace and complexity of change and challenges us to think about what integration truly means laterally.

7. Next steps

Phase 3 of this work aims to identify gaps and risks across the current system against the integrated career and competence framework developed. The integrated facilitation standards would be pivotal to growing the quality of facilitators to support the workplace and across professional boundaries. The integrated facilitation standards would be developed into an interactive learning resource to strengthen facilitation capacity in the region.

8. References

Baskerville, N. B., Liddy, C., & Hogg, W. (2012). Systematic review and meta-analysis of practice facilitation within primary care settings. Annals of family medicine, 10(1), 63.

Bennett, C., & Rockwell, K. (2003). A hierarchy for targeting outcomes and evaluating their achievement. University of Nebraska, Lincoln.

Bergin, P. (2015) Increasing awareness about self and facilitation practice in preparation for transitioning to a new role – the critical reflective process of becoming a certified professional facilitator. International Practice Development Journal 5 (2) [8]

Berry, M. (1993). Changing perspectives on facilitation skills development. Journal of European Industrial Training, 17(3) 23-32.

Berta, W., Cranley, L., Dearing, J. W., Dogherty, E. J., Squires, J. E., & Estabrooks, C. A. (2015). Why (we think) facilitation works: insights from organizational learning theory. Implementation Science, 10(1), 141.

Bidassie, B., Williams, L. S., Woodward-Hagg, H., Matthias, M. S., & Damush, T. M. (2015). Key components of external facilitation in an acute stroke quality improvement collaborative in the Veterans Health Administration. Implementation science : IS, 10, 69

Bird, S., Noronha, M., & Sinnott, H. (2010). An integrated care facilitation model improves quality of life and reduces use of hospital resources by patients with chronic obstructive pulmonary disease and chronic heart failure. Australian journal of primary health, 16(4), 326-333.

Bylund, C. L., Brown, R. F., Lubrano di Ciccone, B., Diamond, C., Eddington, J., & Kissane, D. W. (2009). Assessing facilitator competence in a comprehensive communication skills training programme. Medical education, 43(4), 342-349.

Boomer, C. A., & McCormack, B. (2010). Creating the conditions for growth: a collaborative practice development programme for clinical nurse leaders. Journal of Nursing Management, 18(6), 633-644.

Bousso, R. S., Poles, K., & Cruz, D. D. A. L. M. (2014). Nursing concepts and theories. Revista da Escola de Enfermagem da USP, 48(1), 141-145.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative research in psychology, 3(2), 77-101.

Burrows, D. E. (1997). Facilitation: a concept analysis. Journal of Advanced Nursing, 25(2), 396-404.

Cohen, J. (2013). The nature of learning being facilitated by frontline managers. Human Resource Development International, 16(5), 502-518.

Crisp, J., & Wilson, V. (2011). How do facilitators of practice development gain the expertise required to support vital transformation of practice and workplace cultures? Nurse Education in Practice, 11(3), 173-178.

Cross, K. D. (1996). An analysis of the concept facilitation. Nurse Education Today, 16(5), 350-355.

Delbecq, A. L., Van de Ven, A. H., & Gustafson, D. H. (1975). Group techniques for program planning: A guide to nominal group and Delphi processes. Glenview, IL: Scott, Foresman, 83-107.

Department of Health (2003) Discharge from hospital: pathway, process and practice. Health & Social Care Joint Unit. London

Department of Health Social Services and Public Safety (2012). A strategic framework for enhancing practice development knowledge, skills and expertise in Northern Ireland. University of Ulster, Health and Social Care, Royal Collage of Nursing Northern Ireland.

Diamond, I. R., Grant, R. C., Feldman, B. M., Pencharz, P. B., Ling, S. C., Moore, A. M., & Wales, P. W. (2014). Defining consensus: a systematic review recommends methodologic criteria for reporting of Delphi studies. Journal of clinical epidemiology, 67(4), 401-409.

Dogherty, E. J., Harrison, M. B., & Graham, I. D. (2010). Facilitation as a Role and Process in Achieving Evidence-Based Practice in Nursing: A Focused Review of Concept and Meaning. Worldviews on Evidence-Based Nursing, 7(2), 76-89.

Edgren, L., & Barnard, K. (2012). Complex adaptive systems for management of integrated care. Leadership in Health Services, 25(1), 39-51.

England, N. H. S. (2014). Five Year Forward View. London: HM Government.

Fay, B. (1987). Critical social science: Liberation and its limits. Ithaca: Cornell University Press, 242

Fullard, E. M. (1994). Facilitating professional change in primary care. Annals of Community-Oriented Education, 7, 73-78.

Gibbs, V. (2011). An investigation into the challenges facing the future provision of continuing professional development for allied health professionals in a changing healthcare environment. Radiography, 17(2), 152-157.

Groot, A., & Maarleveld, M. (2000). Demystifying facilitation in participatory development. IIED.

Gordon, T. J. (1994). The Delphi Method. AC/UNU Millennium Project. Futures research methodology, 1-9.

Hardy, S., Jackson, C., Webster, J., & Manley, K. (2013). Educating advanced level practice within complex health care workplace environments through transformational practice development (Vol. 33, pp. 1099-1103).

Harvey, G., Loftus-Hills, A., Rycroft-Malone, J., Titchen, A., Kitson, A., McCormack, B., & Seers, K. (2002). Getting evidence into practice: the role and function of facilitation. Journal of advanced nursing, 37(6), 577-588.

Hatry, H. P. (2006). Performance measurement: Getting results. The Urban Insitute.

Hawe, P., Shiell, A. and Riley, T. (2009) Theorising Interventions as Events in Systems, American Journal of Community Psychology, 43, 3, 267-276.

Heiko, A. (2012). Consensus measurement in Delphi studies: review and implications for future quality assurance. Technological Forecasting and Social Change, 79(8), 1525-1536.

Hughes, C. (2004). The supervisor's influence on workplace learning. Studies in Continuing Education, 26(2), 275-287.

Ham, C., & Curry, N. (2011). Integrated care. What is it? Does it work? What does it mean for the NHS. London: Kings Fund.

Humphries, R., & Curry, N. (2011). Integrating health and social care. London: Kings Fund.

Israel, G. D. (2010). Logic Model Basics. University of Florida.

Howarth, M. L., Holland, K., Lunt, H., & Cosgrove, P. (2006). Shaping the future for primary care education and training project. Best practise in education and training strategies for integrated health and social care: development of a benchmarking tool.

Kinley, J., Stone, L., Dewey, M., Levy, J., Stewart, R., McCrone, P., et al. (2014). The effect of using high facilitation when implementing the Gold Standards Framework in Care Homes programme: A cluster randomised controlled trial. Palliative Medicine, 28(9), 1099-1109.

Kirk, P., & Broussine, M. (2000). The politics of facilitation. Journal of Workplace Learning, 12(1), 13-22.

Kitson, A., Harvey, G., & McCormack, B. (1998). Enabling the implementation of evidence based practice: a conceptual framework. Quality in Health care, 7(3), 149-158.

Kitson, A. L. (2009). The need for systems change: reflections on knowledge translation and organizational change. Journal of Advanced Nursing, 65(1), 217-228.

Kitson, A. L., Rycroft-Malone, J., Harvey, G., McCormack, B., Seers, K., & Titchen, A. (2008). Evaluating the successful implementation of evidence into practice using the PARiHS framework: theoretical and practical challenges. Implementation science: IS, 3, 1-1.

Kumagai, A. K., White, C. B., Ross, P. T., Perlman, R. L., & Fantone, J. C. (2008). The impact of facilitation of small-group discussions of psychosocial topics in medicine on faculty growth and development. Academic Medicine, 83(10), 976-981.

Laferriere, D., Liddy, C., Nash, K., & Hogg, W. (2012). Navigating change: how outreach facilitators can help clinicians improve patient outcomes. Journal of the American Board of Family Medicine : JABFM, 25(2), 232.

Légaré, F., Politi, M. C., Drolet, R., Desroches, S., Stacey, D., & Bekker, H. (2012). Training health professionals in shared decision-making: an international environmental scan. Patient education and counseling, 88(2), 159-169.

Lieshout, F. V. (2013). Taking Action for action: a study of the interplay between contextual and facilitator characteristics in developing an effective workplace culture in a Dutch hospital setting, through action research (Doctoral dissertation, University of Ulster).

Lombarts, M. J. M. H., Klazinga, N. S., & Redekop, K. (2005). Measuring the perceived impact of facilitation on implementing recommendations from external assessment: lessons from the Dutch visitatie programme for medical specialists. Journal of evaluation in clinical practice, 11(6), 587-597.

Macneil, C. (2001). The Supervisor as a Facilitator of Informal Learning in Work Teams. Journal of Workplace Learning, 13(6), 246-253.

Manley, K. (2001). Consultant nurse: concept, processes, outcomes (Doctoral dissertation, The University of Manchester).

Manley, K., Jackson, C., Martin, A. Apps, J., Setchfield, I. & Oliver, G. (2014) Transforming Urgent and Emergency care Together. Final report, Health Education Kent, Surrey, Sussex

Manley, K., & McCormack, B. (2003). Practice development: purpose, methodology, facilitation and evaluation. Nursing in Critical Care, 8(1), 22-29.

Manley, K. M. N., McCormack, B., & Wilson, V. (2008). International practice development in nursing and healthcare. Chichester Oxford: Chichester: Blackwell.

Manley, K., Solman, A., & Jackson, C. (2013). Working towards a Culture of Effectiveness in the Workplace. Practice Development in Nursing and Healthcare, Ed: McCormack B., Manley K., Titchen A. Second edition, Oxford: Wiley-Blackwell, 146-168.

Manley, K., Titchen, A., & Hardy, S. (2009). Work-based learning in the context of contemporary health care education and practice: A concept analysis. Practice Development in Health Care, 8(2), 87-127.

Manley, K., Watts, C., Cunningham, G., & Davies, J. (2011). Principles of Nursing Practice: development and implementation. Nursing Standard, 25(27), 35.

Manley, K., & Webster, J. (2006). Can we keep quality care alive?. Nursing Standard, 21(3), 12.

Marvin, S., Lee, L. & Robson, F. (2010). The evaluation of learning and development in the workplace: a review of literature. Higher Education Funding Council for England

McCormack, B. (2002). The person of the voice: narrative identities in informed consent. Nursing Philosophy, 3(2), 114-119.

McCormack, B., Manley, K., & Walsh, K. (2008). Person-Centred Systems and Processes. International practice development in nursing and healthcare, 17-41.

McCormack, B., & Wright, J. (1999). Achieving dignified care for older people through practice development: a systematic approach. Nursing Times Research, 4(5), 340-352.

Mitroff, I. I., & Turoff, M. (1975). Philosophical and methodological foundations of Delphi. The Delphi method: Techniques and applications, 17-35.

Mold, J. W., Fox, C., Wisniewski, A., Lipman, P. D., Krauss, M. R., Harris, D. R., et al. (2014). Implementing Asthma Guidelines Using Practice Facilitation and Local Learning Collaboratives: A Randomized Controlled Trial. Annals of Family Medicine, 12(3), 233-240.

Moore, G., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., & Baird, J. (2015). Process evaluation of complex interventions. Complex Interventions in Health: An Overview of Research Methods, 222.

Munten, G. (2012). Implementation of evidence based practice in mental health nursing: An action research study (Doctoral dissertation, Tilburg University).

National Institute for Health and Care Excellence. Standards and Indicators https://www.nice.org.uk/standards-and-indicators

Okoli, C., & Pawlowski, S. D. (2004). The Delphi method as a research tool: an example, design considerations and applications. Information & Management, 42(1), 15-29.

Oxford English Dictionary (1989). Online < http://www.oed.com/> accessed December 2015.

Raelin, J. A. (2006). The Role of Facilitation in Praxis. Organizational Dynamics, 35(1), 83-95.

Rycroft-Malone, J., Harvey, G., Seers, K., Kitson, A., McCormack, B., & Titchen, A. (2004). An exploration of the factors that influence the implementation of evidence into practice. Journal of clinical nursing, 13(8), 913.

Rycroft-Malone, J., Kitson, A., Harvey, G., McCormack, B., Seers, K., Titchen, A., et al. (2002). Ingredients for change: revisiting a conceptual framework. Quality & safety in health care, 11(2), 174.

Rhydderch, M., Edwards, A., Marshall, M., Elwyn, G., & Grol, R. (2006). Developing a facilitation model to promote organisational development in primary care practices. BMC family practice, 7(1), 38.

Seligman, M. E., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. American Psychologist, 55(1), 5.

Shaw, T., Dewing, J., Young, R., Devlin, M., Boomer, C., & Legius, M. (2008). Enabling practice development: Delving into the concept of facilitation from a practitioner perspective. International practice development in nursing and healthcare, 9, 147-169.

Simmons, M. (2004). 'Facilitation' of practice development: a concept analysis. Practice Development in Health Care, 3(1), 36-52.

Solman, A., & FitzGerald, M. (2008). Leadership support. International Practice Development in Nursing and Healthcare, 260-272..

Stetler, C. B., Legro, M. W., Rycroft-Malone, J., Bowman, C., Curran, G., Guihan, M., et al. (2006). Role of "external facilitation" in implementation of research findings: a qualitative evaluation of facilitation experiences in the Veterans Health Administration. Implementation science : IS, 1, 23.

Titchen, A., & Higgs, J. (2000). Facilitating the acquisition of knowledge for reasoning. Clinical reasoning in the health professions, 222-229.

Titchen, A., & McGinley, M. (2003). Facilitating practitioner research through critical companionship. Nursing Times Research, 8(2), 115-131.

The Health Foundation (2013) Patient Skills Development Programme: a Guide to Facilitator Training, Skills and Assessment

Thor, J., Wittlöv, K., Herrlin, B., Brommels, M., Svensson, O., Skår, J., et al. (2004). Learning helpers: how they facilitated improvement and improved facilitation--lessons from a hospital-wide quality improvement initiative. Quality management in health care, 13(1), 60.

Tollyfield, R. (2014). Facilitating an accelerated experience-based co-design project. British journal of nursing (Mark Allen Publishing), 23(3), 136.

Van Lieshout, F., & Cardiff, S. (2015). Reflections on being and becoming a person-centred facilitator. International Practice Development Journal 5 (Suppl) [4]

Wales, S., Kelly, M., Wilson, V., & Crisp, J. (2013). Enhancing transformational facilitation skills for nurses seeking to support practice innovation. Contemporary Nurse, 44(2), 178-188.

Watling, T. (2015) Factors enabling and inhibiting facilitator development: lessons learned from Essentials of Care in South Eastern Sydney Local Health District. International Practice Development Journal 5 (2) [3]

Wayne, J. H., Grzywacz, J. G., Carlson, D. S., & Kacmar, K. M. (2007). Work–family facilitation: A theoretical explanation and model of primary antecedents and consequences. Human resource management review, 17(1), 63-76.

Westergren, A. (2012). Action-oriented study circles facilitate efforts in nursing homes to “go from feeding to serving”: conceptual perspectives on knowledge translation and workplace learning. Journal of aging research, 2012.

9. Appendices

Appendix 1 About the Standards for Integrated Facilitation

This section is a brief about the outcome of the Delphi study. This section details the purpose of the integrated facilitation standards, how they differ from existing standards, how the standards can be used and the benefits of the standards to the different stakeholder groups.

What is the purpose of the standards for integrated facilitation?

The purpose of the draft standards is twofold:

- To provide a framework that guides the development of holistic, person-centred and relational skills of new and developing facilitators across different healthcare settings to make a difference within their sphere of influence for individuals, teams, organisations, systems and ultimately the beneficiaries – service users.
- To encourage an integrated facilitation approach to all the activities required for supporting ongoing learning, development, improvement, innovation, inquiry and knowledge translation in the workplace, modelling person-centred ways of working required for a whole systems approach to health care where the person experiencing health care is the central focus.

How are the standards for integrated facilitation different from existing standards?

The standards for integrated facilitation complement existing facilitation standards e.g. RCN standards (2006) which have a similar holistic sentiment/intention around effective facilitation practice in any context. However the current standards for integrated facilitation are more comprehensive in the following ways:

- Focus on the current health and social care context particularly around whole systems ways of working and integration.
- Incorporate an outcome competence approach.
- Provide greater emphasis on clarity of purpose, making more explicit the purpose of facilitation for individuals, team and organisations.
- Are stronger on the importance of an integrated facilitation approach across the improvement, inquiry, innovation and knowledge translation agendas – many different functions have grown up over past decade.
- Identify the enabling factors essential for optimising facilitation outcome and impact
- Identify through consensus of experts the most influential skills and strategies that need to be attended to.
- Provide key ideas around how outcomes and impact can be evaluated.
- In addition, the theoretical underpinnings for facilitation practice are extensively identified.

How can the standards for integrated facilitation be used?

- To guide the content and processes of workplace and education programmes that focus on facilitation practice for multiple purposes of learning, development, improvement, inquiry and knowledge translation across health care.

- 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.

What are the benefits of standards for integrated facilitation?

The standards hold benefits for a number of different users and contexts:

For individuals:

The standards provide an evidence based framework to guide you with:

- building your confidence, skill and expertise across different purposes of facilitation and at different levels
- developing a portfolio to support you with career progression, evidence for revalidation and/or professional or academic accreditation

6.4.2. For workplaces:

The standards will benefit workplaces by:

- Growing the staff resource across workplace teams. These staff will know how to use the workplace as the main resource for learning and development, as well as improvement inquiry, innovation and knowledge translation.
- Enabling workplace teams to become self-directing and effective in their learning and development, improvement, innovation, inquiry and knowledge translation activities.

6.4.3. For organisations and systems:

The standards will enable capacity and capability to be developed across the whole system in an integrated approach to facilitation that:

- Places the workplace as the main resource for learning, development, improvement, innovation and inquiry and knowledge translation.
- Uses public monies in the more effective way through reducing duplication of effort by integrating all activities linked to the core purpose of providing person centred safe and effective care
- Unleashes the full potential of staff in the direction and delivery of future services- ensuring they are person centred, safe and effective

6.4.4. For service users;

The standards provide assurance that staff are supported and developed with the core skills required to facilitate individual, team and organisational effectiveness thus ensuring that future services remain focused on the needs of service users and also the effective use of public resources

Knowledge and understanding underpinning integrated facilitation practice

The expert panel through consensus identified the most essential theories that support knowledge and understanding underpinning an integrated approach to facilitation practice. Theories that may have a more specific focus and may be of additional interest were also identified:

Theories identified as most relevant for facilitation of integrated purposes

Action learning (e.g. Reg Revans)
Action research (e.g. Kurt Lewin)
Work based learning (e.g. Kolb, Falnagan et al)
Reflective models of practice (e.g. Gibbs', Burton)
Principles of practice development (e.g. McCormack et al)
Effective workplace culture (e.g. Manley et al)
Organisational learning (e.g. Peter Senge)
Emotional intelligence (e.g. Goleman D)
Group dynamics (e.g. Yalom I., Kurt Lewin)
Situated learning (e.g. Lave and Wenger)
Appreciative inquiry (Srivastva S & Cooperrider D)
Participative leadership (e.g. Lewin, Likert)
Active learning (e.g. Dewey J)
A six-category intervention analysis (Heron J)

Theories identified for specific single purposes of facilitation

Humanism (e.g. A Maslow, Rogers, Heron)
Leadership (e.g. McCormack & McCance; Cardiff)
Personal and professional development (e.g. Melton J et al)
Adult learning theory (E.g. Knowles M.)
Transformative learning (e.g. Cranton & Taylor)
Evidence based practice (E.g. Eddy)
Critical reflexivity (e.g. Josephsen, Giddens, Bourdieu)
Person centeredness (e.g. Berwick, Carl Rogers)
Critical social science theory (e.g. Brian Fays)
Transformational leadership (E.g. Kouzes and Posner , Bass B)
Learning styles (e.g. Kolb)
Communicative action (e.g. Habermas)
Theory of groups (Burnside)
Organisational development (Porras & Silvers)

Theories that might inform facilitation purposes

Social constructivism (e.g. Vygotsky)
Knowledge translation and utilisation- PARIHS framework (e.g. Rycroft-Malone)
The skilled facilitator approach(e.g. Roger Schwartz)
Support and challenge (e.g. Daloz, Sanford)

Quality improvement (Demming)
Critical companionship (e.g. Titchen A)
Pedagogy of the oppressed (e.g. Paulo Freire)
Phenomenology (e.g. A Scutz, Habermas)
Social cognitive theory (e.g. Bandura)
Humanity, Power and knowledge (e.g. Foucault M)
Grounded theory (e.g. Glaser & Strauss)
Hermeneutics (e.g. Walsh and Andersen, Schleiermacher, Dilthey)
Critical Creativity (Titchen & McCormack)
Power and empowerment (e.g. Bachrach & Botwinick
Emergent leadership (Northouse)
The social self (e.g. George Mead)
Social identity (Tajfel H & Turner J)
Co-production (e.g. Trinh et al)
Postmodernism (Anderson W T)
Vocational knowledge (Young M)
Improving quality together/100 lives (framework for core skills developed for NHS Wales staff)
Systems theory and methodology (e.g. Checkland, Ackoff, Senge, Goldratt)
Critical Realism (Archer)
Scholarly evidence (McWilliams et al)
Scholarship typologies (Boyer, Benner, Gray)
Metacognition (Flavell J)
Theatre of the oppressed (e.g. Augustus Boal)
Theory of leadership (e.g. House R. J)
Solution focused (e.g. McKergow)
Adaptive leadership(Heifetz, Grashow & Linsky)
Relational theories (e.g. Cunliffe & Eriksen ; Uhl-Bien)
Cultural anthropology (Margaret Mead)
Curriculum pedagogy and educational research (e.g. Stenhouse)
Positive psychology principles (e.g. Wilfred Bion)
Complex Adaptive Systems (Holland J)
Transdisciplinary (Hardon G)
The circle of trust approach (e.g. Parker Palmer)
Power and systems (e.g. Barry Oshry)
Psychoanalysis (Freud)
Soft systems methodology (Checkland)
Balance & synchronicity (*Van Lieshout*)
Coaching with the Brain in Mind (Rock D& Page L)
Prochaska stages of change
Ethical literacy (Lunt, Friedman)

Reference List for Theories

1. Argyris, C., & Schön, D. A. (1992). On organizational learning (pp. 115-130). Cambridge, MA: Blackwell.
2. Archer, M. (1998) „Realism and Morphogenesis", M. Archer, R. Bhaskar, A.Collier, T.Lawson, A.Norrie, Critical Realism: Essential Readings: London, Routledge.
3. Bachrach, P., & Botwinick, A. (1992). Power and empowerment. A Radical Theory of Participatory Democracy, Philadelphia.
4. Bandura, A. (1986). Social foundations of thought and action: A social cognitive theory. Prentice-Hall, Inc.
5. Bass, B. M. (1991). From transactional to transformational leadership: Learning to share the vision. Organizational dynamics, 18(3), 19-31.
6. Berwick, D. M. (2009). What 'patient-centered' should mean: confessions of an extremist. Health affairs, 28(4), w555-w565.
7. Boal, A. (1979). Theatre of the oppressed (translated by Charles A. & Maria-Odilia Leal McBride). Theatre Communications Group, New York, NY (originally published in Spanish as Teatro de Oprimido, Ediciones de la Flor, Buenos Aires, 1974).
8. Bion, W. R. (1984). Learning from experience (Vol. 22). Stylus Publishing, LLC..
9. Bolton, G. (2010). Reflective practice: Writing and professional development. Sage publications.
10. Boud, D., & Miller, N. (1996). Working with experience: Animating learning. Psychology Press.
11. Burnside, W. (1911). Theory of groups of finite order. University of Cambrige.
12. Burton, A. J. (2000). Reflection: nursing's practice and education panacea?. Journal of advanced nursing, 31(5), 1009-1017.
13. Boyer, E. L. (1996). From scholarship reconsidered to scholarship assessed. Quest, 48(2), 129-139.
14. Cardiff, S. (2014). Person-centred leadership: a critical participatory action research study exploring and developing a new style of (clinical) nurse leadership (Doctoral dissertation, University of Ulster).
15. Checkland, P. (1999). Soft systems methodology: a 30-year retrospective.
16. Checkland, P. (1981). Systems thinking, systems practice.
17. Cranton, P., & Taylor, E. W. (2012). Transformative learning theory: Seeking a more unified theory. The handbook of transformative learning: Theory, research, and practice, 3-20.
18. Cunliffe, A. L., & Eriksen, M. (2011). Relational leadership. Human Relations, 64(11), 1425-1449.
19. Daloz, L. (1986). Effective teaching and mentoring: Realizing the transformational power of adult learning experience. San Francisco: J ossey-Bass Publishers.
20. Deming, W. E. (1981). Improvement of quality and productivity through action by management. National productivity review, 1(1), 12-22.
21. Dewey, J., & Small, A. W. (1897). My pedagogic creed (No. 25). EL Kellogg & Company.
22. Dilthey, W., & Jameson, F. (1972). The rise of hermeneutics. New Literary History, 3(2), 229-244.
23. Eddy, D. M. (1990). Practice policies: where do they come from?. JAMA, 263(9), 1265-1275.
24. Fay, B. (1987). Critical social science: Liberation and its limits.

25. Freud, S. (1921). A general introduction to psychoanalysis. Boni and Liveright.
26. Flanagan, J., Baldwin, S., & Clarke, D. (2000). Work-based learning as a means of developing and assessing nursing competence. Journal of Clinical Nursing, 9(3), 360-368.
27. Flavell, J. H. (1979). Metacognition and cognitive monitoring: A new area of cognitive–developmental inquiry. American psychologist, 34(10), 906.
28. Foucault, M. (1982). The subject and power. Critical inquiry, 777-795.
29. Friedman, B. (1995, May). “It's the computer's fault”: reasoning about computers as moral agents. In Conference companion on Human factors in computing systems (pp. 226-227). ACM.
30. Gibbs, G. (1988). The reflective cycle. Kitchen S (1999) An appraisal of methods of reflection and clinical supervision. Br J Theatre Nurs, 9(7), 313-7.
31. Giddens, A. (1994) ‘Living in a Post-traditional Society’, in U. Beck, A. Giddens and S. Lash Reflexive Modernisation: Politics, Tradition and Aesthetics in the Modern Social Order, pp. 54–109. Cambridge: Polity Press.
32. Glaser, B. G., Strauss, A. L., & Strutzel, E. (1968). The Discovery of Grounded Theory; Strategies for Qualitative Research. Nursing Research, 17(4), 364.
33. Goleman, D. (1998). Working with emotional intelligence. Bantam.
34. Goldratt, E. M. (1990). Theory of constraints. Croton-on-Hudson, NY: North River.
35. Habermas, J. (1984). The theory of communicative action, volume I. Boston: Beacon.
36. Hadorn, G. H. (2004). Unity of knowledge in transdisciplinary research for sustainability. Encyclopedia of Life Support System (EOLSS).
37. Heifetz, R., Grashow, A., & Linsky, M. (2009). The practice of adaptive leadership. Boston, MA: Harvard Business School Publishing.
38. Heron, c. (1982). The making of Thompson, ep-Marxism, humanism, and history-palmer, bd. University of Toronto Press
39. Heron, J. (1976). A six-category intervention analysis. British Journal of Guidance and Counselling, 4(2), 143-155.
40. Holland, J. H. (1992). Complex adaptive systems. Daedalus, 17-30.
41. House, R. J. (1996). Path-goal theory of leadership: Lessons, legacy, and a reformulated theory. The Leadership Quarterly, 7(3), 323-352.
42. Josephsen, J. (2014). Critically Reflexive Theory: A Proposal for Nursing Education. Advances in Nursing, 2014.
43. Knowles, H. (1998). A theory of adult learning: Andragogy.
44. Kolb, D. A. (1971). Individual learning styles and the learning process (Working Paper 535-71).
45. Kolb, D. A., & Fry, R. E. (1974). Toward an applied theory of experiential learning. MIT Alfred P. Sloan School of Management.
46. Kolb, D. (1984). Experiential learning: Experience as a source of learning and development. Upper Saddle River, NJ: Prentice Hall
47. Kouzes, J. M., & Posner, B. Z. (2006). The leadership challenge (Vol. 3). John Wiley & Sons.
48. Lave, J., & Wenger, E. (1991). Situated learning: Legitimate peripheral participation. Cambridge, UK: Cambridge University Press
49. Lewin, K. (1948). Resolving social conflicts. Washington, DC: American Psychological Association.

50. Lewin, K. (1946). Action research and minority problems. Journal of social issues, 2(4), 34-46.
51. Lieshout, F. V. (2013). Taking Action for action: a study of the interplay between contextual and facilitator characteristics in developing an effective workplace culture in a Dutch hospital setting, through action research (Doctoral dissertation, University of Ulster).
52. Likert, R. (1967). The human organization: its management and values. McGraw-Hill, New York
53. Manley, K., Sanders, K., Cardiff, S., & Webster, J. (2011). Effective workplace culture: the attributes, enabling factors and consequences of a new concept. International Practice Development Journal, 1(2), 1-29.
54. Maslow, A. (1968). Some educational implications of the humanistic psychologies. Harvard Educational Review, 38(4), 685-696.
55. McCormack, B., & McCance, T. V. (2006). Development of a framework for person-centred nursing. Journal of advanced Nursing, 56(5), 472-479.
56. McCormack, B., Dewing, J., Breslin, L., Coyne-Nevin, A., Kennedy, K., Manning, M., & Tobin, C. (2009). Practice development: Realising active learning for sustainable change. Contemporary Nurse, 32(1-2), 92-104.
57. McKergow, M. (2012). Solution-focused approaches in management. C. Franklin, TS Trepper, W. Gingerich, y EE McCollum, EE (Eds.). Solution-focused brief therapy: A handbook of evidenced-based practice, 3-19.
58. McWilliams, A., Siegel, D., & Van Fleet, D. D. (2005). Scholarly journals as producers of knowledge: Theory and empirical evidence based on data envelopment analysis. Organizational Research Methods, 8(2), 185-201.
59. Mead, M. (1964). Continuities in cultural evolution (Vol. 34). Transaction Publishers.
60. Mead, G. H. (1913). The social self. The Journal of Philosophy, Psychology and Scientific Methods, 374-380.
61. Melton, J., Forsyth, K., & Freeth, D. (2012). The Individual Practice Development Theory: an individually focused practice development theory that helps target practice development resources. Journal of evaluation in clinical practice, 18(3), 542-546.
62. Mezirow, J. (1997). Transformative learning: Theory to practice. New directions for adult and continuing education, 1997(74), 5-12.
63. Northouse, P. G. (2015). Leadership: Theory and practice. Sage publications.
64. O'Hara, M., & Anderson, W. T. (1991). Welcome to the postmodern world. Family Therapy Networker, 15(5), 19-25.
65. Oshry, B. (1999). Leading systems: Lessons from the power lab. Berrett-Koehler Publishers.
66. Palmer, P. J. (1997). The heart of a teacher identity and integrity in teaching. Change: The Magazine of Higher Learning, 29(6), 14-21.
67. Paulo, F. (1970). Pedagogy of the Oppressed. First Published in USA by Herder and Herder.
68. Porras, J. I., & Silvers, R. C. (1991). Organization development and transformation. Annual review of Psychology, 42(1), 51-78.
69. Prochaska, J. O. (2013). Transtheoretical model of behavior change. In Encyclopedia of behavioral medicine (pp. 1997-2000). Springer New York.
70. Revans, R. W. (1982). What is action learning?. Journal of Management Development, 1(3), 64-75.

71. Rock, D., & Page, L. J. (2009). Coaching with the brain in mind: Foundations for practice. John Wiley & Sons.
72. Rogers, C. R. (1951). Client-centered therapy: Its current practice, implications and theory (p. 491). Boston: Houghton Mifflin.
73. Rogers, C. R. (1964). Toward a modern approach to values: The valuing process in the mature person. Journal of Abnormal and Social Psychology, 63(2), 160-167.
74. Rycroft-Malone, J. (2004). The PARIHS Framework—A Framework for Guiding the Implementation of Evidence-based Practice. Journal of nursing care quality, 19(4), 297-304.Senge, P. M. (2006). The fifth discipline: The art and practice of the learning organization. Broadway Business
75. Sanford, N. (1966). Self and society: Social change and individual development. Transaction Publishers.
76. Schleiermacher, F. (1809). General hermeneutics. Schleiermacher: Hermeneutics and Criticism, 227-268.
77. Schutz, A. (1967). The phenomenology of the social world. Northwestern University Press.
78. Schwarz, R. (2002). The skilled facilitator: A comprehensive resource for consultants, facilitators, managers, trainers, and coaches. John Wiley & Sons.
79. Srivastava, S., & Cooperrider, D. (1990). Appreciative inquiry and leadership: The power of positive thought and action in organizations.
80. Stenhouse, L. (1984). Artistry and teaching: The teacher as focus of research and development. Alternative perspectives on school improvement, 67-76.
81. Titchen, A. (2001). Critical companionship: a conceptual framework for developing expertise.
82. Titchen, A., & McCormack, B. (2010). Dancing with stones: critical creativity as methodology for human flourishing. Educational action research, 18(4), 531-554.
83. Trinh, T. H., Kachitvichyanukul, V., & Khang, D. B. (2013). The co-production approach to service: a theoretical background. Journal of the Operational Research Society, 65(2), 161-168.
84. Turner, J. C., & Tajfel, H. (1982). Social identity and intergroup relations. Social identity and intergroup relations.
85. Uhl-Bien, M. (2006). Relational leadership theory: Exploring the social processes of leadership and organizing. The Leadership Quarterly, 17(6), 654-676.
86. Vygotsky, L. S. (1978). Mind in society: The development of higher mental process.
87. Walsh, K. D., & Andersen, P. (2013). Group Facilitation as Hermeneutic Practice. A Research & Applications, 15.
88. Yalom, I. D. (1995). The theory and practice of group psychotherapy. Basic Books.
89. Young, M. (2006). Conceptualising vocational knowledge: Some theoretical considerations. Knowledge, curriculum and qualifications for South African further education, 104-124.