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The Venus model for integrating practitioner-led workforce transformation and complex change across the health care system

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Abstract

Aims and objectives: The aim of this paper is to present the Venus model for workforce transformation, demonstrating its research origins, theoretical foundations, and practical application for enabling individuals, teams, and services to sustain transformation in the workplace.

Methods: The paper provides a brief synopsis of how the Venus model was generated from four large-scale mixed-method studies embracing workforce transformation, safety culture, integrated facilitation, and continuous professional development.

Results: The Venus model has five stems and identifies key integrated skill sets pivotal to successful transformation, which are interdependent:

1. Being able to facilitate an integrated approach to learning, development, improvement, knowledge translation, inquiry, and innovation—drawing on the workplace itself as an influential resource;
2. Being a transformational and collective leader building relationships that encourage curiosity, creativity, and harnessing the talents of all not just a few;
3. Being a skilled practice developer focused on achieving the key values of being person-centred, and the ways of working that are collaborative, inclusive, and participative;
4. Applying improvement skills that enable small step change using measurement wisely to focus on measuring what is valued as well as evaluating positive progress; and, finally
5. Facilitating culture change at the micro-systems level while being attuned to the organizational and systems enablers required to support this.

Conclusion: The paper concludes with consideration of implications for implementation of the model and its relevance for practice, policy, education, and future research as well as outlining potential limitations and conclusions.

KEYWORDS
culture change, facilitation, improvement, innovation, leadership, practice development, workforce transformation

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1 | INTRODUCTION

Developing the evidence base for supporting large-scale transformation to meet global challenges in health care is an identified need.[1] New approaches that support complex change bottom up, as opposed to top down, are crucial to understanding how to transform services and cultures of care within and across systems to deliver new models for 21st century health.[2-4] Inter-professional learning that supports shared decision making and person-centred, compassionate, safe, and effective care are the value-based approaches recognized internationally for achieving quality that should guide transformation.[5] Much work has been done on articulating what person-centredness looks like:

> Person-centredness is an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users, and others significant to them in their lives. It is underpinned by values of respect for persons (personhood), individual right to self-determination, mutual respect, and understanding. It is enabled by cultures of

FIGURE 1 Venus Model describing the skills required for person-centred transformation

empowerment that foster continuous approaches to practice development.[6]

Building a workforce that is responsive and creative in responding to increasing health care challenges and is empowered to evolve better ways to achieving quality and provide care, with the right skills at the right time in the right place, is an under-focused resource for supporting the transformation agenda.[5,7,8]

This paper presents the Venus model for guiding workforce transformation from micro- to macro-systems level of the health economy. The model is a synthesis of the theoretical and practical insights derived from four interconnected national and international practice-based research studies[9-14] involving practitioners and patients over the past 4 years. This has been honed and refined by working with our International Fellows network, many of whom are service users, as well as presenting for discussion at a range of workshops, international conferences, and sessions involving patients and the public (Figure 1). The purpose of the Venus model is to describe the key most influential workforce strategies, skills, and know-how required to enable an empowered workforce to provide person-centred, safe, and effective care across the system in a way that enables people to meet their health care needs in partnership. These themes constitute the five stems of the Venus model, so named because of its association with "brilliance and brightness" and its ability to provide a strong beacon for the direction that needs to be taken if the challenges of achieving sustainable person-centred transformation are to be met.

The paper explores the foundations of the model and the five key stems and inter-related skills and know-how required to support workforce transformation from micro-systems-level practice and across the system. A case study illustration is used to demonstrate its practical application in the workplace. It also considers implications for future policy, education, research, and practice to support workforce transformation.

2 | BACKGROUND

2.1 | What does transformation mean in the health care context and what skills are required to deliver it?

Transformation implies radical ways of doing things to reflect the values aspired to; it is not about quick wins or key performance indicators. Taking a whole-systems approach based on person-centred approaches, to many, is radical. It requires a shared understanding and meaning of the term, the underpinning values, and the key concepts at the heart of systems working—integration and interdependence. Systems leadership is based on shared values that focus on being person-centred, delivering care that is both safe and effective, and embracing continuous learning, improvement, and development. Systems leaders need

1. skills in sustainable cultural change, required to break down silos enabling others to be empowered, especially at the micro-systems level;
2. a strong focus on enabling and developing the workforce and its talent system-wide;
3. research and inquiry skills to monitor and evaluate subsequent impact; and
4. consultancy models that disseminate evidence and expertise rapidly, which is the key.[9]

Leaders need to be compassionate and collective if people are to experience quality care, and those providing it promote good places to work. This interdependence impacts on health outcomes and performance.[15,16]

Large-scale transformation that draws out and mobilizes the talents and natural creativity of the workforce bottom up underpins improvement in processes and outcomes. This is linked to creating positive conditions for change through work environments that harness relationships, skills, and capabilities of individuals in the system, in contrast to many top-down approaches that focus on control of change,[1,5] thus reinforcing the pivotal involvement at the micro-systems level.[17] Focusing on how people work in large-scale change is more important than attaining pre-determined targets when working towards transformation,[1] and shared leadership is more effective than a hierarchical approach, as it gives staff autonomy in their work along with developing shared responsibility.[18]

2.2 | What role does culture play in enabling workforce transformation?

Embedded ways of working are culturally set and influence how people think and behave at all levels of complex systems. Specific patterns have been recognized that influence systems transformation either positively or negatively at the organizational level, and these are powerful drivers that impact on social norms (Figure 2). The patterns that work against whole system transformation are frequently not recognized or challenged[19] and reflect assumptions that are often taken for granted and not explored from a critical perspective.

2.3 | Theoretical foundations of the Venus model

The Venus model has been synthesized from the findings and insights arising from four practice-related studies to identify the key workforce strategies for enabling sustainable transformation summarized in Table 1.

Pattern	Enabler	Barrier
Relationships	That generate energy for new ideas and innovation	That drain the organisation
Decision-making	Is rapid by experts	Is bogged down in hierarchy and are position bound
Power	Used 'to enable' Collective purpose	Used 'over' others Self interest
Conflict	As opportunities to embrace new ideas	Experienced as negative and destructive feedback
Learning	As curiosity and eagerness to learn	As threatening to the status quo

FIGURE 2 Enablers and barriers to system transformation in relation to five patterns of behaviour and thinking (after Plsek)[19]

TABLE 1 Key insights developed from each of the four studies that inform workforce strategies around the essential skillset required for person-centred, sustainable transformation

Study	Findings	Workforce strategies for transformation
Transforming the urgent and emergency workforce across the health economy—a whole systems approach[9]	Clinical systems leadership across the health economy enables • integration to happen and silos to be broken down, • workforce development, • dissemination of expertise, and • evaluation of impact A single career and competence framework identifies the composite competences required from the multi-professional team to wrap person-centred, safe, and effective care around peoples' needs rather than around the professional Work based facilitators are required to use the workplace as the main resource for learning, development and improvement	• To grow facilitators with the skills to use the workplace as a key resource for learning, developing, and improving • To develop clinical systems leadership across the health economy to break down silos and achieve integrated whole-systems approaches • To enable whole systems working informed by values-based care • To align integrated career and competence frameworks with the health needs of people
Delphi study developing international standards for supporting an integrated approach to facilitation following on from the study above[10]	The key qualities and skills facilitators need to support inter-professional teams to flourish and optimize performance were identified in a set of international standards Facilitation practice is a cornerstone for developments in the delivery of health and social care in the workplace because it embraces a number of different and integrated purposes: • learning • development • improvement • inquiry • innovation • knowledge translation Holistic workplace facilitation • supports the integration remit across health and social care systems and avoids duplication of effort and waste of valuable resources • embraces the complexity of the workplace from individual to system	• To develop the facilitation skill set required for all purposes and contexts across the system to enable person-centred, sustainable transformation • To enable facilitators with expertise in all purposes to support inter-professional teams to flourish and optimize performance
The Continuous Professional Development (CPD) study[12,13]	Clarity of the role and purpose about CPD in health care in relation to: • providing person-centred, safe and effective care • influence the workplace and system more directly • growing and retaining the workforce Four CPD transformation theories developed to explain what works, for whom and why about: • Enabling individual professional practice • Developing more effective and responsive teams /services across the system • Achieving knowledge translation and knowledge based cultures • Developing workplace cultures based on values that enable person-centred, safe and effective care	• To implement CPD strategies that directly impact on the workplace, its culture and the system • CPD commissioning to prioritize skills development in: • practice development, • leadership and culture change, • facilitation • CPD is evaluated in relation to: • Person-centred, safe and effective care, • the needs of people, and achievement of meaningful change • team effectiveness and integration across the system • adaptability to meeting society's changing healthcare needs • knowledge translation to develop knowledge rich cultures

(Continues)

TABLE 1 (Continued)

Study	Findings	Workforce strategies for transformation
	Potential indicators of CPD identified The positive impact of CPD demonstrated on: • service user experiences, • team effectiveness, • career progression opportunities • organizational partnerships • knowledge rich cultures • active contribution to practice development, innovation and creativity. The role of practice development, facilitation, leadership and culture change identified as influential	• workplace cultures that reflect shared values
The Safety Culture, Quality Improvement Realist Evaluation (SCQIRE) Project[11,14]	Empowered frontline staff, transformational and collective leadership are key to effectively implementing safe, effective, person-centred care Embedding person-centred and safety values with everyone experiencing and providing care, is crucial to developing a safety culture. These values are interdependent and influence appreciative learning and ways of working and behaviours The need for corporate facilitation and leadership support to frontline teams that: • crosses the silos of learning, improvement, development • co-creates shared meanings The importance of organizations and organizational leaders • supporting and empowering individual teams to do the right thing for patients • having integrated governance systems in place to support organizational learning	• To invest in clinical leadership that is transformational and collective • To develop effective, empowering person centred, and safe cultures at the microsystems level • To develop integrated facilitation skills for engagement, learning, improvement and development

2.4 | The five key stems of the Venus model

The Venus model identifies the five key stems and linked concepts (and relationships) required to support front-line teams to transform practice through inter-professional learning, development, improvement, and innovation, as well as the essential organizational and systems factors required to enable this, namely

1. Facilitation skills across a continuum of complex purposes in the workplace
2. Leadership development at clinical to systems levels
3. Practice development for developing person-centred, safe, and effective care and cultures and enabling knowledge translation
4. Improvement skills and tools to assist with measuring progress
5. Culture change skills at the front line of practice for person-centred, safe, and effective care, supported by organizational and system enablers.

These five elements are presented in more depth in relation to the insights from the four studies and their practical relevance when sustaining person-centred transformation. We have taken a *What Works* approach to highlight the strategies, skill sets, and know-how required.

2.4.1 | Stem 1: Skilled facilitation

Facilitators with the skills and qualities to use the workplace as the main resource for learning, development, and improvement is a feature identified in our research underpinning Venus.[9-13] The facilitation focus has varied in purpose from

1. growing the workforce within and across the system flexibly, through systems leadership, to
2. helping the workforce through continuing professional development (CPD) achieve role clarity, career progression, and
3. as high-performing teams, adapt to the changing context to meet health needs, or, knowledge translation and culture change.[9-12]

While in its simplicity facilitation is often referred to as a helping activity,[20] the reality is that it involves a complex array of

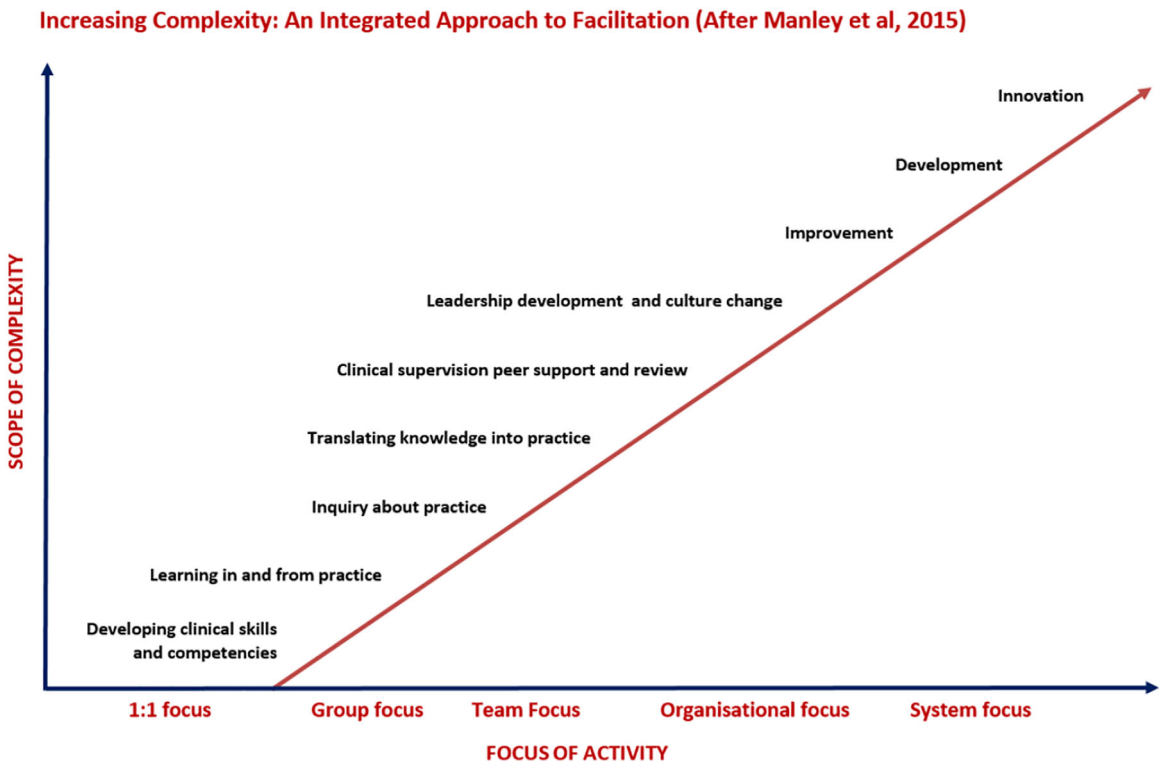

FIGURE 3 Increasing scope of complexity and the focus of activity in holistic facilitation practice

activities focused around purpose, context, and effectiveness: specifically

Bringing together different purposes (learning, development, improvement, knowledge translation, inquiry and innovation) … to achieve a holistic approach to person-centred care and improving public health outcomes[7] (p. 42).

Facilitation skills have previously been identified as an enabler to work place learning,[21] achieving effective workplace cultures,[22] practice development,[23,24] and knowledge translation.[25,26] All of these purposes are required to enable workforce transformation based on the learning context and purpose. The scope and range of facilitation activities is illustrated in Figure 3, which shows how complexity ranges from facilitating individuals and groups through to organizations and systems, across activities that focus on different contexts and purposes to embrace a full range of integrated functions. Many of these are currently supported through a "silo" rather than an integrated approach across organizations and systems.[10]

The facilitation strategies that work and why they work are presented in Figure 4. Facilitation strategies have been identified as catalytic when enabling others to be more effective.[27] The SCQIRE study[11] subsequently clarified the relationship between staff outcomes (i.e., staff feel supported, engaged, enabled, trusted, valued, and empowered) and the mechanisms that account for these outcomes.

To illustrate this clinically, a vignette, based on 360° feedback, was obtained by an effective clinical leader and facilitator from different members of her role set. This feedback endorses the qualities, values, and beliefs experienced by the staff and has a powerful impact on developing awareness and insight and creating positive relationships that drive improvement.

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

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

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

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

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

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

- Feedback obtained from different members of role set validate consistency of approach by the clinical leader and facilitator
- Endorses the qualities, values and beliefs experienced of effective clinical leaders and facilitators

Further, we have developed a set of international facilitation standards (Figure 5) which provide individuals with a framework for career progression and academic accreditation.[10] The integrated facilitation

standards provide a framework for growing facilitation expertise at every level of the system. This is the primary skillset for enabling others to develop the skills and expertise required for transformation in the other four stems of the Venus model. Comprehensive and holistic facilitation skills and know-how, therefore, support systems transformation through not just a focus on learning, but integrating all the key purposes required for transformation to enable a person-centred, safe, and effective care to be provided. These skills are vital for systems leadership as a facilitator of learning, development, improvement, innovation, and inquiry focused on developing a workforce that can liberate its creativity and talent for creative solutions towards flexible solutions.[10,12]

2.4.2 | Stem 2: Leadership

The four studies have demonstrated the need for leadership expertise and skills at every level of the system to support transformation. Leadership that is facilitative and based on values is the key to enabling empowerment of bottom-up teams and creative solutions to sustainable system change that is people-centred. Leadership expertise in the form of authentic enabling relationships is required for developing collective direction across boundaries, to grow others as leaders, and to enable transformation to happen in every part of the system as well as across it.

Leadership skills for supporting sustainable person-centred transformation are recognized at three levels: micro, meso, and macro (Table 2). Transformational leadership across the levels characterize quality clinical leaders and facilitators, and reflect the tenets of Kouzes and Posner's model of leadership practices[28]: modelling the way; inspiring a shared vision; challenging the process; enabling others to act; and encouraging the heart.

While the characteristics of transformational leadership and relationship-based approaches in the form of individual behaviour and collective leadership are common to each level, there are also additional strategies associated with different levels.

At an organizational level, organizations need systems in place to support and implement learning, development, and improvement about what works, and embrace and support innovation and solutions towards transformation. They also need to be committed to the development of the workforce as leaders, incorporating infrastructure to grow a movement of critical companions and coaches with the skills required to support transformation. One would recognize such organizations by radical changes in patterns of behaviour across the organization through integrated support systems that achieve flourishing for staff and patients and an organizational reputation for excellence in person-centred, timely, safe, effective, equitable, and efficient care with financial integrity. The vignette below shows how supporting clinical leaders to grow their capacity and capability through providing a critical companion impacts positively on the service provided.

> Critical companions[29] build supportive, challenging, and enabling relationships that foster mutual learning and improvement. The critical companion in this instance is an expert facilitator of practice development, a nurse and midwife. She was able to illustrate through her own evidence base the positive impact she had on those she supported. One example includes

Facilitation Strategies 'The What'	Mechanisms 'The Why'	Outcomes
✓ Building good relationships that enable: • shared meanings, • challenge, • new ideas for improvement • values to be embedded ✓ Creating safe spaces for conversations and reflection; ✓ Enabling service user feedback to drive improvement ✓ Positivity	• Being given time, being listened to; • Being supported to ask questions and report adverse events; • Participating in collaborative change; • Knowing what best practice is; • Having clarity of role and expectations and shared meaning about what is expected.	Staff feel: • supported, • engaged, • enabled, • trusted, • valued • empowered

FIGURE 4 What works and why in facilitation[11]

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

FIGURE 5 Standards for integrated facilitation in and about the workplace[10]

TABLE 2 Leadership strategies that work at each level and why

Level	Strategies that work	Why they work
Microsystems level: most immediate frontline team	Clinical leaders (ward managers, clinical leads, team leaders, shift leads: • Model respectful relationships and person-centred values • Are approachable, actively listen to and value patient and service user expertise, engagement and participation • Pay attention to both patient and staff well-being • Support teams with patient safety/ improvement • Are clinically credibility, model self-awareness, reflection and learning • Creates shared vision/direction and embeds this • Connects everyone for the patient, encourages innovation • Possess personal attributes and qualities, and are transformational leaders	Consistently endorses and enables: • service users and staff to feel heard and listened to, to become empowered and this improves experiences • Person-centred respectful relationships between all staff members and with service users, so people feel valued and respected • impacts positively on: ○ collaborative approaches to developing workplace culture ○ team effectiveness ○ workplace culture, values and shared meanings ○ safety behaviours and environment
Meso-system level: across the organization	Organizational and senior leaders: • Live organizational values authentically • Enable frontline teams to feel empowered and supported through for example, a bottom up focus, non-hierarchical, non-power driven bottom-up driven learning organizations, adaptive capacity/draw on local innovation • Actively support collective leadership and the development of skills to help others for example, support for capacity and capability building in facilitators of leaning, development and improvement, developing learning communities, protected time/ opportunities for reflection, mentoring learning/creativity/innovation, critical companionship • Implement integrated governance systems for learning, improvement, quality, and safety building appreciatively on what works	• Credibility and leadership rests on living values espoused and recognition that transformation of services require transformation of self • Values are embedded in organizational systems and guide decision making and priorities • Empowers staff to make their own choices about projects rather than being told what to do • Provides an opportunity for the organization to look at culture within teams and consider a different way of working from bottom-up grass roots level to grow and sustain innovation • Grows a critical community of people with the skills internally to support organization learning and support frontline staff • Governance systems enables "form to follow function", organization wide learning that building on what works and sharing of initiatives across different teams
Macro-system level: across the health economy	Systems-wide leaders: • Role model high quality, person-centred, compassionate relationships based leadership, translating shared values for others into expected patterns of behaviours to ensure person-centred, safe, effective, care/services are delivered by all • Facilitate workplace cultures that are person centred, safe, effective and good places to work through enabling collective leadership that embeds shared values in workplace systems and networks • Facilitate collective leadership capability and capacity • Lead strategic direction for the development of person-centred, compassionate, safe and effective care and on-going transformation in changing contexts	• Achieves culture change based on clinical expertise which helps remove silos across the system because of clinical credibility • Works with behavioural norms, develop common values and a shared purpose that positively impact on workplace cultures, ways of working, team work, staff well-being and satisfaction, as well as patients' experience and outcomes, and efficient use of resources • Creatively reshapes care services through drawing on staff and service users expertise and innovations, while coping with change and reducing duplication

> the support provided to a medical colleague, a surgeon participating in the organization's clinical leadership programme. The critical companion was able to show that through using her facilitation skills with him, the surgeon was helped to also embed these critical companionship skills within his own team. This resulted in greater team cohesion and also positive impact on the service provided, as demonstrated through improved national audit results.

At the systems level, the need for clinical systems leaders with expertise in a number of functions has been recognized when transforming the workforce.[9] Clinical systems leadership is defined as

> the leadership approach that drives integration across boundaries based on specialized clinical credibility working with shared purposes to break down silos and deliver person-centred, safe and effective care with continuity[9] (p. 5).

This is achieved through

- integrated ways of working and effective teamwork across partner organizations;
- the dissemination of expertise to as many people across the system through advanced consultancy approaches;
- creating a learning culture that uses the workplace as the main resource for learning, development, and improvement;
- growing the workforce capabilities across the system, evaluating effectiveness, and fostering inquiry and curiosity.[9]

The following vignette demonstrates this in practice.

> A consultant pharmacist implemented a system-wide service to improve the review and uptake of anticoagulants for people with hypertension that led to a reduction in local morbidity and mortality. The consultant practitioner realized that face-to-face clinics in general practices would not achieve what was required. Through their leadership role, they worked with commissioners to set up virtual clinics, mentor other pharmacists, and also up-skilled the primary care workforce. This all resulted in a dramatic improvement in blood pressure (BP) control. This level of improvement could not have been achieved by the pharmacist working in a clinic alone, but resulted from the skills drawn on as a systems leader to positively impact on the health economy in terms of health and cost benefit.

2.4.3 | Stem 3: Practice development

Practice development is a complex methodology that focuses on collaborative, inclusive, and participative approaches with stakeholders to develop person-centred, safe, and effective cultures[23,24,30,31] and sustainable practice change.[32] Practice development is defined as

> a continuous process of developing person-centred cultures. It is enabled by facilitators who authentically engage with individuals and teams to blend personal qualities and creative imagination with practice skills and practice wisdom. The learning that occurs brings about transformations of individuals and team practices. This is sustained by embedding both processes and outcomes in corporate strategy.[24] (p. 8)

Practice development was identified as a key in our findings. The skills inherent to this approach are summarized in relation to the principles outlined in Table 3.

2.4.4 | Stem 4: Improvement

While improvement approaches offer much in relation to measurement,[32] it is important, when keeping clarity of purpose, to be cognizant of the tension between valuing measurement per se rather than measuring what we value.[33] The values that guide transformation from the perspective of WHO Europe are people-centred health care that puts people's health needs and what matters to them at the centre in partnership with them.[34] The Kings Fund argues for the need to share responsibility for quality improvement with leaders at all level—a collective leadership approach—and that there are no magic bullets or quick fixes. They identify a need for consistency in the approaches used, the effective use of data, a focus on relationships and culture, enabling and supporting engagement of frontline staff, and working as a system involving patients, service users, and carers.[35]

At the micro level, knowing which improvement tools to use, how to use them, what the results mean, and how to act on the results are key skills that benefit from linking with practice development and facilitation: for example, plan, do, study, act cycles have much in common with participatory action research and systematic practice development linked to refection, learning, and collaborative action.[32]

At the meso level, leadership's commitment to achieving zero patient harm, a fully functional culture of safety throughout the organization, and the widespread deployment of highly effective process improvement tools characterize high-performing organizations.[36] The support that is required to frontline teams from organizations needs to include expertise in the use of improvement tools and small-scale change integrated with the other skills outlined in the Venus model.

At the macro level, the need for clinical systems leadership skills that integrate improvement to help the system understand what needs to improve as well as how to improve is linked to population health and characteristics.

In summary, the need for improvement skills to support person-centred, holistic safety, and effectiveness, combined with the values and processes of practice development, has been identified as mutually beneficial at the micro, meso, and macro systems levels.[32]

TABLE 3 Nine principles of practice development[23,27]

Principles of practice development	Examples about how the principles are used in practice and the skills required
1. Develop person-centred, evidence-based care demonstrated by human flourishing and a healthy workplace culture which is effective	• Working with teams to identify and agree the values that are important to staff collectively with service users • Working with these teams to identify how these values are recognized in practice and embedded in everyday ways of working • Helping teams to understand and develop shared meanings about being person-centred and healthy workplace cultures
2. Focus on relationships at the microsystems level where care is provided and experienced at the frontline of practice by patients and care professionals	• Helping frontline teams (actual or virtual) to develop clarity of purpose and direction in relation to the values held and the ways they work with each other • Helping staff understand how agreed ways of working translate into role clarity, role understandings, and expectations • Obtaining feedback from staff and service users about how the workplace and care are experienced
3. Facilitate active learning and formal systems learning processes to enable real-time learning and care transformation in the workplace	• Helping frontline teams and collective leaders to use the workplace as the main resource for learning, development and improvement together • Developing skills in helping people to learn in the moment of practice or by reflecting on their practice and being actively reflexive
4. Enable the use of evidence generated in, through and from practice to transform and improve care delivery and outcomes	• Identifying and blending different sources and types of evidence to inform what needs to change and to evaluate progress
5. Promote the importance of free thinking by blending creativity(heart, mind, soul) with more formal learning approaches to promote human flourishing referred to as critical creativity)	• Using and modelling critical creative ways of expressing direction and experiences that guide action in the workplace • Using imagination and possibility to identify novel and innovative ways of working and solutions
6. Select from a range of practice development methods in an intentional and systematic way to help people to learn, change, and develop their practice in a sustainable, effective way	• Use different methods to enable a rich picture to be built up and understood about what matters to people whether health care providers or those experiencing care • Enable collaborative use of methods and data analysis to build up ownership for what needs to change and how improvement would be recognized • Enable a systematic approach to change that builds on cycles of learning, action, and reflection
7. Ensure these methods accord with the methodological principles used and the stated objectives of the endeavour	• Helping teams to use methods that are consistent with values and focuses on what matters to people • Using evaluation approaches and measures that focus on what matters
8. Use processes (including skilled facilitation) which can be translated into the specific skill-sets required for any context	• Using the processes outlined in the facilitation standards to guide support with learning, improvement and development • Create a safe environment for learning • Provide 1:1, team, organizational and systems-wide leadership for a range of different purposes
9. Integrate evaluation approaches that are collaborative, inclusive and participative Collaboration, Inclusion and Participation (CIP)	• Use approaches with people that are inclusive and participative • Enable collaboration between key stakeholders, joint reconnaissance, decision making and reflection valuing the claims concerns and issues of different people

2.4.5 | Stem 5: Culture change

Our published studies[10-14,37] have provided detailed insights into culture change at the micro systems level, although organizational factors were also contextually recognized. The skills for culture change at the micro systems level are particularly important, as this is where care is provided and experienced.[17] Culture is about *the ways things are done around here*,[38] and this is extremely influential on the social norms adopted, underpinned by values, beliefs, and assumptions[39] and will therefore influence whether any transformation can be achieved. Insights from our published research,[12-14] identified transformation of workplace culture as one of the key sub-purposes of CPD contributing to service user's experience of person-centred, safe, and effective care. This was also interdependent with contexts that develop a culture of inquiry, learning, and implementation, and its impact on developing professional skills, as well as developing a culture for knowledge translation, and expanding and maintaining the skills and competences to meet the changing needs of people.[12,13] The individual enablers of role clarity, transformational leadership, and skilled facilitation are essential ingredients for culture change.[14]

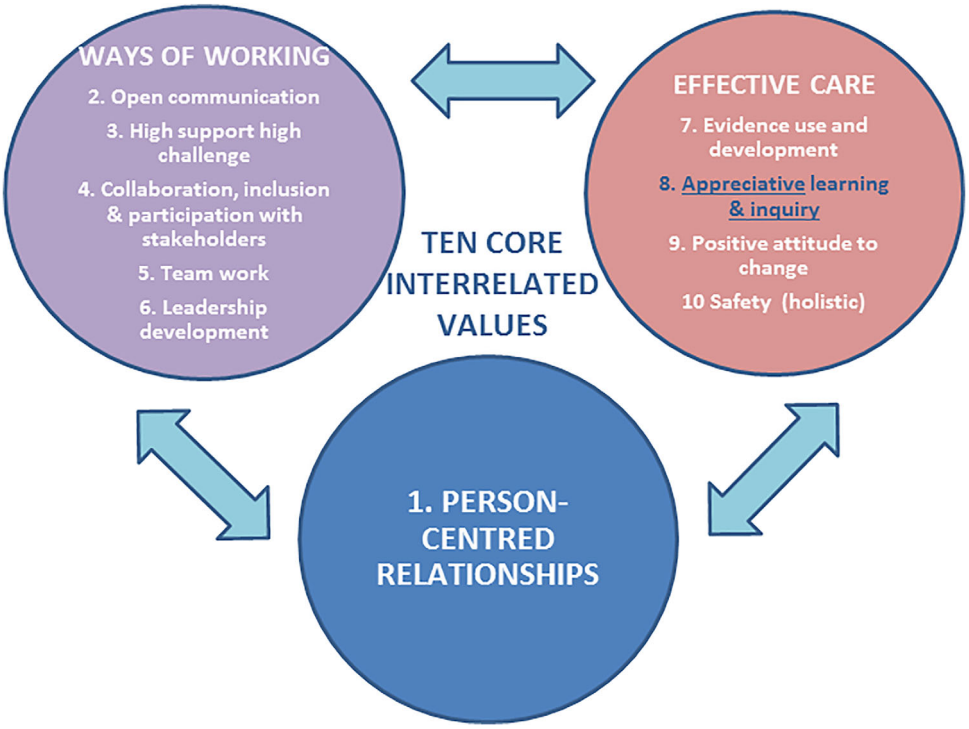

FIGURE 6 The three clusters of interdependent values needed for person centres, safe and effective workplace cultures

Culture change in frontline teams involves integrating values about effective care, (including holistic safety and appreciative learning and inquiry) with being person centred in all relationships, and ways of working that build effective teams through:

- ✓ **Individual enablers;** specifically, transformational leadership, skilled facilitation (that engages staff in co-creating meaning and shared purpose), and role clarity
- ✓ **Embedding values** in local and appreciative formal systems of evaluation, learning, development, improvement and stakeholder participation that reflect and sustain them
- ✓ **Organisational enablers,** specifically: collaborative and authentic senior leadership; focus on supporting bottom-up change; organisational readiness; and human resource management's role in recruiting for shared values
- ✓ **Embedding values** in integrated organisational systems for learning, development, and improvement, based on appreciation of what works, and growing organisational; capacity and capability in leadership and facilitation

Effective workplace cultures will be recognised by:

- Values observed and experienced in practice
- Effective teamwork – high performing self directing teams
- Consistent achievement of standards and goals, evidence-based and continuous development, improvement and innovation in practice linked to the needs of patients.
- Empowered and committed staff
- Flourishing of all involved

FIGURE 7 Refined theory of culture change[14] (*International Practice Development Journal* permission to be obtained)

There are 10 key values clustered in three themes that have been identified by previous research (Figure 6). The three themes of person-centredness, ways of working, and continuing effectiveness are the key values to work with, and through developing shared direction and purpose, the main aim is to enable the values to be lived and embedded. This is achieved through a journey that starts with agreeing shared values, purpose, and ways of working; talking about these in relation to what they mean for practice (espoused values); challenging and supporting everyone to live the values; and then embedding values in formal systems, for example, shared governance and evaluation as "form follows function".[39]

It is leadership and relationships that are the most influential ways of changing culture (Figure 7), and this is helped if organizational enablers are also present, these being

- Collaborative and authentic senior leadership;
- Focus on supporting bottom-up change, organizational readiness, and human resource management's role in recruiting for shared values;
- Embedding values in organizational systems for learning, development, and improvement, based on appreciation of what works, and growing organizational; capacity, and capability in leadership and facilitation.[14]

An effective workplace culture is recognized by values observed and experienced in action: an effective team, empowered and committed staff, evidence-based practice, continuing learning, development and innovation, consistent achievement of standards and goals, and flourishing of all.[14] This reflects and complements the findings of other studies. Albeit at the organizational culture level, these include continuous learning and quality improvement, enthusiastic teamworking, cooperation, and integration.[40] These are enabled by an inspirational vision of high-quality care, clearly aligned goals at every level with helpful feedback, and good people management and employee engagement.[40]

In summary, having the skills to achieve culture change at every level of the system is important, as well as recognizing the enablers that need to be in place at each level. Culture will be the most important aspect to address if sustainable transformation is to be achieved.

3 | CONCLUSION, IMPLICATIONS, AND LIMITATIONS

Transforming the workforce to achieve the future challenges of 21st century health care is a key enabler for supporting systems integration. While there has been a strong focus on strategic intent with very strong messages globally about placing the systems around the health needs of people and what matters to them, there is less understanding of how this will be achieved. It is argued that such transformation needs to primarily focus on the microsystems level where care is experienced and provided and the role of organizations and systems is one of enablement. The Venus model derives strong theoretical and philosophical foundations from four large complex research studies focused on whole systems working at different levels. Even though the model describes five key skill sets pivotal to successful transformation, no one skill set or approach is sufficient in itself.

The model can be used by a wide range of stakeholders to guide future workforce policy, education, and training. The implications of this model for transforming the workforce relate to how the workforce is prepared and developed to address a different way of framing health care that is wrapped around people and the person, person-centred practices, relationships, and what matters. This requires in itself a radical transformation in patterns of thinking and an approach that builds on collective leadership to grow social capital. Systems leadership skills will be vital if silos and boundaries are to be dismantled. The strong focus on values of people-centered approaches, safety, and effectiveness means that working with values to guide decision making will be a crucial skillset. Much more investment in the facilitation skills is needed to enable frontline teams to feel supported and empowered to contribute creatively to the solutions required. The powerful resource of CPD, too, needs to be marshalled to support the transformation agenda. Inter-professional learning, practice, and leadership, as well as continuous professional development, are all pivotal to the delivery and evaluation of sustainable transformation across the health economy to impact on future new models of care with a foundation in person-centred values, relationships, and shared decision making. This requires investment in new models of learning for the future workforce and a radical shift in the way in which we prepare undergraduate health and social care practitioners to learn in through and from practice in real time.

4 | LIMITATIONS

The Venus model has been developed over a number of years from inter-related and independent national and international studies and tested out in different contexts with policy makers, educationalists, health care leaders, practitioners, and service users. It has the potential to be adopted by professional regulatory bodies, policy makers, and higher education and health service providers, and embedded in the curriculum as the foundation for learning, development, innovation, and improvement for the future transformation of workforce. To achieve this, there is a need for visionary leaders and policy makers to see and understand the value of such an approach.

Further testing out of the model in practice at the individual, service, organizational, and system level in multiple contexts is needed to strengthen its application and further development.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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REFERENCES

1. Best A, Greenhalgh T, Lewis S, Saul JE, Carroll S, Bitz J. Large-system transformation in health care: a realist review. *Milbank Q*. 2012;90(3):421-456. https://doi.org/10.1111/j.1468-0009.2012.00670.x.
2. IOM (Institute of Medicine). *Committee on Quality of Health Care in America. Crossing the Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.
3. Bate A. Accountable Care Organisations Briefing Paper Number CBP 8190 July 6, 2018 House of Commons Library file:///C:/Users/kim.manley/Downloads/CBP-8190.pdf services. The secretariat. 2016. World health Authority, 2018.
4. WHO Europe. Towards People-Centred Health Systems Briefing Note. 2014. Health Services Delivery Programme, Division of Health Services and Public Health, Copenhagen: WHO Regional Office for Europe Copenhagen, 2014
5. Lanham HJ, McDaniel RR, Crabtree BF, et al. How improving practice relationships among clinicians and non-clinicians can improve quality in primary care. *Joint Comm J Qual Patient Saf*. 2009;35(9):457-466.
6. McCormack B, McCance T, eds. *Person-Centred Practice in Nursing and Health Care: Theory and Practice*. Oxford: John Wiley and Sons; 2017.
7. Beech J, Bottery S, Charlesworth A, et al. *Key Areas for Action on the Health and Care Workforce*. London, England: Health Foundation, The Kings Fund, The Nuffield Trust; 2019.
8. NHS National Health Service. *Interim NHS People Plan*. NHS; 2019.
9. Manley K, Martin A, Jackson C, Wright T. Using systems thinking to identify workforce enablers for a whole systems approach to urgent and emergency care delivery: a multiple case study. *BMC Health Serv Res*. 2016;16:368.
10. Martin A, Manley K. Developing standards for an integrated approach to workplace facilitation for interprofessional teams and social care contexts: a Delphi study. *J Interprof Care*. 2017;32(1):41-51.
11. Manley K, Jackson C, McKenzie C, Martin A, Wright T. *Safety Culture, Quality Improvement, Realist Evaluation (SCQIRE) Evaluating the impact of the Patient Safety Collaborative initiative developed by Kent Surrey and Sussex Academic Health Science on safety culture, leadership, and quality improvement capability*. Canterbury: England Centre for Practice Development; 2017 ISBN 978-1-909067-79-0.
12. Manley K, Martin A, Jackson C, Wright T. A realist synthesis of effective continuing professional development (CPD): a case study of healthcare practitioners' CPD. *Nurse Educ Today*. 2018;69:134-141.
13. Jackson C, Manley K, Martin A, Wright T. *Continuing Professional Development for Quality Care: Context, Mechanisms, Outcomes and Impact*. Canterbury: England Centre for Practice Development, Canterbury Christ Church University; 2015 ISBM 978–1–909067-39-4.
14. Manley K, Jackson C & Mckenzie C. Microsystems culture change—a refined theory for developing person centred, safe and effective workplaces based on strategies that embed a safety culture. in press. *Int J Pract Dev*. 2019.

15. Dawson, J. Staff Experience and Patient Outcomes: What Do We Know? A Report Commissioned by NHS Employers, 2014.
16. England NHS. Links between NHS staff experience and patient satisfaction: analysis of surveys from 2014 and 2015 NHS England. *Leeds*. 2018.
17. Nelson EC, Batalden PB, Huber TP, et al. Microsystems in health care: part 1. Learning from high-performing front-line clinical units. *Joint Comm J Qual Improv*. 2002;28(9):472-493.
18. West M, Eckert R, Collins B, Chowla R. *Caring to Change: How Compassionate Leadership can Stimulate Innovation in Health Care*. Kings Fund; 2017.
19. Plsek, P. Structures, Processes and Patterns: Key to Understanding and Transforming. http://www.directedcreativity.com/pages/PatternsOnePage.pdf. Accessed October 31, 2019
20. Cranley LA, Cummings GG, Profetto-McGrath J, et al. Facilitatio nroles and characteristics associated with research use by healthcare professionals: a scoping review. *BMJ Open*. 2017;7:014384.
21. Manley K, Titchen A, Hardy S. Work-based learning in the context of contemporary health care education and practice: a concept analysis. *Pract Dev Health*. 2009;8(2):87-127.
22. Manley K, Sanders K, Cardiff S, Webster J. Effective workplace culture: the attributes, enabling factors and consequences of a new concept. *Int Pract Dev J*. 2011;1(2):1-29.
23. Manley K, McCormack B, Wilson V, eds. *International Practice Development in Nursing and Healthcare*. Oxford, England: Blackwell; 2008.
24. McCormack B, Manley K, Titchen A, eds. *Practice Development in Nursing & Health Care*. 2nd ed. Oxford, England: Wiley; 2013.
25. Kitson A, Harvey G, McCormac B. Enabling the implementation of evidence based practice: a conceptual framework. *Qual Saf Health Care*. 1998;7:149-158.
26. Crowe C, Manley K. Person-centred, safe and effective care in maternity services: the need for greater change towards best practice. *Int J Pract Dev*. 9(1):8. https://www.fons.org/Resources/Documents/Journal/Vol9No1/IPDJ_09_01_08.pdf.
27. Manley K, Titchen A. Facilitation skills—the catalyst for increased effectiveness in consultant practice and clinical systems leadership. *Educ Action Res*. 2016;24(2):1-24.
28. Kouzes JM, Posner BZ. *The Leadership Challenge: How to Make Extraordinary Things Happen in Organisations*. 5th ed. San Francisco, CA: Jossey-Bass; 2012.
29. Titchen A. Critical companionship: a conceptual framework for developing expertise. Chp 10. In: Higgs J, Titchen A, eds. *Practice Knowledge and Expertise in the Health Care Professions*. Oxford, England: Butterworth Heinemann; 2001, 2001:80-90.
30. Manley K, McCormack B. Practice development: purpose, methodology, facilitation and evaluation. *Nurs Crit Care*. 2003;1(8):22-29.
31. Manley K, Titchen A, McCormack B. What is practice development? In: McCormack B, Manley K, Titchen A, eds. *Practice Development in Nursing and Healthcare*. 2nd ed. Chichester, England: Wiley-Blackwell; 2013:45-65.
32. Manley K, Buscher A, Jackson C, Stehling H, O'Connor S. Overcoming synecdoche: why practice development and quality improvement approaches should be better integrated. *Int Pract Dev J*. 2017;6(1):15. www.fons.org/library/journal/volume6-issue1/article15.
33. Edward M. Valuing what we can measure or measuring what we value? *Philantr Blog Opin Comment*. 2012.
34. Europe, WHO. *Lessons from transforming health services delivery: compendium of initiatives in the WHO European region*. *Health Services Delivery Programme, Division of Health Systems and Public Health*. WHO Europe; 2016.
35. Alderwick H et al. *Making the Case for Quality Improvement: Lessons for NHS Boards and Leaders*. London, England: Kings Fund & Health Foundation; 2017.
36. Chassin MR, Loeb JM. High-reliability health care: getting there from here. *Millbank Q*. 2013.
37. Manley K. A transformation culture: a culture of effectiveness. In: McCormack B, Manley K, Garbett R, eds. *Practice Development in Nursing*. London, England: Blackwell; 2004:51-82.
38. Drennan D. *Transforming Company Culture*. London: McGraw-Hill; 2002.
39. Schein EH. Organizational culture. *Am Psychol*. 1990;45(2):109-119.
40. West M, Dawson J, Admasachew L, Topakas A. *NHS Staff Management and Health Service Quality: Results from the NHS Staff Survey and Related Data Lancaster University Management School and The Work Foundation Aston Business School*. Government UK: Department of health and Social Care; 2011.

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