EVALUATION OF NDS INNOVATION FOR HIGH PERFORMANCE PROJECT

NATIONAL DISABILITY SERVICES (NDS)

FINAL REPORT

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Executive summary

Innovation for high performance refers to practices to improve service delivery by encouraging the engagement and creativity of the workforce. They typically involve greater autonomy for frontline staff in a high trust learning environment.

In February 2016 National Disability Service (NDS) offered members the chance to participate in a 10-month Community of Practice to trial innovative practices for high performance. In April 2016, NDS engaged ARTD Consultants as monitoring, evaluation and learning facilitators for the project. ARTD was also tasked with synthesising learnings for implementing innovation for high performance practices that may be useful for other disability services providers.

This report documents the processes and learnings from the project. While the project was not a trial of specific work practices providers were implementing approaches inspired by a common philosophy and design principles. Given the new context of individualised funding packages and the NDIS it was not surprising that ten out of the twelve participating disability service providers (83%) interviewed gave a rating of 9 or 10 out of 10 in terms of how likely they would be to continue to focus on these types of innovative practice in their organisation—the remaining two (16%) gave a rating of 7 and 8 out of 10. As one provider said *'We are making permanent changes to survive. If they have worked we have stuck with them, if they haven't we drop them, but we will keep going.'*

The Innovation for High Performance Project

Thirteen disability service providers from across Australia took up an NDS offer to participate in the project. Representatives from these service providers had the opportunity to develop and strengthen their approaches, document lessons and share learning along the way by participating in a community of practice. A number of other organisations and individuals also took part in the project as peers, expert advisors/ consultants and observers.

A range of opportunities were available to service providers throughout the project, including networking and information sharing activities (e.g. workshops and webinars), phone advice and consultations with NDS and ARTD, and access to resources and templates to assist with project planning, and with monitoring, evaluation, learning and reflection. ARTD also developed and administered a staff survey to benchmark drivers of innovative practices for high performance across organisations. This survey, including a brief 10-item version is available to the sector via NDS for providers to use for ongoing monitoring and evaluation. Drawing on the experience, but independently of this project ARTD is developing an App for simple, real-time data collection on outcomes for clients.

The innovation for high performance project was not a trial of specific work practices for which results might be measured and replicated. No two service providers were trialling the

same work practices and no two service providers were at the same stage of implementation. Service providers were experimenting with a range of approaches involving more devolved decision making to frontline staff. Many of these involved a reduced amount or change in scope of the role of middle management. While reducing staffing costs in an NDIS context was a key motivator for many service providers, it was the possibility of greater staff engagement and empowerment to provide more flexible client-centred services that drove enthusiasm for the approach.

Drivers of innovation for high performance

A core component of implementing innovation for high performance is having knowledge of the drivers for these practices amongst staff. Sophisticated analysis of the staff survey data revealed seven factors that can be distilled to just two key factors for IHP.

- an organisational commitment to continuous improvement based on staff engagement
- workers' self-confidence and the confidence workers perceive their managers have of their ability and decision making.

These two factors can be measured by 10 survey items: 'the IHP10'. Responses to these survey items are important for understanding the extent to which an organisation is creating a culture of innovation for high performance. Responses to these items were strongly predictive of staff stress using a validated stress scale, as well as thoughts about leaving the organisation. This analysis supports the use of these items for benchmarking and ongoing monitoring and evaluation.

1. At our organisation we highlight the learning that comes from successful service delivery
2. At our organisation we review the causes of our failures
3. At our organisation we frequently refine the provision of existing products and services
4. I feel that my opinions and views are listened to in my organisation
5. I feel that my knowledge and skills are recognised in my organisation
6. I feel valued by my organisation
7. My manager believes that I can handle demanding tasks
8. I am confident in my ability to understand the changing support needs of my clients
9. I can talk freely to my peers about difficulties I am having at work
10. I can make my own decisions on how I do my job

A framework for implementing innovation for high performance

Implementing innovation for high performance includes a process of leading change, and often of changing culture to empower frontline staff. As a result of the experiences of project participants a framework for implementing innovation for high performance has been developed. This incorporates findings from the staff survey, interviews and the literature on

these practices, as well as the broader literature on change management and navigating complex systems (including monitoring and evaluation).

The innovation for high performance implementation framework comprises 8 principles. While there is certain chronological order from top to bottom the principles are presented below in Figure E1 in a manner that depicts their interdependence.

Figure 1. The eight principles of implementing innovation for high performance

Overall the collective wisdom of the group might be summarised as

> *Communicate the vision with everyone. Ensure you have staff that actually enjoy working in a team-based, solutions-focused environment. Be transparent about the magnitude of any challenges and engage staff, carers and people with disability in finding solutions. Don't get stuck waiting till you have worked it all out before you start. Create an organisational environment of incremental change in which there is a continuous process of reviewing, reflecting and responding. Demonstrate the commitment of the leadership to devolve more responsibility to staff. Focus on teams that are led by the client and based on their local communities or neighbourhoods. Recognise the additional responsibility your workers are taking on, encourage them to apply their skills and be their most enthusiastic supporter. While a grand vision is motivating, and incrementalism is important to getting*

things going, staff need to be confident in their own abilities, and must feel supported while believing the change will ultimately benefit their clients.

The value of the innovation for high performance project

At the conclusion of the project service providers were interviewed by an ARTD Consultant who had not been involved in the project. All providers were very positive about their experience of the project and were highly motivated to focus on innovative work practices as a result.

Participants feedback focused on two key factors that made the project valuable for them: being able to hear what other service providers were doing while sharing information with each other, and adding rigour to the process by involving ARTD as an external consultant.

Different providers found different methods useful but overall, people found the workshops and survey data most helpful, and the webinars and online resources/ templates least helpful. Specifically, participating disability service providers liked the information presented by NDS and ARTD; a few commented that working through the program logic was especially useful and a couple that the presentation by NDS about self-organised teams was excellent.

1. Introduction

This section outlines the nature of the Innovation for High Performance project and the support provided to Community of Practice members.

1.1 The concept of innovation for high performance

Innovation for High Performance (IHP) refers to practices used to improve quality of service delivery by encouraging the engagement and creativity of the workforce. They typically include:

- people working with greater autonomy in a high trust environment
- simplified procedures and policies, made possible by staff having shared vision and values, and explicit ground rules of behaviour
- investment in training with personal responsibility for professional learning

By applying these practices typical changes observed in organisations are:

- flatter and less hierarchical organisational structures
- teams taking on more functions, responsibility and initiative
- multiskilling and enlarged job roles
- supervisors moving into a coaching and mentoring role.[1]

The logic of IHP is that it leads into more flexible service and better service delivery for clients by empowering staff and increasing their autonomy to respond client needs and wishes. This is intended to increase job satisfaction and reduces the cost of back office and management support.

IHPs are thought to align well with service delivery in the social care sector, especially as disability service providers strengthen their focus on person-centred support and high levels of customer satisfaction. This focus is relevant for service providers in the Australian context as they transition from block funding to individualised funding under the National Disability Insurance Scheme (NDIS). As these disability service providers are typically mission-based, it is expected that IHPs will mobilise workers' desire to deliver quality care that is responsive to the needs of customers—people with disability, their family and carers.

Current research also shows that high performing organisations are not only more profitable and productive in delivering quality, but that they also, 'perform better in many important "intangible attributes", such as encouraging innovation, leadership of their people, and

[1] National Disability Services, 'NDS High Performance Work Practices Innovation Project', 2016 [document supplied by NDS]

creating a fair workplace environment.'[2]

1.2 National Disability Services' Innovation for High Performance project

National Disability Services (NDS) is Australia's peak body for non-government disability service providers. It represents members that together operate several thousands of services for Australians with all types of disability. NDS advocates on policy issues and provides resources, training, networking and other supports to strengthen disability employment, business development, service quality and professional development across the sector. In recent years, NDS' work has also involved assistance to the disability sector as it transitions to the NDIS.

As part of this support, NDS held five workshops for disability service providers in 2015 and early 2016—one in Canberra, Melbourne, Adelaide, Perth and Tasmania—focusing on innovative work practices associated with high performance. This was undertaken as part of the Australian Government-funded Disability Workforce Innovation Network project. In February 2016, NDS invited selected service providers to a masterclass on one of the prime examples of innovation for high performance in social care, the Buurtzorg model (see section 1.2.4). Subsequently, service providers from across Australia, including many of the masterclass participants took up an NDS offer to participate in a 10-month collaborative project to trial innovative practices for high performance (the IHP project). Some other service providers joined the project mid-way through 2016.

1.2.1 A key contextual factor: introduction of the NDIS

In some cases there have been moves toward IHP for a long time, but the introduction of individualised funding under the NDIS has required services to be innovative in service delivery to be able to respond to individual needs of their clients. However traditional workforce practices and associated award conditions can constrain the ability to be flexible and maximise client choice and control.

All the service providers participating in the project faced some variant of the following problem: the introduction of the NDIS means only lean and efficient services that are nimble and responsive to client needs will survive. Also, service providers may face existing challenges with staff satisfaction, stress and retention in traditional hierarchical management structures that are costly and which can reduce timeliness, flexibility and above all, the client-centred services that are required for service providers to remain viable.

[2] Boedker C., Vidgen R., Meagher K., Cogin J., Mouritsen J., and Runnalls J. M, *Leadership, Culture and Management Practices of High Performing Workplaces in Australia*, University of NSW, Australian School of Business, published by Knowledge Economics, Sydney Society, October, 2011 [funded by Department of Education, Employment and Workplace Relations].

1.2.2 Aim and scope of the IHP innovation project

The aim of the IHP project has been to support disability service providers that are experimenting with new models based on high performance work to strengthen their approaches, and to document lessons and share learnings along the way. The project has also aimed to capture lessons of wider significance that can be shared across the disability sector.

The project was set up to include service providers adopting a range of IHP approaches—potentially but not necessarily involving the adaption of the principles of international models to the Australian context—that were at different stages of trialling or implementation. It could include service providers testing IHPs within particular sections or teams, or rolling these out across the service provider as part of a whole-of-business transformation.

The important implication is that the IHP project was not a trial of specific work practices for which results might be measured and replicated. Instead the focus was on individual and systemic learning that may be of use for other services considering implementing innovative work practices.

1.2.3 Components of the project

The IHP project involved a network of thirteen disability service providers from across Australia, coordinated by NDS, which are experimenting with these news ways of working.

These service providers submitted business cases outlining the rationale and key elements of the IHPs being trialled or implemented and signed a Memorandum of Understanding with NDS that outlined expectations around their participation in the project as part of a Community of Practice (CoP). Another five organisations/ individual consultants engaged with the network as peer contributors or observers. Others 'dipped into' the project through occasional participation in the Community of Practice webinars.

In April 2016, NDS also engaged ARTD Consultants as monitoring evaluation and learning facilitators to assist these service providers to develop, refine and reflect on the approaches to monitoring and evaluation around their IHPs. ARTD supported services to question and refine their IHP changes by developing resources (e.g. the Monitoring, Evaluation and Learning (MEL) template in Appendix 1), providing feedback on findings along the way (e.g. the IHP Project Newsletter in Appendix 3), phone based support, and contributing to webinars to assist services to undertake their own developmental evaluation. ARTD was also tasked with documenting and reflecting on the overall project through a realist lens to identify lessons for these and other service providers in the sector to consider if embarking on IHPs in the future.

Networking and information sharing activities

A range of opportunities were available to disability service providers throughout the project. This included online and face-to-face forums through which to network and share information/ experience about IHP implementation or evaluation, as well as tailored guidance to individual service providers about specific implementation or evaluation approaches (provided face-to-face and over the phone by NDS and ARTD respectively).

In doing this, NDS worked closely with six of the thirteen service providers that were still in the scoping, planning or early implementation stages while ARTD worked closely with six service providers that were at a more advanced stage of implementation. Figure 1 summarises these activities in a timeline of events.

Figure 1. Summary timeline of networking and information sharing activities

Month	Activity	Purpose/ focus
Feb-16	Workshop 1	Explore the Buurtzorg model
Mar-16	Webinar 1	Consider other HPWP models and experiences
Apr-16	Webinar 2	Emerging themes from business cases, introduction to developmental evaluation
May-16	Webinar 3	ARTD's role as learning facilitators; HPWP intended outcomes and program logic
Jun-16	Workshop 2	Network; HPWP transformation principles; thinking about monitoring and evaluation
Jul-16	Webinar 4	Types and approaches to forming self managing teams
	NDS interviews/ consultations	Discuss 'early phase' business cases and implementation plans
	ARTD interviews/ consultations	Discuss 'late phase' approaches to monitoring and evaluation
Aug-16	Webinar 5	Communication approaches, implementation risks and challenges
	Webinar 6	Observations around evaluative thinking
Sep-16	Reflections newsletter	Share insights on monitoring, evaluation and reflective thinking
	NDS interviews/ consultations	Follow up progress with implementation
	ARTD interviews/ consultations	Scope and refine HPWP survey with sample of organisations
Oct-16	Webinar 7	Preliminary HPWP survey findings
	HPWP survey summary reports	Individual reports for organisations compared to organisational average
	NDS interviews/ consultations	Follow up progress with implementation
	ARTD interviews/ consultations	Realist interviews: -what works well, when and why?
Nov-16	HPWP survey data distributed	Raw data to allow further analysis
	NDS interviews/ consultations	Follow up progress with implementation
	Workshop 3	Network, reflections, learnings and next steps
Dec-16	Webinar 8	Reflections and project closure
	ARTD feedback interviews	Satisfaction with the HPWP innovation project

Resources

Resources were also developed and shared online with CoP members. These included case studies, research papers, and tools and frameworks relevant to implementing IHPs (such as

the Monitoring, Evaluation and Learning (MEL[3]) template in Appendix 1). Evaluation resources and templates were also shared online.

1.2.4 Buurtzorg and JP van den Bent models

There are a number of well-developed examples in the international literature of social care service providers that embed IHPs. Many of these examples are described as having high performing teams that are 'self-organising', 'self-managing', 'self-governing', or 'self-directed' (often used interchangeably) or 'semi-autonomous', depending on the types and degrees of decision-making authority that teams are empowered with at the local level.

Throughout this report we have used the term 'self-organising teams'. This better reflects the reality that teams are not independent of oversight or management. This aligns with the experience of a former Buurtzorg (see below) employee who provided reflections of their experience working in the model. It is also more consistent with the principles of self-organisation in complexity theory, from where the concept originates.

Two examples from the Netherlands were explored more in depth in the project and inspired a lot of the trials of the CoP-members. NDS reviewed, translated and shared relevant literature and visited these organisations in the Netherlands.

One of these organisations is a leading example of IHP named Buurtzorg Nederland, a not-for-profit Dutch homecare provider. Buurtzorg (Dutch for "Neighbourhood Care") started in 2007 with one team of nurses that wanted to change how in-home care was being delivered in the Netherlands. They put the patient back at the centre of care delivery. Their focus is on delivering community nursing and social care services that makes the most of people's existing strengths and capacities, with a view of empowering people towards being as independent as possible. For this to work they realised that nurses needed to have the autonomy to work closely with each person and their 'care system' of family, friends, other care professionals and the local community to find supports and solutions for each individuals situation. This resulted in 'self-organising' neighbourhood teams responsible for all aspects of the organisation and delivery of care in a particular neighbourhood from in-take, assessment, developing the care plan and providing care to rostering, planning, recruitment, budget management and procurement. The nurses have 'coaches' (rather than managers) on hand to help solve problems, as well as a bespoke IT system for scheduling appointments, rostering, patient documentation, and a small back office for administration. Buurtzorg has grown rapidly while maintaining this flat organisational structure; in 2015 it was employing 10,000 nurses in 800 neighbourhood teams (i.e. about 12 nurses per team) and providing care for 70,000 people. Owing largely to its very low administration and management costs they run on very low overheads. Notably, Buurtzorg was awarded 'Best

[3] The role of ARTD evolved over time, originally conceived of as of monitoring and evaluation of the trial, it quickly evolved to include a focus on facilitating the reflection and learning of service providers for better service provision in light of their specific innovations.

Employer of the Year' in 2011, 2012, 2014 and 2015 and has been found to have some of the highest satisfaction rates among patients in the Netherlands.

Another example, specific to the disability care sector, is JP van den Bent Foundation (JPvdB) which provides a range of accommodation, in-home support and day activities for people of all ages with mild to very complex and multiple (intellectual) disabilities. Teams are responsible for direct service delivery, take ownership of day-to-day decisions about how they support people, and are responsible for their team's finance, procurement and HR. Staff are provided with internal training, making use of train-the-trainer methods, to ensure they have the skills they need to work directly and responsively with clients, their families/carers. Unlike Buurtzorg, however, JPvdB does not work with fully self-organised teams; they have a location coordinator who facilitates decision making at the frontline, and who is supported by a regional coordinator. JPvdB has also been recognised with industry awards for employer satisfaction, client satisfaction, and has operated with low overhead costs by industry standards.[4]

1.2.5 Project participants—Community of Practice (CoP) members.

Thirteen disability service providers from across Australia participated directly in the IHP project: Able Australia, ACES, Aspire, The Bridge, Cooperative Home Care, Community Living Project, EACH, Essentials Employment & Training, EW Tipping, Lifebridge, Parkside, Rise and Sharing Places. The participation of these service providers was led by staff from a range of positions: CEOs, general managers, divisional directors or managers, and HR managers. Together these participants formed a Community of Practice (CoP).

An overview of key features of these service providers and their IHP implementation sites is presented in Table 1 (over the page). As evidenced in the table, they represent a full spectrum of the diverse range of disability service providers in Australia; from small service providers operating in a local area providing specialised support for a community of people with disability, to large interstate service providers that operate across a number of sectors (e.g. aged care, mental health) as well as the disability sector. Some of the service providers are fairly new while others have been established for many decades. Some already have a culture around innovation while others are taking steps to develop this for the first time. By virtue of their location, there are service providers that are already operating under the NDIS; some that were in trial sites, and others that will start making the transition over the next couple of years.

A number of other organisations and individuals also took part in the project as peers, expert advisors/ consultants and observers. This included representatives from Project Independence, UnitingCare Community QLD, Kath Milne and Associates, North West Residential Support Services and My Supports.

[4] Stamet, Y., 'Innovation for High Performance: Case study JP van den Bent', NDS, 2016

Table 1. Key features of service providers and IHP teams

NDIS transition	Location	Whole/ part of the org. implementing IHPs	Year that IHP change commenced	Location of IHP team(s)	No. of staff in teams+	No. clients supported by teams+
Roll out since July 2016	Tas.	Part	2016	One residential house	<10	5
To start in July 2017	NSW	Whole	Late 2014	Teams across regional centre	48	98
To start in July 2017	NSW, Vic	Whole	2016	Teams across regional towns	35	143
To start in Sept 2018	Vic	Part	2016	Teams in metropolitan are	12	34
Started in July 2016	NSW	Whole	2013	Teams in four locations across metropolitan area	25	20
Roll out since July 2016	SA	Part	2016	Team in one location in metropolitan are	t.b.c.	t.b.c
Various	Vic, NSW, Qld, Tas. and ACT	Part	2015	Disability service workforce across states	140	t.b.c
To start in July 2017	NSW	Part	2016	Teams in regional centre	10	2
Various	Vic	Part	2016	Over 30 teams across metro and regional areas	347	165
To start in July 2017	NSW	Part	2016	Two teams in regional town	6	13
Roll out since July 2016	Tas.	Part	2016	Two teams in regional town	3-6	12
Trial site	WA	Part	Late 2015	Disability services workforce across metropolitan area	215	180
Complete	ACT	Whole	Early 2016	Teams across metropolitan area	100	140

+Approximate numbers based on head counts: may include team coordinators/ leaders, excludes managers

1.2.6 The scope of innovation in the IHP trial

The IHP project was not a trial of specific work practices for which results might be measured and replicated. While the two Dutch models provided inspiration for all disability service providers participating in this IHP project, no two service providers were trialling the same work practices and no two service providers were at the same stage of implementation. Service providers were experimenting with a range of approaches involving more devolved decision making. Many of these involved a reduced amount or change in scope of the role of middle management. While reducing staffing costs in an NDIS context was a key motivator for many service providers, it was the possibility of greater staff engagement and empowerment to provide more flexible client-centred services that drove enthusiasm for the approach.

The scope of change being implemented varied for different service providers. Many might be characterised as small scale, 'safe to fail' experiments, whilst others were whole organisational changes involving considerable reforms—even if slowly and incrementally implemented—with no going back.

There is a common view that the types of changes trialled in the IHP project are necessary for survival under the NDIS. In the post project survey, ten out of the twelve CoP members (83%) interviewed gave a rating of 9 or 10 out of 10 in terms of how likely they would be to continue to focus on 'high performance work practices' in their organisation—the remaining two (16%) gave a rating of 7 and 8 out of 10.

As one CoP member said *'We are making permanent changes to survive. If they have worked we have stuck with them, if they haven't we drop them, but we will keep going.'*

1.3 Monitoring evaluation and learning for the project

This collaborative, developmental approach to the project saw the evaluation consider a number of different approaches to facilitate learning by creating resources and opportunities to build evidence, reflect on experiences and share lessons before identifying the best way to support service providers during their IHP transformations.

As noted above, it soon became evident that the implementation of IHPs was not so much a discrete 'trial' but rather part of what is expected to be a cultural change in how business is done. Accordingly, we found that service providers—especially those in the later stages of their IHP transformation—needed assistance with thinking about how best to use and build on their existing systems/ processes for gathering data (i.e. information about staff experiences, workplace satisfaction, client satisfaction and outcomes) and ideas for how to fill specific data gaps, rather than assistance to do "mini-evaluations" around their IHP teams.

Ultimately, our approach was to make available a range of resources (e.g. a program logic, templates, a staff focus group guide) and opportunities (e.g. participating in reflective discussions and an IHP staff survey) for service providers to engage with, and encourage them to engage with, to the extent they saw fit according to their needs and priorities. This utilisation-focused approach was chosen so as not to impose obligations, or 'hoops to jump through', that may not contribute to their IHP transformation. It was also felt to be an approach that appropriately acknowledges the different stages that service providers are at (one size does not fit all) and the high levels of sophistication, especially around evaluative thinking, that already exist in a number of service providers.

Interviews and reflective practice discussions

Working closely with six of the 'late phase' service providers, ARTD conducted at least two and often three interviews with each of these service providers between July and November 2016. Interviews, which generally lasted at least an hour, were semi-structured and involved a large reflective discussion component.

ARTD encouraged CoP members to think deeply about what they are trying to achieve, how they think their activities will contribute achieving the outcomes set out in the program logic, what success and failure would look like (outcomes), and how they would identify these (what kinds of information is being collected). ARTD also challenged CoP members to consider new ways to think about these issues and to reflect on what they have learnt, and CoP members used the opportunity to bounce ideas off the learning facilitators.

Realist synthesis interviews were conducted with early and last phase service providers in the last month of the project to gather insights about 'what is working' and in what circumstances: the mechanics and contexts around which outcomes are observed. These interviews were semi-structured and tailored to the stage of IHP implementation relevant to the service provider.

As part of these interviews, CoP members were encouraged to reflect on the IHP staff survey data and what this told them about the drivers of high performance in their service provider.

The results of these interviews are contained in the framework for implementing IHPs in Section 3 of this report.

Templates to document progress and learnings

ARTD, in partnership with NDS, developed a number of templates: Project Overview, Planning and MEL. These templates were designed for service providers to complete, in collaboration with ARTD and/or NDS, using information gathered through interviews and the IHP survey (with ARTD focusing on using the MEL template with late phase service providers). The generic MEL template is in Appendix 1.

ARTD individualised MEL templates for each of the seven late phase service providers and populated these with information about their IHP transformation that had been gathered from business cases and interviews. A summary report of the IHP survey data was appended to the template.

NDS individualised the planning template for early phase service providers, updating this with information about their progress in designing, setting up or implementing IHPs. NDS provided ARTD with these templates, contributing a valuable source of data to the evaluation.

Sharing lessons and learning through webinar, workshops and newsletter

ARTD also worked with NDS to create opportunities for reflective practices across the board—between the early and late phase service providers. ARTD contributed to the workshop and webinars hosted by NDS (see Figure 1) to share insights about evaluative practices observed across service providers.

ARTD also developed an evaluation newsletter mid-way through the project to document and share findings that were emerging from interviews (Appendix 3).

IHP staff survey to benchmark drivers for IHPs

Many CoP members were interested in getting a sense of their progress in implementing IHPs and transforming their organisational culture. This was identified by ARTD as a data gap across service providers: while some already ran staff surveys (annually or on the occasional basis), these were not tailored to pick up on the factors most relevant to understanding IHPs.

Accordingly, ARTD developed a survey to:

- assess the presence of four key drivers of IHPs in each service provider: professionalism, leadership approach, learning culture and person-centred approach

- gain insights among staff involved in the IHP transformation about their buy-in to the change, confidence in outcomes of the change, and workplace stress.

The survey made use of a number of items from the Study of Australian Leadership survey[5], the Intentional Personality Item tool[6], and a standardised job stress scale[7], and some new items developed by ARTD and NDS.

The survey was completed online. It was distributed to the staff of 12 IHP trial service providers (one had recently completed a staff survey and chose not to participate). In some cases the survey was sent directly to staff by ARTD using individual web links, in other cases the survey was sent by the service provider directly to their staff. In total, 214 people responded to the survey resulting in an overall response rate of 39 percent.

Project feedback interviews

An ARTD staff member, external to the learning facilitation team, conducted final feedback interviews with CoP members to gather their views on the overall experience of being part of the IHP innovations project. The interviews covered their satisfaction with networking, information sharing opportunities and resources made available by NDS and ARTD, and views on what they had gained from being a member of the IHP community of practice. Suggestions about how NDS can continue to support disability service providers that are trialling or implementing innovative ways of working were also gathered from CoP members.

1.3.1 The organisation of evidence in the framework

The framework in Section 3 provides a holistic account of key issues associated with movement towards IHPs. It is intended to be useful to any disability service provider considering going down the path of IHP as a means of empowering staff, increasing the sustainability of their organisation, and better meeting the needs of clients. We have done this through a synthesis of the experiences of IHP CoP members, viewed through a realist, complexity-navigating, change-management lens. But what does that mean?

Realist evaluation seeks to uncover what it is about a set of actions that generates change and the features of context that constrain or enable that change. While the actions are themselves observable, the real knowledge is about the hidden or abstract mechanisms that can be called upon time after time to generate change in other situations with similar contextual conditions. For example, on a realist account, "opening the books" to staff is not

[5] 'Study of Australian Leadership—Leadership at work', The Centre for Workplace Leaderships, http://sal.workplaceleadership.com.au/

[6] International Personality Item Pool, 'A Scientific Collaboration for the Development of Advanced Measures of Personality and Other Individual Differences', http://ipip.ori.org/

[7] Job Stress Scale by Lambert, Hogan, Camp & Ventura 2006, cited in 'Workplace stress evaluation tools', Australian Centre for Research in Employment and Work (ACREW), Monash University, Tracey Shea and Helen De Cieri, October 2011, p.g. 30 www.iscrr.com.au/__data/assets/pdf_file/0011/297758/Workplace-Stress-Evaluation-Tools_Full-Report_1011.pdf

meant literally as something that generates change, but it is the abstract mechanism of financial 'transparency' that, in a context of honest and committed staff, generates greater understanding, engagement and commitment to the need for a new way of working to ensure the service provider is financially sustainable.

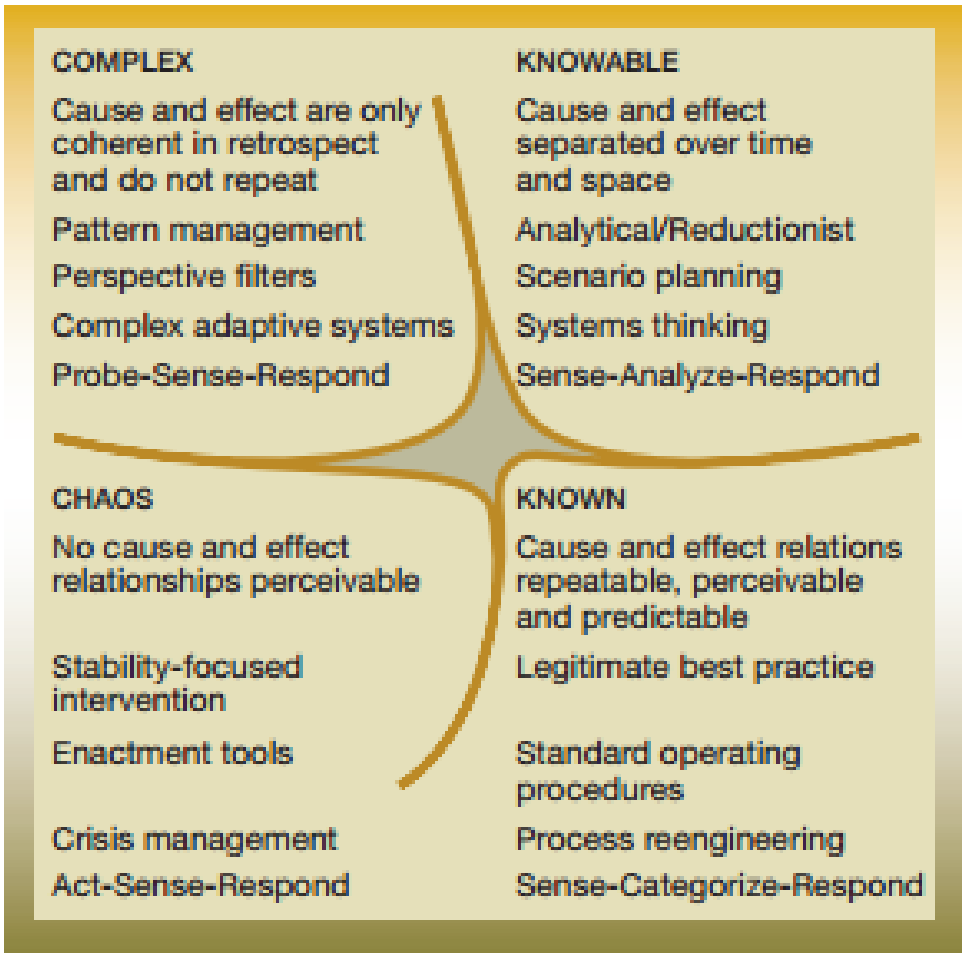
Change management is about how organisations marshal the people and resources at their disposal to move from one state of affairs to another. Our experiences in this project have revealed great diversity in services providers' starting points and the ambitiousness or scope of IHP change being attempted, yet there are common threads in the effective and ineffective means of leading a change that, broadly speaking, is about shifting their organisation from a command and control hierarchy, to one with empowered decision making among front-line staff.

Navigating complexity is about recognising that when a situation is complex, it is not possible to develop a recipe book of how to proceed. Rather, a principle-based approach that includes "safe to fail" experiments and a commitment to scale up success and terminate failures, is more useful. With more simple or complicated problems, such as how to install a wheel chair ramp, there can be best practice approaches. But when the situation is complex, when it is about equipping staff to respond to a client's changing needs, effective practice emerges and changes over time.

The Cynefin framework for decision making in complex systems recognises[8] that different types of actions (and their monitoring and evaluation) are more or less appropriate depending on the system in which interventions are being made. For example, rather than a linear approach from defining a problem to developing a simple solution, the most effective means of action in complex circumstances is often to Probe-Sense-Respond (See Figure 2). While often implicit in the actions of CoP members, some were familiar with this framework as a result of NDS support.

[8] 'A Leader's Framework for Decision Making', Harvard Business School, https://hbr.org/2007/11/a-leaders-framework-for-decision-making

Figure 2. The Cynefin framework for decision making in complex systems



Source: Kurtz, C. F., & Snowden, D. J. (2003). The new dynamics of strategy: Sense-making in a complex and complicated world. IBM Systems Journal, 42(3), 462–483.

Pulling it all together

Theories can be dense, but their true value for policy and practice lie in their implications. The Cynefin framework and complexity theory when combined with a realist understanding of causality, provides a firm theoretical foundation for innovation in service delivery AND a rigorous approach to evaluation that is appropriate to the context. In many cases this will involve a process of 'Probe-Sense-Respond' using action-research principles. That is, looking at current circumstances, developing ideas of what might be effective, testing them on a small scale, seeking to understand how and when these approaches are effective, and then doing more of what you have learned is effective, in the different contexts.

The emphasis of monitoring and evaluation in this context is more on 'evaluative thinking' than trying to endorse or warrant certain practices as 'effective' through experimental design. It will often involve gathering data that provides a relatively complete picture of the service delivery landscape (including outcomes for clients, staff and the service provider), while seeking to understand how interventions work or could be improved through lots of

solution-focused discussions with frontline staff and clients. For more detail see Sections 3.7 and 3.8.

1.3.2 Using program logic to inform monitoring and evaluation, and to support reflections

During the initial stages of the project we drafted a generic program logic diagram to describe the sequence, or hierarchy of conditions to be achieved by trial activities, in a move from a one state of affairs to another, from a problem to an intended outcome (Figure 3).

It is an idealised description of an intervention and simplifies a complex reality. It is a tool to support thinking—not a replacement for thinking. The model is designed to be useful for communication about a trial and can provide a framework to guide monitoring and evaluation by identifying key milestones.

The program logic has been used to frame discussions and interview guides, and has been used as a tool by service providers to structure their reflections on what things appear to be working well, or not so well, and why.

The program logic focuses on the *necessary* conditions for the program to be implemented as intended to deliver outputs that will then be *sufficient* or *contribute* to ultimate intended outcomes. It focuses on ends, not means. It has two main parts.

Starting at the bottom and working towards the middle level outputs we have the

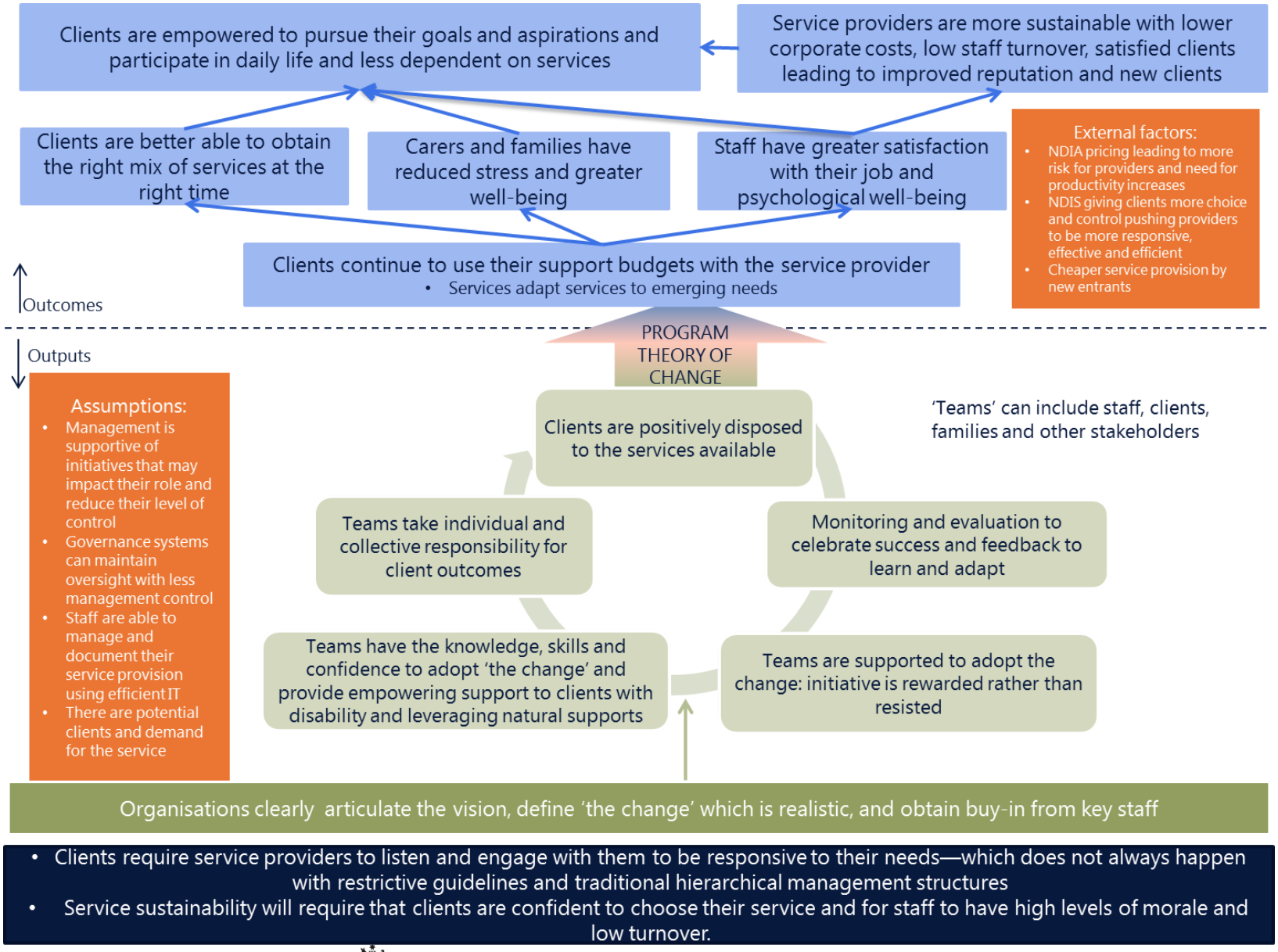
- problem we are trying to address
- necessary foundations or things that must be in place before we have any chance of being able to deliver the change as intended
- immediate and intermediate changes necessary for the delivery of outputs that will drive the change
- assumptions we are making that will, if they hold, ensure that our outputs will be sufficient for generating our intended short term outcomes.

From the middle level outputs to the top level outcomes we have the changes we hope the trial is *sufficient* for generating. This is where the theory of change describes why or how we expect the outputs of our actions will lead to intended outcomes. It displays

- short term outcomes generated as a result of our outputs and in the event that our assumptions hold
- long term outcomes we expect to contribute towards that help keep us focused and which provide the rationale for the program in the first place
- external factors outside the control of the intervention that will affect the degree to which we can achieve our long term outcomes.

The program logic proved to provide a robust description of the inherent logic of changes being trialled for increasing the autonomy of frontline staff working in teams and required only a very minor update by the end of the trial (see Section 4.2).

Figure 3. IHP generic program logic



2. Key factors in innovation for high performance

A core component of implementing IHP is having knowledge of the drivers for these practices amongst staff. In the section below, we describe how data from the ARTD staff survey was analysed to determine the key factors underlying IHP, and the shorter IHP10 was developed survey for benchmarking and ongoing monitoring and evaluation.

2.1 Understanding high performance work practices from a staff perspective

The development of the IHP staff survey is described in Section 1.4. We report the responses to survey items in Appendix 4. In this section we move straight to the analysis of hidden patterns in the data that can explain the drivers of IHP.

Using a principle components analysis (with varimax rotation) the survey data can be found to reveal seven 'factors'[9] for IHP (Table 2). The factor number represents statistically how important each factor is for describing the survey data. That is, the first factor is more important than the second and so on. In the IHP survey these factors generally fall out of the data in the order of organisational factors describing the most variation, moving towards team factors, and then to personal attitudes. For example the factor explaining most variation (and potentially therefore the most important to get right) was being valued and supported by the service provider (factor 1) followed by a monitoring and evaluation culture (factor 2). These were relatively more important than personal attitudes of staff (factors 5 & 7).

[9] These seven explain 67% of all the variation in all 39 items designed to measure IHP

Table 2. Seven key factors of IHP at the level of the service provider, relationships and personal attitudes

	Organisational Factors	Relationship with mangers/ peers	Personal attitudes
Stronger explanations	Being valued and supported by the service provider (factor 1)		
	A monitoring, evaluation, learning and adapting culture (factor 2)		
		Feeling trusted by management (factor 3)	
	Innovation and tolerance for risk (factor 4)		
			Confidence in own abilities (factor 5)
		Sense of peer support (factor 6)	
Weaker explanations			Satisfaction in autonomy (factor 7)

2.2 Job stress and staff perceptions of 'the change'

The survey also included a Job Stress Scale (JSS) and 12 items about staff perceptions of 'the change' being trialled in their service provider.

'The change' items can be described by three key factors that should form the key focus for 'selling' the change to staff. These are addressed in more detail in the framework for implementing IHPs in Section 3.

- Belief in outcomes for the service provider and clients (factor 1).
- Alignment with organisational and personal vision (factor 2).
- Staff and organisational readiness for change (factor 3).

2.3 Development of the IHP10

Using a series of factor analysis and scale construction metrics, it was determined that the responses to just 10 items can determine whether a service provider is providing an IHP environment. These scores have good predictive validity for staff stress and intentions to quit the organisation.

1. At our organisation we highlight the learning that comes from successful service delivery
2. At our organisation we review the causes of our failures
3. At our organisation we frequently refine the provision of existing products and services
4. I feel that my opinions and views are listened to in my organisation
5. I feel that my knowledge and skills are recognised in my organisation
6. I feel valued by my organisation

7. My manager believes that I can handle demanding tasks
8. I am confident in my ability to understand the changing support needs of my clients
9. I can talk freely to my peers about difficulties I am having at work
10. I can make my own decisions on how I do my job

A confirmatory factor analysis suggested two key factors that summarise the seven factors referred to in Section 2.1:

- an organisational commitment to continuous improvement based on staff engagement
- workers' self-confidence and the confidence workers perceive their managers have of their ability and decision making.

The final 10 item scale was developed in the following way

- a factor analysis of the 39 items to identify 7 key factors
- a construction of reliable scales for factors 1,2,3,5 & 6 (factors 4 and 7 could not be reliability constructed were incorporated into other scales) using 2-4 items per scale for a total of 20 items[10]
- a further factor analysis suggesting 10 items with high loadings across different factors, and clearly distinct aspects of IHP
- a scale score for the 10 items that was calculated for each survey respondent (using the mean score from the 10 items)
  - a reliability analysis showed this scale had very well internal consistently (alpha=0.87)
  - a very high correlation with the 20 item version (.97) further suggesting the simplicity of the 10 item scale over the 20 item version on the grounds of parsimony.

The predictive validity of these 10 items is suggested by the fact that for every 1 unit increase on the IHP10, there is a 0.6 unit decrease in 'I often think about quitting this job' and a 0.5 unit decrease on the JSS.

2.4 Implications for ongoing monitoring of staff attitudes

The analysis here shows the importance of a supportive and reflective culture and the development of staff skills and confidence for a high performance workplace where stress is managed. We recommend that services pay attention to these key factors for IHP and use the IHP10 and the six item JSS to monitor IHP and staff stress on a six-monthly, annual or other basis (as determined by the service provider) against the baselines measured in October 2016. This will provide useful diagnostic information as well as provide a source for identifying trends in the data over time and amongst different groups of staff.

[10] High to acceptable reliability was achieved for each scale with Cronbach alphas ranging from .933-.606 for a total of 20 items across 6 scales

3. A framework for implementing innovation for high performance

> *I've realised that high performing teams is not about finding high performing workers to put into teams, but about creating a team in which people can perform highly, to build them up. (CoP member)*

If it wasn't already clear at the outset, it became clear there is no recipe for becoming a high performing service provider. Each service provider had a different starting point and has tried different things—and all are still on the journey and remain dedicated to this way of working.

Despite this diversity we identified eight common principles (Figure 4) that emerged from CoP members' experiences (including through statistical analysis of staff survey data and interviews). These principles, represented below, create a framework that should be relevant to any service provider when considering *what to focus on when implementing* IHPs.

Figure 4. IHP implementation framework

In considering these items, it is important to remember that IHPs do not occur in isolation from broader business development strategies—they are one part of a bigger picture, not the ''magic bullet'. In the words of one CoP member in the IHP project, IHP principles, '*should be thought of like a symphony';* led and harmonised through a common vision.

3.1 Lead with a clear vision that speaks to staff and clients alike

A clear vision for change has been a recurring theme. Where we observed that changes had been implemented most smoothly, those leading the change have done so by inspiring acceptance of a vision among their staff and clients—not simply by telling people what to do, or what has been done. Fortunately, the kind of vision needed to inspire support of IHPs is often broadly similar to, and conducive to, the visions that already exists in many mission-based disability service providers: that is, around making the lives of clients better and providing staff with meaningful and sustainable employment e.g. *'happy and safe customers and a viable business that excels'*.

A broad vision may need to be slightly refined or re-articulated to clarify exactly *how* it aligns with objectives around increasing choice and control for clients over their lives, and increasing flexibility and autonomy for staff in decision making. We have observed that emphasising client and staff empowerment and the opportunities that arise from this—such as creative problem solving and innovation—can be effective in linking the vision to the objectives. Moreover, an effective vision tends to be one that articulates how IHPs can actually make the achievement of these objectives easier e.g. by empowering staff to make good decisions based on the practical wisdom they have gained from their increasingly direct transactions with clients.

This process of clarifying the vision and aligning it with objectives can take time and requires ongoing attention to communications (see 3.2). A view expressed by a number of CoP members in the IHP project was that organisational leadership needs to model the vision with coherent action so that key messages are reinforced. In service providers where changes have progressed well, this is been led through a dedicated "change team" that is focused on supporting the translation of the vision into practice by bringing staff and clients along with the journey through mentoring and coaching.

3.1.1 Develop a memorable vision that can be applied in practice

A clear vision—such as a mission of value statements that states broad principles and sets expectations—can function as a heuristic that facilitates staff to make self-organised decisions that cohere with the objectives of high performance, and can be applied without having to resort to defined policies and practice procedures.

> *Clarity on the vision coupled with discernment in decision making can be a more agile, efficient and effective means of generating outcomes than ruled based procedures. (CoP member)*

This approach is supported by complexity theory[11] and is also consistent with literature of self-organised teams. Hart for example, emphases the value of storytelling and making a vision memorable by using your own words i.e. using language that is familiar and accessible to staff.[12]

Once the vision is set staff need the authorisation and encouragement to apply these as situations arise. One service provider has adopted the "SELFI" principle for guiding decision making in line with the organisational vision: when making decisions, staff need to ask themselves, '*Is it safe, ethical, legal, financially viable and innovative'?*

3.1.2 Align personal and organisational values through the vision

It is important for staff to identify an alignment between their personal and professional vision, and that of the service provider. This is important for taking ownership and a sense of responsibility for outcomes and commitment to the service provider.

> *The vision needs to articulate both collective and individual accountability. (CoP member)*

> *Everyone has a stake in the entire organisation so they commit, create a 'yes'' culture. (CoP member)*

Staff should be allowed room to come to realise this alignment themselves (and if there is no alignment for an individual staff member, discussions held about their future at the service provider), although the process can be supported informally through key messages to staff (3.2) or facilitated more formally e.g. through specific activities or initiatives with staff.

Box 1: Examples of ways to support the alignment of personal and organisational visions

- In one service provider, staff is supported to develop a one page profile for themselves that describes their interests, priorities and needs. Their profiles are reviewed with team leaders on a 3 monthly basis to inform discussions around what is working well or not so well with the aim of achieving alignment between their professional values and goals and the organisational vision.
- One service provider ran a series of team building exercises around values where staff workshopped the organisational values and came up with six personal values and six team values that support this. In this way, values are explicitly spoken—people are encouraged to talk about how they make their decisions based on these values. It is a powerful accountability tool because teams have ownership of the values that they created.

Ensuring that clients and their carers/ families endorse the vision and recognise how this is conducive to leading a more empowered and independent life is crucial to forming a positive

[11] Snowden, D., *Multi-ontology sense making; a new simplicity in decision making*, Management Today Yearbook. 2005.

[12] Hart, W., 'Twisted self-directed organisations', 2015, translated by Gilbert Kruidenier, April 2016 www.verdraaideorganisaties.nl

team dynamic led by the client and their family (see 3.4). As one manager participating in the project said,

> *We want to help families envisage a good life for the person with disability. We will be successful when there is a match between the vision of the family and the vision of [organisation] about what is a good life for the person. (CoP member)*

We have observed that, when staff and clients start to take personal and professional ownership of the vision, the devolution of decision making authority towards self-organised teams is enabled. This might, however, take some time—'*you need to be patient and persistent*' (CoP member)—and so service providers often need to start taking other steps towards high performance while monitoring the progress of this during implementation (see 3.3).

3.2 Communicate, communicate and communicate

The clearest source of both successes and challenges faced by service providers involved in the IHP project are related to communications—communicating the vision to begin (3.1), but also communicating the steps along the way.

> *Keep talking about it till everyone tells you, "it's ok, we get it!" (CoP member)*

> *We didn't create a strong enough vision for the workforce about why we were making the changes. It's worthwhile spending time on this before making changes. I thought we had done a good job – maybe in some locations with stronger leadership we had done enough – but overall we hadn't achieved this. (CoP member)*

When communications have been successful, we have observed the key messages are tailored to difference audiences in a way that addresses everyone involved, and are framed in a way that is both positive *and* realistic.

A number of CoP members in the project reflected that they had not spent enough time explaining to their workforce *why* they were making the changes such that there have been pockets of acceptance, but the whole workforce is not on board.

3.2.1 Open channels of communication to include everyone

We've consistently observed that it is crucial that *all* staff affected by changes are engaged in the conversation, not just senior staff. This means that communications should be tailored and layered to account for the perspectives and concerns of staff in different positions within a service provider: people need to understand why it is in their interests and those of clients to implement IHPs. Communications should also be adapted to emerging contexts and refreshed so that the messages are relevant and energising. Often, this has involved practical changes to things like meetings so that there are more regular opportunities to share experiences.

Opening up communication forums has made a big difference. (CoP member)

What and how language is used can set the tone for inclusive conversations. While service providers do this in different ways, perhaps unsurprisingly it was more common among the service providers participating in the IHP project to engage *communications consultants* rather than hire change management consultants. Another tool that has been particularly effective for a service provider in the IHP project in keeping communications open, and for making difficult conversations easier, using a simile to describe the journey of the service provider, staff and clients.

Box 2: Crafting language to communicate the change
One service provider has made use of maritime similes to describe how their organisation, a large ship, has been on the dock to rebuild in preparation for the NDIS. It is now navigating somewhat unchartered territories, which are moving and changing. Like a large ship, the organisation is big and so slow to steer through these waters, but the staff and clients are like the winds in the sails that provide the energy and motivation to change.

A benefit of inclusive communications—rather than avoiding the difficult conversations—is that it can spot resistors to the change early on and bring these people along by genuinely engaging, listening and responding to their concerns. Sometimes this may mean having both one-on-one and group conversations to air these issues. Service providers have found that doing this prevents resistance from fermenting, and can in fact convert people into supporters of the change, *'one of our early resistors is now one of our biggest champions' (CoP member)*.

Dedicating time with clients to communicate the change is similarly important so that they feel empowered to take on a more proactive role with more self-organised teams—potentially even leading the team that is centred around them (see 3.4). Clients and their families need to have a clear sense of how changes to how workers decide how deliver care means that they will also have more direct say in what and how they receive care. In service providers that are envisaging that clients and their family become the team leader, then deep, ongoing and nuanced communications are especially critical in forming a positive team dynamic. At the same time, communications with clients and their families need to address any concerns head on and explain the rationale for changes in service delivery—being transparent about this can built trust.

3.2.2 Communicate positive and realistic messages that build urgency around the change and secure trust in its rationale

Effective messaging around IHPs need to make the rationale for change very clear—a sense of urgency can be useful to motivate focus, which might be related to the sustainability of the service provider and services on which people rely—while framing this need both *positively*, so people have confidence in its success, and *realistically*, so people are prepared for challenges ahead.

The introduction of the NDIS has been the catalyst for action for many service providers, and often the sense of urgency already exists due to pressing concerns around financial viability. Yet we have also found, depending on NDIS roll-out timeframes, that the sense of urgency has not been so immediate in some service providers. In these cases, more work has been required to get "buy in" from board members, staff and clients about the imperative to start doing business differently. Insofar as it is often helpful to have a sense of urgency, however, lessons from the IHP survey indicate that this should be done in a nuanced way that frames the NDIS as an opportunity to be captured rather than a threat or cause for pessimism.

> *Although a sense of urgency is important you also need to communicate a sense of optimism as people are worried about their jobs. And some people are not impacted by NDIS yet. So you need to create the optimistic picture alongside the sustainability picture. (CoP member)*

Box 3: Lessons from the IHP survey—support the philosophy of the NDIS

While it may be tempting to blame the NDIS for making change necessary, the survey data showed the strongest predictor of staff support for change that would lead to better outcomes for their clients, was their level of support for the NDIS[13]. Attitudes to the NDIS are heavily shaping attitudes towards the change. The more that can be done to promote the benefits of the NDIS the more staff are likely to support the need for change as being good for their clients—even if it is relatively easy to convince them of the benefits for the service provider and to an extent themselves.

It is also important that key messages engage external stakeholder, including unions. In a couple of instances in the IHP project, CoP members have observed the need to engage unions in the rationale for change and proactively address their concerns about resources and working conditions

> *IHP raises the risk of industrial action, we were about to start a trial but hit protected industrial action, this impacted on our ability to implement the pilot, we got totally de-railed. We replaced the team leaders with few coordinators and they bring new things like coaching and mentoring. Unions see an IHP as reducing the resources that staff have to call on. They see the NDIS as leading to the casualization of the workforce. Before we make the changes we should have consulted with the unions because we had a heavily unionised workforce. Unions don't seem to appreciate that providers really will go out of business under new arrangements i.e. the combination of modern award and NDIS. (CoP member)*

Relatedly, we have observed in numerous service providers participating in this IHP projects that a key mechanism for generating this sense of urgency has been through transparency.

3.2.3 Transparency is a crucial part of communicating the urgency for change in a way that builds trust

Engaging boards, staff and clients with the need for change has most commonly been done through transparency about the financial reality of service provision in an NDIS environment and so "opening the books" to staff, and sometimes clients too.

[13] The only item that predicts whether people think the change is good for their clients is whether they think the NDIS will be good for their clients (see Table 9 in Appendix 4)

Box 4: Using transparency around fleet vehicle costs to communicate the need for change
A service provider explained how they would not be able to pay for the vehicle fleet if their business as usual model continued. They were transparent about this issue with clients and families and together agreed on a solution:

We had a meeting with parents and showed them the figures. We knew we had to charge clients for their use or down size the fleet. We gave them the options and they overwhelming wanted to work out a way to keep the vehicles. So we had to downsize or collect payments. It went down really well with parents as we set out all the facts and worked through the solutions together. Users now play a flat fee per trip based on distance in band i.e., 0-5 km, 5-10 km etc. (CoP member)

Service providers have done this to different extents, choosing to share more or less information or different types of information depending on their circumstance and what they feel is appropriate for their current workplace climate. Yet it has been consistently reported that this approach has had a productive impact on engagement with the need for change by engendering trust in management from staff who feel more confident that IHPs are being implemented with the best interests of clients and staff in mind, and who in turn feel respected by being included in these conversations that they had not been privy to in the past.

Trust can also motivate full engagement in the co-production of new solutions. For example, transparency around changing financial circumstance can also be effective in explaining why certain resource s (e.g. transport) may need to be delivered differently, and so teams of staff and clients look locally for community facilities, such as local pools and parks, that do not require a longer drive to the service providers' "drop in"' centre.

3.3 Take the first step to start but then adapt along the way

A journey of a thousand miles starts with a single step, it is important not to wait till everything is ready before getting started. Once the vision and objectives are clear and accepted among staff, clients and families, and stakeholders then take the first step. Don't wait till you are 'ready' to start, and don't over think it. You may need to take the first step before everyone is 100 per cent on board, or before you have defined all the fine details about teams and their roles; otherwise things will never start!

We have observed that an incremental approach that embraces trial and error is required to move towards IHPs.

> *Have a plan but be ready to throw it away. Principles over plans. (CoP member)*

> *The quicker you get into it, the quicker you solve the problem–but, this doesn't mean rushing into something hastily. Our approach has been explorative, tentative, with a tolerance for risks where it is safe to fail. (CoP member)*

In other words, an IHP change should not be approached as a grand "5 year plan" that is pre-designed, packaged and rolled out in entirety, but rather as an evolutionary process that is guided by a clear vision, energised by the motivation of staff and clients, and participatory in

that there are ongoing opportunities for input, refinement and co-design along the way. It may start locally, at a small scale or within one team, or start by devolving decision making power around just a couple of roles and responsibilities. Given that you can't design everything perfectly in advance, we've observed that a factor that supports success is having an ear to the ground with effective feedback loops so that service providers can be adaptive and share good news stories. This incremental approach is consistent with principles of effective monitoring and evaluation in complex systems (See 3.7& 3.8).

3.4 Form a positive client-focused team dynamic

Organising teams around client need, and management team and back office supports based on the need of frontline teams, rather than a top down approach of determining what services to provide, forming teams to deliver these and offering them to clients was emphasised as a key part of IHPs. This is consistent with the NDIS principle of putting the client at the centre of planning. This is also consistent with the idea from complexity theory that what works at one level of an organisation (putting people's needs first) often works at other levels. Teams can evolve in different ways and have different compositions, often depending on whether the service provider is establishing teams within an existing workforce or with new staff.

IHP teams tend to be defined by their location more than their function and tend to revolve around the clients in those locations rather than their service offerings. In more mature forms this tends to include teams where the client is the team leader, and teams that work in neighbourhood "hubs" around a group of clients. The size and composition of teams, the resources they have and the resources they access, will be defined by clients' neighbourhoods rather than the service's catchment. Locally-based teams also enable workers to maximise their time "in the field". This can often require that they are well supported by technology that links them to the office (see 3.7).

It appears there is a natural alignment between teams that are person-centred and maximise opportunities for clients to be independent, and empowered teams that make the most of their self-organisation by leveraging mainstream community resources to create these opportunities within a 'neighbourhood'.

It was stressed that no two teams will be exactly alike and will be at different stages of maturity and readiness for a more self-organising role

> *In the future we will be looking at assessing teams against a framework to work out where they fit on IHP continuum, and this will help us work out what we need to do to help these teams move forward. (CoP member)*

3.4.1 Within an existing workforce, teams can emerge from existing networks between staff and clients

Teams within existing workforces tend to be most successfully created and sustained when they are supported to develop organically around clients or local communities of clients, and informed by existing staff networks. With full alignment of the organisational vision with that of staff and clients, we've found that teams can be re-defined with the client as the team leader, and with workers belonging to multiple client-led teams clustered around a local area.

> *We started with an existing organisation and workforce, and needed to change that. This process started early, a year or so ago, when we allowed attrition to lean out the back end, and started focusing on getting the cultural and team setting right: we did this, establishing mutual trust by having conversations with staff about what needs to happen. We also ran a staff survey to understand the culture, if and how they feel supported and ready for the NDIS.*
>
> *But we struggled with the idea of the 'team' for a long time, then realised that the team is centred around the client: the client is (or is notionally, with their family/ carer) the leader. These teams have formed organically over the years, and so we are relaxed about defining them. But, the client at the centre now is still a big shift in thinking: it means that staff need to work alongside family as part of the team, and that requires trust. (CoP member)*

In this context, the potential risks that come with transferring responsibility to teams are managed by ensuring there is sufficient ownership of issues through the vision—this includes clients and their families being coached to partner with workers in problem-solving around issues, and workers being motivating through coaching/ mentoring relationships with other staff (see Section 3.5).

> *Rather than workers asking managers 'can we do this?' they are now asking the person with disability, 'how will we do this?' (CoP member)*

Responding to feedback or issues identified may require that emerging roles and responsibilities are clarified—not necessarily "set in stone", but clarified on the basis of their relationship to the vision, principles and expectations. This is as much a conversation about what new things are required, as well as what old ways of working need to be retired—especially for those who were in management or coordination roles moving into coaching roles.

3.4.2 There is a role for natural attrition and self-selection out of the workforce

It is not uncommon for teams to have to have difficult conversation among themselves and with staff who are resistant to working in more autonomous ways. Team conversations are important, but it also helps to engage one-on-one with staff who have concerns to ensure that they feel heard. Self-organised team work may simply not suit some peoples'

preferences or reflect what they want out of a job. That's ok. They need to feel comfortable if they choose to select out of the organisation. This was an experience among service providers in the IHP project: they found that, by having open conversations about expectations and future directions, staff who felt unable to align their personal values and the organisational vision (3.1) would quickly realise this and tend to move on with minimal conflict or disruption.

3.4.3 Recruiting wholly or largely new teams best occurs in response to clients and their need

When new staff or a whole new team is needed, we have observed that service providers in the IHP trial tend to form new teams—and do so most successfully—when new staff are recruited *for a new client*, or for a growing local community of clients. In other words, the worker's role exists in response to client demand, rather than to fill a position or roster vacancy.

Box 6: Forming new teams around clients

One service provider involved in the project only recruits workers for a new client, and they work in a self-organised team of about 12 workers (with a team coordinator who works across teams) within a defined local area. While workers operate fairly independently in the field, with responsibility for their own rostering and care coordination, they meet monthly to share experiences and every three months with their team coordinator to discuss performance and professional development. *'The advantage is worker retention: people want to stay workers for longer. We have very low turnover, and are collecting data on this. And we have satisfied workers.' (CoP member)*

Service providers recruiting new staff often sense this must be easier than forming teams within an existing workforce because for new team members—especially people new to the disability sector— self-organised ways of working do not feel like such a big shift in practice, "*they have clean eyes*" (CoP member). While this can be true, it is not always the case. There are plenty of examples of experienced hands who are committed to the vision and who welcome the freedom to innovate and respond more flexibility to client needs.

3.5 Mentor and coach staff to become professionals in all they do

Mentoring staff in how they work with clients and in how they manage responsibilities as part of a team has been a common theme. Many service providers have found that using online modules for core competencies, supported by on the job training, works well: not only is this feasible in an environment of low resources, but it also fits well with the ideal of tailored, person-centred support for clients. For example, basic core competencies in manual handling can be taught online and then refined with on-the job training for specific clients.

A focus on inter-personal communication through professional development that uses mentoring and train-the-trainer techniques also complements these approaches and can

build rapport between staff with different levels of experience. These skills are transferable to relationships with clients and family members. CoP members described how mentoring/ coaching is important to ensure that staff are supported. The resilience and self-reliance of workers is an important step towards the resilience and self-reliance of future managers—this is another example of the way in which "what works" to improve outcomes at one level of an organisation, can be reused and reapplied at other levels, as appears in complexity theory.

3.5.1 Value, encourage and support staff to instil confidence in their ability

The staff survey (Section 2) demonstrated the importance of an organisational commitment to continuous improvement and self and manager confidence in personal ability and decision making. IHP teams are effective because staff are engaged, celebrating successes helps to increase the fuel for future success. Highlighting success and responding to challenges are instrumental to making change, but a process of *celebrating success* and communicating short term wins also builds momentum for future successes.

Giving staff confidence they have the ability to make difficult decisions, and that you have confidence in their ability is a crucial factor for implementing IHP. This can be achieved through lots of 'positive affirmation' and 'catching people doing the right thing' and reinforcing good practice. It is important that you 'let go' of staff gradually, sensing where they are ready to make their own decisions and where they need guidance. Over time it should be possible to increase levels of autonomy, such as transferring control over training budgets.

3.6 Unleash the potential, but prepare the IT and administration

It is natural to raise concerns about oversight and risk managements when teams are more autonomous. In a newly developed team where staff have not yet developed sufficient ownership of problems they observe it is possible that team members who perceive a risk may not react as it is their personal responsibility, but a responsibly of a someone in a more senior or different position. In the JPvdB model this issue is addressed by introducing the phrase 'stop hold it' a safety sentence someone from within or outside of the team could use to start a process of reviewing reflecting and responding.

For many a key risk management approach is ensuring that teams enter all necessary administration, incident reports etc. in an appropriate IT system so that oversight is maintained. Teams that no longer expect 'the system' to be responsible for outcomes and that take more responsibility for client outcomes can increase the appreciation of why it is important to keep accurate records to inform decision making.

Many service providers reflected that they had not fully worked through the changes to IT and administration that were needed to allow teams to be more self-organised. While it is hard to implement IHP in isolation from other business planning needs, this doesn't mean waiting until the "perfect" IT system has been identified or developed (see 3.3). Developing or investing in new systems is costly and once an investment is made it can be hard to 'go back'. It can be helpful to take small steps to work out which are the *essential* features of a system, and which can be let go of. Where possible, systems that integrate service delivery, management and payroll functions can work well – to this end some service providers are experimenting by developing bespoke systems.

Box 7: Developing an integrated social media and human services IT system to facilitate client-centred self-organised teams

One service provider in the IHP project is in the process of developing a fully integrated social media and human services system through which staff and clients connect directly to make care arrangements, linked to back end administration and payroll. Service users and clients have been engaged throughout the development process to inform and pilot the platform that should be ready in mid-2017. The service provider has offered other service providers in the IHP project the opportunity to be involved in testing the platform with the aim of making it available to these service providers at low cost.

3.7 A two-pronged approach to monitoring and evaluation

It is important for all services to know what success looks like without being too rigid about how it will be judged. Monitoring and evaluation should have a clear focus but be equally agile and consistent with the principles underpinning the project. As the CEO of one of the most IHP advanced services said

> *Don't overthink or micro-manage it: let things develop organically, but do carefully monitor progress with the big picture in mind. (CoP member)*

The final two parts of this IHP implementation framework combines the wisdom of CoP members with that of the ARTD evaluation team's experience and knowledge of the literature on evaluating innovative and developing initiatives in complex systems. It is focused on monitoring and evaluation that is accurate and useful for learning and decision making.

As has already been observed, while complexity theory has provided inspiration for program design, it also has implications for monitoring and evaluation. In line with the Cynefin framework[14] and Results Based Accountability[15] and Realist Evaluation[16], an outcomes focused approach in complex adaptive social systems is not primarily about *measuring* 'attributable' long term outcomes. This is because innovative interventions are usually diffuse

[14] 'A Leader's Framework for Decision Making', Harvard Business School, https://hbr.org/2007/11/a-leaders-framework-for-decision-making

[15] Friedman, M., *Trying hard is not good enough*, Charleston, SC: BookSurge Publishing. 2009.

[16] Pawson, R., *The Science of evaluation: a realist manifesto,* SAGE Publications Ltd. 2013.

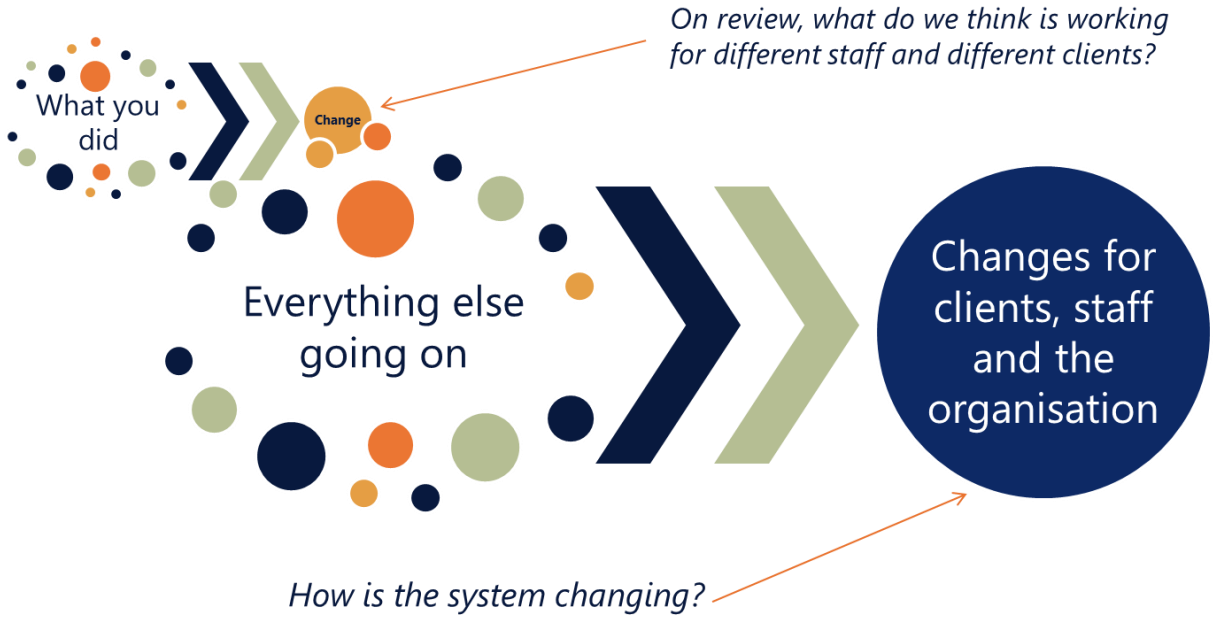
and evolving,[17] and there are simply too many causes to be disentangled that while sometimes understandable in retrospect, often do not repeat (see Figure 1 and footnote 15).

We discuss these implications as a two-pronged approach to monitoring and evaluation (Figure 5).

- The first is the importance of 'evaluative thinking' and a review, reflect and respond cycle of action research that engages people in the conversation about outcomes—this is the less formal and more day to day approach to monitoring and evaluation focused on learning and improvement.
- The second is more formal and focused on 'measuring outcomes' using a basket of proxy indicators with sufficient range to represent the important parts or the 'health' of the system. While these indicators can be referred to as outcomes, it is more correct to refer to them as changes—an outcome implies it was the result of just your actions and somehow separate from all the other factors that are necessary for a change to occur.

This second approach will not always be sufficient for 'rigorous' evaluation of attributable outcomes often requested (and rarely achieved) to provide accountability to funders. We suggest that despite this much expense can be spared following our two pronged approach and that is more appropriate and useful in the context of innovative work practices.

Figure 5. A two-pronged approach to monitoring and evaluation focused on understanding how to generate local change while keeping track of overall system changes



[17] Patton, M. Q., *Developmental evaluation: applying complexity concepts to enhance innovation and Use*, Guildford Press. 2011.

3.8 Review, reflect and respond

Thinking evaluatively is a critical element of planning and conducting MEL activities, especially within small service providers and those with limited capacity to run MEL projects. Evaluative thinking means that reflective practice is embedded in everyday ways of doing things and can be structured in more or less formal ways: making use of team meetings to routinely ask reflective question and monitor progress of issues can work well.

> *Evaluative thinking is not just limited to evaluation projects…it's an analytical way of thinking that infuses everything that goes on. Willingness to do reality testing: to ask 'How do we know what we think we know?'*[18]

We were very encouraged to see that 'evaluative thinking' was a natural tendency for most CoP members, and second that survey data revealed that engaging in these practices was the strongest predictor of staff stress and 'thinking about quitting', across all elements of IHP. Both were related to what we are calling an organisational culture of Monitoring, Evaluation, Learning *and Responding* (MEL_R). This kind of culture is typified by positive responses to such survey items such as:

- at our organisation we highlight the learning that comes from successful service delivery
- at our organisation we review the causes of our failures
- at our organisation we frequently refine the provision of existing products and services.

It was often remarked that when the right thing to do is not determined by a set procedure—people need to be more explicit about the reasons for doing something a certain way. It is also only logical that a more empowered workforce that is making more decisions needs ways of probing and sensing, reviewing and reflecting in order that better decisions can be made. This requires a culture of evaluative thinking, of being able to answer the questions of 'why do we do it that way?'

In addition to, or as part of cycles of review, reflect and respond, an innovative service provider will be well served in learning how to generate intended outcomes by testing their ideas or 'theories' about what they did. While theories are often implicit and talk of them may cause people to 'roll their eyes', they are a constant feature of any intentional action. Most of what we do in our professional life is based on some theory as to why we think it will work. Testing theories can be done by answering the evaluative thinking question: 'what makes this the right thing to do?' An answer to this question may be arrived at using a range of methods. It might include both qualitative and quantitative data; it may be more or less precise and it may use the full range of methods for impact evaluation[19] depending on the questions being asked, the time and money available and the level of certainty required.

[18] Michael Quinn Patton: 'In Conversation: Michael Quinn Patton', International Development Research Centre, www.idrc.ca/en/article/conversation-michael-quinn-patton?PublicationID=771

[19] See *Choosing appropriate designs and methods for impact evaluation* published by the Australian Government Department of Industry Innovation and Science.

A positive MEL culture is also important for dealing with an unintended consequence of IHPs—that in a more self-organised team that has ownership over its decisions there is no longer a system to blame! While workers need to be able to face feedback, learn mentoring skills, and be open to doing things differently, individual blame was considered particularly corrosive in the more devolved decision making environment. It was considered that when problems arise (which they will) these need to be treated as being about the team or process (rather than an individual), as something to be expected and managed, and as opportunities for learning, rather than framed as the result of mistakes by individuals.

In practice a MEL culture might include the following types of interactions for team members

- Regular team-based meetings (daily/ weekly) to discuss specific clients and issues.
- Semi-regular team-team (fortnightly/monthly) forums to discuss issues and share ideas.
- Periodic review and analysis of quantitative data for discussion of patterns and trends at meetings/ forums.

Box 8: Evaluative thinking in team meetings
One service provider in the IHP project uses a 'mind map' technique in teams meeting to foster evaluative thinking. The mind map is drawn with a client in the centre, problems written in red and potential solutions written in green. In the next meeting staff can refine their understanding of any problems and report back on the utility of any solution attempted.

Appendix 2 contains a focus group template that ARTD developed for CoP members to use with their staff in team meetings to foster reflection and learning around the IHP change.

As with most aspects of the framework, 'evaluative thinking' will be strengthened by what happens in other aspects—in particular the greater the focus on professional development and mentoring and team identified learning opportunities the more developed the MEL culture is likely to be.

3.9 Focus on measuring improvements across a range of indicators

It is only natural to want to know how much of a change you brought about when engaged in social policy and programs. Yet, many evaluators that have worked in and studied complex adaptive systems are wary of measuring 'attributable' long term outcomes or net impact as a means of determining the value of some intervention. This is such that understanding past impact is not always useful for understanding how to generate future impact[20].We agree with Snowden (see footnote 15) that a new simplicity in decision making is required rather than trying to disentangle complex causal webs, and we agree with Friedman (see footnote 16) about the need to 'let go' of measuring 'attributable' outcomes.

[20] Cartwright, N., and Hardie, J. *Evidence-based policy: a practical guide to doing it better*, Oxford University Press. 2012.

Despite the difficulty of measuring 'attributable' outcomes in complex systems, a focus on and accountability for outcomes in evidence-based policy and programs is more important than anything else. If proxy indicators are broad enough, based on program theory and logic and focused on both outputs and outcomes they can be blended together (often also with reference to changes in the operating environment of a program) to construct an evidence-based performance story about an organisation, program or service.

During the development of the IHP Program logic and MEL templates it became apparent that all service providers had basically six short term and three longer term outcomes about which data could be collected. These are shown in Box 9 below.

Box 9: Commonly identified shorter and longer term outcomes of IHPs

Intended shorter term outcomes

- Workers support the change being trialled
- Workers and customers are valued as individuals
- Workers feel a sense of professionalism and accountability for outcomes
- The service provider cultivates a high trust and values based model of leadership that focuses on decentralised decision making
- The service provider supports a learning culture—creativity, innovation, safe to fail experiments, joint problem solving and feedback loops
- Workers have higher levels of satisfaction and lower levels of job stress.

Intended longer term outcomes

- Customers are empowered to pursue their goals and aspirations including more choice and control over activities in their daily life
- Customers are living fulfilling lives
- Service provider is financially sustainable.

These outcomes can be transformed into qualitative and quantitative indicators with success criteria for judging to the extent to which an outcome can be considered to have been achieved[21] (Table 3). This data can be combined to develop performance stories. These stories need both performance information and comparisons to help judge whether performance is good enough. In many cases the comparisons will be improvements to the service provider's own history—but it may also include comparison to indicators for different parts of the organisation not involved in the project or reference to industry benchmarks.[22]

[21] Measuring longer term outcomes related to customer was identified as a data-gap for many CoP members in the IHP project. Drawing on the experience gained through the IHP project, but independently of it ARTD is developing an App for simple, real-time data collection on outcomes for clients. Several of the CoP members of the IHP project have agreed to test this App.

[22] The data reported in the IHP survey for this project from 13 different IHP service providers can be used and updated to create an IHP staff satisfaction and engagement industry benchmark

Table 3. Suggested indicators emerging from consultations with CoP members about their IHP transformation

Question	For whom?	Methods/ Indicators
How much did we do?	Clients	Number of clients, change in client numbers by disability type, and geographic location etc.
	Organisation	Spend on salaries, vehicles etc.
	Staff	Number of staff by qualification, FTE, skills, salary level etc.
How well did we do it?	Clients	Feedback on activities, planning, client numbers (and $ spend), client absences etc.
	Organisation	Revenue, % spend on overheads etc.
	Staff	IHP10 survey items
Is anyone better off?	Clients	Client quality of life – using surveys or the app for real time client outcomes monitoring (see footnote 21)
	Organisation	Financial position
	Staff	Stress levels and turnover
What are the broader longer term changes we hope to contribute towards?	Clients	Quality of life for people with disability in our region (SDAC – data, HILDA or other longitudinal data set based survey)

Overall, it is important not to lose sight of the purpose of doing monitoring and evaluation. What really matters for a sustainable service provider is that the lives of clients and the wellbeing of staff are getting better, that they maintain a positive connection to the service provider and that the service provider and its staff learn how to generate better outcomes—a dissatisfied staff member or client won't stay because a statistic tells them their service provider is high performing. A set of measures at different levels of the system and for different stakeholders will alert you to problems before the clients start leaving. When complemented by frequent or periodic attempts to make sense of the data and make changes that are themselves reviewed, service providers give themselves the best chance of retaining the right staff and assisting clients to live fulfilling lives.

3.10 Conclusion

We have identified the following key messages from service providers participating in the IHP trial which are likely to be important for any service provider contemplating an IHP approach.

Communicate the vision with everyone. Ensure you have staff that actually enjoy working in a team-based, solutions-focused environment. Be transparent about the magnitude of any

challenges and engage staff, carers and people with disability in finding solutions. Don't get stuck waiting till you have worked it all out before you start. Create an organisational environment of incremental change in which there is a continuous process of reviewing, reflecting and responding. Demonstrate the commitment of the leadership to devolve more responsibility to staff. Focus on teams that are led by the client and based on their local communities or neighbourhoods. Recognise the additional responsibility your workers are taking on, encourage them to apply their skills and be their most enthusiastic supporter. While a grand vision is motivating, and incrementalism is important to getting things going, staff need to be confident in their own abilities, and must feel supported while believing the change will ultimately benefit their clients.

4. Project feedback

Of the thirteen service providers that were involved in the IHP project, twelve were interviewed by an ARTD Consultant who had not been involved in providing MEL support to CoP members. We were unable to interview one service provider as they did not respond to email or telephone messages.

Interviewees were encouraged to provide their honest feedback about the project's process, the methods used and the support provided by both NDS and ARTD.

4.1 Overall feedback

All CoP members interviewed were very positive about their experience of the project. CoP members said that with the roll-out of the NDIS and in the current climate of change, there is some confusion within service providers about how to adapt their work practices to suit the new conditions. CoP members said they were grateful for the opportunity to receive this support and it has been vital for their planning.

Overall, CoP members identified two key factors that made the project valuable for them:

1. being able to hear what other service providers were doing and sharing information with each other, and
2. adding rigour to the process by involving ARTD as an external consultant.

Most service providers had not started developing their high performing work practices and/ or had not heard of self-organising teams prior to the IHP project. During the interview, CoP members were asked on a scale of 0-10, where 0 is 'not at all likely' and 10 is 'definitely', how likely they were:

1. to continue to focus on 'high performance work practices' in their organisation
2. to continue or start to place greater emphasis specifically on self-organising teams.

Ten out of the twelve CoP members interviewed gave a rating of 9 or 10 for question 1 (the remaining two gave a rating of 7 and 8) and eight of the twelve provided a rating of 9 or 10 for question 2 (the remaining four CoP members provided a rating of 7 or 8).

The high ratings for these questions indicate that CoP members are highly motivated to focus on high performance work practices as a result of the project.

4.2 Feedback about different methods

Different CoP members found different methods useful but overall, people found the workshops and survey data most helpful, and the webinars and online resources/ templates least helpful.

Webinars

Some CoP members found the webinars really useful and especially appreciated the opportunity to hear what other service providers were doing and to receive regular updates about what was happening in the sector. A couple of people said they were very well moderated.

However, several CoP members found the webinars difficult to engage in and put this down to technical issues and wasted time trying to deal with these. All of these CoP members said that the webinar format is useful but they were frustrated by the technical issues and put off from participating.

Suggestions made for improvement included sending out meeting requests for the webinars well in advance so people could block out sufficient time, and sorting out the technical issues. A few people also said it was difficult to participate in a webinar during the working day due to busy or noisy offices so would have liked these to be available to be watched at another time too.

Workshops

CoP members were most enthusiastic about the workshops. People said they liked being able to meet other service providers and discuss what they were doing, either formally during sessions or through informal chats in breaks. A few people said the second workshop was particularly helpful as service providers had made progress and could share what they had been doing as well as how they were dealing with various challenges.

CoP members also liked the information presented by NDS and ARTD; a few people commented that working through the program logic (Figure 3) was especially useful[23] and a couple of people said the presentation by NDS about self-organised teams was excellent.

Two suggestions were made for improving the workshops. One was to make it possible for people to dial in via video conferencing, as some people were unable to attend due to lack of time or budget to travel to the workshop sites. The other was to organise CoP members into different groups throughout the day; for example by state, then by size and then by stage/ progress in the process.

[23] A minor amendment to the program logic in Figure 3 was made in the final workshop to emphasise that the 'teams take *individual and collective* responsibility for client outcomes', whereas initially it was just referring to teams taking responsibility.

Resources/ templates

Two interviewees found the templates really helpful at the beginning of the project, especially the one that helped them describe their project and think through what they would be doing. However, most people interviewed had either not used the templates and other resources or had not found them that useful.

A couple of interviewees had found the readings provided useful and had shared them with others in their service provider, particularly with management to orient them to high performance work practices and the models used. One interviewee had used NDS's paper about the two models and found this explanation of the principles very helpful.

Staff survey

All CoP members interviewed found the staff survey to benchmark IHP drivers helpful and useful. Several people said they thought it was very well-designed and robust, and this gave them confidence in the results, as well as in using the survey in the future.

Most people intended to re-administer the survey to their staff in the future to obtain some longitudinal data on progress during the changes. A couple of small service providers only had three or four respondents but they still said that the questions gave them something to think about, and as their service provider grows, they intend to keep using the survey.

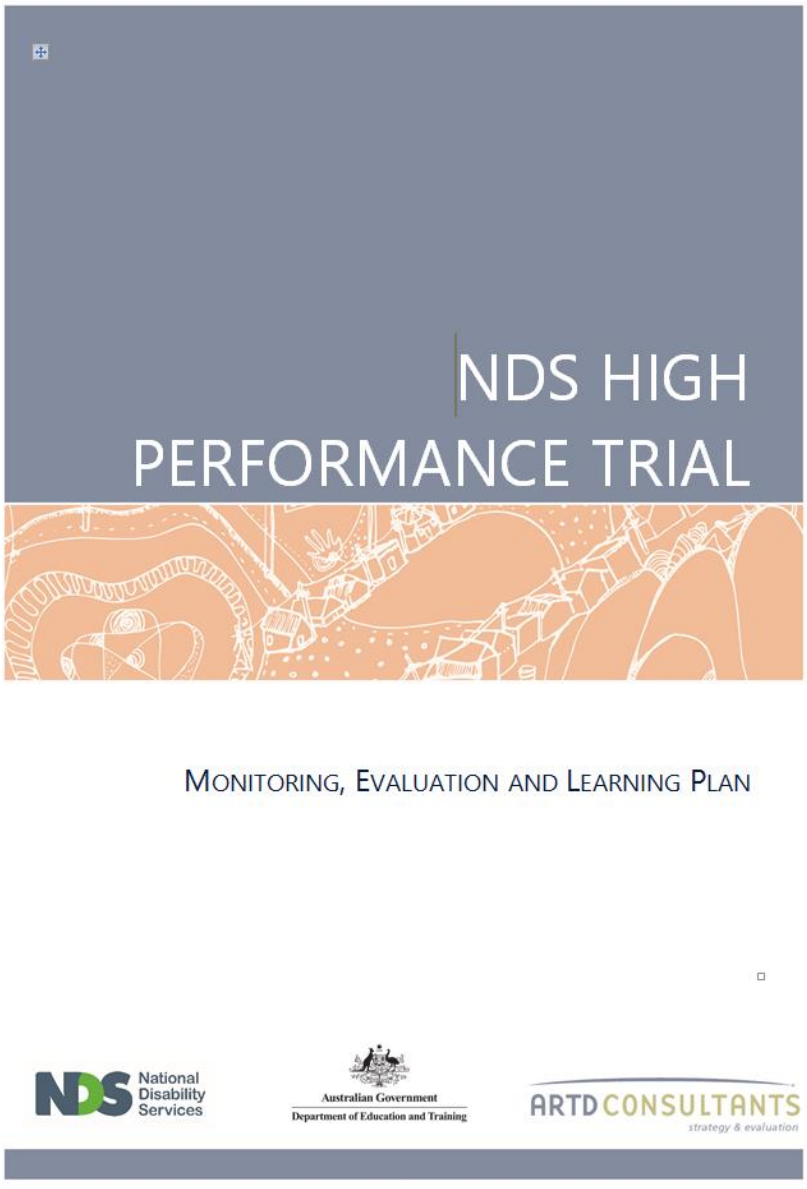
4.3 Support provided by NDS and ARTD

All CoP members were very positive about the support they had received from both NDS and ARTD. CoP members were grateful that NDS had arranged this trial and they were able to take part in it. Comments made about the support from CoP members included:

> *We really appreciated the one-on-one support from NDS. It gave us more clarity around our plans.*
>
> *ARTD brought a depth of insight to the process. Their summary at the end of the last workshop was brilliant and so useful.*
>
> *ARTD's involvement added weight and sophistication to the pilot.*
>
> *NDS is always really responsive to our emails and questions and that has made a big difference to us.*
>
> *Keep using [NDS staff] as a salesperson – she came and spoke to our board and she was excellent.*
>
> *I'd really like to commend NDS and ARTD on an excellent job.*

Appendix 1. Monitoring, evaluation and learning templates

There are numerous different approaches to evaluation that will be useful at different stages depending on the stage of implementation and the resources/ degree of certainty required in the monitoring and evaluation of results.



1. Evaluation overview

The general purpose of the monitoring, evaluation and learning strategy (MEL) is to track progress with the high performance trial and document the things that worked well and not so well, plus identify and document lessons for the future.

In addition, you can more precisely state the purpose and scope of your MEL in the box below so that data collection can be strategic and effective in answering the questions that you need to know.

Tip: Check out the useful online resources at http://betterevaluation.org/plan/engage_frame

Who is it for?	Who will use the evaluation results?
Action	What will they use it for?

Key evaluation questions

Develop **about three-five specific evaluation questions**. These questions could consider:

- what outcomes have been achieved (e.g. did staff/client satisfaction change?)
- what were the contributing factors to what worked and what didn't work so well.
- how well trial implementation (processes) have been implemented (e.g. did everyone involved in the trial understand the rationale for the trial and its intended outcomes?)

Please list these questions below.

Key evaluation questions

Overall responsible person

Person	Overall responsibility for the evaluation

2. Identifying outcomes

Your intended outcomes

Complete this table by listing specific outcomes for your trial, relevant to answering your key evaluation questions—there may be more than one outcome per row, and for your site some rows might not apply given the focus of your evaluation. When thinking about outcomes, consider how they relate to these three areas:

- Client satisfaction and empowerment: short term and longer term outcomes
- Worker skills, satisfaction/ engagement: short term and longer term outcomes
- Organisational sustainability (more clients, reduced costs etc.): longer term outcome

You may also find it helpful to refer to the program logic for high performance trial to identify relevant outcomes (see appendix).

Specific outcome for your trial, relevant to answering your key evaluation questions	Data on or perceptions about current state
Shorter term outcomes	
e.g. Staff make more independent decisions about how best to provide client supports	*Staff do not have the confidence to work more independently*
Longer term outcomes	
e.g. The trial site has a good reputation in the community which attracts new clients to the service	*The site has been losing clients as they move to other services*

Reflecting on the overall program logic

How well does the program logic reflect your trial site? Are there differences that need to be reflected?	
Do you agree with the **foundational statement**? Do you need to refine this, how?	
How relevant are the **assumptions**? Do you need to refine these, how?	
How relevant are the **shorter term outcomes?** Do you need to refine these, how?	
How relevant are the **longer term outcomes**? Do you need to refine these, how?	
Are there other **external factors** that need to be taken into account?	

3. Data sources and methods

Existing evidence and data collection

What kind of information relevant to understanding your trial outcomes does your organisation or team already routinely collect? How is it recorded? How/is it reported?

(e.g. client or carer feedback surveys, staff surveys, administrative data)

Note: The ARTD staff survey will provide some information that you can use
To gather systematic data about staff responses to the high performance trial and to help organisations understand short-term outcomes, ARTD will run a staff survey in September 2016 (It will be open for two weeks, from Monday 12th to Friday 23rd Sept).

The survey will explore questions such as staff sense of 'buy in' to the trial, sense of team, confidence working flexibly with less management, job satisfaction and wellbeing. ARTD will seek input from organisations on the questions during the August 2016 webinar.

ARTD will report the survey findings to NDS and organisations participating in the trial at a webinar in October 2016 and in a newsletter/flyer.

ARTD can also provide summary reports and the data files to individual organisations for their analysis (for confidentiality reasons, data files can only be provided if 5 or more staff participated in the survey).

Is there any existing evidence (e.g. resent research or evaluations) that might provide contextual information to understand progress on your trial outcomes?

Evidence and research gaps

To identify and understand your trial outcomes, what new information needs to be collected? How might this be collected, recorded and reported?

	Outcome indicator	Success criteria	Methods		Understanding outcomes
Trial-specific outcome	**How would you notice the outcome?**	**How would you judge performance on the outcome?**	**Source:** How will you gather the outcomes data?	**Timing:** When will you collect and analyse this data?	**How will you explore what worked/didn't work to get that outcome along the way?**
Shorter term outcomes					
e.g. staff in teams have the confidence to work independently of management	*Staff make more independent decisions about how best to provide client supports*	*The majority of staff report feeling a lot more confident making independent decisions how best to provide client supports*	*ARTD staff survey* *Staff interviews*	*September 2016* *October 2016*	*Feedback from clients about changes they have observed in how staff work; analysis of records on staff professional development*
Longer term outcomes					
The trial site has a good reputation in the community which attracts new clients to the service	*Higher than expected numbers of new clients enter the service through word of mouth*	*At least 10 new clients who enter the service by the end of the trial period were referred of self-referred through word of mouth*	*Intake assessment data: referral source*	*January 2017*	*Feedback from new clients about the reputation of the trial site in the community*

4. Evaluation and monitoring activities

Activities and tasks

Activity/ tasks	Lead person(s)	Start/end or repeat dates
Evaluation and monitoring - planning activities		
e.g. Complete this MEL and share with team		
Data collection and analysis activities		
e.g. undertaken on to capture their observations about the trial as it proceeds	*Team leaders*	*A weekly basis*
e.g. monthly report on outcomes		
Reporting activities		
e.g. trial diary completed by all staff	*Whole team*	*Updated weekly*

Ethical considerations

Ethical issues to consider and how to address these
e.g. ensuring that participants (staff/ clients) understand the purpose of evaluation activities and that participation is voluntary; asking sensitive questions; protecting the confidentiality of participants

Key deliverables

Key deliverable	Due date
e.g. Report to Board	*November 2016*

5. Reflecting and reporting

The sections here provide options; you may not want to use all questions. Your reflections, supplemented with evidence can be added at a the appropriate point in your trial

5.1.1 Reflecting on implementation

a. **Were teams and staff ready for the change?**	
b. **Were clients, families and carers ready for the change?**	
c. **How appropriate were the activities you trialled?** Consider the needs of clients, families and carers, and staff readiness for change,	
d. **How effective were key messages?** Consider whether a sense of urgency for change was communicated and understood.	
e. **Did you adapt elements of the trial in response to emerging issues? How and why?** Consider adaptions to supports, roles and responsibilities.	
f. **Did you identify and celebrate successes along the way? How?**	

5.1.2 Identifying impacts and outcomes

Impacts of implementation and early outcomes	
a. Overall, how has your organisation has been affected by the trial?	
b. Overall, how have the trial team(s) affected by making the change?	
c. What outcomes or benefits have you noticed for:	
i. Clients	
ii. Carer and/or family	
iii. Staff	
d. Have there been any outcomes that have surprised you?	
e. Were there outcomes that you expected to see, but didn't?	

5.1.3 Understanding impacts and outcomes

What worked, for whom and in what circumstances?	
a. What worked well to support the achievement of your intended outcomes? In what situations did it work well?	
b. What didn't work so well in your trial? In what situations didn't it work so well?	
c. Do you think that you measured the right things? Is there other information that you need to better understand outcomes?	

5.1.4 Learning and sharing lessons

Impacts of implementation and early outcomes	
a. Knowing what you know now, what would you do differently?	
b. Knowing what you know now, what would you do the same?	
c. What broader lessons have you learnt about making this change that you think other organisations like yours could benefit from?	
d. To what extent to you think that sustaining these changes will deliver what clients need?	
e. Are you optimistic or pessimistic about the future of your intervention, and why is that?	

Appendix 2. Focus group template

Focus group template

Instructions to facilitator

This focus group template has been developed for use in staff or team meetings. It usually takes about an hour to run this exercise. You may choose to tailor some of the script so that it best describes the HPWP change in your organisation.

Duration	Task
5 minutes	Intro
10 minutes	Reflections and individual brain storm on Q1a-b
15 minutes	Individual reflections to the group on Q1a-b
10 minutes	Reflections and individual brain storm on Q2
15 minutes	Individual reflections to the group on Q2
10 min	Individuals circle the top three ideas on this list

Script

The purpose of this focus group is to document lesson learnt and identity areas where the change in our organisation can be enhanced.

1. I'd like to ask each of you to spend ten minutes thinking about the implementation of the change [INSERT DESCRIPTION] from your perspective. Then, I'd like you to
   a. write something about this new way of working that has pleased you.
   b. write something about this new way of working that has concerned you.

   We will then discuss these reflections as a group.

2. After that, I'd like you to turn off your critical thinking hat for a moment—be creative without thinking about actual feasibility—and list as many things as you can that might improve how teams can work to support clients/customers, particularly in the context of the NDIS. Suspend your judgement about whether they are good ideas or not.

Don't put your name on the sheet – this is just a way of exploring ideas.

1a. Write something about this new way of working that pleased you.

1b. Write something about this new way of working that concerns you?

Take off your critical thinking hat for a moment. Don't be constrained by what you think is appropriate or feasible for your organisation at the moment. Suspend your judgement about whether they are good ideas or not.

1. **List as many things as you can that might improve how your team can work to support clients from here on in?**

After discussing this list with the group and adding any new ideas (but without deleting anything),

- **circle the top three ideas** that you think would be clear candidates for action and which are in your 'circle of influence'
- **mark with an asterix the top one or two ideas that might be a bit left field**, but if they were considered in more detail might improve your ways of working.

Additional discussions points with staff

This guide has been developed to provide managers/ team leaders/ coordinators with discussion points to guide meetings with staff about how the change is progressing, and to support reflections on what is working well (or not so well) and why. It is intended to complement existing routine feedback mechanisms. Questions should be asked at times that make sense for your organisation, and may need to be tailored to best suit the context or type of change. It might be useful to ask these questions regularly, and to review actions that follow after each meeting.

1. **What is working well for the team about this new way of working? Why and how do we keep/grow this?**
   - What are ways to celebrate these successes?
2. **What is not working so well for the team? Why and how to improve this?**
   - What are ways for you to raise this with the team and/or management and proposed solutions? Would you feel comfortable doing this?
3. **What is working well for clients about this new way of working? Why and how do we keep/grow this?**
   - What are ways to celebrate these successes?
4. **What is not working so well for clients? Why and how to improve this?**
   - What are ways for you to raise this with the team and/or management and proposed solutions? Would you feel comfortable doing this?
5. **What has been most helpful in supporting you to feel confident about this new way of working?**
6. **Is there anything else that you didn't receive or have access to that would have helped you more?**
   - What are possible solutions so that there are the right supports in place in the future, or for new staff?
7. **In six months' time—if this new way of working is a success—can you describe what a great day at work would look like?**
8. **In six months' time—if things are not working well—can you describe what this situation might look like?**
   - What are ways for you to raise concerns and propose solutions? Would you feel comfortable doing this?

Appendix 3. Project Newsletter

Evaluation newsletter (1) for NDS' Innovation for High Performance project

August 2016

Over the past couple of weeks, we have interviewed five of six organisations that are well underway with implementing their HPWP trials to discuss their approaches to monitoring and evaluation.

These conversations have been illuminating. In this newsletter, we share our reflections on what we have learnt and what this means for the next stage of our formative and developmental evaluation.

Reflections on monitoring and evaluation (M&E) approaches among HPWP trial participants

First and foremost, it is evident that the staff who are leading the HPWP change in their organisation are already *thinking evaluatively* about the process and expected outcomes.

> *Evaluative thinking is not just limited to evaluation projects...it's an analytical way of thinking that infuses everything that goes on. Willingness to do reality testing: to ask 'How do we know what we think we know?' (M. Patton)*

Thinking evaluatively is a critical element of planning and conducting M&E activities, especially in small organisations and those with limited capacity to run M&E projects, because this can save time and resources by ensuring that activities are strategic, and make good use of existing processes.

> ***Evaluative thinking**: the cognitive process of asking questions, explicating beliefs and assumptions, learning and reflecting, and developing new understanding to make informed decisions and prepare for action. When a group of people repeatedly apply and practice this cognitive process, it provides the opportunity for establishing shared understanding, developing relationships, transforming disagreements and conflicts, engaging in mutual learning, and working together toward a common goal—all ingredients for creating a sense of community.* (Lee & Chavis 2015)

Some more ideas and resources about evaluative thinking can be found here.

Second, and relatedly, the change is often about a 'tweak' to how the service is operated—which can involve different staff and management—but is not a wholly new or separate project. Accordingly, organisations already have in place as part of their usual business systems mechanisms to 'check the pulse' of staff experiences and workplace satisfaction with the change, and client satisfaction and outcomes.

Although these mechanisms vary in scale and sophistication—sometimes involving collaborations with university research projects—they are generally appropriate for the size and given the capacity of each organisation at this point in time. Examples are listed below.

- **Processes to formalise informal feedback**

Many organisations make the most of informal feedback from staff and clients by documenting what is reported through regular meetings.

Having good processes around staff meetings, including training staff in how to minute meetings well (Co-operative Home Care) and clear reporting on identified agenda items are all helpful ways to routinely collect data. ACES, for example, documents what is reported in meetings and the progress of issues against a detailed project plan.

While lots of qualitative data are collected through these processes, it is not necessary to systematically analyse these to make informed decisions as the relevant information is usually at hand. Of course, if there is a future need to evaluate the effectiveness of HPWP implementation, these records will be a good source of data to review. See: <http://betterevaluation.org/resources/guides/document_review>

- **Staff surveys**

Different organisations have different approaches to staff surveys that suit their needs, from:

- bespoke surveys that are integrated into ongoing staff self-assessment and professional learning (ACES); to
- biannual and targeted surveys administered by an external consultancy that reports against workforce benchmarks (E W Tipping).

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Data collected through these processes is often linked to staff competency frameworks.

These processes work well overall and some organisations have identified opportunities to target or re-administer surveys at relevant times to capture changes around the HPWP trial. Yet there are some evidence gaps specific to HPWP changes e.g. team-work skills and feeling comfortable with the responsibility of more autonomous decision-making.

- **Information on client/ customer experience**

All organisations have mechanisms for collecting information on client/ customer experience, such as annual surveys, monthly phone 'check-ins', occasional focus groups, and meetings to discuss progress against case plan goals.

There is a general view that client/ customer satisfaction surveys, especially hard copy annual surveys, tend to have poor response rates and are not always as useful as collecting feedback through conversations, or by capturing client experiences using photographs.

A number of organisations (Sharing Places, E W Tipping, Aspire) also photographs regularly to capture client experiences, and ACES is developing an online social media platform (to be integrated with their HR systems) that would allow clients to communicate more easily with staff, including photo sharing.

Implications for ARTD's formative evaluation of the trial

In taking a formative approach to this evaluation, we have been working to identify how best to support organisations good M&E approaches around their trials.

We originally envisaged that our role would involve helping organisation to complete M&E templates, but it has become clear that the HPWP changes are not being trialled as distinct 'add-on' programs to be evaluated in the traditional sense. Rather, these changes represent new ways of doing business that organisations are already monitoring and evaluating—even if these activities are not named as such!

This means it is imperative that data being collected around the trial is integrated into existing systems, and that any new data that is collected is well-targeted to address specific evidence gaps.

We can now see that we are best placed to assist organisations to fill identified evidence gaps—and that there are a number of gaps in common.

Organisations may still find it helpful to review the M&E Templates (saved in the HPWP Dropbox), but we propose running the following (optional) activities to help fill evidence gaps.

(a) **Administer staff survey**, tailored to understanding the readiness of direct service workers and team leaders to operate in HPWP context.
(b) **Trial a photo diary tool,** where clients/carers can upload photos of significant things in their life, and tag these with information about whether these are positive or negative.
(c) **Develop a staff focus group template and discussion guide** with exercises and questions to facilitate discussions around staff experience of the change. This could be run by team leaders or by self-managing teams.

We have drafted tools based on our consultations with organisation, and we plan to discuss these and our approach to analysis/ reporting in the August webinars to refine our approach.

Finally, we have also started to provide specific advice to organisations on their current or planned data collection activities or tools. We will continue these conversations to help organisations enhance their existing processes and activities. If you have any questions or would like to discuss this further, please contact us.

- Alexandra Ellinson (Alexandra.ellinson@artd.com.au)
- Andrew Hawkins (Andrew.hawkins@artd.com.au)

Since the project commenced, NDS has been interviewing organisations that are at an earlier phase for planning or implementing their high performance trials, and capturing this information in project plan templates. We have been meeting regularly with NDS to share learnings and discuss the progress of the trial.

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Appendix 4. Staff survey data

A full data report on the results of the survey of staff of service providers participating in the IHP project was provided to NDS in October 2016. This appendix contains a summary of key data. It provides the data at an aggregate level for participating service providers. It does not seek to interpret the data. Interpretation will be included in the final trial report. Individual data has been provided to service providers.

The following survey data is presented by grouping together survey items intend to measure four dimensions. It should be noted that these are not the final factors identified in the analysis of the survey data as described in Section 2.

Professionalism

- Workers feel more ownership of their work and more accountability for the outcome of their actions (Prof 1)
- Workers experience greater trust in their ability to do their job (Prof 2)
- Workers feel capable and supported to do their job well through e.g. training, coaching, peer support, the collective intelligence of their team/work group (Prof 3)

Leadership approach

- High trust, clear values versus command and control them (LA 1)
- Effort focussed on increasing the chance of things going well instead of trying to ensure nothing will go wrong (illusion of control) (LA 2)
- Bottom up/decentralised decision making versus top down decision making (LA 3)

Learning culture

- Open to experiments, divergent thinking and innovation. Mistakes and faults are acceptable as learning experiences (LC 1)
- Transparency, collaboration and free sharing of knowledge throughout the service provider (LC 2)
- Staff are enabled and supported to reflect on their own practice through e.g. coaching and joint problem solving (LC 3)
- Direct feedback loops between clients, workers and management (LC 4)

Person centred approach

- Need to customise supports to unique clients based on their specific and changing needs and preferences (PC 1)
- Valuing workers as unique individuals with various different strengths; extending person-centred thinking to the workforce as well as service users (PC 2).

Professionalism

Table 4. Professionalism survey items

Professionalism		n	Tend to agree	Agree	% Pos.	All agencies mean^	Standard Deviation
Ownership and Accountability	My manager allows me to do my job my way	192	38%	47%	85%	3.3	0.5
	This organisation has a great deal of personal meaning for me	174	31%	58%	89%	3.4	0.2
	I gain considerable pride from performing my job well	181	17%	81%	98%	3.8	0.2
	Ultimately, I am responsible for the quality of support that I provide to my clients	182	21%	76%	97%	3.6	0.3
Experience trust	My manager believes that I can handle demanding tasks	190	24%	72%	96%	3.6	0.4
	My manager believes in my ability to perform at a high level.	191	19%	78%	97%	3.6	0.4
	My manager expresses confidence in my ability to perform at a high level.	192	25%	69%	94%	3.5	0.5
Capable and supported	I often think about quitting this job (R)	179	13%	13%	26%	3.1	0.5
	I have confidence in my ability to solve problems creatively	180	24%	75%	99%	3.8	0.1
	I am confident in my ability to understand the changing support needs of my clients	179	25%	74%	99%	3.8	0.2
	My organisation gives me the support I need to do my job well	180	32%	52%	84%	3.2	0.4
	I am confident that I have the knowledge and skill to do my job well	182	28%	71%	100%	3.7	0.2

Mean scored out of four (4). Note. (R) = Reverse scored

Leadership Approach

Table 5. Leadership Approach survey items

Leadership approach		n	Mostly agree	Agree	% Pos.	All agencies mean^	Standard Deviation
High trust strong values	I can make my own decisions on how I do my job	181	39%	40%	79%	3.2	0.4
	People are trusted to do the right thing in my organisation	181	27%	66%	93%	3.5	0.4
	Inappropriate attitude and behaviour at work are not tolerated and quickly dealt with	172	30%	54%	83%	3.2	0.6
	At our organisation we are told what to do—there is little freedom for staff to work out the best way to support a client (R)	179	15%	7%	22%	3.1	0.3
% Positive approach to risk	My manager makes it more efficient for me to do my job by keeping the rules and regulations simple	191	32%	52%	84%	3.3	0.4
	We have clear guidelines to indicate what good service looks like in our organisation	180	32%	57%	88%	3.2	0.5
	At our organisation the focus is more on safety and security than on opportunities for clients to make mistakes they can learn from (R)	169	31%	21%	53%	2.4	0.5
Decentralised decision making	My manager allows me to make important decisions quickly to satisfy customer needs.	187	32%	58%	90%	3.4	0.4
	I have a say in decisions that directly impact how I do my job	174	32%	48%	79%	3.2	0.4

Mean scored out of four (4). Note. (R) = Reverse scored.

Learning culture

Table 6. Learning culture survey items

Learning Culture		n	Mostly agree	Agree	% Pos.	All agencies mean^	Standard Deviation
Innovation culture	At our organisation we frequently refine the provision of existing products and services	154	43%	39%	82%	3.1	0.5
	New ideas are readily accepted here	167	36%	47%	83%	3.3	0.4
	It is useless for me to suggest new ways of doing things (R)	175	12%	8%	20%	3.1	0.3
	At our organisation we highlight the learning that comes from successful service delivery	172	31%	51%	81%	3.2	0.6
Transparency and collaboration	I can talk freely to my supervisor about difficulties I am having at work.	177	21%	69%	90%	3.5	0.3
	I can talk freely to my peers about difficulties I am having at work.	172	29%	56%	85%	3.4	0.3
Reflective practice	At our organisation we regularly ask ourselves questions about the best way of providing our services	179	31%	58%	89%	3.5	0.3
	At our organisation we review the causes of our failures	167	40%	40%	80%	3.1	0.4
	At our organisation we are encouraged to engage in informal discussions about what is working well and not so well	178	34%	51%	84%	3.3	0.4
Direct feedback loops	I can trust my peers to approach me personally if they have comments on how I do my job	178	34%	50%	84%	3.2	0.4
	I receive regular direct feedback from the people I support on how I am doing my job	175	34%	38%	71%	2.9	0.6
	My immediate manager asks me personally to tell him/her about things that I think would be helpful for improving this workplace	172	29%	45%	74%	3.1	0.4

Mean scored out of four (4). Note. (R) = Reverse phrased

Person centred approach

Table 7. Person-centred approach towards clients and workers

Person-centred approach		n	Mostly agree	Agree	% Pos.	All agencies mean^	Standard Deviation
Towards clients	Our clients' needs rather than our available services drive the supports our clients receive	174	37%	41%	78%	3.1	0.5
Towards workers	I feel valued by my organisation	175	30%	53%	83%	3.2	0.5
	I feel that my knowledge and skills are recognised in my organisation	177	30%	56%	86%	3.3	0.4
	I feel that my opinions and views are listened to in my organisation	174	34%	48%	82%	3.2	0.5

Mean scored out of four (4).

Job stress and confidence

Table 8. Job stress survey items

Item	n	Mostly agree	Agree	% Pos.	All agencies mean^	Standard Deviation
A lot of time my job makes me very frustrated or angry	173	16.2%	5.8%	22.0%	1.9	0.5
I am usually under a lot of pressure when I am at work	176	17.6%	11.9%	29.5%	2.4	0.6
When I'm at work I often feel tense or uptight	174	9.8%	5.7%	15.5%	2.0	0.5
I am usually calm and at ease when I'm working (R)	173	44.5%	41.0%	85.5%	1.8	0.3
There are a lot of aspects of my job that make me upset.	172	12.8%	3.5%	16.3%	1.8	0.4
Stress Scale Score	*172*				*2.0*	*0.4*

Mean scored out of four (4). Note. (R) = Reverse phrased

Table 9. Confidence going forward survey items

Item	n	Mostly agree	Agree	% Pos.	All agencies mean^	Standard Deviation
I feel confident that I understand where my role fits in with the overall goals of my organisation	173	35.3%	58.4%	93.6%	3.6	0.2
I feel confident about how my role will or will not change under the NDIS	160	30.6%	34.4%	65.0%	2.8	0.6
I think the NDIS will be good for my clients	140	41.4%	42.9%	84.3%	3.1	0.7

Mean scored out of four (4).

The change being trialled

Each service provider provided a brief description of the change they are trialling to tailor the survey to their staff.

Table 10. The Change – Understanding and Attitudes survey items

Item	n	Mostly agree	Agree	% Pos.	All agencies mean^	Standard Deviation
I understand the vision about what 'the change' is trying to achieve	111	42%	50%	93%	3.2	1.1
The change' is consistent with my preferred way of working	101	49%	38%	86%	2.9	1.0
The change' is too risky for the safety of my clients (R)	98	7%	4%	11%	3.5	0.6
The change' will lead to better outcomes for my clients	97	45%	43%	89%	3.0	1.1
Overall, 'the change' is a good idea for my team	98	43%	48%	91%	3.0	1.1

Mean scored out of four (4). Note. (R) = Reverse phrased

Table 11. The Change – Confidence in its Outcomes survey items

Item	n	Mostly agree	Agree	% Pos.	All agencies mean^	Standard Deviation
People in our organisation will be able to deal with the change	104	51%	29%	80%	2.7	1.0
Our IT systems are adequate to support 'the change'	92	36%	23%	59%	2.4	0.9
The change' will help us fulfil our organisation's mission	102	52%	39%	91%	3.0	1.1
The change' will increase the sustainability of our organisation	94	51%	39%	90%	3.0	1.0
The change' will lead to better outcomes for our clients	99	45%	45%	91%	3.0	1.1
Overall, the change is a good idea for our organisation	96	42%	49%	91%	3.0	1.1

Mean scored out of four (4).

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