

PARTICIPANT GUIDE

Your IASC Learning Journal



ISA 360°
growing safer leaders

PARTNER
LOGO

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Intention of this Guide

This guide is a place to learn, reflect and commit to whatever you and your team creates together to help you all **safely thrive!**

Our research has shown that leadership and culture are levers for organisational performance, including safety.

What would it mean to you if had leadership capability that enabled teams that felt:

- ✓ 41% more valued
- ✓ 59% more listened to
- ✓ 57% more likely to share their ideas and concerns
- ✓ 58% less avoidant of safety issues
- ✓ 63% more confident that changes would result in improved processes

What would it mean if you knew that leaders who actively engaged in transformation activities could create;

- ✓ 17% more staff, that felt safe to stop the job if unsafe?
- ✓ 34% more staff, who had confidence in safety processes?
- ✓ 15% more staff, who felt empowered?

What about knowing that if your team could increase its generative culture it can create results like:

- ✓ 79% decrease in TRIFR;
- ✓ 43% decrease in SIFR;
- ✓ 60% reduction in vehicle collisions;
- ✓ 10% increase in productivity while maintaining all maintenance schedules and targets
- ✓ 84% positive response to colleagues ability to display 'genuine care'.

Exploring what your team have shared via the IASC is the beginning of a conversation and process that will help you explore ways to grow and sustain **generative** leaders, teams and organisations – so you can all **thrive at work and at home!**

Enjoy the journey!



Education



Background Theory: Safety Culture and Leadership

Introduction

Our understanding of safety has and continues to evolve.



Over time, the theories and practice of **safety management have evolved** to address the changing landscape of work.

In the early days, the focus of safety was on establishing regulations and governing institutions to ensure **working conditions** were fair, reasonable and safe for workers. Over time, the emphasis shifted between the focus on **individual behaviour** on the one hand and working conditions and the system design on the other.

Generally, through each progression, safety performance improved up to a point and then levelled off, soon followed by another shift in focus and more incremental progress.

If we stand back and look at the development of safety practice over time, we see that **each progression represented a partial truth, a piece of the safety puzzle, which is valid but not the whole story**. Our intent is to bring together the best of what has been done over the history of safety into an **integrated view**.

The **IAS360** and **IASC360** assessments reflect our commitment to represent the best of safety practice, and to use assessment itself as a way to help people reflect on where they are at in their safety journey and so that they can design where to go next.

These safety assessments reflect our understanding of the most current thinking in safety research and practice while at the same time appreciating the contributions of the past.

The original research that led to the development of these tools was based on a discovery of the common threads that linked divergent safety practices together. Two of those threads were the important roles of **Safety Leadership and Culture**.

Creation of assessments that represent the best of safety practices.



Culture and leadership are the catalysts and glue.



We found that whether safety practice focused on individual contributions to safety performance or the process (or systemic) factors, both culture and leadership were key.

They were the catalysts and glue that both moved the needle forward and held the course steady.

Since safety performance emerges from a healthy system, our approach puts emphasis on creating a **Generative Safety Culture**.

Generative Safety Culture is not an end state, or a state of perfection where things don't go wrong, but is a way of working together, learning, being curious and purposeful, and continually getting better at detecting and addressing hazards. More will be said about this in the pages to come.

Because **leaders** have a crucial influence on safety performance, we provide specific feedback to leaders at all levels so they can learn to **create the conditions that lead to a Generative Safety Culture**.

Safety Culture and Leadership are important levers that can be used to improve performance in safety while also ensuring that people are engaged and happy in their work.

In summary, our approach is **integral**, which means that it is important to recognize the many contributions that have been made to safety and include the best of them as we continue forward.

Our **focus on leadership and culture** is a broad and inclusive one that integrates these views.

Brief History of Safety Approaches & Philosophies

We want to include those lessons that still have value in our current practice.

Safety has come a long way over the past 100+ years or more. In earlier times, a significant price for humankind's major accomplishments was measured by the large number of lives lost, limbs taken, and the well-being sacrificed. For many centuries, this loss was assumed to be inevitable, a cost of doing business, so-to-speak.

At many points along the way, people realized that we could do better, that through the invention of some new technology, method, or a shift in mind-set, we could reduce the unnecessary suffering, perhaps even eliminate it. It is useful to review these improvements to ensure we go forward with those lessons in mind.

We have included a simplified overview of the major safety developments and key learnings. We identify seven waves of development that have origins at a particular time, but that overlap and converge throughout the decades. The seven are:

- Regulatory
- Scientific Management
- Behaviour-Based / Human Factors
- Systems & Complexity
- Safety Management
- Safety Culture
- Resilience Engineering

The following table highlights the key elements for each of the seven waves of development: the problem addressed at the time it emerged, key areas of focus, the result of it both good and bad, and the main lesson we want to retain from it.

TABLE OF SAFETY DEVELOPMENTS

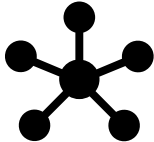
	Problem Addressed	Key Focus Areas	Results	Take Away
Regulatory (1900+)	Workers had very little protection in high-risk work environments Major losses of life and well-being.	<ul style="list-style-type: none"> • Creation of Governing bodies • Work standards created with penalties enforced 	Positive <ul style="list-style-type: none"> • Significant improvements in safety Unintended <ul style="list-style-type: none"> • Corruption • Violations are hidden 	A good regulatory environment holds businesses to account
Scientific Management (1910s+)	The cause of accidents and their resolution had never been studied systematically, so the rules could be arbitrary and unfair	<ul style="list-style-type: none"> • Use of scientific method to study the patterns and causes of accidents • Application of general approach and process of improvement 	Positive <ul style="list-style-type: none"> • General improvements across broad categories of work Unintended <ul style="list-style-type: none"> • People were treated as “cogs” in the machine, dehumanized 	A science-based approach to safety is necessary to weed out safety myths
Behaviour Based Safety/Human Factors (1930s+)	A large degree of variability in individual behaviour is seen as a major cause of accidents	<ul style="list-style-type: none"> • Study the primary causes of accidents and use reinforcement to change behaviour • Understanding the limits of humans and redesigning systems accordingly • Application of psychology to safety 	Positive <ul style="list-style-type: none"> • Better understanding of the human role in safety Unintended <ul style="list-style-type: none"> • Too much focus on individual behaviour and human factors as the cause of accidents 	Understanding of the strengths and limits of human cognition and resulting behaviour
Systems & Complexity (1950s+)	Engineered systems become more complex and difficult to control by traditional means	<ul style="list-style-type: none"> • Application of systems theory to engineered systems • Understanding that accidents can result from system design and the interactions between system elements • Studies of high performing organizations in high risk situations (HROs) 	Positive <ul style="list-style-type: none"> • A broader understanding of how accidents can happen, beyond individual behaviour Unintended <ul style="list-style-type: none"> • Underemphasis on the role of individual beliefs, values, behaviour 	Safety is a property that emerges from the system’s design

Safety Management (1990s+)	The fragmentation of safety into specialized and competing views makes it difficult to determine what practical approach to use	<ul style="list-style-type: none"> • Safety Management systems provide a comprehensive approach to organizing the safety function • Focus on the organization balances an overfocus on the sharp end • Focus on risk and the management of risk 	<p>Positive</p> <ul style="list-style-type: none"> • Many organizations implement comprehensive safety systems and use them to monitor and improve <p>Unintended</p> <ul style="list-style-type: none"> • Safety largely become a “paper” exercise and companies believe the SMS will keep them safe 	Importance of organizing the elements of safety into a management system that can be tracked, measured and improved
Safety Culture (2000s+)	Large and catastrophic accidents around the world suggest that even the best safety management is insufficient. There is a hidden source of behavior that drives performance	<ul style="list-style-type: none"> • A shift from a purely mechanical view of safety to a more human one that includes values, beliefs and basic assumptions • Further focus on the organizational factors that drive behaviour • Emphasis on the role of leadership as a key influence on safety behaviour 	<p>Positive</p> <ul style="list-style-type: none"> • The human element in safety is brought to the foreground as both an individual and collective phenomenon <p>Unintended</p> <ul style="list-style-type: none"> • Safety Culture is often not well defined, and can sometimes be seen as the answer to everything 	With safety, you can get everything right but culture trumps everything else. Safety culture is the intangible regulator of safety, risk, and resilient performance.
Resilience Engineering (2010s+)	Safety improvement has plateaued, and much of safety thinking and practice is based on a mechanistic worldview, therefore focuses heavily on individual human behavior as the cause and remedy for poor safety performance	<ul style="list-style-type: none"> • New principles for safety are formulated based on a living systems view • The causes of safety, either good or bad, are thrown into question • A new focus on design of safe (resilient) systems is highlighted 	<p>Positive</p> <ul style="list-style-type: none"> • Humans are seen as the source of innovation, improvisation, safe and resilient systems <p>Negative</p> <ul style="list-style-type: none"> • Sometimes viewed as making other ways of thinking about safety wrong 	Resilient systems learn to adapt to changing situations, and the best humans can do is to learn how to nudge them toward a desired state (versus command and control)

Notes

An Integral Approach: Personal and Process Safety (Complex Systems)

Integral: A model that identifies personal, behavioural, cultural and systems views.



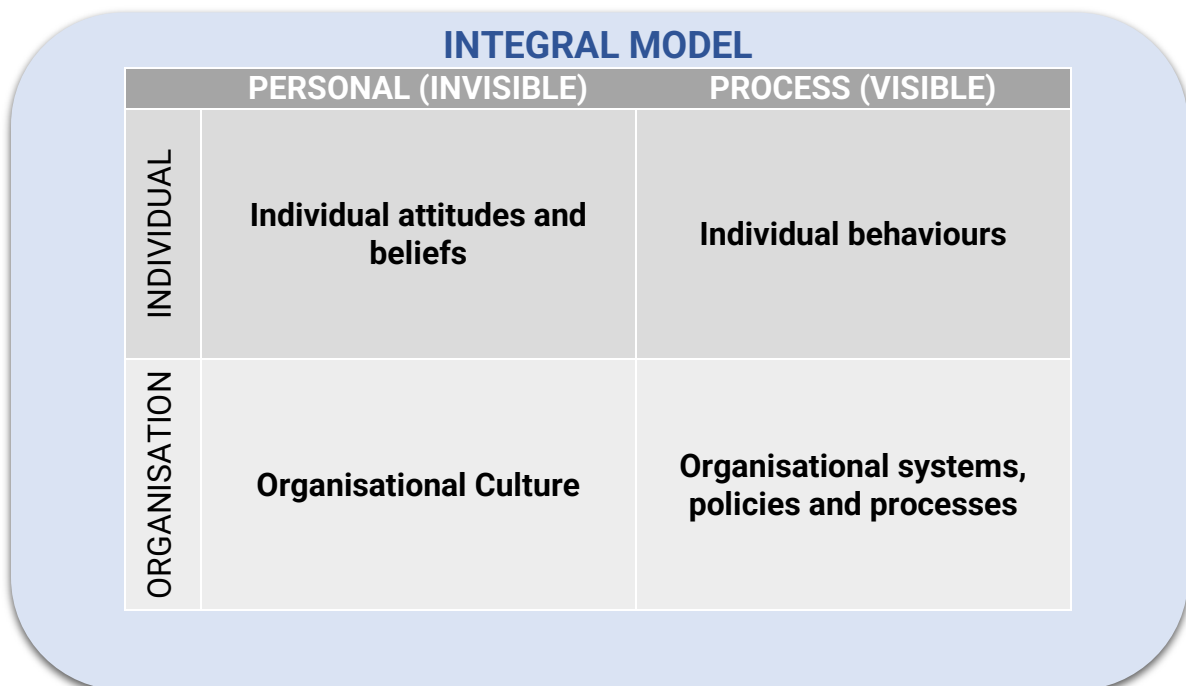
And helps us remember the importance of the subjective/interior view alongside the objective/exterior view.

Each of the waves of development in safety improvement provides a partial solution which is based on what was missing in safety performance at the time it emerged. Some of these ideas and practices continued on in isolation from other developments, some of them merged or integrated with others, and some lost appeal. There were many others that are not listed in the table above.

An integral approach to safety aims to include as many of these perspectives as possible but to also keep the approach as **simple as possible**.

The 4-quadrant model, shown below, is a useful way to think about these partial, and real perspectives that have been important to safety's evolution. The 4-quadrant model (K Wilber) identifies personal, behavioural, cultural and systems views, and also helps us remember the importance of the subjective/interior view alongside the objective/exterior view.

It has been our experience that safety is often reduced to the technical, objective, and structural (visible) elements while forgetting the non-technical, qualitative, and personal (invisible) elements.



The history of safety can be viewed as a swinging back and forth between the personal view of safety and the systems view, with each movement reflecting a more nuanced and integrated perspective.

For example, the behaviorist view in the 1930s was quite blind to the nature of the system and the system view of the 1940s was unconcerned with individual behaviour.

However, the resilient systems view of current times reflects a more comprehensive view that includes both. At the same time, the qualitative view of safety (the left side of the integral model) is often left out of the story completely.

Learning grew as perspectives altered back and forth from personal to process safety

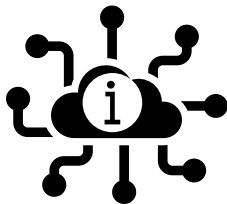


We used the integral perspective to remind us of the need to include personal, process and systems views as safety progresses. This perspective was provided in greater detail in R. Strycker’s 2011 Paper.

Notes

Generative Safety Culture

Information flow and what leaders preoccupy themselves with as signals to safety culture.



Our approach to culture identifies specific aspects of culture that are connected to high performance in general and to extraordinary performance in safety in particular. Our research has shown that a specific cultural pattern, when present, enables both **team performance and extraordinary safety**.

Identified by Westrum more than 20 years ago, Generative Safety Culture has been supported by researchers and practitioners around the world. The characteristics of a Generative Safety Culture are closely aligned with studies in High Reliability Organizations (Weick & Suttcliff), Safety Culture Maturity (Parker & Hudson), and an Informed Culture (Reason).

These studies were integrated into a set of advanced safety practices by Strycker¹, and later synthesized into a set of factors that define Generative Safety Culture by Datadrivesinsight.com.

Generative Culture was first identified by noticing **how groups of people relate to the flow of information** in their work environment. Groups that support the free flow of information have established qualities that lead to higher performance, better coordination, high trust, good communication, many of the qualities that we now associate with psychological safety.

By observing how groups deal with information, especially safety specific information, we find a key indicator that regulates and enables good safety performance.

The insight about information flow led to the development of a culture typology which identified three dominant types: Detrimental, Bureaucratic, and Generative (Westrum²). The features of these types are shown in the following table.

A primary determinant of these types is what **leaders preoccupy themselves** with: power, rules, or purpose. This focus will eventually result in a climate where people and teams orient their work in ways that are more or less productive, more or less risk aware, and more or less safe. Although culture type is not the only determinant of safety performance, it is a key one.

¹ Looking For A 21st Century Solution for Safety Performance: Integrating Personal and Process Safety Rick Strycker, JMJA Associates February 2011

² A Typology of Organisational Cultures, R Westrum, Qual Saf Health Care 2004;13(Suppl II):ii22–ii27. doi: 10.1136/qshc.2003.009522

TYPOLOGIES OF CULTURE

Detrimental	Bureaucratic	Generative
<p><i>Power Oriented</i> Characterized by low cooperation, blame, hiding incidents. Information is often withheld for personal gain. It is not safe to speak up, especially if doing so might be embarrassing. Messengers are shot, responsibilities are shirked. When things go wrong, a scapegoat is found and punished. There is no real learning from failure.</p>	<p><i>Rule Oriented</i> Focused on positions, hierarchy, span of control. Responsibilities are compartmentalized by departments that seek to preserve their own existence and power. Information must flow through standard channels or procedures, in order to preserve status quo. Messengers are neglected, responsibilities are narrowed. When things go wrong, there is a process to produce retribution. Learning is institutional.</p>	<p><i>Purpose Oriented</i> The hallmarks are good information flow, high cooperation and trust, bridging across teams, and conscious inquiry. Psychological safety creates openness, curiosity, care, and systemic learning. There is awareness of the importance of getting the right information to the right people, in the right form at the right time. When things go wrong, people look for a systemic cause and for systemic solutions, a recognition of the interrelated parts of the organization. Messengers are trained.</p>

From these definitions we see that only a **Generative Culture** can be understood as a **genuine safety culture**. Both Detrimental and Bureaucratic cultures are seen as detrimental to safety, but to different degrees.

The Detrimental culture is seen as individual safety focussed where a person's desire to stay (physically, mentally, socially and psychologically) safe may inadvertently put the safety of others at risk.

For example, not speaking up when a hazard is spotted in order to not be seen to challenge a teammate, leaves that teammate exposed to risk – is less safe.

Bureaucratic culture is seen as having certain characteristics that reduce safety and some that are more supportive.

For example, "best practices" might be stored in the information system that is collated or developed by a particular function. If the nature of that work lends itself to a 'police state,' the culture will be less open to information sharing. However, if that work is done with a customer focus in mind, it can be supportive of the free flow of information and better coordination.

For this reason, we see the **Bureaucratic culture as having two poles**, one that tends toward Detrimental and one that tends toward Generative. This is a point of leverage for developing toward a high performing safety culture.

Notes

Factors of Generative Culture

The Generative Culture type is like a garden and needs to be cultivated and cared for.

Our approach includes the use of four factors that support and develop a Generative Culture, factors that can apply to individual leaders, teams, or groups of people working toward common goals.

Our research has shown that these four factors have a positive impact on how you and the people around you perform.

The four factors often develop at different rates, and these practices can be operating to achieve different safety cultures depending on the development of that practice. For example, one individual may demonstrate “Purposeful” at a level that may be working towards a Generative Safety Culture, they might also be demonstrating “Curious” at a level that will achieve a Bureaucratic Safety Culture.

In addition to our definitions of each factor, we provide a QR Code to a video that explores elements of this factor and is intended to help grow your understanding of them.

Purposeful

- Purposefulness provides practical guidance and orientation to a person, team or organisation, indicating the direction of change. When people know why they are doing a project or task, they can self-correct when they get off course. Purpose is enacted through shared commitments.
- People make commitments to safety explicit and visible, engaging each other in the possibility of, and practices that support everyone going home safe every day. When integrity is broken, it is restored by returning to commitment, rebuilding trust. Leaders engage others to be purposeful, committed, and continuously learning how to improve safe performance.

SCAN ME



SCAN ME



Caring

- Care is regard for the intrinsic value of people, actively providing what is needed to support health, safety and wellbeing. Care is personal, connecting with others based on understanding of how it is and what is needed from their perspective. Regard for others creates an environment where people respect each other and build trust and willingness to say what is true.
- Caring springs from care for oneself, ensuring one has the capacities and energy to provide real help. It balances a focus on building strengths with a compassionate drive to address gaps in performance and realise potential.

Curious

- Curiosity creates openness to learning how things actually happen in order to improve safe performance. It includes the capacity to suspend what you know, and actively seek out what you don't know.
- Openness means that people are slow to make judgments or to blame people when things go wrong. Inquiry is kept open as long as possible in order to fully understand what happened and to generate lasting change.
- People listen to as many diverse perspectives as possible in the time allowed in order to create a more complete picture.

SCAN ME



SCAN ME



Connecting

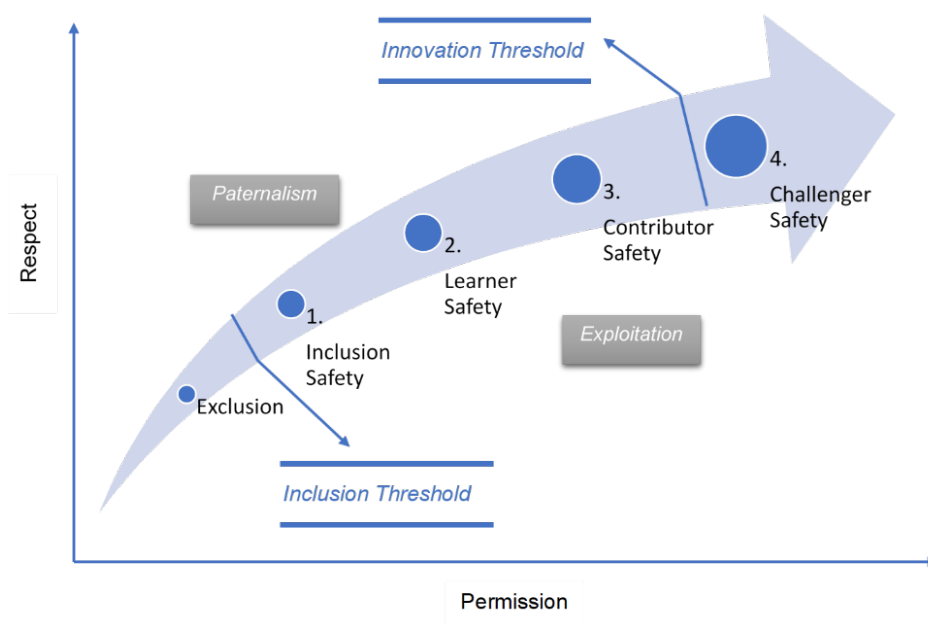
- Allows us to see how things are related, people seek to understand how roles, teams and functions must integrate to optimize the performance of the whole system.
- Connecting is increased when people work together to create models of how the system works and then continually updated as new information is revealed. There is a concerted effort to understand how people close to the work understand the work, updating systems to match how work is actually done.
- There is work on the right things at the right time with the right people. There is use of highly intentional and focussed approaches that leads to operational discipline and maximises the use of all resources to achieve the purpose.

Notes

Psychological Safety

Although the idea of psychological safety is built into the factors, it is also helpful to feature it separately. In her work on team performance, Amy Edmondson³ suggested that team learning was a key factor in team performance and that learning was dependent upon an environment that supported mutual respect, trust, personal risk taking—an environment she labelled “psychological safety”.

Psychological safety is a condition in which you feel (1) included, (2) safe to learn, (3) safe to contribute, and (4) safe to challenge the status quo— all without fear of being embarrassed, marginalised, or punished in some way.⁴



This term has grown in popularity over recent years and for a good reason. It is missing in many work environments and that absence makes work both miserable and unproductive. The relationship between psychological safety in a team environment and a team’s safety performance is significant.

Our view is that psychological safety is a key characteristic of a Generative Culture and so we have embedded these features into the four factors.

It is also an outcome of the development of the four factors and a good measure of a team’s working environment so we include it in our assessment of culture to indicate how well leaders and teams are progressing in their journey toward high performance.

³ Psychological Safety and Learning Behavior in Work Teams Author(s): Amy Edmondson Source: Administrative Science Quarterly, Vol. 44, No. 2 (Jun., 1999), pp. 350-383/

⁴ <https://www.leaderfactor.com/4-stages-of-psychological-safety>

Notes

What the Assessments Measure

Overview

The culture and leadership assessments developed by Datadrivesinsight.com enable insights for the individual, team and organisation into their current strengths and opportunities for growth in relation to the four factors that create generative safety cultures.

There are two assessments that enable insight.

ISA360

An individual 360 assessment designed for leaders at all levels and an Executive360 for those with strategic roles at Executive levels.

The assessment is completed by the Individual (self) as well as the line manager, peers and direct reports to provide insights into strengths and potential blind spots.

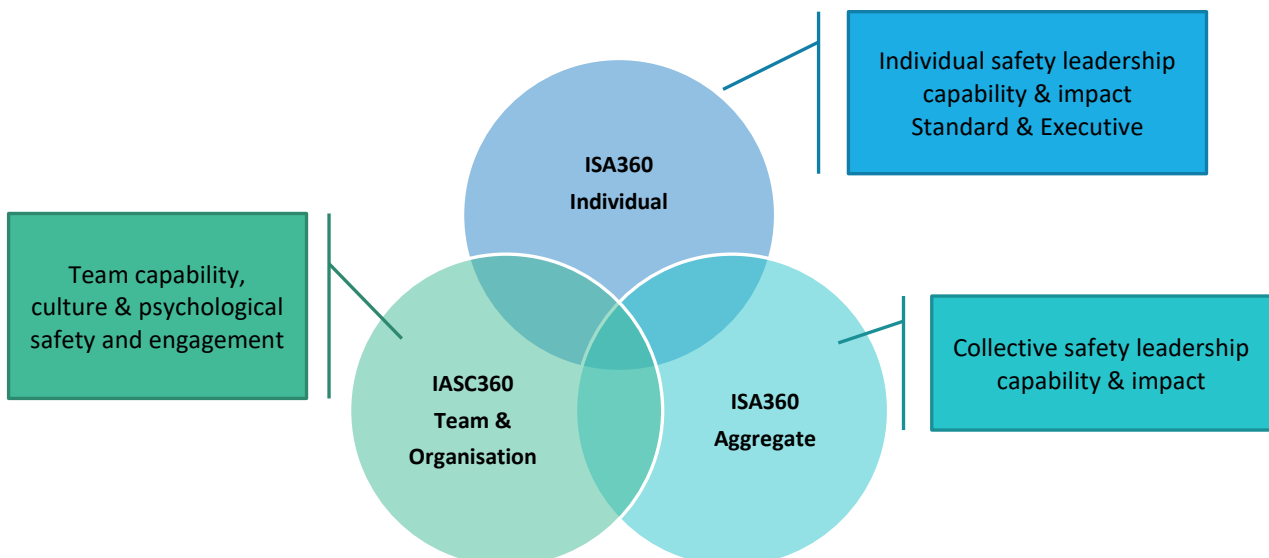
IASC360

A team-based assessment designed for teams in any industry. The team or group is usually defined as the collection of people that have work in common and must rely on each other and coordinate amongst themselves to get things done. This approach is a practical way to assess safety culture (at the team level), it is also a primary location where safety improvements will have the most impact.

The assessment can be completed by the team members, leaders and interfacing teams.

Both assessments can be aggregated to create a collective view:

- Of individuals, a group of leaders for example, to help identify collective growth and development needs and develop tactics to meet these needs, through leadership programs for example.
- Of teams to get holistic view of the organisation or multiple teams.



Notes

Debrief Reflection



My Relationship with Safety

Each person as a member of a team, has an impact on the culture and performance of that team. Take some time to answer these questions below. How would you rate your current relationship to safety?

Circle the answer that is most accurate for you.

- 1. When driving, I eat food or drink coffee or other beverages?**
1 = never 2 = occasionally 3 = frequently
- 2. When driving or stopped at traffic lights, I make calls, text, check emails or calendar appointments?**
1 = never 2 = occasionally 3 = frequently
- 3. When I cross an intersection as a pedestrian, I only cross when the “Green Man” is flashing?**
1 = always 2 = occasionally 3 = rarely
- 4. When I’m given a job to do that I’m unsure about, I just push ahead and work it out?**
1 = never 2 = occasionally 3 = frequently
- 5. Before commencing a job, I thoroughly read all safety materials relevant to the job?**
1 = always 2 = occasionally 3 = never
- 6. When I do work around my house or garden, I use PPE (personal protective equipment)?**
1 = frequently 2 = occasionally 3 = never
- 7. When I notice someone from a different “crew” to mine doing something “less safe”, I talk to the person about it.**
1 = every time 2 = occasionally 3 = rarely
- 8. When I’m heading off on a long drive or holiday, I make sure that I give some thought to my fatigue levels.**
1 = always 2 = occasionally 3 = never
- 9. When using chemicals around the house (eg: pool, garden, cleaning) I make sure my family aren’t in harms way?**
1 = always 2 = occasionally 3 = rarely
- 10. If I’m asked to do a job that I worry is unsafe, I stop the job and report it.**
1 = always 2 = occasionally 3 = rarely

Now, please add up your scores:

TOTAL SCORE

My Relationship to Safety Score:

- If you scored **10 to 14 points**, you have an extraordinary relationship with Safety.
- If you scored **15 to 22 points**, you have an ordinary relationship with Safety.
- If you scored **23 to 30 points**, you have an insufficient relationship to Safety (it is not going to happen to me!)



Personal Reflection:

What thoughts has this simple assessment raised for you?

Is your current level of 'relationship' to yours/others safety sufficient to generate the results you want?

What ideas have you got about improving your 'relationship' with safety?

Team Results Reflection



Before the results are shared - How would you describe the current culture?
Take a total of 100 points and allocate them across the three typologies.

Detrimental	Bureaucratic	Generative
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TYPOLOGIES OF CULTURE

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Let's 'try on' the three typologies. The intention of this exercise is to reflect on a time as an 'observer' to understand and learn.

Start by thinking about a time when the culture became Detrimental in response to something happening. What happened? What was the impact?

Then considered the same question about a time when the culture became bureaucratic and generative. What happened? What is the difference between the responses?



Capability Assessment

What stood out for you on the Spidergraph?

What could it mean to make a shift from 3 (some of the time) to 4 (most of the time)? What would that take? What impact/benefit could it have for me, my team, others?

Where are there different views and large gaps between where we are now and where feedback providers (raters) would like to see the team in 12 months time?

Where are there similarities in views?



Culture

We measured the current culture using Westrum's Typologies of Culture: Detrimental, Bureaucratic and Generative.

Consider what is working well and what could be better and spend a few minutes working in pairs or small groups to brainstorm some dot points to describe the default future. i.e. if we keep doing what we have always done.

Question: How does this 'default future' sit with you, or fit with the team?

What would it mean to you if the team could create a more Generative Culture?

What does the preferred future look like for you and the team?

- What would people be doing?
- What would you hear others say?
- What would you see/hear from your leaders?
- What would you feel encouraged to do?

Impact



We measured elements of employee engagement and psychological safety

What stood out for you in the results?

What does that mean for you and your team?

What is important to shift to improve engagement and psychological safety?

Team Development Plan



Team Development Journey

Current State

Team Name: _____

Our Purpose: _____

Our Vision/Goal: _____

IASC360 Debrief Date: _____

Our Strengths and Areas for Growth

Key Strengths	Opportunities for Growth

Current Beliefs and Key Learnings about our Team

Our Default Future

Desired State

How will we make a change?

Our Preferred Future

Transformed Beliefs

We are Committed to

Value	Behaviour

Getting into Action

We will hold ourselves accountable by

Our measures of change and success are:

Our immediate next steps are:

What will we do, who will do it, when will it be done?





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Creating thriving organisations