



Formative Evaluation of NHS England and NHS Improvement's Culture and Leadership Programme

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Formative Evaluation of NHS England and NHS Improvement's Culture and Leadership Programme

Final Report

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Sue Jones, Kelly Singh, Professor Naomi Chambers

April 2020

Original Thinking Applied

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Glossary

BME: Black and minority ethnic, which is a UK demographic category

CEO: Chief Executive Officer, the usual term for the chief executive of an NHS organisation

CQC: Care Quality Commission is the independent regulator of health and social care in England.

CLP: Culture and Leadership Programme

Change Team: the change team is a key component of the CLP; programme guidance states it is multi-disciplinary team in an organisation, representing a cross-section of staff and also including an executive sponsor, project/programme manager and expertise in organisational development and communications. The purpose of the change team is to disseminate learning and influence culture change.

Evaluation Advisory Group (EAG): a group of academics and interested stakeholders available to advice the commissioner and evaluation team throughout the course of the evaluation

HR: Human Resources as a department but also taken to mean personnel generally involved in systems, processes and procedures involve with the management of people.

LA: Leadership Academy referring to the collective term for the seven regional leadership academies.

Likert Scale: a psychometric rating scale on surveys, commonly comprising of five points

NHSEI: National Health Service England & Improvement is one national body integrating two national bodies, NHS England and NHS Improvement came together on 1 April 2019 as a new single organisation; for the purposes of consistency throughout the report, the reference will be NHSEI. NHSEI or NHSE may be contained in quoted excerpts and this is retained for accuracy. (National Health Service England [NHSE] did oversee the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS in England and was created as part of revised structural arrangements associated with the Health and Social Care Act 2012. The

National Health Service Improvement [NHSI] was a national body responsible for overseeing NHS foundation trusts, NHS trusts and independent providers, supporting consistently safe, high quality, compassionate care within local health systems that are financially sustainable.)

NHSLA: NHS Leadership Academy is a national body which commissions leadership support for NHS organisations

SOF (segmentation): refers to the NHS Oversight Framework which is a way of categorising performance and support required by NHS trusts across five performance areas including new service models, preventing ill health and reducing inequalities, quality of care and outcomes, leadership and workforce and finally, finance and use of resources. The level of support and monitoring is denoted by four levels with level 1 affording maximum autonomy, level 2 requiring targeted support, level 3 mandated support, and level 4 is special measures.

OD: Organisation development

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We are grateful to the commissioners of this evaluation, for their sincere and honest approach to seek out answers, challenge assumptions, and be committed to an evaluation process of this scope and depth. We also wish to extend our gratitude to all members of the NHSEI Culture and Leadership Programme Team; the team has changed in composition during the course of the evaluation but this has not in any way diminished the thoughtful and diligent contributions from all – our thanks to you.

We would like to acknowledge the engagement and involvement of colleagues from the regional leadership academies, their staff and connected associates. Further, it has been enlightening and rewarding to draw on the expertise of national experts working in the field of inclusion, equality and diversity, and we thank them for their input.

Finally, it is important to acknowledge the wide range and number of significant contributions to the intellectual endeavour reflected in this report and to this end, we would like to thank all members of the Evaluation Advisory Group for their considered and thoughtful discussions. Of note also are the significant and insightful contributions from Professor Russell Mannion from the University of Birmingham. Further, we would like to extend our thanks to Crispen Sachikonye at the University of Manchester for his expertise and contributions on realist evaluation methodology.

Executive summary

The Culture and Leadership Programme (CLP) is a phased organisational approach to shape leadership and culture, such that it positively effects the quality of patient care. The programme has at its core the themes of inclusion and compassion, and supports sustained focus on these for all leaders and staff. It is a national programme which has become mandated for some NHS trusts requiring fundamental performance improvement. This contributed to an increasing number of trusts engaged with the programme, hence it became increasingly important to commission an evaluation to explore, understand and affirm how the programme was working, for whom, when and how. Understanding the answers to these questions will equip NHSIE to optimise the impact of CLP.

This evaluation report distils initial scoping work through to a full formative evaluation, spanning an 18-month period. The evaluation team is formed from a collaboration between the universities of Manchester and Birmingham, and has also drawn from a wide network of academic advisors and stakeholders. As the evaluation commenced, the policy context in a post-Francis era focussed on the themes of inclusion and compassion, within NHS leadership and culture, and how this manifested in the experience of all staff in NHS organisational life.

Whilst concluding this evaluation, the Covid-19 pandemic has resulted in unprecedented, rapid and startling implications for the NHS. The evaluation findings are presented in this context, acknowledging there is an opportunity to take these evolving circumstances into account when considering the recommendations.

The principal evaluation questions were devised to understand how the CLP is being implemented, the support and resources needed to effectively implement the programme, what impact the programme is having on leadership, behaviours, and more broadly, culture itself, and the degree to which new cultural norms are reflecting compassionate and inclusive leadership. The evaluation also solicited how diverse and inclusive cultures could be made manifest in the programme's materials, and to develop understanding about how to secure consistent support within regional structures to programme delivery, with regard to knowledge, skills and capability.

The evaluation team generated a model for understanding how the CLP is creating impact, through the interactions between sustainable implementation, engagement and inclusion approaches. We have considered a wide range of literature notably Schein's model of culture,

the notion that the sustainability of large scale culture change, and the idea of organisational traps.

The evaluation adopted a realist evaluative framework, and a more detailed account is provided in a supplementary document. Summarising the realist framework were six hypotheses, generated during the evaluation process, as follows:

Hypothesis 1: Where a programme has **external status and credibility** (evidential, academics, think-tank endorsements, implemented by other trusts) the CEO and board, clinicians and staff will be more persuaded that it can help them change the culture of the organisation.

Hypothesis 2: The way in which the CEO and the board/executive sponsor **conceptualise, communicate and engage trust staff around the purpose and destination of the culture change** will be a significant determining factor in the way staff engage with/respond to programme implementation/culture change.

Hypothesis 3: Where the **approach to programme implementation** is consistent with the ethos and values of the programme, aligned with other change initiatives and integrated with strategic priorities and direction, and the trust frames and communicates the task as changing the culture of the institution (rather than implementing a programme) – i.e. the programme serves to institutionalise culture change and is a means to an end not an end in itself – then the programme is more likely to become embedded rather than seen as something to be endured, with a finite end.

Hypothesis 4: The type and amount of **dedicated support and resource available**, influences the way the trust goes about change. Where there is sufficient and dedicated resourcing for the programme, it enables the change team to more effectively progress through the three phases, in a timely manner. The more bespoke and sophisticated this resource is - and the larger the capacity provided - the more the trust will be able to extend implementation more widely. Where there is an experience of being supported when implementing the programme, it helps maintain motivation, and increases the potential for working through the change and being innovative.

Hypothesis 5: Fidelity to the Phase 1 diagnostic model Where trusts both use the specified diagnostic tools and follow the specified structure, activities and process (fidelity to the Discover phase) it will result in - better quality data for deciding on the design and deliver phases, because it will provide a more comprehensive picture of the trust's performance and culture. Where understanding of the programme - its ethos, values and behaviours; its processes, tools and activities; what data is needed and why; how the data can be used to craft a process of change – is not deeply understood

(immersive), then the Discover phase will just be understood/approached as a data collection task to be completed (focus on content), rather than seen as a process for engaging staff and finding out what the trust's current culture looks like, and how this needs to change. This then means that good data will not be collected or is unhelpfully narrow.

Hypothesis 6: Organisations that see the need to go beyond compliance and regulation, and work to embed the principles of equal access to opportunities, social justice, fairness and human rights into the organisation's policies and into the 'DNA' of leaders' practices, are likely to be better at developing and sustaining *diverse and inclusive* cultures.

A mixed methodology was devised consisting of surveys, workshops, site visits, interviews and document analysis across a sample of 20 NHS organisations engaged in different phases of the CLP programme. Data was analysed, synthesised and triangulated through a formative process of peer collaboration, involving the commissioner of the evaluation and a wider academic network of advisors.

There is a substantial amount within the current CLP programme that is positive, constructive and purposeful in supporting NHS trusts to develop a compassionate and inclusive culture. The range of findings describe the implementation of the programme, the support required for implementation, and what promoted impact and facilitated the impact to become sustained and embedded.

We identified key findings about how the programme was implemented, in that sign-up was influenced by academic credibility, energy/arrival of new leaders and/or regulatory and quality concerns. Further, the change team were seen as a critical vehicle for staff engagement and this worked well where change teams reflected staff from a wide range of front-line service, disciplines and from all hierarchical levels. A range of engagement methods were employed but the preponderance of informal encounters and interactions which facilitated credible social connection was noted. The use and efficacy of programme materials was considered in depth, and we concluded that the flexibility conferred from the overall phased programme approach was helpful. However, although some participants saw integration with wider programmes of work within individual organisations was needed, the evidence from the literature reinforces the view from other participants that such integration impacts negatively on cultural change. The

need for committed and sustained infrastructure and resources was also emphasised. These findings are significant in that they provide evidence of characteristics of effective organisational development interventions in NHS trusts.

There was a strong appreciation for the range of support to implement the programme, particularly of external support from NHSEI and regional associates. However, it was apparent that support could be reconstituted more consistently in terms of amount, type and duration across the programme, to optimise the programme's impact.

All trusts wrestled with the difficulty in identifying evidence of impact, and for some trusts, it was still too early in their implementation path. We noted a reliance on existing metrics, particularly NHS staff survey and equality, diversity and inclusion data reported on at national level. Some of the struggle to identify impact related to the degree to which the organisation's cultural destination was articulated at the outset, and the need to track baseline evidence over time, seeing new cultural norms embedded. As part of the evaluation, a Summative Impact Evaluation Framework has been developed, which is provided as a supplementary document.

We concluded that at the programme level, the six hypotheses were upheld, however, this cannot be generalised to each individual trust, as context in each will be quite different. The hypotheses, and the related relationship between sustainable implementation, engagement and inclusion approaches can be used as both a developmental tool, to facilitate reflection on process, and a local evaluation tool, to track outcomes.

Based on our evaluative insights, we present the following recommendations:

- I. The CLP phases are extended and enhanced to include additional activities with increased attention on engagement and evaluation and all phases can be viewed as one life cycle which can subsequently be repeated.
- II. In the initial phase, logic models are used to facilitate and articulate the organisation's cultural destination.
- III. The connection between cultural destination and the function of teams needs to be highlighted and made much more explicit in the CLP materials.
- IV. Guidance, tools and activities are developed for targeted involvement of middle-tier leaders.

- V. The proposed redesign of the programme phases and activities includes feedback loops, to facilitate iteration across activity/phase and board, change team and wider organisation.
- VI. Trusts need to establish dedicated infrastructure at the outset that will sustain the programme over the long term.
- VII. Trusts establish and fund a dedicated infrastructure that is sustained across all CLP phases and activities with specific expertise in social media and communications, accommodating staff's time and development needs.
- VIII. CLP guidance on how change teams are established needs to be strengthened with regard to membership, recruitment and selection, and capability and skill mix.
- IX. In building the dedicated infrastructure, the range of support is addressed, which is likely to involve a blend of internal and external resources.
- X. The term equality, diversity and inclusion should be used consistently in oral and written communications for CLP work.
- XI. WRES and WDES data is included within Discover tools.
- XII. Equality, diversity and inclusion indicators are embedded in the Culture and Outcomes dashboard.
- XIII. CLP tools are reviewed to address gaps in equality, diversity and inclusion.
- XIV. Branding work is undertaken at the outset to capitalise upon the credibility of the CLP.
- XV. A strong social marketing and communications approach is agreed and resourced at the outset.
- XVI. Regular developmental and networking opportunities are facilitated to enable trusts to exchange information throughout their CLP life cycles, phases and activities.
- XVII. The support from regional teams is targeted to optimise the CLP work and momentum at specific junctures: contracting, supporting work on cultural destination, impact and behaviours, change team initiation, support for synthesis with capacity to provide early support to emerging issues.
- XVIII. Recruitment, selection and orientation for regional associates are standardised.
- XIX. CLP guidance is developed to address how to support trusts undergoing structural change.
- XX. CLP materials are developed to include guidance and case studies illustrating how new cultural norms pertaining to compassionate and inclusive leadership and culture are experienced in practice.

- XXI. The Summative Impact Evaluation Framework is iterated and finalised with key stakeholders to integrate multiple perspectives.
- XXII. Additional work is undertaken to improve indicators which track cultural change, to include research on evaluating behavioural change pursuant to compassionate and inclusive leadership.

In conclusion, we have appreciated the strong foundations of the CLP and looking to the future, there is rich potential to extend the programme into health and social care systems and enhance the programme by working in collaboration with patient, carer and community groups.

1 Introduction

Alliance Manchester Business School, University of Manchester in collaboration with the Health Services Management Centre, at the University of Birmingham, were commissioned by NHS Improvement in October 2018 to undertake an independent evaluation of NHS Improvement's Culture and Leadership Programme (CLP). The evaluation was commissioned in two distinct phases; a scoping (reported on April 2019) and a formative phase (concluded in April 2020).

Since 2016 the NHS policy landscape has somewhat altered, with deepening workforce shortages, uncertainties caused by Brexit, growing concerns about the fragility of social care, and only modest levels of increased funding for the NHS. There have been restructures, changes in leadership of the Arms-Length Bodies (ALBs), and a new Secretary of State for Health. Meanwhile, the publication of the NHS Long Term Plan in 2019 signalled a policy focus on stronger population health and illness prevention, as well as continuing to drive the modernisation of services that capitalises on scientific discoveries and technological innovations.

Notwithstanding the change in policy focus, the challenges arising from the Francis Inquiry Report in 2013 following events at Mid Staffordshire Hospital remain: how to provide the leadership which is necessary for care that puts patients first remains. There is increasing evidence that compassionate and inclusive leadership is connected to higher levels of staff engagement and to better patient experiences. The development of a Well Led Framework for both developmental and regulatory purposes summarises the expectations of leaders within NHS provider organisations. A recent evaluation of the Well Led Framework¹ highlighted the balance between organisational culture and robust governance although it is noted that the inherent tensions between this dual purpose remain unresolved. Unfortunately, there is also evidence of variations in leadership practices and behaviours across the NHS, as evident in NHS staff survey results, CQC reports as well as academic publications.

The case for an inclusive and compassionate organisational culture within the NHS has been described in recent publications²³ and is said to be integral to the NHS Long Term Plan⁴ as the means to achieve high quality patient care. The features of a compassionate healthcare culture have been detailed⁵⁶ and indeed within the current NHS Staff Survey a wealth of indicators are revisited annually providing insight into the extent to which this cultural destination is being realized. Staff survey results indicate a sizeable challenge ahead with almost one in five staff

reporting bullying, harassment and discrimination from colleagues, as a routine experience⁷. Such results are an important reminder of the progress still required.

The task of implementing a compassionate and inclusive culture in the NHS is challenging due to a complex interaction of factors. There is a long-standing tension for organisations operating within the NHS due in part to a perception that leadership focused on developing an inclusive and compassionate culture will not help to achieve the politically driven requirements for speedy, measurable improvements in performance. This is further reinforced by a regulatory regime where publicly available ratings are based in large part on the attainment of performance targets adding to the tension. Ultimately the 'ask' of steering complex, NHS organisations to deliver both a high quality experience for staff and patients inside a performance regime rigorously pursuing efficiency and reduction of cost, results in the former sometimes/always giving way to the latter. These factors together with the political overlay for senior leaders being seen to fail if performance targets are missed means that many NHS organisations have been in the hands of interim executive leaders and/or have experienced many changes of personnel at board level⁸. In a recent report⁹, 8% of executive posts were either vacant or filled on an interim basis, 37% of trusts had at least one vacant executive director role, and 3 years was the median tenure of a chief executive; the extent of this 'leadership churn' is problematic in all systems but the impact is compounded in organisations that are already reporting performance challenges. Length of tenure facilitates the ability to undertake strategic planning and appreciate and subsequently influence, culture in a meaningful way.

The role of compassion in healthcare leadership and culture emanated from findings post-Francis; the NHS published a report called 'Building and Strengthening Leadership - Leading with Compassion' (2014)¹⁰ which set out what compassion means for the self, the manager/leader, the team and the organisation. As the report says "*Leading with compassion is an outcome not an input. If you get the basics right, and help people reconnect with their work, it can truly transform patient care.*" (p.7). More recently the Interim People Plan (June 2019)¹¹ states the need to "*improve our leadership culture: positive, compassionate and improvement focused leadership creates the culture that delivers better care. We need to improve our leadership culture nationally and locally*" (pg 8). The Culture and Leadership Programme (CLP) is therefore a response to a growing body of evidence and the recent history of the NHS.

1.1 Assumptions regarding organisational culture

Within the literature there is a broad dichotomy between those who believe that organisational culture can be purposefully managed towards a cultural destination and those who believe culture itself is a far more intransigent construct¹². Views are polarised between culture as an attribute, largely convened by senior leaders; this perspective has much more positivist origins. In contrast is the notion of culture as metaphor, which has its roots in phenomenology, and translates into a more socialised view of culture, in that all organisational members are responsible and involved in culture (and indeed sub-cultures). Our approach here has been to mediate a path which recognises the value of both paradigms, distilled into the following considerations:

- the structural dimension – what is the prevailing culture?
- the process dimension – how does cultural change happen?
- the contextual dimension – what change is needed?

Accounting for each of these can determine an organisation's cultural destination.

1.2 Leadership, culture and compassion in the context of Covid-19

The production of the final evaluation report has been written during the developing global crisis of the Covid-19 pandemic, underlining the salience of compassion, the need for effective leadership, and enabling inclusive cultures. It is too early to comment authoritatively on the impact of the pandemic but tentatively, there appears to be a mix of responses from innovative (developing vaccines for example) to hierarchical, the latter typifying a command and control approach (directing workforce to new facilities for example¹³). The prevailing culture may be amplifying the leadership style during the crisis phase. There are some indications which suggest the NHS has experienced a pivotal moment of change, in the way in which it has moved swiftly dissipating bureaucracy and relying on local empowerment with a clear line of sight from chief executive to clinical teams, described thus,

“The NHS has shown that, when galvanised behind a single, clear, vital, imperative, it can change at a pace that would previously have been inconceivable. Trust leaders have been empowered to change what their trust does at the drop of a hat – they’ve been given a clear objective and told to do whatever they thought was best. That’s then cascaded down

throughout the rest of the trust – frontline teams have been able to change how they work to best meet what they know needs to be done.”¹⁴

The authority and autonomy to act appears to be a significant feature of how the NHS has responded, and learning about this could inform future iterations of the CLP. What is not yet apparent is the extent to which compassionate and inclusive leadership is being experienced. This is an important question in the context of both the speed of change and the potentially high level of trauma experienced by staff in the immediate response phase, and possibly in the longer term. The possible changes in how the NHS is structured, funded, and resourced cannot be known yet. The seismic impact of the pandemic is likely to have a longer-term impact in how compassion, inclusion, leadership and culture are featured in the NHS, and therefore the findings from this evaluation are presented with this in mind, to offer a foundation of learning and insights to build the road ahead.

1.3 Evaluation Questions

The CLP builds on the body of evidence¹⁵ that proposes the behaviour of everyone in the organisation affects the quality of care it provides, vis-à-vis the socialised view of culture described above. Based on these concepts, the CLP creates a multidimensional programme in which five cultural elements are linked to intended outcomes, associated leadership behaviours and an organisational view of how each cultural element translates to all organisational levels.

The programme process is described as three phases Discover, Design and Deliver, visualised in parallel, and described as iterative and interconnected. The first phase was published in September 2016 - 'discover the cultural issues you need to address', and the second phase - 'design strategies for developing compassionate and inclusive leadership' in September 2017. The third phase – 'deliver the strategies' has no published guidance.

The formative evaluation sought to answer the following questions and produce the desired deliverables (see table 1 below):



	
<ol style="list-style-type: none"> 1. How is the programme being implemented? 2. What support and resources are needed to effectively implement the programme? 3. How are participating trusts working toward developing a culture of compassionate and inclusive leadership (new cultural norms)? 4. What impact is the CLP having on the leadership cultures and behaviours in participating trusts? 5. What concepts and evidence associated with diverse and inclusive cultures need to be included in programme materials? 6. How can the NHSLA regional centres provide a consistent approach to programme support across England and what knowledge, skills and capability is needed to effectively support this programme? 	<ol style="list-style-type: none"> I. Collect, collate and analyse data, and report on programme activity across specific programme variables. II. Identify early indications of impact occurring in the areas predicted by the evidence and determined by the scoping review. III. Provide a set of recommendations on any changes that are needed to the programme's content, design and/or delivery to optimise its effectiveness. IV. Provide an assessment of the expected impact of the programme on organisational characteristics in the short, medium and long term, as predicted by the evidence and observed in the course of the evaluation. V. Provide a set of recommendations for establishing data gathering processes to develop metrics, in anticipation of an impact evaluation in future. VI. Provide a framework that could be used to conduct a summative/impact evaluation at a later date based on a review of the recommendations in phase 1.

Table 1 Summarising the evaluation questions and the associated outputs.

1.4 Summary

The report is organised in the following way: we have presented an overview of the theoretical influences for the evaluation in chapter 2; this includes theory relevant to both the subject matter – compassionate and inclusive leadership and organisational culture, along with a discussion of the realist paradigm and methodology. We then provide a brief overview of our methodology, and approach to analysis and synthesis. The following three chapters (3, 4 & 5) present the findings in detail, with links to supporting evidence. In chapters 6 & 7, we discuss the findings followed by our conclusions and recommendations. There is a supplementary document with this final report, containing the realist evaluation framework and the Summative Impact Evaluation Framework.

2 Conducting the evaluation

In this chapter we present how we conducted the evaluation. We start by outlining the principles that underpinned our approach, and the theories of change and realistic evaluation methodologies that were generated. Then we describe the conceptual framework that informed our data collection and analysis, showing how this relates to existing theory and evidence about culture and leadership in general, and specifically within the NHS. This is followed by an overview of the methods that we used for data collection, and our approach to analysis, followed by how we approached sampling, and a brief overview of the evaluation sample. Finally, we have summarised our approach to ethical principles and practices which have underpinned the evaluation.

2.1 Principles

Our approach to the evaluation was underpinned by three key principles. The first principle was to facilitate on-going learning by the NHSEI team, staff from participating trusts and other stakeholders, so that the CLP and its implementation could be improved, and impacts enhanced from the very start. Such learning rests on engaging with the issues that concern stakeholders, and by understanding how the programme works to bring about change within a very complex context, often subject to many external influences. We sought to facilitate on-going learning by creating spaces for reflection 'on action'¹⁶ where people were active participants looking to develop their own understanding, rather than merely providing data for the evaluation team to analyse. We also provided regular feedback to the NHSEI team supporting the programme, building on relationships and systems established during the preceding scoping study, so that they could make sense of emerging findings and insights, and initiate change. Discussions about the feedback also helped to draw out generalised learning for the benefit of the wider system; the learning was prefaced with caveats about generalisability and validity relating to completion of a full synthesis, and a relatively small sample size.

Our second principle was to be holistic, seeking to identify and engage with the various influences on the programme, focusing on the **process** as well as **content**, considering the whole scope of the programme, and using multiple methods of data collection.

Our third principle was to make sense of this complex reality by seeking to give an account of how programme activities are linked to outcomes and desired impacts; and then elaborating these further through realist evaluation¹⁷ - a deeper exploration of the underlying "mechanisms"

which are activated as the programme activities interact with the local context, and which generate the outcomes. This illuminated which of the different programme interventions and approaches worked, for whom, in what circumstances and why.¹⁸, Our application of the theory of change and realist evaluation methodologies is described briefly in the next section.

2.2 Paradigm: Theory of change and realist evaluation

In our scoping study we identified explicit and implicit change theories that people held about the programme, through interviews with different organisational stakeholders, posing the following questions:

- What is the *impact* the programme is designed to deliver?
- What is the *rationale* for doing this (what is not happening that the programme needs to address)?
- How does the NHSEI and trusts *believe* the change will come about (i.e. what activities and involvement is this theory of change contingent on)?
- What are the interventions used and people involved and how do they come together as a whole and in specific organisations to achieve cultural change?

This enabled us to identify the different components of the programme, and to map out people's existing understandings of what outcomes and impacts the programme would produce. This included how assumptions, external factors and the implementation context could affect this; such questioning continued throughout the evaluation.

Realist evaluation encourages an exploration of more general, underlying "mechanisms" that the particular programme activates. The programme can be thought of as making various resources available to participants (e.g., knowledge, funding, staff etc.), but the impact of these resources depend upon how participants respond to them (e.g. their reasoning, emotions and other responses).

* The theory of change map in appendix # sets out and distinguishes the national theory of change from what we would find locally, in trusts

A mechanism comprises a resource together with an associated response. Both context and the outcomes that are generated^{19,20}mediate the activation of the mechanisms, (e.g. aspects of existing culture and leadership, local and national policies etc.); there may be multiple mechanisms activated by a programme.

2.3 Our hypotheses

A deeper exploration drew initially on existing research-based theories of culture and leadership change already known to research team members, advisory group members and other experts. These were related to the theories of change and data collected by the evaluation, in an iterative process of analysis. Concepts and ideas which were particularly pertinent to the programme and issues of importance to stakeholders were developed, originating from the evaluation questions. These ideas were tested against the data, and modified or rejected. This process also guided on-going data collection, so that this was focused on data relevant to the testing and development process.

The result was the generation of six “realist hypotheses” as follows:

Hypothesis 1: Where a programme has **external status and credibility** (evidential, academics, think-tank endorsements, implemented by other trusts) the CEO and board, clinicians and staff will be more persuaded that it can help them change the culture of the organisation.

Hypothesis 2: The way in which the CEO and the board/executive sponsor **conceptualise, communicate and engage trust staff around the purpose and destination of the culture change** will be a significant determining factor in the way staff engage with/respond to programme implementation/culture change.

Hypothesis 3: Where the **approach to programme implementation** is consistent with the ethos and values of the programme, aligned with other change initiatives and integrated with strategic priorities and direction, and the trust frames and communicates the task as changing the culture of the institution (rather than implementing a programme) – i.e. the programme serves to institutionalise culture change and is a means to an end not an end in itself – then the programme is more likely to become embedded rather than seen as something to be endured, with a finite end.

Hypothesis 4: The type and amount of **dedicated support and resource available**, influences the way the trust goes about change. Where there is sufficient and dedicated resourcing for the programme, it enables the change team to more effectively progress through the three phases, in a

timely manner. The more bespoke and sophisticated this resource is - and the larger the capacity provided - the more the trust will be able to extend implementation more widely. Where there is an experience of being supported when implementing the programme, it helps maintain motivation, and increases the potential for working through the change and being innovative.

Hypothesis 5: *Fidelity to the Phase 1 diagnostic model* Where trusts both use the specified diagnostic tools and follow the specified structure, activities and process (fidelity to the Discover phase) it will result in - better quality data for deciding on the design and deliver phases, because it will provide a more comprehensive picture of the trust's performance and culture. Where understanding of the programme - its ethos, values and behaviours; its processes, tools and activities; what data is needed and why; how the data can be used to craft a process of change – is not deeply understood (immersive), then the Discover phase will just be understood/approached as a data collection task to be completed (focus on content), rather than seen as a process for engaging staff and finding out what the trust's current culture looks like, and how this needs to change. This then means that good data will not be collected or is unhelpfully narrow.

Hypothesis 6: Organisations that see the need to go beyond compliance and regulation, and work to embed the principles of equal access to opportunities, social justice, fairness and human rights into the organisation's policies and into the 'DNA' of leaders' practices, are likely to be better at developing and sustaining *diverse and inclusive* cultures.

Chapter 6 of the report elaborates upon these hypotheses, as the basis for our conclusions and recommendations.

In the next section, we describe the broader conceptual framework which we identified as being particularly relevant to the programme, and which also informed our data collection and analysis.

2.4 Relevant theory and concepts

In conceptualising culture in relation to compassion and leadership, we drew upon a wide body of literature, and we have highlighted here some of the significant influences. Schein's model of culture²¹, is one of these influences; this model reflects different levels: surface level, visible artefacts, such as clothing, myths and stories; espoused values – ideals and aspirations about 'what ought to be' as distinct from the 'what is'; and underlying assumptions about the organisational world that are taken for granted. Another influence is the notion that the

sustainability of large scale culture change²² depends on the nature of the engagement and implementation approach (see below)[†]:

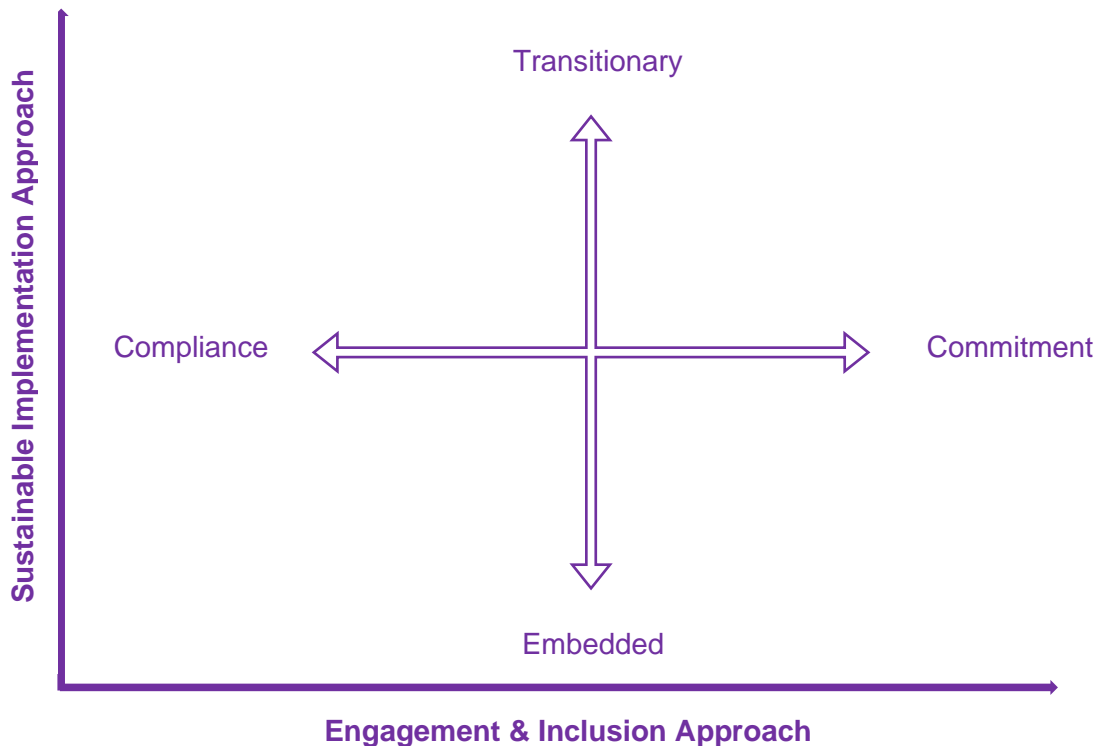


Figure 1 Sustainable Implementation according to the approach to engagement and inclusion.

The axes represent two interdependent spectrums:

- *Engagement*: does a trust work to develop genuine commitment to the change of the staff and other stakeholders who need to enact the change or will be affected by it (cf intrinsic motivation), or does it seek merely that people comply with the change without recognising its value (cf extrinsic motivation)?

[†] Further discussed in chapter 3, senior leaders' mindsets and explicit behaviours are core mechanisms for developing progressive or regressive engagement and implementation approaches.

- *Implementation*: does a trust seek to embed the change deeply in the organisation or does it regard the change as transitional – likely to be superseded by other change initiatives in the near future?

To ensure that engagement is embedded, it is crucial to consider the interaction between different levels in an organisation, connecting top management with frontline staff, with middle managers key to enabling this^{23,24}. It is also important to recognise that embedding new norms and behaviours requires support or reinforcement through training and educational interventions and through organisational systems and processes²⁵.

Embedded new norms and behaviours signify a new and different culture. In this sense, embedded is synonymous with stable, predictable, and replicable over time, and as such, can be described as sustainable change. However, as noted above, culture is a fuzzy and intransigent, contested and any relationship to improved performance²⁶ may not be explicit. Further, an organisation the size of an NHS trust will not have a single culture, but many sub-cultures (e.g. associated with professional groups) which must be considered and addressed – cultures are differentiated²⁷. Cultural change in these circumstances will be localised and incremental and will be influenced by a myriad of factors both within and outside of the organisation. Culture is continually developing as the interpretations made by, and the patterns of connections between, individuals form and re-form but which can nevertheless be described as embedded.

In conducting the evaluation, we recognise the complex and partly invisible nature of culture therefore, we are cautious of claims about rapid and deep culture change. We believe that it is necessary to seek to understand the meanings that individuals place upon themselves in their roles, but also to look beyond such reports to understand aspects which individuals may not be consciously aware of²⁸.

We also considered the work of Chris Argyris identified as 'organisational traps'²⁹, when difficult issues arise in organisational life which are not addressed or dealt with. Further the absence of acknowledgment becomes a shared and accepted approach; patterns of behaviour are self-perpetuating constituting problems 'undiscussable' and intractable, and which can become deeply entrenched. As these patterns of behaviour prevail over time, they endure and develop the status of truth, for they are to some extent, a truth for the organisation. An examination of the characteristics of discourse within organisations can be one of the ways in which these

'traps' can be identified, and reveal assumptions made within, consciously or unconsciously. Further, focussed attention on the process and interpersonal dynamics involved in culture formation and change, informed by Schein's work, can help leaders and staff identify their organisational traps, in a constructive way. Thus, our approach to the evaluation aims to promote dialogue and questioning, and to access different perspectives, from within and outside the organisation.

2.5 Overview of methodology of data collection, analysis and synthesis

Below is a visual summary of the data collection methods. Detail on each specific method has been provided to the commissioner and the EAG throughout the course of the evaluation, and to avoid duplication is not repeated here. However, all resources produced as part of the evaluation can be made available as required. We synthesised findings from each method and triangulated key findings through peer review. Below we have included an overview of the sampling approach, with descriptors of the evaluation sample, as this is useful referent data when considering the findings. We have noted in brief the ethical principles and practices employed throughout the course of our work. This chapter closes with a final section on ethical principles regarded during the evaluation fieldwork.

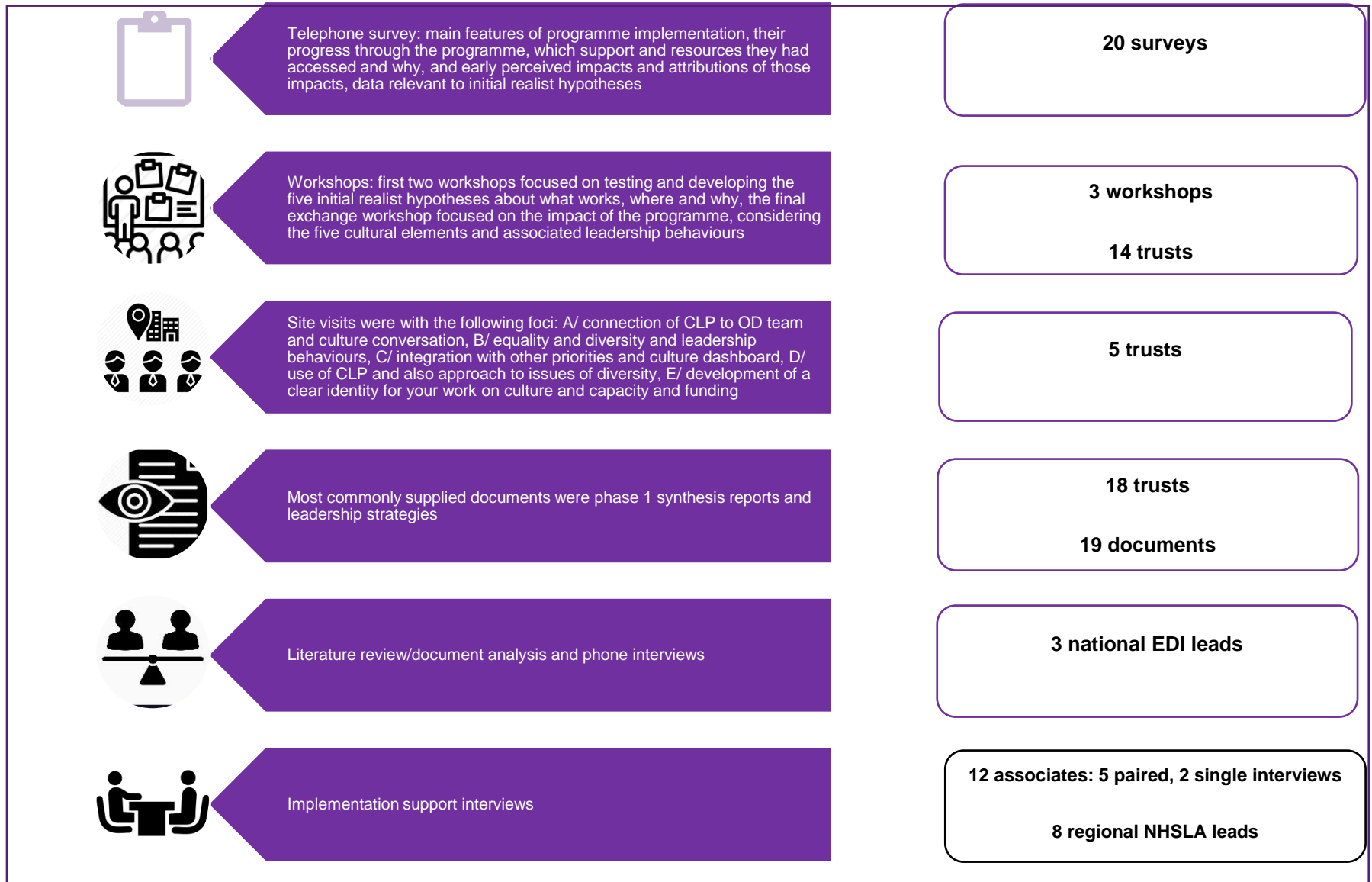


Figure 2 Visual summary of methods and data.

2.6 Sampling approach, sample overview and data sources

The NHS provider trust landscape is summarised below reflecting the characteristics of the 220 NHS provider organisations³⁰. Of these 43 organisations were engaged with CLP. The evaluation sample of 20 organisations was initially formed by convenience sampling, when an organisation's senior sponsor agreed to participate in the evaluation process. The organisations were then selectively sampled across region and CLP phase. Key characteristics of the sample of 20 organisations are illustrated below (the sample does include the 3 pilot trusts). A greater proportion of trusts in the programme were in SOF segments 3 & 4 – 47% compared with 33% of trusts not in the programme. Trusts in these higher SOF segments were more likely to have been recent entrants and were therefore still in phase 1.

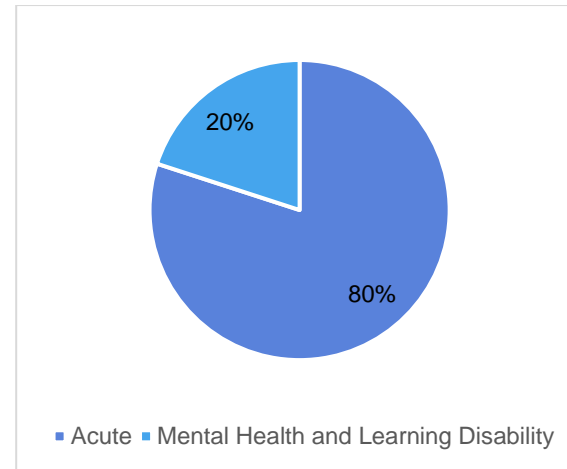


Figure 3 Showing sample trusts by type.

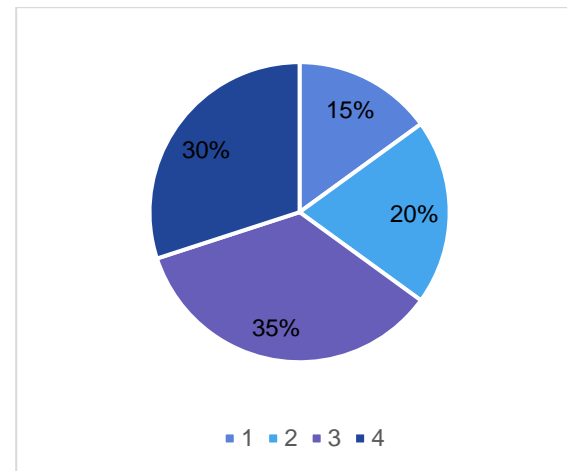


Figure 4 Showing sample trusts by SOF rating

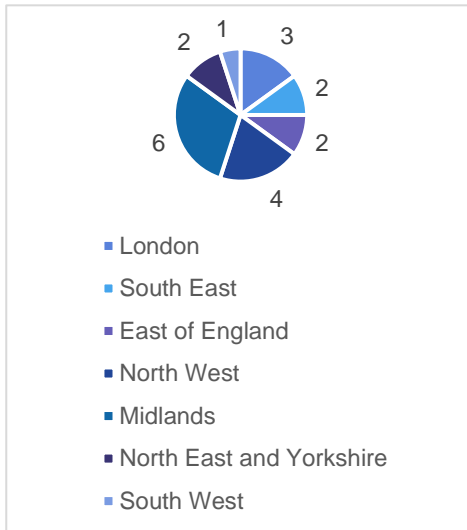


Figure 5 Showing sample trusts by region

Almost all trusts in the programme were either acute trusts or mental health trusts. Take up of the programme was higher among trusts in the East of England and West Midlands, and lower in London and the South East.

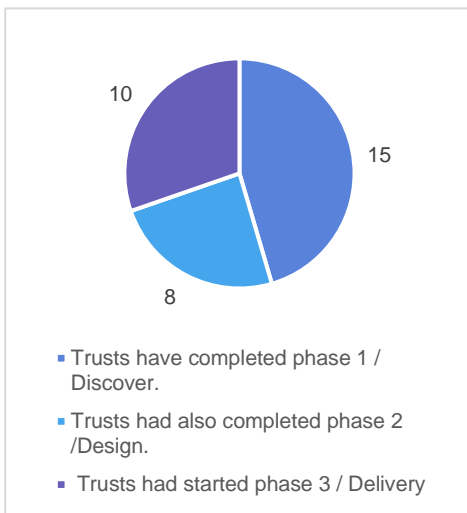


Figure 6 Showing sample by CLP phase.

Unique identifiers are used throughout the report; these link back to the data we collected, however the identifiers ensure that all evaluation participants’ contributions and their organisations are anonymised. Of note in the findings chapters is that there may appear to be a preponderance of illustrative quotes from trusts TR10 and TR18. This reflects greater volume of data from these trusts, as there was much more access, rather than a narrow selection of illustrative material used.

2.7 Ethical principles and practices

The evaluation work has been undertaken in accordance with the University of Manchester's ethical processes, which follow the following principles:

- Information governance principles; specifically the protection of personal identifiable data in accordance with best practice, University of Manchester's guidelines[‡], and all relevant legislation including GDPR
- Permission and consent to participate for each data collection methods, receive future communications, and store relevant data
- Anonymity and confidentiality; all participants' involvement will be recorded with a unique identified, no individual participant/organisation will be named in any report throughout the evaluation process

In practice, this has entailed:

- Participation Information Sheets have been provided for each data collection method, with signed consent forms required for each participant
- All data is stored in encrypted form and password protected
- Unique identifiers are used for illustrative quotes throughout reports
- Commitment to share summary findings with all participants once the evaluation is concluded

[‡] The University of Manchester Research Data Management Policy version 1.1, February 2019.
The University of Manchester Records Management Policy version 1.5, November 2018.
The University of Manchester Data Protection Policy version 1.8, December 2018.
The University of Manchester standard operating procedure for secure handling of recordings and transcriptions - "Taking recordings of participants for research projects", version 1.0, effective October 2018
The University of Manchester Research Data Storage Documentation, <http://ri.itservices.manchester.ac.uk/rds/>
The NHSI has requirements on data management, sharing and security that we comply with and the arrangements described in this data management plan meet NHSI's requirements.

2.8 Limitations

There are inevitably several limitations in presenting the findings and recommendations. A significant limitation originates from the small sample size; access to trusts was mediated by NHSEI in the first instance. It is possible that association with a body with regulatory influence resulted in a degree of protectionism from trusts. Linked to this is the possibility of 'organisational traps' discussed in chapter 2, whereupon trusts find it almost impossible to reveal underlying burdensome issues, preferring instead to invest energy into concealing these. Indeed, license to fully explore prevailing culture is often only truly realised in scenarios of care failings, such as a public inquiry.

Further, the ability to be systematic in collecting and analysing data was confounded by the discovery that not all trusts collected the same data, and further, not all trusts shared their data with evaluators.

2.9 Summary

The following three chapters present the findings that emerged following a comprehensive process of analysis, synthesis and triangulation relating to the first formative evaluation deliverable: **to collect, collate and analyse data and report on programme activity across specific programme variables**. To begin, chapter 3 is focused on the implementation of the programme, and what we have learnt is important about the process of implementation, from sign-up through all three phases, and of note, the inter-phase transitions. The role of engagement is considered, as is the pivotal role of the change team. Themes in relation to programme support and resources, impact and embeddedness are discussed separately, in chapters 4 and 5 respectively.

3 Implementing the programme - findings

The CLP programme is a substantial programme consisting of three phases, as this chapter covers all aspects and stages of the CLP there is a lot to report on. While we have attempted to keep a tight focus on those issues that are significant to the commission, given the depth and breadth of the programme, its activities and materials, it is necessarily longer than other chapters.

3.1 To do or not to do...signing up to the programme

There were multiple reasons that trusts became engaged in the programme. Accompanying these factors was an acknowledgement that the culture was problematic in some way - “we all knew something was wrong with the culture...” that may or may not have been surfaced to date.

Factors prompting participation were[§]:

- the programme was evidence-based (79%)
- there were specific, internal board-level drivers (79%)
- trusts had a perception of particular problems concerning their culture or leadership (58%)
- culture and leadership were already a board priority (42%)
- availability of support for change from NHSEI (42%)
- other participating factors (37%)
- external factors (32%), such as being asked by a regulator, advised by an improvement director appointed as part of special measures or being prompted by general NHS policy for culture and leadership to be more compassionate and inclusive.

Sign-up was often at the behest of a new CEO or the board:

“The new CEO asked for a cultural audit during her first 3 months of tenure – as there was no HR Director; [she] has direct access and communication with the CEO about this. [She] proposed a couple of models and the CLP was selected.” (TR06-SV, 14)

[§] Survey results where n=20

Turnover at the top (CEO and/or board) was frequently cited by trust staff and regional NHSLA staff/associates as a reason for trust sign-up although the arrival of an interim or new CEO/director only featured for 16% of those who initiative sign up. Evidence on turnover at the top in the NHS^{31,32} and more broadly in business and industry,^{33, 34, 35} suggests poor performance is a key factor. A review³⁶ found that the median tenure of an NHS chief executive was three years, and that 'short tenure' had a negative impact on organisational culture and strategic transformation:

"The churn of senior leaders in the NHS is a significant problem. Eight per cent of NHS trust executive director posts are vacant and there are particular challenges in recruiting chief operating officers and strategy directors....[this] short tenure had a negative impact on organisational culture and stopped trusts engaging with strategic transformation." (p7)

Turbulence through management changes at the top as well as lower down featured in a number of trusts, and the question about consistent senior support throughout a long-term culture change process, seemed doubtful for some:

"So one of the change champion teams said, I think they'd had seven general managers in four years, there's been, I don't know, in their 15 years, they'd had, I don't know, seven chief execs, [...] I mean, it's just the level of senior management, you know, is anybody who is senior going to commit to hanging around and helping us to sort these issues out?" (RLA1-I,03)

In a few instances external input (e.g. regulator, special measures) or new members of staff with different perspectives or ways of working coming into influential positions, influenced the decision to sign-up. Both of these influencing factors were more likely to happen if there was high turnover among senior leaders, or if there was a crisis, suggesting perhaps, that an external perspective is needed to help some organisations to 'see' the nature of their problems.

3.2 Levels of performance and sign-up

Sign-up to the CLP was often initiated in relation to external performance or regulatory concerns. Many change teams talked about the trust's staff survey results or outcome of a CQC assessment being the reason the board decided to act; this particularly featured for trusts SOF rated 3 or 4.

"I think things like their CQC, their staff surveys, they recognise, as an organisation, that there is a need for a change in culture and how things are done." (RLA4-I,11)

Trusts with SOF rating 3 also were more influenced to sign up to the programme as a result of hearing about the programme from other trusts, although this did not seem to influence any of the top performing trusts.

At times, the decision to sign-up to the CLP was a more proactive decision; the board already had identified culture change as a priority and proactively were looking for a way in which to do this, because they had aspirations for the trust to become - and be seen as - a highly credible organisation. The majority of these trusts were SOF rated 2.

Trusts that were SOF rated 1-2 were more likely to sign up to the programme because the board already had prioritised developing a compassionate and inclusive culture, were proactively researching how they might improve their culture, and because senior/OD people had some prior personal knowledge or connection with the CLP or a similar programme. This prior knowledge or connection may have been related to pre-existing capacity and high performance (SOF rating 1-2).

3.3 Programme status and credibility

As discussed above, the programme's evidence-base appeared to be an important factor in trusts signing up to participate on the CLP, with frequent references to the status and reputation of the academics and the think-tank involved in conceptualising and designing the programme:

"the selling point for me, was Michael West" (RLA1-I,03).

"...we were exploring where might there be some proof of concept, really [...] and because we were talking with Michael [West], we started to talk to him, to get his advice, in terms of how we might go about some very specific...thinking...about how to enact culture change." (TR18-I,10)

*"...so Michael West, Peter Hawkin's** work, and Amy Edmondson†† around psychological safety..." (TR18-I,08)*

While the evidence-base and status of the programme may well be an important marketing feature for NHSEI, for trusts it is likely to be very important, as it enables them to internally

** Professor of Leadership at Henley Business School

†† Harvard University

'sell it' to clinicians who are likely to be sceptical, and want evidence about what works, before getting involved:

"I think what it's offered us is a good starting point that's based on theory, that had got NHSEI's stamp behind it, that people listened to us" (TR14-SV,01)

For one consultant, the programme's evidence-base was important, and he found it sufficiently compelling to volunteer for his trust's change team:

"...I am a data driven person...[so I] put in an application and was interviewed..." (TR18-SV,06)

Credibility also came from other participating trust's feedback about the programme. The fact that the programme was 'tried and tested' appeared to be what persuaded operational staff, that it might work:

"So I think that it did need that external voice to come in and say well, these are the sorts of things they've tried in other places and this kind of works..." (TR10-ExW2,02)

However, as no actual evidence of impact was available at the time, it appears that staff conflated the tried and tested experience of other trusts with a false impression that evidence of impact was available. The realist framework points to a 'believing is seeing' mechanism as being a factor that persuaded some staff to sign-up for the programme^{‡‡}.

3.4 Identifying the cultural destination

In the programme guidance 'Getting Started', the action trusts are asked to undertake at the outset is to 'build the case and identify the purpose of your collective^{§§} leadership strategy.'

Identifying the ultimate purpose of culture change – what we refer to as the 'cultural destination' - is crucial, as this sign-posts the direction of the change to those involved in engaging the wider organisation and then in implementing the change.³⁷ It is asserted³⁸ that this work is closely aligned to identifying the organisation's vision and values:

^{‡‡} Hypothesis 2 as outlined in chapter 2

^{§§} Interestingly, only five of the trusts' strategies maintained a clear and explicit focus on collective leadership, indicating that this important aspect of this programme was either missed out or left out.

"Changes in ...organisational culture... begin with the creation of a strategic vision — a clear sense of what the organisation aspires to be and a sign post to its future direction." (p243)

It is a core task of a trust board, as is making the cultural destination explicit to the wider organisation. However, identifying the ultimate aims of culture change appeared to be difficult for boards to achieve, with some appearing to not know where to start, or how to do this:

" [The CLP Lead] was having trouble with this piece of work because the organisation was in such desperate need of it, yet [the board] didn't have any understanding of what a positive culture looks like. " (RLA2-I,06)

"You've got some idea that something's wrong and [...] you can't measure it, you can't put a figure on it. It's so...it's such a kind of non-absolute thing; it's not like a digital thing where it's zero or one." (TR10-ExW2,03)

Although one regional associate supporting trust CLP implementation felt that boards were clearer about what this meant now [2020], compared with when the national programme was launched a few years ago:

"... I think that the awareness around the system, you know, different...boards now have a better understanding about where the cultural destination is than they had three or four years ago." (RLA3-I,08)

And in other trusts, staff talked about the clear direction their CEOs and board provided, and the leadership and role modelling they offered to others involved in culture change:

" ...so, when [CEO] took over she had a very different style of leadership; it was much more inclusive, a much more humble approach. And also the people she recruited onto the board – they have a real shared purpose and intention that I experience. So she very easily said, actually you are trying to do too much too soon, and she had a very clear quality improvement plan for the first year, second year and third year, of that journey, and that's been really helpful in getting us focussed on...in getting a staff-led improvement methodology embedded." (TR18-I,08)

"So, she kind of really spears the way in terms of her sense of caring and purpose [...] and she role-models beautifully and lots of people I can see beginning to change because of their proximity with her..." (TR04-ExW3,01)

3.5 Lost in early translations

Documentary analysis revealed that for many trusts, while their vision and values were incorporated into programme documentation, the ultimate aims of culture change were documented in a rather abstract way, rather than made explicit and aligned with their vision and values. Some leadership strategies explicitly acknowledged a lack of clarity:

“Within these findings people reported a lack of clarity and understanding around the vision, values and behaviours...” (TR13-D,03)

Overall, a number of trust strategies and plans appeared to offer ‘grand statements,’ with some copying and pasting the programme’s overview about values and ways of working including about compassion and collective leadership, but providing little explanation about what those statements meant and why they were important in the local trust. Certainly for many strategies and plans, there appeared to be little explanation, clarity or evidence of shared understanding regarding what compassion and inclusion meant locally, and we found no reference to the compassionate behaviours which are referred to in the concepts and evidence as:³⁹

“Compassion in an organisational context can be understood as having four components: attending, understanding, empathising and helping.” (p9)

In the main strategies and plans lacked a focus on outcomes and impact, with only a few articulating anticipated changes in leader behaviours. In addition, where outcomes were identified, these were often ‘outputs’ or processes, and were linked more broadly to policy related requirements that were current e.g. a workforce strategy; a programme of unconscious bias training, without including what this meant in terms of outcomes and behaviours related to a changed organisational culture.

The sense we make of this, is that the vagueness and language involved, reflects ‘how we write strategies and plans around here,’ and that developing strategies are often seen as a job needing to be done, rather than conceptualised as an important and symbolic communication of culture change; i.e. seen as a key tool for change.

As discussed above, translating and communicating the trust’s cultural destination to the wider organisation is a core task of trust boards. It is suggested⁴⁰ that one mechanism for creating readiness for change is strategic ‘messaging’ or persuasive communicating. Bandura⁴¹ asserts this needs to be explicit and clear about the change needed - the desired end-state - and the capacity and capability of the organisation to address that challenge.

The importance of messaging was recognised by one trust who took part in an exchange workshop:

"So the mechanics, the architecture, I don't care about that; to us it's important and we will follow it, but the messaging is way, way, way more important than the process." (TR-20-ExW2, 01)

However, this is no easy task, particularly getting the message to operational and front-line staff who may be dispersed over many locations and across a wide geographical patch:

"...staff didn't know the trust's purpose – it is comprised of mental health and learning disability services across [many] different localities, so staff can be difficult to engage because they are so dispersed." (TR06-ExW3,01)

And indeed, a communications strategy with specific messaging about culture change as an essential element – both instrumentally and symbolically - in creating a narrative about the organisation and its cultural destination, appeared to be overlooked or was not very visible.

We observed that a developing clarity over the aim and purpose of the culture change, often emerged later in the programme in a number of ways, for example by boards, change teams and through the active participation of staff in events. These events often involved large numbers of staff, and were designed to launch the programme, and provided opportunities for staff to identify, reflect on, and generate their own understanding about what change needed to happen, and were an important influencing tool⁴² in getting started.

Using events to generate the outcomes and impact with staff, ensures that the process of implementation reflects the values of the programme (inclusive), and signals the trusts' intention to involve staff in the process, which will also help to build trust and support from staff, in the process. The report now moves on to look more closely at how trusts went about implementing the programme in practice.

3.6 Creating a change team

Guidance on implementation of the programme was made available in many different forms of media, with a guidance document spelling out the different steps to take. One of the first activities is for trusts to create a 'change team' to lead the implementation of the programme. The CLP guidance provides a steer on membership, size, support needs and responsibilities of change team members. Below, we present our findings on these different elements as well as change team recruitment.

3.6.1 Recruitment and selection

The majority of trusts said they had set out explicit intentions for team recruitment, but there were no obvious patterns by SOF segment, for trusts that did or did not have explicit intentions. In many trusts, the opportunity to join the team was open to any staff member and publicised across the organisation.

“...we want to set up a steering group made up of staff working at every level and across the trust to help shape and coordinate the work and decide our priorities. This will make sure any changes we make will have a real impact and deal with the issues which are most important to you.” (TR11-D,02)

Survey data showed that trusts advertised for passionate, enthusiastic, or at least willing, volunteers, who they hoped would commit time and energy to the programme. No one was actively excluded, although quite commonly, permission from a line manager was needed, in view of the time commitment required of team members. In one trust, nominations were sought from the different areas of the organisation, and in a small number of cases there was some "head hunting" of particular individuals who it was felt could make a particular contribution, e.g. because of specialist expertise.

In most of the trusts, even if there was an assessment process, everyone who wanted to participate was accepted into the change team. In a few trusts there was an active selection process. In one case this was based on having the qualities, skills and experience relevant to a team member. In others there was an element of selection so that the team would have a good balance across different professions, or some staff who might not otherwise have been selected for the team were accepted in order to increase “difference”, for example, across Myers-Briggs personality types.

Some trusts designed their recruitment to be appealing to a wide range of staff e.g. by asking for expressions of interest rather than applications; sending out letters of invitation; including recruitment information in presentations to staff; or by explicitly offering training and development opportunities for team members. There was some explicit action to promote recruitment of under-represented groups, e.g. by advertising through existing staff networks for BME, disability, LGBT+ etc.; sometimes underpinned by input from a staff expert in equality and diversity. In one trust there were additional efforts part way through the process to recruit more men, when it was realised that there was a preponderance of women among the existing recruits.

The nature of recruitment was sometimes influenced by the structure, size and function of the change team(s) that the trust was seeking to establish. For example, there might be a small team based primarily on OD expertise supporting a larger and possibly more diverse change team where enthusiasm was the primary characteristic. Potential drawbacks of different structures were mentioned – on the one hand, the danger of becoming over-reliant on expert team members, and on the other hand, the danger of the team lacking necessary skills and hence needing large amounts of training or other support.

Some organisations legitimised staff involvement in the 'change team'; this was presented as a specific role, with a requisite job description, and importantly, recognised and funded time, away from the 'day job' to contribute to the CLP work.

3.6.2 Size of change teams

The size of change teams varied enormously between trusts. Statistically, they would appear to fall into three categories:

- **Small – expert - handpicked:** compact core team of staff, usually hand-picked, often had a senior and OD expertise emphasis, and comprised between 3 - 8 members.
- **Medium – motivated and interested - recruited:** members partly selected for their enthusiasm or interest, and partly on the trusts' consciously seeking to cover the breadth of the organisation and staff levels
- **Mass - social movement – recruited:** trusts deliberately sought to attract and engage wide staff involvement. This size of change team enabled trusts to engage a much wider group of staff (levels, locations and disciplines), but at times the size was found to be unwieldy, so they needed to structure involvement in a way that was more manageable (if they hadn't anticipated this in the first place). Numbers reduced over time.

There were no obvious patterns of team size by SOF segment, type of trust, or an OD/HR focus/sponsor, but we did find that four out of the five trusts with change teams of 30+ members, were based in the midlands.

3.6.3 Diversity of membership

Most trusts sought to involve different staff groups - doctors, nurses, administrative staff etc. (89%); tiers/levels (84%) and departments (79%) in their change team. In many trusts the change team was broadly representative of trust staff on various dimensions. There was

typically some horizontal (departments, staff groups) and vertical (levels) diversity. However, some trusts struggled to recruit doctors to the change team, and/or lower bands of staff. This was not because these groups had been omitted but because recruitment efforts weren't successful.

Seeking to recruit staff from under-represented groups was less common, with only 53% of trusts (10/19) explicitly setting out to do this. Trusts rated as having higher support needs (i.e. SOF 3/4) were more likely to seek to involve under-represented groups.

3.6.4 Equality, diversity and inclusion in change team membership

In some organisations there was some BME diversity in the change team “by default” because the staff as a whole were ethnically diverse. Overall, however, it appeared that many change teams did not reflect the potential diversity possible across the range of protected characteristics, and lacked patient or hospital volunteer involvement; there was little evidence that most trusts had worked to ensure equality and diversity in change team membership.

3.6.5 Mix of skills

Despite the guidance suggesting that change teams needed to “have a mix of skills” (operational doers, influencers, administrative support, clinicians and patients) there was little evidence to show that trusts had selected members for the skills and perspectives they could contribute/that were identified as needed, and survey data suggested that change team members not having the right skills at the outset was seen as a hindrance because it takes time and resources to develop them.

One of the issues we think is likely to have influenced an ‘accept anyone’ approach, was the tension between selection based on criteria versus wide and diverse inclusion. On the one hand, setting out explicit criteria might mean that ‘the usual suspects’ – only those with the confidence, ability and expert/authority power⁴³ - would apply and the desire to be inclusive, ensure equality, and attract involvement from staff who brought lived-experience as well as skills could be lost. On the other hand, accepting all volunteers ran the risk of being faced with a large (unwieldy) number of people, having to create an infrastructure that would encompass everyone, and having to provide a lot of training and support for those who lacked specific change management skills, before they could take up their roles. Certainly, some trusts explicitly offered training and development at the start of the process for all members; this would have engendered some sense of equality at the beginning.

Skill-mix appeared to become more pertinent towards the end of Discover, when some staff were no longer able to be involved, or where it was recognised a different set of skills were needed for Design; this change was often accompanied by fluctuations in membership and in some cases the change team work paused or stopped altogether; this is discussed more fully below.

3.6.6 Capability, capacity and funding

In addition to membership, size and skills, we examined overall capability and capacity of the change team. The survey asked whether the change team had sufficient resources (either from within or access to resources from elsewhere).

Resources were defined in three ways: *capability*: e.g. skills etc; *capacity*: e.g. time, personnel, etc; and *funding*: e.g. a budget. Respondents were asked to rate each of these items on a Likert scale: more than enough; sufficient; a bit lacking and severely lacking. Each item was analysed separately, but we also looked to see if there was any relationship between the three items, and whether trusts SOF rating played a part. Survey responses regarding change teams' capacity, capability and funding are illustrated below in figure 7.

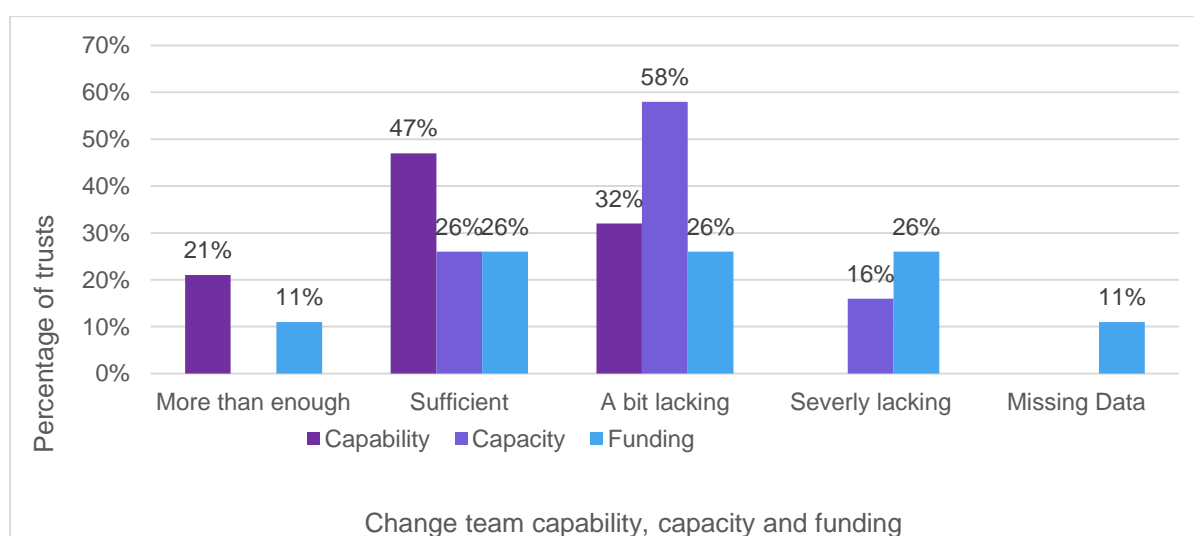


Figure 7 Change team capability, capacity and funding.

Capability of change teams was regarded as at least sufficient in 68% (N=13) of the trusts, but slightly lacking in 32% (N=6) trusts. However, capacity of the change team was viewed to be at least a bit lacking in almost three quarters of trusts (74%, N=14). Respondents from three trusts regarded their change team capacity as severely lacking; with no trusts feeling they had more than enough resources.

Statistical analysis showed a correlation between lack of capacity and lack of capability i.e. those trusts saying the change team lacked capacity were also more likely to say that they lacked capability. For trusts rated SOF 3 and 4, there was a suggestion of a lack of capacity; trusts rated at SOF 4, were the only ones that selected 'severely lacking.' There was also some indication of a relationship between funding and capacity, the relationship between funding and capability was more difficult to discern, and there were no obvious relationships between capability or funding and SOF segmentation.

The need for resources appeared to vary depending on how the programme was implemented and the pre-existing level of resources e.g. in the OD team, and the need to bring in external expertise e.g. for training, or for project management. Two respondents noted that the need for resources could increase disproportionately with the size of the change team, as large teams required more support to maintain cohesion, focus and coordination.

Some respondents also highlighted the importance of team members having dedicated time, rather than doing the work on top of their "day job", so there was a need for backfill arrangements, and capacity could be affected by the holiday season and winter pressures. The proportion of "do'ers" in the change team was also a factor. Although monetary resources were tight because of need for cost savings and control totals, additional money was not typically seen as being a necessity.

Qualitative data indicates that for some trusts they did set aside resources e.g. 2 days per month per member of the change team and this facilitated staff involvement, which staff appreciated. However data also suggests that one of the 'capacity challenges' was about getting middle managers to release staff to engage in the change.

3.6.7 The key role of middle management

A number of trusts identified middle managers as critical to the cultural change effort as they were instrumental in supporting change on the ground, and embedding culture change in systems, processes and practices. In the first instance middle managers needed to agree to release staff to become involved. One trust explicitly drew this to the attention of staff in their change team recruitment letter:

"There is still work to be completed which will have a positive impact on the culture at [trust] and therefore directly affect the success of your division in delivery of excellent

care to patients. Your on-going support is needed in order to make this programme a success. We recognise that this work has implications for your rotas and the management of your workload. To assist you with backfill for a culture change champion please use cost “

And emphasised this in their line manager information, sent:

“It is essential that Culture Change Champions inform their line manager (including rota managers, ward managers, clinical managers) upon their appointment. The support of managers is needed to protect the time and ability needed to complete this very important work. We request that details of your line managers be shared, in order for guidance to be forwarded onto them in regards to cost codes for backfill.”

However, in the main, trusts reported middle managers as blocking change efforts to become involved in the change team and during the initial engagement stage e.g. through scepticism about a new initiative - *“initiatives come and go”* - , not allowing staff time to engage in the process, and not working to resolve resource tensions between operations and OD functions.

It would be easy to scapegoat middle managers as the blockers, however, their position and the tension this brings needs to be appreciated. On the one hand middle managers are accountable for their people, services and delivery of essential day-to-day work and targets. On the other hand they are asked to release staff, but are not given the resources to backfill time lost. This tension may have been behind other examples of a lack of line-manager support, because capacity was implicit in their reasoning:

“My manager said you are not going to make a difference – [you are] just one person...” (TR18-I, 02)

However, this may have been down to pressure on the ward or negative manager attitude, because in the same trust we saw examples of real empowerment:

“Then a new matron came into post, and saw a blog I posted [...] and said – I want you to represent the department.” (TR18-I,04)

Moving the 'capacity gap' between the programme and operations was also an issue, with some evidence of tensions between line managers and OD functions:

“...[there was an] external person engaged for 18 months and the OD team were involved, but we had no front-line recruitment as the OD line manager didn't want to resource wider involvement.” (TR09-S)

The role of the board in recognising middle managers as facilitators of change and deliberately working to engage and mobilise them was acknowledged by one trust:

"...there was a need to develop proposals for strengthening and supporting the 'frozen' middle management within the trust to support communications from ward to board..." (TR10-D)

And in one trust, they felt that middle managers had responded well and felt that there would be rewards from this work:

"I think they've responded really well. I think they don't see it as another initiative. I think it's touched a lot of people because they've got something from it. So they see an aspect of right, the trust said they were going to up some resource in to help us maybe do some development stuff, and it's happened. So there is reward." (TR20-ExW2,01)

3.6.8 The change team as a main vehicle of engagement

The process of recruitment to the change team was viewed as a key mechanism to engage staff on this programme, and ensure that change team membership was diverse, is emphasised in the programme's guidance:

"A diverse change team may help you capture views of those who feel marginalised in the workforce."⁴⁴

People who responded to the survey, involved in the exchange workshops and interviewed in follow-up visits all pointed to the change team as having been **the** vehicle for engaging staff across the wider organisation; implementing the programme; and sustaining programme momentum.

One of the most significant factors here was others being able to see 'people like me' involved in implementing the programme (staff from a wide range of front-line services and disciplines) and felt more encouraged and motivated to become involved, or considered that the CLP might be helpful to them (see realist framework in supplementary document). This emphasis on the front-line reflects Øvretveit's⁴⁵ research that emphasises the importance of involving 'ordinary leaders' as well as mid-tier clinical leaders in a system of leadership for improvement.

One trust, deliberately ensured their change team straddled staff across bands 3 – 8, because they recognised that this was the best way of socialising the change with the front-line:

"...to have 'voices that 'related back to their peers' to 'trickle through.'" (TR10-I,17)

This not only points to the value of embedding a democratic and participative approach when implementing the CLP, but also specifically points to the need to carefully consider recruitment to the change team. It has been suggested⁴⁶ that in order to engender a culture

which is congruent with an organisation's values, recruitment should be focused to people whose individual values will support the organisation's brand. Similarly, it has been emphasised⁴⁷ that the need to train all staff in the care and nurture of the organisation's values/brand and reward staff whose actions support the organisation's values/brand.

3.6.9 Stability and consistency through programme phases

Stability and consistency in change team membership appeared to be an important factor in sustaining programme momentum and providing a 'holding environment'^{48,49} across all phases of the CLP. However, there was evidence of a fluctuation and instability experienced in many change teams. The main pattern observed across the sample was a shrinking of the change team over time. This happened for various reasons:

- where there is no 'burning platform' for change, it is hard to engage senior leadership team interest or the wider staff group, so this can lead to a small core team being established which is then hard to sustain
- teams integrated into a transformation team with a wider brief no longer had a specific culture focus, so the work no longer focussed on the CLP
- there was a difficulty in releasing staff or it was hard for staff to get away
- junior doctor rotation meant that members needed to be replaced
- early work was done by an external person, and internal ownership was not established sufficiently because the OD function did not want to resource wider involvement, so the work was not sustained once they left
- the board was side-tracked by the next external review
- an organisational restructure led to meetings being cancelled as some members were being restructured out of the organisation
- following phase 1 a significant number of staff (10-15) were replaced as some did not want to continue or commit, and people with new/different skills were needed
- the phase 2 change team role seems less clear or as the task became clearer, the need for so many staff reduced
- change fatigue.

3.6.10 Maintaining momentum through transitions

A key juncture in the CLP where membership stability faltered, was at the end of phase one, when a number of change teams underwent a transformation as some members left. Often, this happened because members had fulfilled their initial commitment (time limited at the behest of line-managers) or because change teams realised they needed different or

additional skills for the next phase (intervention design) and not every current member could help with that work. As discussed above, skill-mix became more striking at this stage, but the flux in membership (changes or overall reduction) led to a pause or cessation of the work altogether.

Two specific interdependent factors appeared to influence instability whereby the work paused or ceased (not always permanently), as illustrated below:

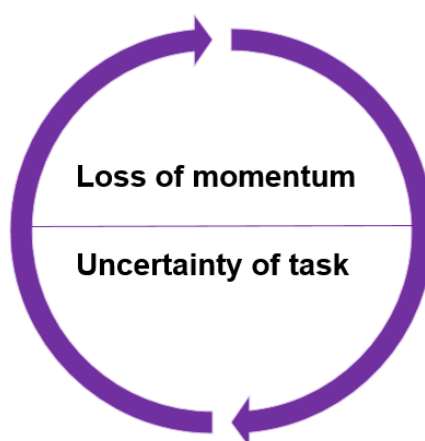


Figure 8 Depicting inter-relationship between momentum and task.

Loss of momentum^{***}: data collection was often situated in events and activities which brought the change team into direct contact with wider organisational members. This helped to build wider interest and staff engagement, which in turn motivated and energised change team members. Momentum was often lost with the transition into phase 2, because there was an extended period of time when members were working out what they needed to do (uncertainty in the task) and had much less contact with others.

Uncertainty of task: the transition into phase 2 meant that the nature of the change work moved from a known set of activities (data collection) to one that was unknown, unclear and for some change team members outside of their skills sets.

We visited one trust at exactly this moment of transition, and one of the change champions articulated the 'hiatus' clearly:

^{***} Change teams also talked about the importance of keeping the board and executives engaged; as soon as the CLP was not in their sights, they forgot about it (focussed on other demands), and that led to a lack of momentum and at times meant the CLP did not progress/stopped.

“...we’ve just finished Discover but are really finding the next phase difficult because ...um...we’re not really sure what to do. We’ve looked at the tools but don’t know which ones to use. And because were in a room trying to do that design, and its taking time, no-one knows what is happening, and coz people aren’t hearing anything, so they think it has stopped...” (TR18-I,01)

Bridges⁵⁰ refers to transitional spaces as the “*neutral zone*” (see figure 9) and talks about how everything can feel in flux, and no-one knows what they should be doing because the direction ahead (new way) is not yet clear, and people “*miss more work than at other times*” (p40).

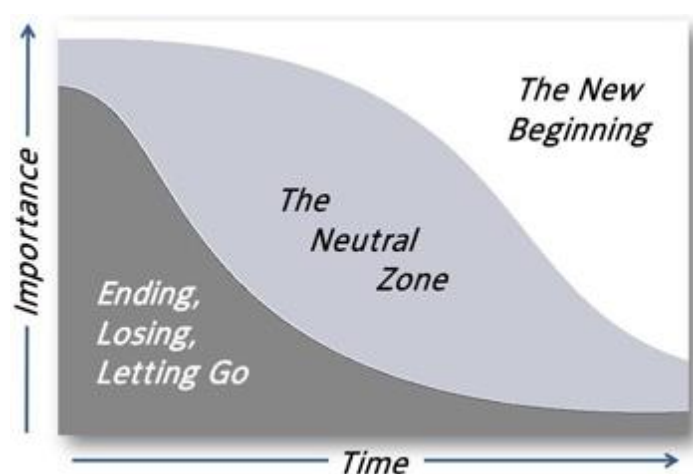


Figure 9 Illustration of William Bridges' stages of transition.

Two other features of the neutral zone may be at play for change teams, both of which will raise change team member anxieties: senior leaders may well become impatient if they perceive a delay; and as change team member's anxieties rise, their motivation falls.

3.6.11 The need for a dedicated change infrastructure

For some trusts, the programme provided a catalyst for establishing and embedding a permanent OD function in the organisation to support culture and leadership development, while others established a dedicated change infrastructure to oversee, and manage the change. These comprised senior leaders and change champions (with the backing of their line managers), and included a mix of roles, levels and professions. They also established project management processes through small teams and team leaders, designed trackers to monitor the work, and kept in contact with line managers (for their support).

The literature and research clearly show the importance of establishing dedicated change infrastructures^{16,51,52} without which many change initiatives fail or drift. Creating a dedicated infrastructure for the CLP seems crucial given our findings that the focus of the change team

is **the** key vehicle for wider staff engagement, but that the culture change effort can become diluted or disappear entirely when integrated into existing or other change vehicles/strategies. Further capacity and motivation reduces or stops overtime, because of a lack of clarity over the role, a lack of leadership, and a lack of a dedicated resource.

One trust senior manager talked about how initially, when an internal funding bid^{†††} had not been supported by the board, the CLP got lost because it was subsumed into a director's tasks, and they had no capacity to give it the time and attention it needed:

"I had bid money for someone to be in a post for a whole job – programme manager – that bid never got funded, so this became another responsibility for the hospital's Director of People, so she has not been able to give it the time, or to give the those involved some direction and pulling them together... this absence means it has been going off the rails, so some of the individuals are very frustrated..." (TR18-I,09)

She reflected on the importance of having a dedicated change function and how this also helped to keep the executive team focussed on the culture change work being done:

"...there are always too many things to do in a busy acute hospital and when you don't have a team whose specific job this it to champion a cause, or a change, or a way of working...[to] command the attention of the senior people [...] it was easier for it to drift down the list of areas requiring the attention of senior people who sort of naturally ..um... direct where time and energy and focus goes." (TR18-I,09)

Many of the larger trusts will be familiar with setting up project management offices (PMOs) in response to policy related changes, so will understand the importance of this resource.

3.7 Engaging staff in culture change

"People have a desire to engage. They have an instinctive drive to express who they are, and who they wish to be, and given a chance at work, they will do so."⁵³

As illustrated above, engagement and implementation are two interdependent dimensions of 'how we do things around here,' and are pivotal to understanding how trusts approached culture change. In practice these dimensions are interdependent e.g. the first steps in

^{†††} This was later funded by the trust

engaging staff are also interventions. Nevertheless, for the purposes of reporting, it is useful to examine engagement separately.

The CLP materials advocate an approach to engagement which focuses on mobilising communication expertise and situating the programme within the organisation's context, i.e. how it is positioned relative to other core business and any other additional programmes of activity. However, there is less focus on what engagement in practice means, and how staff engagement can be secured as an enabler of programme success.

As we have learned in the section above, the change team were seen as **the** vehicle for staff engagement and this worked well where change teams reflected staff from a wide range of front-line services and disciplines.

3.7.1 Presence and visibility of senior leaders was important

Most trusts established a 'board sponsor', and they were commonly the head of the HR/OD or workforce function, which ran the risk of trusts seeing the programme as being owned, promoted and delivered by that function solely (see realist framework in supplementary document). In one trust the board sponsor was the chair - the only instance of a non-executive director being the sponsor. In three trusts the CEO was the sponsor, and in one trust the CEO shared sponsorship with the director of HR/OD.

Following on from 'sign up' by the board to the CLP and agreement about sponsorship, visible face-to-face promotion by board members with staff was seen as an important source of symbolic as well as practical support for implementation. There were many examples of the importance of public attention that leadership figures (be that the CEO or the board sponsor) gave to key aspects of the programme, particularly the way they empowered and energised others to engage.

Significant senior leader impact was experienced through communicating and enacting the behaviours they wanted to see in creating an 'alternative' organisational culture. At an individual level, they role modelled 'being present'⁵⁴ and used 'signification'⁵⁵ and their seniority to engage staff.

Impact was felt through their ability to energise, motivate and empower others (giving the team lead and others authority and freedom to act), who subsequently energised others, spreading this energy more widely through the organisation. This impact was proliferated horizontally amongst peers, and vertically downwards through the organisational hierarchy, or by direct sponsorship of a staff member contact that bypassed line-management

structures. When direct contact and engagement with frontline staff or change team members, particularly when done face to face, enthusiastically and responsively, it was particularly valued by change team leaders.

They were also able to make emotional connections by showing genuine concern,^{56,57} and ensure that there was strong 'branding leadership' for the programme.⁵⁸

I invited him to my department [...] for our trust, a lot of people focus on cost, like, and so in order for them to understand, he actually came and explained why culture makes such a difference in that context. So he quantified it in terms of sickness, in terms of how much it cost to replace someone who leaves, and that gave them much more of an idea of the importance of culture and I think that was very powerful. ...the difference that he brought in [was] the person that he is." (TR10-ExW2, 17)

At an organisational level, senior leaders' impact was felt through signalling this work as culture change (not programme implementation), talking-up the CLP's credibility (evidence-base and academic contributors), being directly involved in launching and promoting the CLP, mandating democratic engagement, authorising dedicated resources and remaining involved beyond the early stages. This approach - *being the change you want to see* – appeared to be a significant 'mechanism' for supporting change teams to engage staff and maintain momentum (see realist framework in supplementary document).

While 'being the change you want to see' by senior leaders is necessary, it is not sufficient to engage staff in change. Research⁵⁹ shows that staff need to perceive that the outcome of organisational decisions are fair (distributive justice) and the way personnel decisions are made e.g. in recruitment, selection, pay, promotion and disciplinary procedures are also perceived as fair (procedural justice).^{60, 61} **How** things are done (fair, reasonable and honest) is therefore important in creating psychological safety and engendering commitment:

"employees who have higher perceptions of procedural justice are more likely to reciprocate with greater organization engagement. Engaged employees are also more likely to have a high-quality relationship with their employer leading them to also have more positive attitudes, intentions, and behaviours." (30, p613)

Low perceptions of fairness are likely to cause staff to withdraw and disengage from work. This means that engagement levels during organisational change are likely to reflect engagement levels in the organisation in general, and 'procedural justice' needs to be a core part of the culture change embarked upon. We would argue that distributive and procedural

justice is all the more important when engaging BME staff, as evidence from the NHS staff survey shows discrimination in HR decisions and actions.

3.7.2 Range of engagement methods employed

“You can't drag a horse to water, but we've tried to do the whole multiple methods [...] what's been quite pleasing this round of feedback to people is when we're asking the staff out on the trolley dashes have you heard about the culture change programme, not one person that the culture change agent spoke to said no. So that was good. That was really promising because they were out in amongst the clinical areas.” (TR05-ExW2,01)

The engagement methods of some trusts were clearly influenced by organisational legacy i.e. the way we do engagement around here' e.g. the 'usual' cascading approach to communications and engagement. For others, it appeared to be more of compliance, with a focus on results, pace and delivery (driven by the board) often led to pragmatic responses and limited staff engagement, as they lacked a participative and democratic approach.

However, for a number of trusts, the approach taken appeared to be much more about a commitment to the programme and employing a wide range of methods to engage staff, presenting opportunities as novel, and by invitations to take up agency and communicate directly to the board and other senior leaders.

There appeared to be a clear preference to initiate new groups and events; it is likely this was perceived as speedier than waiting for existing groups to accommodate CLP activity within ongoing business, and also a recognition that this kind of engagement activity might not be happening anywhere else within the organisation. The use of novel fora for staff engagement may have also signified an attempt to distinguish the CLP programme as a 'new way of working' in contrast to the prevailing cultural norms.

From the data, it seems there was a clear preference for face-to-face, conversational engagement. Other methods of engagement were viewed as secondary to face-to-face forms of engagement (although they served to underpin) text-based information presented in multi-media, such as posters, webpages, leaflets.

There was a strong feeling that providing face-to-face social connections facilitated engagement. Change team members and senior leaders were able to be seen in situ, and it enabled relatively unstructured conversations in the form of enquiry to access staff perspectives and their experience of the organisation. Unstructured conversations and

stories also signified a new kind of social practice or cultural artefact. This kind of face-to-face engagement was facilitated in smaller groups and at much larger scale events, like a festival:

“And it’s interesting how when you sit alongside them and actually ask them questions about their job and, okay, well, can I take that next call, or can I give that patient a cup of tea or whatever it might be, the conversation suddenly changes and they start to tell you things, it’s really, really different.” (TR18-ExW,01)

Utilising novel approaches - communicated to staff as ‘social opportunities’ - facilitated access to front-line staff by ‘collecting data’ in situ e.g. during a night shift, or on the wards, or helped mobilise and motivate engagement through more playful means, and appeared more conversational than for example focus groups:

“So therefore, when the Culture team said, hey for the band threes ‘why don’t we sort of meet up for tea and coffee and I can ask you a few questions,’ it didn’t seem like the process or the procedure that other things like that sometimes are [...] and I think also things like pilates, film club, British Bake Off, I think all of those become much of a real way to talk to people and have those conversations.” (TR10-SV,17)

Moreover, some of the face-to-face connections and conversations were incidental, and the absence of formality may have increased psychological safety, which was recognised as essential to engagement⁶², and is illustrated here:

“...some of the posters that we’ve put up, so we’ve got each of the culture teams and then a quote of what they understand about leadership and also the programme itself. It’s generated a lot of engagement and people coming up to you, people walk in, HR coming and asking HR type questions. Or knowing that there’s a confidence there that they can come and speak to you about something, and it’s not really going to go anywhere. So you get approached by many, many different people that you wouldn’t. I could be on my way to a meeting and I need to allow some time on my way so that I can stop and chat.” (TR10-ExW2,15)

For some trusts, a focus on equality, diversity and inclusion was a significant focus in their engagement approach, with targeted methods to reach previously unheard voices and a concerted effort to ensure diverse representation on the change team.

“But the people at the frontline, we hear them talking about it. We’re also seeing quite an increase in people going to Speak Up Guardian, speaking and getting their voice heard, and feeling that they can speak out.”(TR14-SV,01)

And listening to the experiences of staff signalled an important commitment to make a change:

"...nothing beats getting out face-to-face, standing in front of staff and actually having to have quite uncomfortable conversations and actually having to look at someone..."
" (TR18-ExW, 01)

Engagement activities appear to have had a positive secondary effect for some trusts; creating an increase in the number, diversity and quality of relationships amongst the cross-sectional composition of the change team, and cutting across professional silos:

"Because it's actually done two things to my mind. Number one, you've got huge areas of the hospital represented. So they all feel represented. But also it's allowed those of us who usually work in this little area to get to know... I would never have come across (name) had it not been for the culture team. But now we know each other and I know someone in education. So suddenly the person that's sending the emails about a training has a face, has a name [...] and then once you build those relationships, I mean it just goes to show having the change team almost is a self-fulfilling prophecy, because you're trying to break down those silos, aren't you?"
(TR10-SV,17)

While for other trusts, there was deliberate cross-sectional approaches to capture different and potentially 'unheard' voices in the organisation, focusing on the explicit invitation to take up agency:

"Positive spread... the change team is wide – not just nurses/docs – it includes cleaners, porters, anaesthetists, mid-wives, and were getting feedback from the ordinary people – clinicians – a broad range of people." (TR17-ExW,1,01)

In summary, employing a range of methods is important when engaging trust staff for a range of reasons:

- Staff can be located across a wide and dispersed geography, situated in different divisions, directorates, services and teams, and have different work and shift patterns;
- Staff relate differently because they are at different levels of the organisation or identify with different professional norms and ways of doing things around here, or have less power and may not be as included and equal as others.

From the data collected, it is evident that some trusts recognise and understand these multi-factorial influences and are positively working to engage staff in these different contexts.

3.8 Implementing the programme

Programme implementation across the three phases were focussed on:

- Phase 1 Discover: cultural issues needing to be addressed
- Phase 2 Design: strategies for developing compassionate and inclusive leadership
- Phase 3 Deliver: delivering the strategies

Below, we present our findings on how trusts went about programme implementation, highlighting some of the choices trusts made and challenges faced, as they undertook a diagnosis, synthesised data to makes sense of current organisational cultural issues to be addressed, and developed a collective leadership strategy.

Necessarily, much of what is reported relates to phase 1, as there are common activities all trusts are engaged with, and phases 2 and 3 are bespoke. Additionally, fewer trusts in the sample had completed phase 2 or 3. Data is primarily drawn from the survey, triangulated with data from the exchange workshops and follow-up site visits.

3.8.1 Phase 1 Discover

We begin by looking at the six diagnostic tools used to undertake a diagnostic of organisational culture:

- Culture and outcomes dashboard
- Board interviews
- Leadership behaviours survey
- Culture focus groups
- Leadership workforce analysis
- Patient experience

Guidance on their use is provided in a number of different forms e.g. on the web, in pdf format and in mini-guides. There are therefore related issues of multiple platforms, duplicate guidance and differing information which is discussed further later within the chapter.

3.8.2 Use of diagnostic tools

- 53% (N=10) of trusts said that they aimed to complete all aspects of each phase of the programme including using all diagnostic tools and 47% (N=9) said they would be selective about which aspects of the programme they would use.
- Of the 19 trusts that were part-way through or had completed phase 1, 68% (N=13) of trusts had at least used 5 tools (4 had used all 6 tools).

- For trusts that used 4-5 diagnostic tools, many took a pragmatic approach to use “what best fitted with their existing approach” or what “best fitted the needs of the organisation.”
- The most commonly omitted tools were the workforce analysis and the patient experience template.
- Although 79% of trusts said that one of the reasons they signed-up to the programme was that it was evidence-based, none cited *fidelity* to an ‘evidence-based model’ as a factor in using all/most of the diagnostic tools.

3.8.3 Tools that were used, and tools that were useful

Tools that were used the most were:

- Board interviews (95%);
- Culture focus groups (89%); and
- The culture and outcomes dashboard (89%).

The least used tools were the workforce analysis (42%) and patient experience templates (42%), with 21% of trusts also not using the leadership behaviours survey.

For the four trusts using all 6 diagnostic tools, some of the features of their approach included that they were **comprehensively working to embed all aspects of the programme**, thinking about the sequencing of the diagnostics process, “streamlining it” with other work and developments, be innovative about how they would apply it to the organisation, making active use of the change team in a variety of activities/ways, and making changes to tools that were considered weak or adding other tools that provided more information to work with (e.g. more tangible leadership behaviours information).

Tools ranked as most useful were culture focus groups (47%) and board interviews (39%), while the workforce analysis (36%) and leadership behaviours survey (13%) were ranked the least useful. However this is skewed by the number of times the patient experience template was not used (and therefore not ranked).

It is not completely clear from survey responses why the leadership workforce analysis and leadership behaviours survey were the least useful, although there is some data from scoping interviews to suggest that leadership workforce analysis was a major and complex piece of work, and that the leadership behaviours survey wording was unclear and results too high level, so did not give trusts much that they could work with.

In addition, the lack of use of patient experience data was interesting to note, particularly as this data was already collected by trusts and analysed nationally, although trusts did not provide any explanation for this. We speculated as to whether this was because trusts' focus and understanding of the programme was that it was about the relationship between leaders and staff, or that they were not persuaded by the evidence that if you treat your staff well, staff will treat patients well?

3.8.4 Factors influencing tools used (qualitative analysis)

There was no overall discernible pattern in relation to the number of diagnostic tools used when linked with SOF rating or completion of phase 1. As a result, triangulation with responses to four other survey questions were also examined.

For six trusts that were selective about which aspects of the programme they would use, they only used ≥ 4 diagnostic tools. The themes that emerged from qualitative comments about their approaches and selection of tools were:

- Timing: as a result of pressure from a CEO to complete the work in a very short period of time; and
- Organisational context: there was a lot going on/CQC report including findings on a 'bullying culture' meant that it felt too overwhelming.
- Some diagnostic tools were found to be difficult to use;
- Capacity: across many levels including board and executives;
- Pace: expectations were too fast; in one case a trust brought in external help
- Planning took a long time: e.g. 2-3 months to get board approval and recruit the change team

Although not statistically significant, we observed some patterns that suggest that where the availability of support from NHSEI/NHSLA was a factor in prompting participation in the programme, the trusts were more likely to use all the diagnostic tools as guided, rather than being selective.

3.9 Fidelity to the diagnostic/programme model

There was considerable debate amongst trusts about needing to maintain fidelity to the programme model when using diagnostic tools, with only a minority of trusts using all the recommended tools and advocating for doing so, primarily because it was evidence-based. Many more advocated an approach that only used some of the diagnostic tools, arguing that they did not need to use all the tools as they already had the data or because recent diagnostic work had already been done using another tool or for another process, so they

did not want to duplicate the task e.g. board interviews carried out for a Well-Led Review. In addition, some trusts argued that if they were 'already doing well' then a further diagnostic may not be required. Other trusts substituted recommended diagnostic tools with alternatives; in some cases this was because trusts did not think the recommended tools e.g. leadership behaviour survey gave them sufficient relevant information, while for others, they felt there were specific gaps e.g. cultural assessment tool.

However, for many, the main rationale tended to be around general pragmatism or specific arguments about adapting and translating materials and tasks to make sense locally:

"It's about saying, here is this national programme, it's really well researched, we know there are great tools, because we've tried them out, take them, use them, but make them fit for purpose for your particular organisation and we trust you to do that and we provide you with some expert help and we give you some outside consultancy of the people who are experienced in this area, but actually we trust you. I think that would be a very powerful message, sometimes it didn't come quite through like that." (RLA1-I,02)

Discussions with the Evaluation Advisory Group concluded that what was important was "function not form"; what was important was specifying the type and kinds of data that needed to be collected more than specifying the type of tool, as there was a danger of hitting the target but missing the point.

3.10 Focus on equality, diversity and inclusion

"The materials didn't have that visible diversity that I'd be looking for. So when I write strategies I think if you were the diversity lead in the organisation or if you were a passionate person who wanted to bring around change in diversity what levers are in this document which would help your voice to be heard and make sure you were in the room, and I couldn't see any." (EDI-I,03)

All three interviewees pointed to the lack of explicit and visible diversity in programme materials, and also asked why WRES and WDES data were not integral to the phase 1 diagnostic tools, and why it was not being collected, analysed and reported on as part of the assessment of current culture. As this data was being collected and reported on at a national level since 2015, it was now possible for trusts to include that data, where the difference between the experiences of BME and staff with disabilities are compared with White staff, and examined across a number of indicators:⁶³

WRES data:

- Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
- Indicator 7: Percentage of staff believing that their organisation provides equal opportunities for career progression or promotion
- Indicator 8: Percentage of staff experiencing discrimination at work in last 12 months

From 2016, these were supplemented by five other indicators, which would need to be recorded by trusts by other means: 6

- Indicator 1: Percentage of BME staff in each band and Very Senior Managers (VSM) compared with the percentage of staff in the overall workforce
- Indicator 2: Relative likelihood of BME staff being appointed from shortlisting across all posts
- Indicator 3: Relative likelihood of BME staff entering the formal disciplinary process
- Indicator 4: Relative likelihood of BME staff accessing non-mandatory training and career progression development (CPD)
- Indicator 9: Percentage BME vs. White board membership

WDES data:

Indicator 4a: q13b - In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?

Indicator 4a: q13c - In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?

Indicator 5 q14 - Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?

Indicator 6: q11e - Have you felt pressure from your manager to come to work?

3.11 The synthesis stage

"...the clarity comes around almost simplifying what culture means, which is the way we do things around here. And there was a good discussion quite early on around: this is what this stage is telling us, it's how are we doing thing around here and how do we want things to be in the future, and trying to keep that quite a simple message, from a background of, we know we need to do something here" (RLA4-I,11)

Synthesis is the culmination of all the data collection, and the workshop offers an important opportunity to make sense of all the 'hard' data. As one trust OD lead eloquently put it:

"I think it is bloody hard work" (TR13-ExW2,01)

For the majority of trusts we met with, preparation for the workshop took a considerable amount of collective effort, and depending on the trust's capacity and capability, they either co-opted in some of the skills and expertise needed (data analysis and synthesis) or trained change team members and then supported them in the run up to the day and during the day, and talked about the day being powerful, hard hitting and challenging:

"...and I ended up being quite not hard but having some quite challenging conversations with some of my change agents because they then tended to go down the, well, this is important to me, or this is my personal experience. And we brought it back to, this is not about personal agendas, remember we need to theme it" (TR05-ExW2,01)

"Synthesis was powerful, emotional and hard hitting. 70 people came including 10 seniors, and an external facilitator." (TR13-ExW2,01)

One OD lead was clear that on the day, one of the most important things to have was skilled workshop facilitation, and a conclusion:

"...what we found...so it's all about the facilitation and being clear that we've got...that we can talk about this forever but we've got to get to a conclusion." (TR05-ExW2,01)

However, in an exchange workshop three trusts said that synthesis had been much more rapid:

" [it was a] mini-synthesis – 2 hours – went through all 6 diagnostics – then intentionally took them out of their comfort zone - to think about this: quite quickly people were honing in on processes – so had to bring them back" (TR01-ExW1,01)

"Synthesis – fast – lunch and biscuits"

"And we think we had a...we had a lot of data actually and we just triangulated it all together very quickly really and started headlong into doing something about the leadership. So I can't put my hand on my heart to say whether I followed it to the absolute letter." (TR20-ExW2,01)

Guidance⁶⁴ (from Discover) on translating findings from the synthesis of the data into a report to the board set out the purpose and what needed to be done:

“the results from the diagnostics is an assessment of the current culture and leadership which is used to inform the design stage...“You will need to consolidate the findings to produce a short report or presentation for the board. It will be important to both produce an easily digestible and engaging report while keeping the richness of the data generated in the diagnostics - perhaps through a longer version or appendix.” (p79)

However, despite this clear guidance, translating findings into a clear statement of the cultural destination – what the impact and changed leadership behaviours was needed - appeared difficult for a number of trusts (as discussed above), and the quality of some of the outputs were poor.

3.12 Reflecting on the process and dynamics

“I think from the design, which gives you a lot of really rich and useful data to chew over and think, actually what does that need, it's the real hard facilitation stuff and there's some hard stuff about where are we as a team, where are we as an organisation, how are we going to move this forward? How are we going to measure it internally? How much commitment? We signed up to it, yeah, but it might be getting a bit difficult now.” (RLA5-1,13)

At the end of phase 1, programme guidance acknowledges that it will be too early to review programme outcomes but suggests that trusts could evaluate the *“process and impact on the change team.”*

This seems a useful time to reflect on and use 'process' data; to reflect on how everyone works together (or not) and the way phase 1 was carried out, whether the change team and boards' values, approaches and behaviours mirrored and enacted the values and behaviours in the CLP.

However, we would argue that trusts should reflect on the process and the dynamics of culture change throughout phase 1 (and indeed through the entire programme), and these observations should be shared in feedback loops, between the change team, board and across the wider organisation.

Programme guidance did not provide a framework for looking at and identifying processes and dynamic. Schein⁶⁵ offers a useful framework for understanding what this means:

- focussing the content, process and structure of the work undertaken; and

- paying attention to the task and inter-personal dynamics that emerge in the course of the work.

3.13 “No fisherman likes to admit to stinking fish...”

Despite the guidance clearly stating that the “*purpose of communications at this stage is to maintain engagement while demonstrating openness and transparency on findings ...*” in practice this was difficult for some change teams to fulfil.

Interviews with change team members during site visits and LA regional associates, and feedback from trusts in the exchange workshops all pointed to a great deal of protectionism in what was fed back to the board. Indeed we found it hard to access trusts and their data throughout the field work, which felt like a mirror of this protectionism.

One evaluator's note from a site visit highlighted the difficulty change team members faced:

‘They see the CLP as a highly political programme - managing tricky conversations – “we wouldn't be successful if we went on ‘raw emotions.’” There is a saying from the Caribbean “No fisherman likes to admit to stinking fish.” The stories uncovered by the change team members about racial discrimination during discover were truly shocking. Some had to be escalated as a duty of care by the CLP lead, but this had to be done very carefully as an early emerging theme was fear of speaking up “some individuals we need to change without exposing negatively.” (TR10-SV,13)

In one case, even though much time had been spent preparing a report for the board, they dealt with it as if it were another agenda item (albeit it with a little more time than other items) and appeared not to ‘own’ the work, and a *counter-transference*⁶⁶ was involved, where the board were also protecting themselves from hearing about the trust's current culture:

“... initial offer from the board was ‘1 hour’ - I said no, not enough [...] the CEO and the board said we have not seen the culture change “they” want to see, have others?” (TR14-ExW,01)

3.14 Lost in later translations

Programme guidance states that *synthesis* is the bridge between phase 1 and 2, and enables trusts to bring together the results of the data collection to form a ‘current state’ analysis on culture and leadership.⁶⁷

However, in reality that was not always clear. As indicated in an earlier section, trusts experienced some difficulty identifying their ‘cultural destination’ and although some trusts

were able to develop more clarity over the aim and purpose of the culture change during phase 1, when it came to synthesis, this difficulty re-emerged; how to move from diagnostics to design with clarity about what needed to be done. One regional NHS LA associate reflected on their work with a trust:

"...well I think people have a vague idea of what it's delivering, but I don't think there's a solid theory of change. And so in that sense there hasn't been a real conversation about what the outcome might be in a real sense; not just in terms of the artefacts of the process. You know, what is it meant to be delivering in terms of outputs? But what are the outcomes for the organisation? What do organisations think they are getting from it in terms of outcomes?" (RLA3-I,07)

The transition created uncertainty for some change teams; the combination of ending phase 1, needing to alter change team membership (new/different skills) and not being clear about how to proceed, led to a loss in momentum, and for some change teams, a tailing off, of the programme.

A theory of change⁶⁸ logic model⁶⁹ can be a useful tool to draw on to help trusts be clear about the outcomes, impacts and behavioural changes they want to see.

Using a logic model at the beginning of phase 1 with the change team and board would help provide some early clarity about the cultural destination, and would act as a framework during synthesis, when trusts needed to make explicit, what the work for the next stage – Design - would look like. However as discussed above, it is important that the work doesn't just look at *what* has been done – inputs, outputs, outcomes and impact – the assumptions, external factors, process and dynamics are all important elements for analysis and synthesis.

3.15 Programme guidance and materials

To date on-line guidance and materials have been provided for phase 1: Discover and phase 2: Design but phase 3: Delivery remains unpopulated, although a number of trusts describe themselves as having completed it.

On-line materials were found to have a number of different routes into the main page which many report as "not intuitive" "too theoretical" "difficult to know where to start" "too much", and indeed it may be that there is more than one landing page, some with older materials and others with more updated versions.

Feedback from some trusts indicates that the programme could benefit from a clearer overview of the CLP as a whole i.e. it needs greater clarity about cultural destination and the

key components that take you there e.g. a diagram, explanation, video, etc. The closest example we saw that met this need was a slide presentation to gain buy-in from boards.

3.15.1 Equality diversity and inclusion in programme materials

Interviewees pointed to a national report that had been produced⁷⁰, and this together with other literatures on equality, diversity and inclusion were examined and synthesised as part of this work to assess specific recommendations for the way in which EDI should be considered, understood and embedded into organisations and culture change work.

In addition, interviewees made helpful suggestions about adding a number of different interventions to address gaps in equality and diversity tools. In particular mentoring, reverse mentoring and sponsorship of BME staff as a priority and this is supported elsewhere.^{71, 72}

These approaches provide opportunities for leaders (and sometimes peers) to understand more about lived experience of e.g. BME individuals, signal that diversity of voices is valued, provide support and act as advocates to help improve outcomes, and can increase the contact of leaders with minority groups and play a part in changing culture and addressing issues.⁷³

Feedback from trusts and interviews with national and regional EDI leads suggested that equality, diversity and inclusion was not sufficiently evident in the concepts and evidence provided or explicit in materials. They observed that:

- The underpinning concepts and evidence for the programme only includes two publications focussed on equality and diversity, with workforce being a dominant focus. In these cited publications, power differences/imbances are only mentioned once, and not in any material way that would support programme participants understanding the significance and impact of this, and knowing what to do, as a result of that understanding.
- Equality is mentioned once and diversity mentioned twice (p 16 & 18) in the document relating to protected characteristics and in relation to workforce capacity; the substantive point made in the latter, broadens out to focus on patient care, and appears more as a persuasive mechanism.
- Creating a culture that is equal and diverse is more implicit than explicit in the programme's conceptual framework; the five cultural elements mentions 'inclusion' but subsumes this concept into support and compassion, such that it loses its specific impact.

Findings from interviews with trusts and documentary analysis suggest that use of the term *inclusion* generally appeared to be conflated with, or interpreted as, *inclusivity* i.e. not leaving anyone out. Underpinning this is either an unconscious or conscious avoidance of recognising differences in power (power deficit) and inequalities; perhaps reflecting the difficulty in acknowledging this (shame and guilt), talking about this (saying the unsayable) and changing this (new social norms needed). This may be resolved by ensuring that the term 'inclusion' is not used on its own i.e. it is always prefaced with equality and diversity, as this helps to signal that the issue of social power is embedded in this concept.

National and regional EDI leads recommended that the concepts and evidence paper be strengthened by links to an increased number of current and relevant studies, and embed equality, diversity and inclusion more explicitly into the cultural elements and diagnostics phase, for example:

Cultural elements	Values	The way we do things
Vision & values	Constant commitment to quality of care	Everyone taking responsibility in their work for living a shared vision and embodying shared values
Goals & performance	Effective, efficient, high quality performance	Everyone ensuring that there are clear priorities and objectives at every level and intelligent data constantly informing all about performance
Equality, diversity and inclusion	To be defined with input from WRES team and research evidence	To be defined with input from WRES team and research evidence
Support & compassion	Support and compassion for all patients and staff	Everyone making sure all interactions involve careful attention, empathy and intent to take intelligent helping action
Learning & innovation	Continuous learning, quality improvement and innovation	Everyone taking responsibility for improving quality, learning and developing better ways of doing things
Team work	Enthusiastic cooperation, team working and support within and across organisations	Everyone taking responsibility for effective team-based working, interconnectedness within and across organisations, systems thinking and acting

Table 2 Showing recommended cultural elements, values and the way we do things.

3.15.2 Language in guidance and materials

Change team members who attended exchange workshops offered a number of examples, and made a number of pleas relating to language used in programme guidance, suggesting that it variously:

- very corporate;
- turned people off;
- lacked stories (not just case studies) to connect with;
- was difficult to understand (meaning of terminology)

this was particularly the case for phase 1: Discover, when staff are engaged and involved in data collection or responding to questions:

“the information that went out with questions – people don’t know what you mean? – what does it feel like – do you enjoy being supported? Tools and guides are good, but need translating.” (TR07-ExW1,02)

In one trust a bank of 10 PAs ('ordinary leaders') were used to translate and explain what was meant, so that front-line staff could relate to them, and respond to them.

As suggested above, it may be helpful to do this in collaboration with trust change team and regional NHS LA staff/ associates.

3.15.3 Diagnostic tools

There were mixed views about the degree of flexibility possible or expected in relation to the diagnostic tools in phase 1: Discover. Whilst there is an understanding of the comprehensive nature of the diagnostic tools there was evidence that trusts had substituted pre-existing information where they judged that to be appropriate. Similarly some trusts chose different tools or methods to engage and collect the required information e.g. focus groups not practicable so a hybrid 'marketplace' event was designed instead. Key to this feedback is a need to focus on function not form i.e. what is important is specifying the type and kinds of data that needs to be collected, not specifying the tool that must be used, unless it is validated to collect specific types of data.

3.15.4 Design

While change teams appreciated the range of tools provided, most found the design toolkit overwhelming, and many change teams had real difficulty knowing which tools to select and what tool would be best in their content. This needs to be reviewed, holding accessibility

and usability uppermost, perhaps drawing on the experience of experts with tacit knowledge such as trust change team and regional NHS LA staff/associates.

There is no tool in Discover that is easily and reliably reapplied to measure progress e.g. pulse checks on the qualitative/perceptual aspects over and above some of the usual NHS indicators. However, we are aware of other 'free' tools which were being used e.g. Culture of Care Barometer; explicit reference to measure and report on progress could usefully be explored.

3.15.5 Synthesis

Translating findings into a clear 'cultural destination' - the impact and changed leadership behaviours needed - appeared difficult for a number of trusts, such that the quality of some of the outputs were poor.

Discussions focussed on providing a framework or template at the beginning of phase 1, for the change team and board to complete together, which hopefully would provide some early clarity about the cultural destination, and would act as a framework during synthesis, when trusts needed to make explicit, what the work for the next stage – design - would look like.

We found it is important that the work doesn't just look at *what* has been done – inputs, outputs, outcomes and impact – but also encompasses the assumptions, external factors, process and dynamics.

3.15.6 Developing a culture and leadership strategy

From both a practical (other things are happening in trusts) and a theoretical point of view (culture and leadership changes are not the answer to everything), development of a culture and leadership strategy needs to take account of findings from the Discover phase alongside those from other activities. Priorities and actions in the CLP strategy need to cross reference priorities and actions in other strategies.

3.15.7 Timescales for and visibility of change

Culture is deep; it is operating at different organisational levels, is complex, can be ingrained, and functioning at unconscious levels) so culture change takes a long time and is hard to manifest. Leaders and staff need to feel that real progress is being made in order to remain engaged in the programme. Attempts may be made to identify "quick wins" and visual cues/signifiers of deeper change, however, care needs to be taken to sustain implementation, engagement and inclusive approaches.

3.16 Summary

- Apparent in these findings is the need for equality, diversity and inclusion to be included throughout the programme materials (concept and evidence/guidance/ Discover & Design) so that the CLP can optimise engagement and enable new cultural norms from the beginning.
- The change team is a pivotal vehicle across all phases of the CLP; its creation, size, diversity skillmix, capacity, capability, funding are all critical factors in determining impact.
- Middle-tier managers are a target group for involvement, engagement and understanding of the CLP, as they signal agency to others in respect of receptivity to CLP, and mandating and resourcing the CLP activities.
- The opportunity for greater clarity about the cultural destination and the iterative and long-term nature of culture change and evolution is in danger of being lost. Being clear about the differences a trust is aiming to see and how they will experience and evidence these cultural differences is pivotal to monitoring and demonstrating impact. Using a logic model to support the focus on outcomes and distinguish them from outputs could assist with this.
- This need for greater clarity and expectations for boards to focus on culture over the longer term would be helped if the commitments involved in 'sign up' are made more explicit with each constituent (the board, the change team, staff groups and patient groups). Scoping (pre work: planning, communication and engagement), and reflection on process, at key stages of the CLP will aid this and need to be formalised within the CLP phases and this is discussed further in the recommendations (chapter 6).
- Momentum can be maintained by targeting interventions at key transitional points in the CLP, and ensuring there is a dedicated and resourced infrastructure.
- The CLP materials offer a sound range of tools focussed on compassionate and inclusive leadership, however, further development, alternative presentation in different mediums, and support to translate them would enhance the offering.
- Equality, diversity and inclusion needs to be placed more centrally across the CLP phases and activities, and attended to as part of developing the cultural destination. Additionally, further work is required to fully embed equality, diversity and inclusion within the programme materials.
- Initial engagement done well can signify the beginnings of increased compassion and inclusion. To sustain and embed what is begun here (pre CLP and in the Discover

phase) the importance of establishing multiple 'feedback loops' to ensure ongoing, meaningful participation and involvement are crucial.

4 Support for implementation - findings

Trusts accessed a range of external support in addition to the programme materials; the NHSEI Programme Team, NHS LA's (national and regional), support from NHS LA associates, and other external colleagues including independent providers.

This section draws together the findings from the evaluation in relation to external support for implementation of the CLP and culture change in NHS organisations, and touches on the links with, and coordination of, support between external and internal support. In separating out external support, it is important nevertheless to stress the significance of the role of national and regional people in supporting trusts' change teams. This support at different stages of implementation was highly regarded and seen as invaluable.

Six main themes were identified relating to external support: access to external support, expectations and roles, approach and activities, skills and capabilities, space for thinking and reflection and the interplay of supporting relationships. Data relating to programme materials has been covered in chapter 3 for purposes of cohesion within the report.

4.1 Access to external support

There was clear recognition of the value that expert support, guidance and mentoring in various forms to complement internal expertise.

Trusts had experience of regular and substantial support from NHSEI staff that have detailed knowledge of the programme, so that internal teams can quickly understand the tools and interpret the results. NHSEI LA leads took up roles in contracting with external associates to deliver support. Some external associates were already known to the trusts and contracted with them directly to support programme implementation.

Within trusts, OD leads often performed the operational coordination role internally. Their experience and approach varied requiring different levels and types of external support. They very much appreciated contact with trusts already implementing the programme (this was guided by NHSEI/NHSLA colleagues) and would welcome greater levels of such networking to gain effective support and learning; this was evident through the exchange workshop participant evaluations.

The value of programme informed OD expertise to guide and support trust core (HR/OD) teams was expressed by many and external OD practitioners have been widely involved, some funded and provided by the NHS LA described as a:

“benefit in kind” (RLA3-1,09).

and others sourced and funded by trusts themselves. There appeared to be funded support from NHSEI for the Discover phase but less for Design and Deliver phases. In addition the external associates were aware of the irony of pump priming the initial start up and Discover phase support when the larger scale investment was often required in the Deliver phase:

“So, for me, to do a programme around culture, where you licence people in the organisation to do some really interesting discovery work, but then strip away the licence when you get down to the hard-edged work of delivering on some of those things, well not so much strip away, but perhaps limit the licence or...you know, accept that that's the end of a particular task, that runs counter to the culture piece for me” (RLA3-1,07)

This mirrors the energy and emphasis that was recalled by many when describing the experience of Discover and the danger of losing momentum after the synthesis report ‘goes to the board’ (see section below).

Also important was to match the external OD support to complement and build on the trust's existing OD capacity and capability with local NHSLA leads best placed to coordinate this. Some leads were consciously doing this whilst for others it was not mentioned as a proactive objective and rather left to the external associate to negotiate (see section below).

4.2 Expectations and roles

Briefings and learning exchange were welcomed at every level of the support system. For example, regional LA leads valued the NHSEI learning day to orientate to the programme and their role and external associates welcomed orientation to the programme and the trusts from regional LA leads.

Helpful practices for initiating support included; planning for support across the whole programme (not just in Discover), creating opportunities for key leads to agree expectations and roles early in the process of initiating the programme and agreeing ways of working.

From the data, a person who understands both the programme and organisational change and development is best placed to be the ongoing contact with a trust across all phases of the programme (rather than phase by phase). Across trusts this role was being fulfilled by any one of the roles: local NHSEI lead, regional LA lead or an external associate.

Some leads described themselves as a coach/mentor throughout each phase, some as facilitators and others located themselves more as 'broker' between parts of the system. In addition NHSLA leads described their information-giving/reporting role to the centre in relation to the number of trusts adopting the CLP and their progress.

There was variability in the way NHSEI provided initial orientation to trust leads and external associates; whether they supported and deployed external associate support to match the needs of trust leads; the amount of preparation/orientation provided and the degree of active review and reflection on how the relationship between the external associate support and the trust team was progressing.

It was seen as important to match the external associate support to complement and build on the trust's existing OD capacity and capability. Regional NHS LA leads were often in the position to navigate and match need with availability. The way support was provided to trusts was clearly 'in development' with each regional NHSLA doing things differently particularly during the organisational restructuring of NHSEI. As a result there was a range of experiences reported by external associates reflecting different approaches taken in different regions:

"I think it worked well when there was that partnership approach early on, face-to-face, so it helped the organisation, it helped me." (RLA4-I,11)

"...from a regional perspective, we were being pushed into the activity very quickly but without a clear sense of what the developments were. And clearly people at NHSEI and people at the academy hadn't had the conversations they needed to have about what it looked like in practice." (RLA3-I,07)

The importance of clarity of purpose and style of collaborative working between local trusts, external associates, the local NHS LAs and the two national bodies, NHSEI and NHSLA, was emphasised by many participants:

"I think it would be really helpful if we all shared a common view that support for the organisation, around the roles, and that there is a role to be played by the centre in terms of them helping the diagnostic frameworks to be executed well. So that people understand, you know, how to analyse the data, how to fill in the outcomes framework." (RLA3-I,07)

There was an emphasis by some external associates to provide both support and guidance in a way that built the internal OD capacity and capability of the trust:

“for me, organisation development is more about... building the capacity in the organisation to have a culture of compassion and inclusion at the heart of everything it does, and the ability to step back from an organisation and see the whole organisation.” (RLA3-I,08)

4.3 Approach and activities

There were two broad approaches to supporting organisations characterised as ‘doing unto’ as expert or ‘working alongside’ as a partner. In the former, the external supporter has high content expertise and shares this through advice and training. In the latter, the external supporter is more orientated to creating space for learning and collaborating on tasks and the process of change. In both of these approaches, people in support roles dovetailed their knowledge and understanding of the programme materials with their approach.

For regional LA leads, all had taken the opportunity to inquire about use of the programme and engage those trusts interested or participating within their region. In two regions there was one trust being supported (one by the regional LA lead and one by an external associate). In remaining regions there were up to eight trusts receiving support, provided by multiple external associates and co-ordinated by the regional LA lead.

In terms of fidelity to the programme model, some participants in the evaluation felt it was important to have high alignment with the programme model in the support role, whilst some participants felt it was most important to have flexibility and pragmatism in the approach of external associates:

“And with our role traditionally being a role of support to facilitate the model of the programme, and with a quite a, I guess a pretty formulaic approach to what we were required to do which was my understanding, support the change teams in there with a package of support.” (RLA8-I,20)

“So I suppose there was some translating and there was also some, I think, sense checking with them. So, again, being quite pragmatic with them about, you don't need to do everything slavishly to the letter as one of the diagnostics was laid out, if you think one of the diagnostics is 80 per cent useful then let's focus on the 80 per cent that's useful.” (RLA2-I,06)

In practice, the collective external support system had potential to balance these approaches, explored further in the ‘interplay of relationships’ section below.

With all approaches, the need to build a strong mutual relationship and understanding of roles between the trust's core team for the programme and any external support was seen as vital.

The initial start of the support where the external associate would 'gain entry' reflecting an Organisational Development cycle⁷⁴, listen to the 'story so far' and discuss how best to utilised time and skills was described:

"it's really important to gain entry into the organisation carefully... and I was surprised at how much educating I was giving [name of person], the director of culture and his team about what this tool was. Now I was really happy to do itbut it was surprising that I guess they were...I thought at one point, I wonder what they thought they'd signed up for?" (RLA2-I,06)

Trust leads viewed external support very positively as they experienced a 'fresh' and informed perspective about a trust's culture and how the CLP could best be applied. Initially external associates reported providing facilitation and training to change teams although there were differences across trusts. Most external associates worked primarily with the change team lead and the change team:

"For me specifically, very much at the Change team, not exec level. "(RLA4-I,12)
"Yeah, for me, where it's working, it was the Change Team level. I think where it's working slightly less, it is at that probably exec level, actually, although it's the Change Team leader we've been negotiating with, but they're in quite a senior role in the organisation. But, I guess, I don't think it's any surprise that I haven't formally met the Change Team in the other two organisations but I've been working around this for about six months" (RLA4-I,11)

There were common activities that those in external support roles were involved with:

- programme launch workshops
- preparatory workshops for events and discover activities
- communication and interview skills training
- using organisational change and development expertise in one to one conversations and workshops
- synthesis and synthesis workshops
- strategy development
- creating space for reflection and creating shared understanding

The different approaches and activities of those providing external support reflect attention to both content and process, although the emphasis and focus is varied across these two elements. Decisions about each approach and activities were made with varying levels of partnership between NHSEI, regional leadership academy leads, trust leads and external associates.

4.4 Skills and capabilities

Linked to the approach and activities described above, people providing external support to trusts utilise a broad range of skills and capabilities in their roles. As an overview, people in support roles had knowledge, expertise in the following areas:

- group facilitation
- organisational development
- organisation culture
- organisational change (including Quality Improvement)
- presentation and communication skills
- consultancy skills
- coaching and mentoring
- leadership and management development.

A key point highlighted by a number of external associates was the need to enable and facilitate development of change team members, more than provide training. The data suggests the approach of the external supporter (either regional NHS or external associate) corresponded with their skillset:

“And for me the skill set you need to train and the skill set you need to facilitate, I think they're quite different really” (RLA1-I,01)

This point emphasises it is important to match the external OD support to complement and build on the trust's existing OD capacity and capability,

From the perspectives of people across the support roles, there was a sense of enabling the change team and senior leadership team to hold what was experienced as a 'risk' of working with cultural change and what were often new engagement activities and ways of working:

“I think we did need the help though, I think particularly with perhaps talking to the staff. We didn't know. We were all starting anew. So I think that it did need that

external voice to come in and say well, these are the sorts of things they've tried in other places and this kind of works.” (TR10-ExW2,01)

There were examples of points in the process where this role was particularly welcomed; working with board members, conveying difficult messages when leads or change team members felt overwhelmed. The external supporter needs to be able to contain and 'hold' this sense of risk in their role:

“So therefore, being able to hold an amount of discomfort or give people permissions to raise things that they feel are slightly dangerous. So we had, for example, people starting to talk about bullying in the trust, as an issue, could we please raise this as part of the cultural leadership programme because if that doesn't show, nothing is going to change. So people felt able to raise that.” (RLA2-I,04)

From the data, the implementation of the programme is complex and informed by each trust context. The sections above detail the approaches, roles, skills and capabilities that are being used to support trust implementation of the programme. The range of approaches and activities suggests that external supporter roles have the potential to encompass both task and process support. However, it was not always easy to be sure what support to prioritise and in what form:

“So, I'm not quite sure even now, as an associate, how much support I should be giving, because there's been a lot of mixed messages. So, that's the other thing I think in terms of not just clarity but real consistency of message. So, so, some examples are.....well, there's the really clear message I was given in you mustn't help too much because this is about enabling these people to stand on their own two feet. But actually my senses said, do you need some more help? So, I found that quite difficult.” (RLA1-I,01)

At the same time, many external associates identified that their contribution was to shape timescales and support the management of pace,

“So I suppose I was definitely in the critical friend support, it all sounds a bit cheesy, doesn't it? But I think the most valuable thing I was doing with [name of person] was slowing him down” (RLA2-I,06)

4.5 Space for thought and reflection

External associates described challenging unrealistic expectations of pace and the need to use their skills to balance 'getting it done' with taking the time needed to complete activities

as intended from programme materials. There were a number of external associates who emphasised the need to create space for thinking and reflection. However, most external associates described being contracted to work for a number of days with a high degree of 'task' to complete each day. At the same time, external associates talked about pauses and gaps in activity, usually as a result of change in leadership or a shift in priorities for trust leads, or sometimes the reason was unknown:

“So, I've been quite, you know, I haven't really followed up as much, you know, I am thinking about dropping the person in, the change leader, an e-mail to say, how are you? How is it going? Because I did an event with them on 18th November, spent the day with them and have heard nothing since.” (RLA1-I,01)

External associates described how reflection and spaces to think amongst themselves as a group could provide a more efficient and effective change team over all: less reinventing of roles, processes and materials. They talked about the benefit of meeting together facilitated by the (NHSLA) to share approaches and enable informal mutual support. Both trust leads and external associates felt that encouraging and sustaining 'communities of practice' and networks were crucial for shared learning and embedding trust impact.

4.6 Interplay of relationships

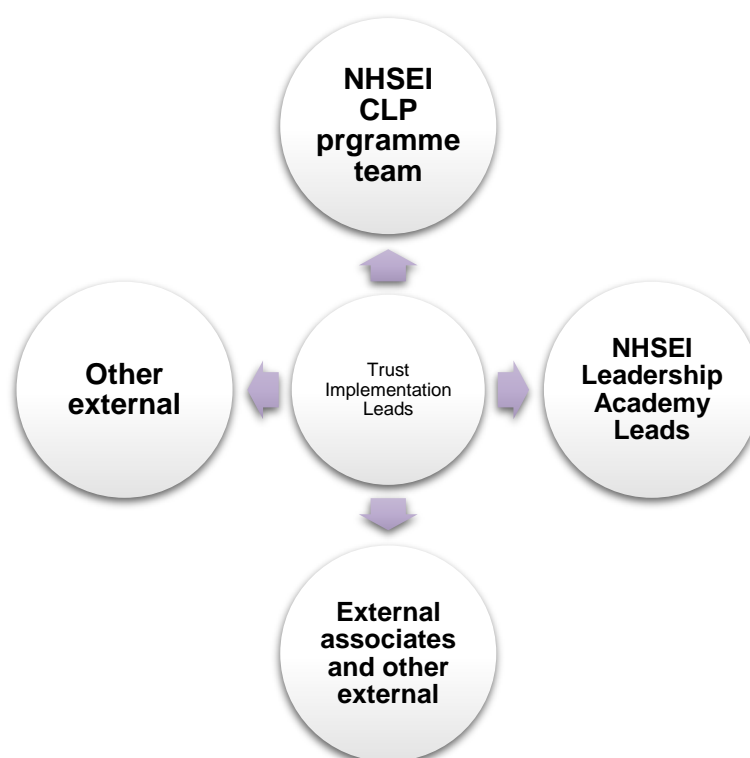


Figure 10 Illustration of individuals providing support to trusts.

The data suggests the coordination and understanding of roles and contribution between the NHSEI LA and external associates is important to clarify at an early point in trust sign up to the programme, and is illustrated above in figure 10.

Expertise about the programme materials was located with the NHSEI programme team. For all participants in the study, they were trusted to have the most up to date information on programme implementation and examples from other trusts that were shared were highly valued.

Discourses of power are linked here⁷⁵ and language can be seen to reveal the power dynamic. NHSEI can be perceived to have power and the authority to make 'rules'. There is also regulatory power at play in supporting relationships through assumptions of associates about their approach and style (assumptions then often challenged by the approach of the NHSEI individual).

"On a philosophical level, I think that there is perhaps a need to have more continuity throughout the whole of the project and maybe the associate role and the National Leadership facilitation role becomes a little confused. So for me, I think to have one of those partners taking a lead and providing full continuity for the trust would be a preferred way of working." (RLA6-I,17)

One external associate noted an inherent danger in trusts being mandated to 'do' the programme if there is no explicit discussion about its true aim and the potential performance benefits of creating a compassionate and inclusive culture:

"I think helping organisations understand how this programme, the culture and leadership programme, can support and be aligned with programmes of work they already have going, so that it's not just a you must tick all of this and follow it all through" (RLA1-I,01)

Participants in the study identified uncertainties in understanding their roles and contributions and that of others,

"So, it was really confusing. And then I get to the day and NHSEI coming as well; so I was sort of left thinking, well what is my role in this. I did have a conversation with NHSEI and said, what is it you want from me and expect from me? (RLA1-I,01)

4.7 Summary

- There is considerable scope to strengthen the approach to contracting and sign up to the CLP between the NHSEI and trusts. Due to the regulatory role of the NHSEI and implicit power perceived by trusts negotiating a developmental relationship for the CLP has a particular challenge. Again as in chapter 3 the need to create a shared understanding about a trust's cultural destination and priorities for focus as well as the approach required to either build or supplement capacity and capability of the trust CLP team/infrastructure, is important to make explicit. Balancing attention on both the content (the 'what') and the process (the 'how') throughout the relationships between external support and the trusts is important; this should include an ongoing review process between the 'support partnership' for each trust throughout the phases of the programme.
- The expert support and mentoring already in place (from the NHSEI, regional LAs and external associates) was highly valued and the need for it to become more regular and substantial over the full course of the CLP was made clear. Practical suggestions made were for greater coordination between NHSEI, regional LAs and external associates with recruitment, orientation and support for external associates becoming more consistent. The facilitation of this developing pool of OD expertise (across NHSEI, regional LAs, external associates and trust OD personnel) through the creation and support of 'communities of practice' was seen to have a strong level of support from participants involved in the evaluation.

5 Impact and embeddedness - findings

This chapter aimed to answer the original research questions looking at both the impact the CLP is having on the leadership cultures and behaviours in participating trusts and how participating trusts were working towards developing a culture of compassionate and inclusive leadership as the new cultural norm. However, the conceptual framework and hypotheses developed through the evaluation process set out how we have come to think about the interplay of factors that relate to potential impact as a result of programme implementation.

Hence the idea that culture can be changed is in itself a complex proposition. Identification and attribution of direct 'cause and effect' is notoriously difficult to demonstrate. With any intervention, it would be ideal to be able to evaluate (and so eventually predict) its value. This would require a documented baseline including measures that can be reliably re-measured. Only then would it be possible to ascertain some insight into the level of improvement (impact) and sustainability over time.

This latter notion of sustainability is related to the notion of embeddedness. The Oxford Dictionary defines embeddedness as "the quality of being firmly and deeply ingrained or fixed in place"⁷⁶. Applied within this evaluation in relation to culture change it is defined as the degree to which impacts are integrated into everyday experiences so that they become unconscious expectations, positively reinforced by day-to-day experiences, which continue to reinforce each other over time.

This chapter presents the early indications of how as the result of the programme, culture is changing in terms of both what participants described what was different and how they were doing it. The degree to which those differences were being discerned as more or less embedded in organisations is also explored. The data comes in the main from the small sample of trusts that participated in the exchange workshops (n = 14) and the follow up visits and interviews (n = 5/14). It is also important to bear in mind that the people we listened to were central to the programme and therefore highly committed and enthusiastic about the programme and its impact. As a result the lens through which we recount the findings may well be a more positive and 'up beat' version of the day-to-day reality of impact and embeddedness experienced by the majority of staff.

5.1 Early indications of impact

Trusts described a range of measures that are included in the culture and outcomes dashboard that come from the annual NHS staff survey, supplemented in some trusts with

indicators from the WRES data. However, the time lapse for impact to be seen in these indicators and their relative insensitivity to localised change was a common frustration:

“For me it's the staff survey stuff. But I've been really, really clear from the outset, it's too early to measure the impact. It will not happen now, it won't happen in this year's survey. It's probably going to be 2020's survey which we won't get till '21” (TR20-ExW2,01)

In order to address this some trusts had supplemented the way they measured culture by carrying out more frequent 'pulse' checks with one trust using the 'Culture of Care' Barometer⁷⁷, another 'Go Engage'⁷⁸ and another the Cultural Values Assessment⁷⁹. These tools were being used more frequently and at a local department or team level, measuring perceived changes particularly in relation to behaviours experienced by staff.

For trusts where overall performance measures were relatively low the potential to demonstrate improvement was easier. In that sense there were some trusts that were able to predict, track and report particular impacts in relation to a point in time that was deemed their 'lowest point' as signified by a very poor CQC rating or a particular incident. For example one trust with a focus on bullying and (racial) harassment identified a range of the indicators from WRES, the NHS Staff Survey and the internal use of the 'Freedom to Speak Up' process: preparing the board for the likely patterns ahead. For example 'Freedom to Speak Up' requests doubled and the NHS staff survey completion rates increased by over 20% from one year to the next. These were both attributed to staff feeling a greater sense of psychological safety as a result of the early engagement work completed by both the trust executive team and the change team. For other trusts too pointed to positive changes in the NHS Staff Survey attributing the improvement to the programme activities.

5.2 Attending to the beginnings of cultural change

For many trusts the nature of the impacts beginning to be noticed were often more about the experience of being in the organisation: the essence of how things felt:

“I'm seeing and I'm hearing people have got more clarity and hopefulness, if that's such a word.....for the future. I think the chief exec is doing a lot of that. But this is part of that message. It's too early for us to see the impact. So, not fully. There's a definite buzz and there's a difference, but I wouldn't be able to measure it at the moment” (TR14-SV,01)

As described earlier in the report trust CLP leads and change team members would exemplify CEOs and other sponsors who demonstrated a more inclusive, caring and humble approach and took the time to underline the importance of supporting the programme visibly and regularly.

Some trust leads recounted how they had prompted and were now witnessing reflexive conversations at the board focussed on their behaviours, expectations and included constructive challenge about leadership styles not modelling compassion and inclusion. However although this might be apparent at senior levels there was also recognition that this was difficult to ensure throughout an organisation:

"...the [new] board believed the old style approach to finances has changed, but it is not necessarily translating to what staff are currently experiencing at lower levels of the organisation. Pressure to deliver may result in 'old style' management action to deliver the financial outcomes closer to the front-line." (TR19-D01)

There were clear examples about how as a result of behavioural expectations being made explicit and attention focussed positively on people exhibiting such that over time more notorious departments had changed:

"There are 'before and after' stories' emerging from Maternity and A&E as areas where high levels of bullying and harassment were known...a lot of negative stories of staff experience rife and as the stability of Executive team and CLP focus grew, expectations became known and acted on and some of the key culprits left, and the positive focus on positive leader models dominated" (TR10-SV,01)

Similarly another trust described how the nature of teamwork was changing and how this both indicated progress and presented an opportunity to reflect on why this was happening for some and not other teams:

"Yes, difficult to know how to see changes in any kind of quantitative way but teams work more closely together, there's lots of evidence there that it would have huge impact on organisation performance. The thing about diagnosing exactly what it is that stops people from doing that, isn't it? Because actually it's so multifaceted potentially, isn't it, you know, it could be interpersonal something or other...it could be organisational..." (TR4-ExW3,01)

Overall there was a sense from trust leads and change team members that there were more opportunities being created for reflective conversations about the way people behaved:

"...the most improved area was reflexivity" (TR18-1 08)

"it's the shift in conversations that's happened more in our organisation, so in some respects, it's not that something significant or tangible has happened, but there are conversations now happening about actually do we have the right people in the room to be able to make a really good decision? And when I say that, when I think about diversity, I'm thinking about diversity in its broadest sense..." (TR12-ExW3,01)

5.3 Enablers of embeddedness

5.3.1 Coherence and authenticity and focus on culture

From the analysis of documentary evidence referred to earlier in the report there are examples that would indicate a lack of alignment between strategic documents e.g. the vision and value statements in annual reports with those referred to in the leadership strategies and OD plans resulting from the programme. Similarly historical accounts of the process of developing trust vision and values that are not recognised by the majority of staff - where they do not feel they have been a part of the process - can create a sense of disconnect between senior leaders and staff as it lacks connection and authenticity.

The importance and challenge of ensuring connection and integration with existing programmes (particularly quality improvement work) was also noted:

"...and actually then we could effectively knit what has felt like, at times, two opposing methodologies and it's actually been called out, you're off there doing culture change and we're off here doing QI and actually our methodology is better than yours, and there's been that kind of competition element where actually, if we'd done that, we might have knitted the two together." (TR18-ExW3,11)

Where integration was achieved there was a noticeable sense of momentum:

"...we brought them (leads for improvement methodology) in right from the very beginning, so when we did the diagnostic and then went into the design phase, that rich picture that I shared, that was a collaborative piece of work between transformation and the OD team, and the change team, because we recognised that we needed to...again language and symbolically be able to connect day to day operational, you know, what we do on a day to day basis with culture and people" (TR12-ExW3,01)

However as highlighted earlier in the report, integration of the CLP with other programmes or subsuming a change team within a broader OD function, has diluted and in some cases

completely dissolved, the focus on culture change. As a result, we would emphasise the need to see culture change as an on-going task and strategy with dedicated support that is linked but remains separate with its own energy and spotlight.

5.3.2 Participation and involvement

The size and nature of the change team and the way they were enabled to work with staff was seen as an early enabler in that they created new relationships across the organisation and carried a different kind of credibility with staff who may have hitherto viewed managers' questions (possible attempts to engage staff) as negatively motivated:

"Well, again I think a lot of it was that they recognised the people that were asking the questions. So it wasn't the... I think there's a bit of mistrust of authority by lots of staff. I think, you know, they've always got at the back, if the manager's asking that question what's the ulterior motive, whereas I think lots of people within the Culture team I think again their behaviour's represented what they would like." (TR10-ExW2,03)

The way engagement is organised within the Discover phase was time and again talked about as a fundamental difference, marking the new culture:

"to do the diagnostic, actually it was quite a significant intervention of its own, and yes, you do want the design phase and the strategy phase to have that spread and sustained ability but the actual diagnostic phase itself was a significant shift in the way it got us to think differently and to trigger some of those change because some of what you're describing has I'm sure happened as a direct result of just doing the diagnostic, not because you then decided, oh, it's now in our plans?" (TR12-ExW3,01)

In some trusts the change team was referred to as a 'movement' with evidence that it was refreshed at each phase so that the experience of being a part of the change team became an opportunity available to more members of staff. In this way the experience of meaningful engagement became more widespread and integrated across the organisation.

5.3.3 Anchoring vision and values

Within the design and deliver phases there were examples of how the new cultural elements (behaviours and actions) were being 'anchored' into the routines and processes within organisations. Actions included incorporating the values into the criteria for recruitment and

the fabric of selection activities; the crafting of policies and processes that enacted the new expectations into the day -to-day rituals and systems:

“So, there’s something about the appraisal process and how we embed objective setting, and helping our managers to actually positively reinforce good performance in staff rather than using it as a...it’s not about correcting poor performance, it’s about building a culture of good performance. “(TR12-ExW3,01)

“One of the things that we were looking at that we would hope to see is they’re starting to use the values in decision-making, so if we’re talking about business cases or the right way to do things, they were actually testing the kind of routes of our decision against the values to say are we living and breathing the values in the decisions that we make?”(TR6-ExW3, 01)

Another example of this was where new starters were now receiving a welcome letter directly from the CEO setting out the expectations for themselves and the organisation based on the trust vision and values.

5.3.4 Narrating the evidence of the emerging impact

The importance of documenting and crafting a narrative about the evidence of cultural change was exemplified by some trusts describing proactive communications strategies integral to the programme where stories of change and impact could be shared and an accompanying narrative built as a result. One trust CLP lead talked about ‘nudging’ the appointment of a communication and branding professional in order to create an organisational narrative in line with the reality of what was changing.

Another example described a high percentage of the staff population as very local with high familial connections and networking. Historically there had been many situations of familial roles reversed in the managerial hierarchy, decision making about progression been taken about family members by family members: favoritism and a lack of transparency dominated many staff perceptions. It would take a proactive ‘campaign’ to share the new reality of openness and transparency within recruitment and appraisal processes in order to change the dependency on the historical bank of stories.

The impact of recounting stories was felt to become more powerful when told by ‘people like us’: change team members familiar to staff on the ground:

“And I think we use all kinds of...you know, we’re quite active on Twitter and we’ve got a new comms team now which has been fantastic in terms of helping to drive

some of that engagement but nothing beats getting out face to face, standing in front of staff and actually having to have quite uncomfortable conversations and actually having to look at someone..." (TR18 –ExW3,02)

One trust in reporting that they now were only using images and words from trust staff (rather than generic library materials) emphasised this as an indicator of impact and embeddedness in itself. Another trust pointed out that in having an active communications element to the programme it was vital that this was in line with the reality of what staff on the ground were experiencing as opposed to abstract promotional materials that staff could not connect with.

Another form of narrative that seemed to be reinforcing cultural changes were new 'feedback loops' connecting with staff consistently over time, often in relation to data collection. One example was of a new 'real time' data display system that was becoming available to teams and another was how data submitted by staff was acknowledged through a pre-existing organisational process making it more relevant and accessible:

"I think we did a lot of work to sort out data collection and data production, but what staff were saying we collect all this data and it just goes... [Inaudible 00:27:42], you don't ever see it again, so what has now changed is that the team brief communication, which has always been there, and it's a face to face thing and there's a video of that and there are different versions as well so everybody can access it and that is much, much more data-driven than it used to be." (TR16-ExW3,01)

5.3.5 Keeping a holistic focus

Even with trusts that were at the time in financial deficit committing investment to for example a Leadership Development Programme over an 18-24 month period was interpreted as an enabler of embeddedness. However, with many of the trusts in financial deficit (pre March 2020) it was felt that the likely the need for investment required to implement a delivery strategy should be made explicit from the beginning particularly with board members sponsoring the programme.

The expectation for required evaluation within the programme was also felt to place a sharper emphasis on the way baselines are established in order that they can be revisited, creating a holistic expectation over a longer period of time. Similarly, the link to the CQC 'Well Led' requirements was appreciated as a consistent 'lever' for many OD people trying to keep the programme on the board agenda:

"I think helping organisations understand how this programme, the culture and leadership programme, can support and be aligned with programmes of work they already have going, so that it's not just a you must tick all of this and follow it all through. Its the sustainability bit – the end bit – we need to build that – tools for sustainability – at the end – messages about the value – integrate it into 'business as usual' - otherwise momentum and the programme will be lost" (RLA1-I,01)

5.4 Equality, diversity and inclusion

Of the 12 trusts that shared outputs from their discovery phase (synthesis workshop outputs, leadership strategies, organisation development plans), most recognised equality, diversity and inclusion as an issue, with one trust in particular experiencing major challenges with discrimination. Embedding change related to equality, diversity and inclusion required enduring and unremitting attention:

"...this agenda should be seen more of a marathon than a sprint, and for organisations to understand that. What we have in the NHS is quite unique, it's an [...] institution that's been around now for over seven decades. That very often has deep-rooted cultures embedded within it, not only at an organisational level but also at directorate and team levels. And for us to transform those cultures overnight is something that's not going to happen. And so I guess be patient but persistent on this endeavour and know that this will take some time, effort and resources to shift." (EDI-I,02)

Trusts were variable in how much they reported on, or prioritised equality diversity and inclusion. For example, TR2 didn't mention EDI in the discovery findings, but did recommend "increasing opportunities for staff in minority groups' in line with our Workforce Race Equality Scheme and equality objectives." In addition, TR18, which includes EDI as one of nine priorities following the discovery phase did not include it as one of the four core priorities they proposed for their design phase. Meanwhile TR12 and TR8 reported positive findings on EDI. However, even where some organisations were more committed to, and explicitly focused on, building an equal and diverse organisational culture, at times people did not behave in ways that reflected this commitment:

"...if you want these to really be culturally changing conversations [...] bring some diversity of thought into the room. Because we know we've got an unbalanced senior leadership team, so if we don't have the diversity there can't you bring the staff closest to those pay bands into the room. [...] All of the spaces that are created as

part of this concept are safe spaces for senior leaders, but they're too safe, they're not challenging themselves. So in terms of the way it's being implemented here, I think we'll come out with a strategy but I don't think it will change anything." (EDI-1,03)

Trust actions were fairly formative during the evaluation period: we cannot report on impact at this stage, and results from staff survey and WRES data do not show any significant findings between the experiences of e.g. BME staff and White staff, although we saw some marginal improvements in some trusts in the sample. A focus on numbers of people responding to the staff survey (BME staff) did however appear to show more improvement, and this might be important in measuring change.

5.5 Programme implementation and the SOF

Findings from the evaluation suggest that the programme has high credibility within the NHS. There is trust in the underpinning evidence base and in most of the programme materials. Take up of the programme relates to this credibility and also due to the regulatory influence of NHSEI. For some trusts, the programme is a mandated course of action to help improve organisations that have low SOF ratings. Trusts with the lowest SOF ratings must make use of the programme materials and ethos as part of a wider programme of mandated improvement. Drawing on theories of absorptive capacity⁸⁰ senior leaders in trusts with low SOF rating may find it harder to harness their dynamic capability to absorb the external knowledge and practices associated with the CLP alongside multiple demands and pressures. This indicates a crucial role for NHSEI or NHSLA staff and associate support.

5.6 Summary

The NHS Staff Survey and other nationally required indicators although helpful are generic measures and insensitive to the particular cultural destination that individual trusts aim to achieve via the programme. The Summative Impact Evaluation Framework (see supplementary document) sets out additional indicators to supplement the range of measures trusts may find useful in evidencing progress on their priorities for culture change. However, the day-to-day experience of working in an organisation particularly at a local level may be usefully monitored and evaluated through other 'pulse' instruments that staff at team level can own and use to inform their continued development.

Culture is the kind of phenomenon that is all about lived experience and although incidents deemed as important and stories that are recounted as being pivotal can be dismissed as

attributing impact without hard evidence, they were a strong feature of the exchange workshops and follow up visits.

The 'most significant change' (MSC) approach⁸¹ structures a way of collecting and analysing stories in a way that can provide insights into both the causal mechanisms (how change comes about) and in what situations and contexts. In this way trusts using MSC could learn more about their own local cultures and particularly the similarities and differences in the values and behaviours operating in different parts of their organisation.

The difficulty in articulating 'what okay culture looks like' in practical ways has an important link to clarity of cultural destination and measurement. Without being able to be clear about the outcomes and impact desired, how can trusts know when they have achieved that or are demonstrating the required behaviours? This will require a greater focus in the early stages of the programme where the board is helped to make explicit their expectations about what will be different in the compassionate and inclusive culture of the future (together with their role within it) and that this destination is then further refined through discover and synthesis, applied through design and monitored proactively through shared feedback loops.

What is clear is that how staff engagement is initiated (via the change team) becomes a key mechanism that can signify the new cultural destination creating the readiness (and credibility) through showing that staff are being listened to and so valued, for moving to the next stage of collective accountability across an organisation⁸². How it is sustained and embedded requires a great deal of attention to the nature and quality of communications: feedback loops at various levels of the organisation and importantly at team level reinforcing a sense of connectedness between 'tops, middles and bottoms'.

6 Discussion, conclusions and recommendations

This section builds on the summaries in each of the preceding three sections, distilled into a set of recommendations. There is a substantial amount within the current CLP programme that is positive, constructive and purposeful in supporting NHS trusts to develop a compassionate and inclusive culture. The evaluation has captured examples of positive change and it is evident the programme is making a difference. Looking forward, notwithstanding the inherent challenges of change in large, complex organisations, there is the exigent context of longer term recovery post-Covid 19. It is overwhelmingly clear that trusts will continue to require support, to focus on compassion and inclusion, and secure capacity to enable corresponding culture change. It will be imperative to contemplate how CLP is situated in the future, to align with needs linked to trauma through to renewal and recovery. It is noted earlier that the NHS national and regional structures have provided robust means to co-ordinate the initial response to Covid-19. Moreover, the recent structural changes bringing together key stakeholders in national and regional leadership development functions may provide good foundations for CLP to be adopted at scale.

6.1 What works for whom, where and why

We developed six hypotheses (reproduced from chapter 2 below for ease) about engagement and implementation of the programme at a local – trust – level, which were then translated into a realist evaluation framework (see supplementary document). These hypotheses were first formulated from theories relating to leadership, management, change, improvement and implementation and supplemented with, or adjusted by, information gathered during the scoping phase, and further refined, as we collected data from the formative evaluation phase. Here we re-present the hypotheses which preface our recommendations. **In summary all six hypotheses were upheld at the programme level, however, at individual trust level, this may not be so because of the contextual variances for each organisation.**

Hypothesis 1: Where a programme has **external status and credibility** (evidential, academics, think-tank endorsements, implemented by other trusts) the CEO and board, clinicians and staff will be more persuaded that it can help them change the culture of the organisation.

Hypothesis 2: The way in which the CEO and the board/executive sponsor **conceptualise, communicate and engage trust staff around the purpose and destination of the culture change** will be a significant determining factor in the way staff engage with/respond to programme implementation/culture change.

Hypothesis 3: Where the **approach to programme implementation** is consistent with the ethos and values of the programme, aligned with other change initiatives and integrated with strategic priorities and direction, and the trust frames and communicates the task as changing the culture of the institution (rather than implementing a programme) – i.e. the programme serves to institutionalise culture change and is a means to an end not an end in itself – then the programme is more likely to become embedded rather than seen as something to be endured, with a finite end.

Hypothesis 4: The type and amount of **dedicated support and resource available**, influences the way the trust goes about change. Where there is sufficient and dedicated resourcing for the programme, it enables the change team to more effectively progress through the three phases, in a timely manner. The more bespoke and sophisticated this resource is - and the larger the capacity provided - the more the trust will be able to extend implementation more widely. Where there is an experience of being supported when implementing the programme, it helps maintain motivation, and increases the potential for working through the change and being innovative.

Hypothesis 5: Fidelity to the Phase 1 diagnostic model Where trusts both use the specified diagnostic tools and follow the specified structure, activities and process (fidelity to the Discover phase) it will result in - better quality data for deciding on the design and deliver phases, because it will provide a more comprehensive picture of the trust's performance and culture. Where understanding of the programme - its ethos, values and behaviours; its processes, tools and activities; what data is needed and why; how the data can be used to craft a process of change – is not deeply understood (immersive), then the Discover phase will just be understood/approached as a data collection task to be completed (focus on content), rather than seen as a process for engaging staff and finding out what the trust's current culture looks like, and how this needs to change. This then means that good data will not be collected or is unhelpfully narrow.

Hypothesis 6: Organisations that see the need to go beyond compliance and regulation, and work to embed the principles of equal access to opportunities, social justice, fairness and human rights into the organisation's policies and into the 'DNA' of leaders' practices, are likely to be better at developing and sustaining **diverse and inclusive** cultures.

During the formative evaluation phase we sought to identify the underlying “mechanisms” at play in the different contexts within which the programme was being implemented, and understand the different ways in which those mechanisms relate to two interdependent spectrums:

- *Engagement:* do staff and stakeholders who need to enact the change or will be affected by the change show genuine commitment (cf intrinsic motivation), or is their

felt response one of compliance to what they are being asked to do (cf extrinsic motivation)?

- *Implementation*: does a trust seek to embed the change deeply in the organisation or does it regard the change as transitional; likely to be superseded by other change initiatives in the near future?

The inter-relationships are illustrated below:

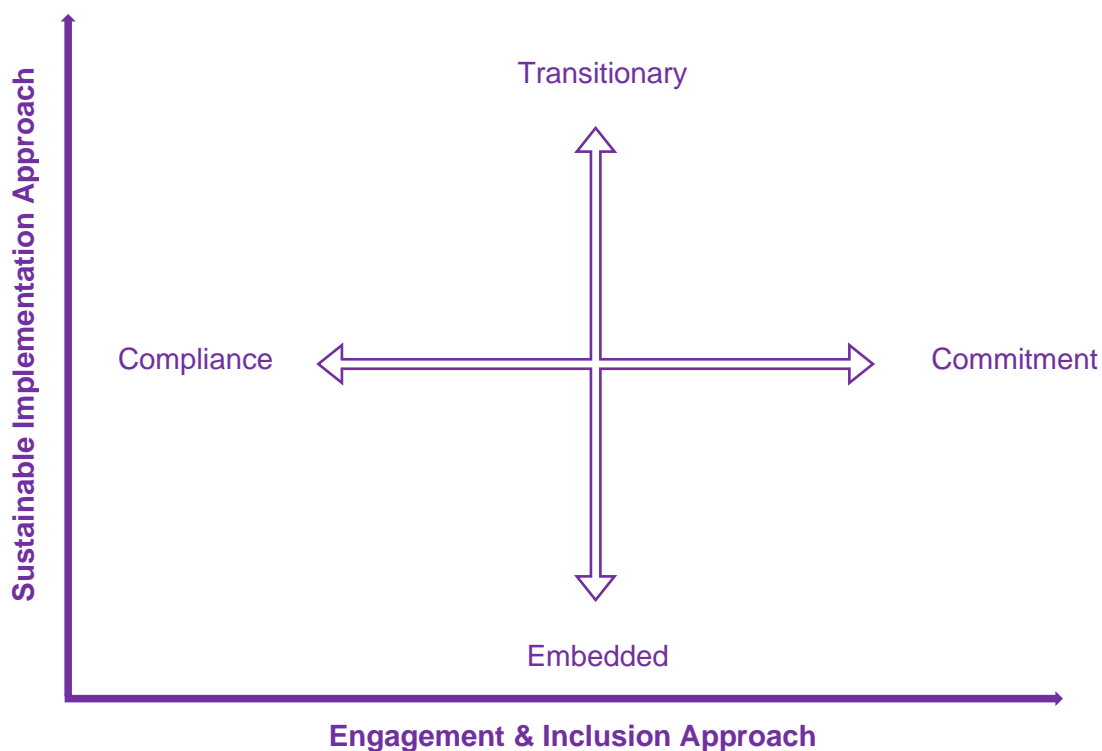


Figure 11 Depicting the approach to change.

From this work, we developed a series of scenarios around the way in which different trusts conceptualised and enacted: organisational leadership, implementation, engagement, inclusion, support, and ways of embedding the change; these appeared to be 'default' or starting points, rather than permanent 'positions', and the evidence shows trusts moving through and adopting different or additional positions. There is a prevalence of concepts and ideas presented as neatly operating quadrants on two axes and it may be tempting for trusts to privilege one particular quadrant over others, reflecting the trusts' "corporate personalities" such as the "ramshackle trust"⁸³. However, it is important to balance a focus on culture and leadership with those of good governance, systems and processes. On this basis the diagrams below reflect our evaluation insights generated by the six hypotheses detailed above but they can also be used as a developmental tool to support trusts in their CLP work.

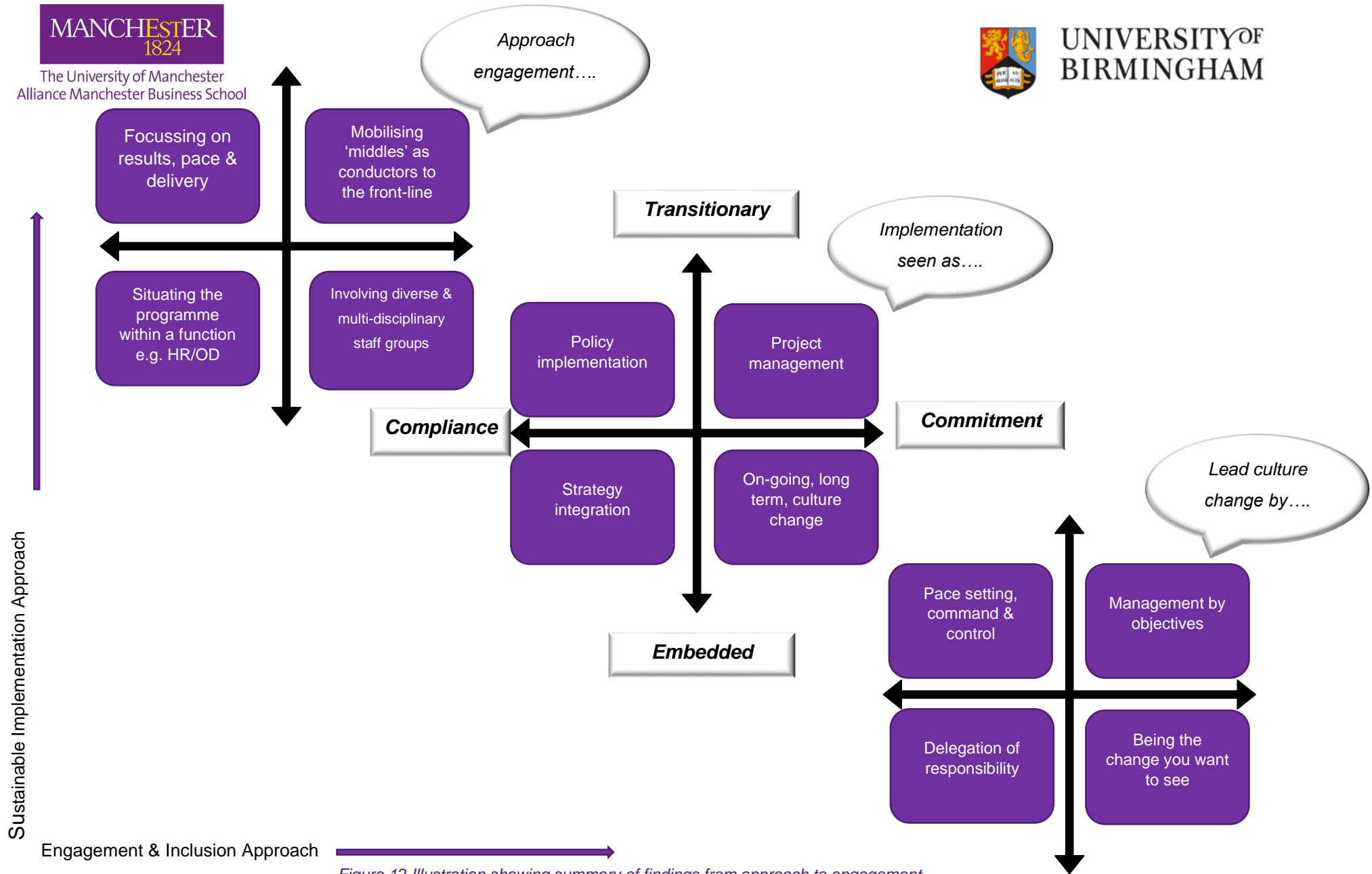


Figure 12 Illustration showing summary of findings from approach to engagement, implementation, and leading of culture change.

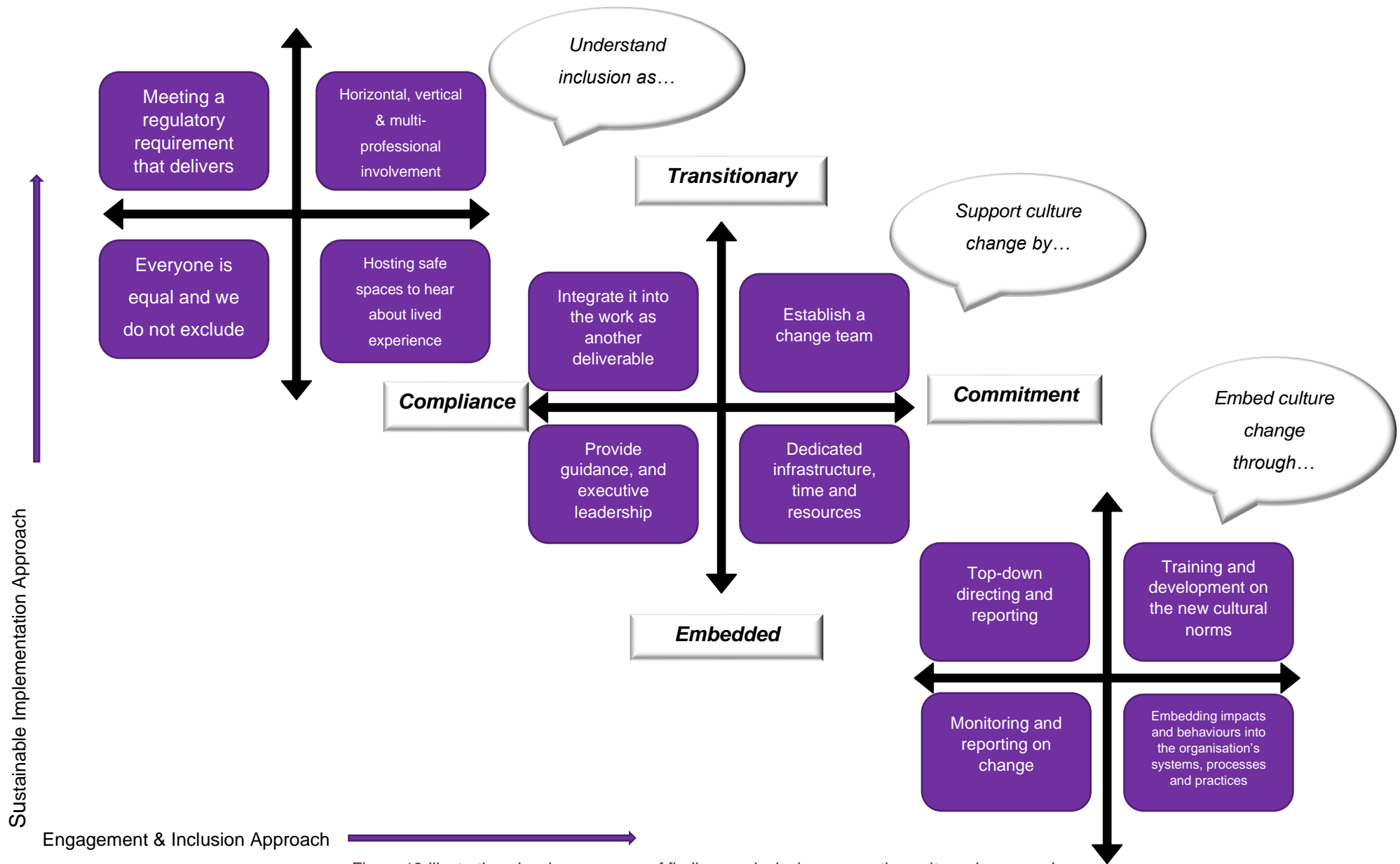


Figure 13 Illustration showing summary of findings on inclusion, supporting culture change and embedding culture change.

There are some strong foundations within the current programme structure to build upon, however, based on our findings, we propose a number of ways in which the programme structure can be developed, expanded and enhanced – we believe this could be instrumental in future delivery of the CLP. Based on these evaluation insights, we now detail our recommendations.

6.2 The structure of the programme

As we encountered change team members through the various data collection activities, many felt inspired and energised by the programme and were deeply committed to making a change for the better. They talked positively about the programme design, process, materials and were appreciative of the resources provided on-line as well as the support provided in person.

Their experience of implementing the programme and using the resources and materials brought opportunities for reflection on what worked and what needed to be adapted. Comments on the accessibility and usability of tools, materials and resources are detailed in chapter 3. Connecting with our sample trusts and confirming their understandings of the CLP, what became clear was that there were a number of different conceptualisations of what it was that trusts were engaged in, and how this influenced their approach to embedding compassionate and inclusive leadership and culture.

In the NHS, policy implementation is the most common externally driven change, so has have a major influence on the way in which trusts understand what it is they are engaged with and approach any kind of change (see realist framework in supplementary document; hypothesis 3, context 2). Typical features of this approach are: top-down power, with change perceived as *having* to be done and being *told* what to do, needing to complete the work and report on it, usually in very short timescales, with a focus on results (*what* has been achieved).

This then sets up a notion of a ‘programme’ (and ‘programme’ terminology used reinforces this) with a finite beginning and end, that has to be established, managed and delivered, with a concomitant focus on diagnostics and tools as ways in which to deliver the change.

This is a very different picture to a conceptualisation that notices that “*the way we do things around here*” which appears to have a negative impact on staff, impacts upon the quality of care patients experience and receive, and affects the efficiency and effectiveness of the organisation. The complexity of this kind of work (multi-dimensional across all organisational

levels) is work over the long term, and moreover is best viewed as iterative and overlapping, in contrast to a linear process. We therefore propose that programme design, phases and associated activities are expanded and enhanced and this can also be repeated, adopting a life cycle perspective. We have illustrated this below in figure 14:

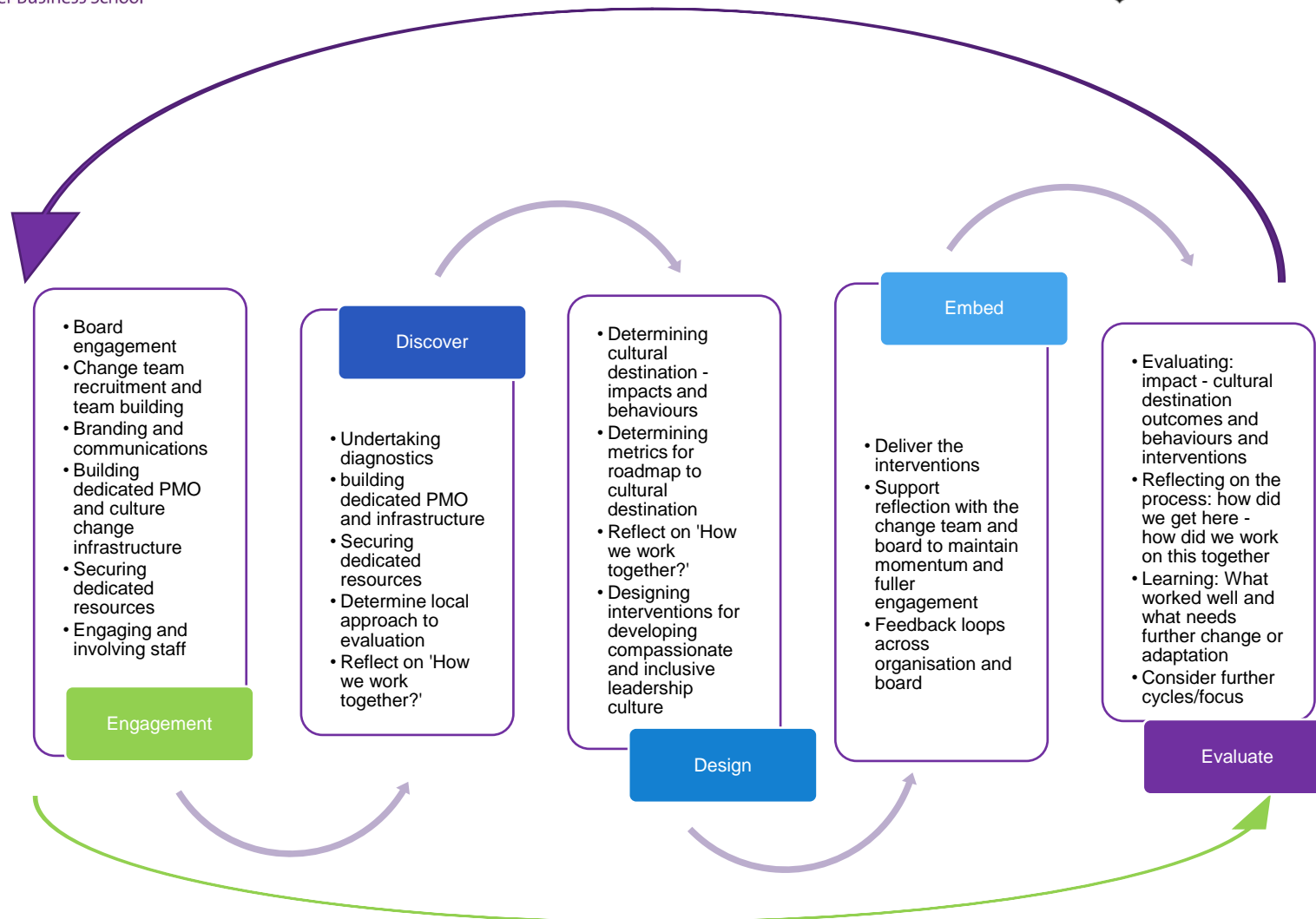


Figure 14 Illustration showing recommended programme redesign of CLP phases and activities.

Key to this re-conceptualisation is the need to make clear that the process is not linear; some activities will overlap and recur throughout e.g. engagement and evaluation, because change activities are not exclusive i.e. as soon as you start to collect data you are intervening, and as soon as you have discovered something, you may quickly be able to take some actions while other interventions are still being designed. Similarly, although depicted at the end of this process, evaluation commences in Discover and carries on throughout embedding, with the final task focussed on impact, process and further change.

A central part of this process is building in clarity about identifying the cultural destination; what differences would be expected and how they would be evidenced is a key part of the vision that needs to be crafted and socialised throughout the initial phase, with this work being done at the beginning of the programme and again at synthesis at the end of phase 1. Further, using a logic model at the beginning of phase 1 with the change team and board would help provide some early clarity about the cultural destination. Finally, we noted the absence of focus on teams and as such, we suggest that within the CLP trusts are encouraged to consider at the Design phase where to prioritise efforts based on the conception of culture as an ever changing, multiplicity of cultures within any one organisation or system. The functions of teams in achieving the organisations cultural destination could be brought to the fore much more explicitly.

I. The CLP phases are extended and enhanced to include additional activities with increased attention on engagement and evaluation and all phases can be viewed as one life cycle which can subsequently be repeated.

II. In the initial phase, logic models are used to facilitate and articulate the organisation's cultural destination.

III. The connection between cultural destination and the function of teams needs to be highlighted and made much more explicit in the CLP materials.

6.1 The design of the programme

In the main, programme guidance focuses on the 'what' of implementation, with some suggestions around 'how' as it relates to the change team, or when reflecting on the process of implementation during post-stage evaluation activities. While many of the materials in the phase 2 'toolkit' also pay attention to 'how', or 'process', the main guidance does not provide sufficient focus on change teams needing to focus on both the content and process of change.

Edgar Schein suggests we need to simultaneously maintain a focus on content, process and structure as well as the task and inter-personal dynamics, and offers a useful frame for this (see table 4 below):

	Task	Interpersonal
Content	1. Formal agenda, goals	4. Who is doing what to whom
Process	2. How the task is done	5. How members relate to each other, communicate, etc.
Structure	3. Recurrent processes; standard operating procedures	6. Recurrent interpersonal relationships, roles

Table 3 Summarising the focus on the what and the how.

Following on from this, it is important to understand how this will be operationalised, that is, what this means in practice. A focus on governance, relationships, and activities are key, featuring:

- strong collaborative working relationships between the board and the change team to develop a shared understanding of **how** the work will be approached, agreement on how to embed culture change and enable ongoing reporting and reflection on the process, impacts and behaviours;
- recognition and involvement of middle tier leaders, as they are critical to releasing staff to be involved in the change team and change activities, communicating developments and expectations, and promoting culture change. A targeted

involvement of middle tier leaders will help to channel their authority and influence in support of the culture change.

- opportunities for regular feedback loops critically between the board and the change team, but also across the organisation to sustain focus on how the work is being undertaken, and keep the desired cultural destination in sight.

IV. Guidance, tools and activities are developed for targeted involvement of middle-tier leaders.

V. The proposed redesign of the programme phases and activities includes feedback loops, to facilitate iteration across activity/phase and board, change team and wider organisation.

6.2 The need for dedicated programme infrastructure

What trusts' have signed up to needs to be re-conceptualised as leadership and culture change (not a programme), so the work is seen as long term, and therefore needs to have a dedicated infrastructure, with resources allocated to support the work. Whilst trusts may need to build infrastructure, such as a programme management team, to support the leadership and culture change, it is important that trusts recognise this is an ongoing part of the trust's business, akin to service improvement.

- identifying and securing resources to support the programme's initial phase and set expectations for the likelihood of further investment for the deliver phases
- establishing a dedicated programme management infrastructure, to include recruiting a diverse and representative change team (small constant core, wider additional involvement)

VI. Trusts need to establish dedicated infrastructure at the outset that will sustain the programme over the long term.

Trusts should establish a dedicated infrastructure to operationally oversee, plan, lead and manage the culture change. We recommend that this features:

- a small core of people e.g. board sponsor, change team lead, project manager and administrator;
- a wider group (champions or change team) that is big enough to do the detailed work but not so large that it becomes unwieldy e.g. 10-15 members;
- linked to networks (of individuals and groups) to reflect trust staff e.g. protected characteristics, divisions, services, professional groups, locations, etc.
- social media and communications expertise
- sufficient capacity, with at least 2 days per month per change team member (10-15) dedicated time
- dedicated funding for buying out change team members' time
- adequate resourcing for software, training and development needs.

The funded dedicated time for the change team lead and members is required for involvement, engagement, undertaking the culture change activities, teamworking and communication including reflection, and regular interaction with the board. The clear arrangements for backfill should ensure that there are good levels of clinical involvement on an on-going basis.

VII. Trusts establish and fund a dedicated infrastructure that is sustained across all CLP phases and activities with specific expertise in social media and communications, accommodating staff's time and development needs.

There should be more robust and detailed guidance on how change teams are established, to help create a sustainable and manageable function. Change teams by default function as both a vehicle for mobilising and shaping credible staff engagement and for facilitating the on-going culture change. Key components to be worked through and agreed are:

- membership: the size, membership and diversity;
- recruitment and selection approach: democratic and participative;
- capability and skill mix: OD, HR, equality diversity and inclusion, clinical, lived patient experience, inter-disciplinary

VIII. CLP guidance on how change teams are established needs to be strengthened with regard to membership, recruitment and selection, and capability and skill mix.

Additional support is sourced and provided as and when it is needed:

- process consultation, i.e. reflection on the dynamics of how things are happening, and what is going well/what needs to be different
- expertise in data analysis and synthesis (quantitative and qualitative)
- peer support and collaboration
- delivery support (for interventions).

We anticipate that this can be delivered through a blend of NHSEI support, external associates, and internal trust OD expertise.

IX. In building the dedicated infrastructure, the range of support is addressed, which is likely to involve a blend of internal and external resources

6.3 The integration of equality, diversity and inclusion

Our findings indicate that equality, diversity and inclusion was not sufficiently evident in the concepts and evidence provided or explicit in materials, specifically:

- The underpinning concepts and evidence for the programme only includes two publications focussed on equality and diversity, with workforce being a dominant focus. In these cited publications, power differences/imbances are only mentioned once, and not in any material way that would support programme participants understanding the significance and impact of this, and knowing what to do, as a result of that understanding.
- Equality is mentioned once and diversity mentioned twice (p 16 & 18) in the document relating to protected characteristics and in relation to workforce capacity; the substantive point made in the latter, broadens out to focus on patient care, and appears more as a persuasive mechanism.
- Creating a culture that is equal and diverse is more implicit than explicit in the programme's conceptual framework; the five cultural elements mentions 'inclusion' but subsumes this concept into support and compassion, such that it loses its specific impact.

Further, the use of the term *inclusion* generally appeared to be conflated with, or interpreted as, *inclusivity* i.e. not leaving anyone out. Underpinning this is either an unconscious or conscious avoidance of recognising differences in power (power deficit) and inequalities; perhaps reflecting the difficulty in acknowledging this (shame and guilt), talking about this (saying the unsayable) and changing this (social norms). This may be resolved by ensuring

that the term 'inclusion' is not used on its own i.e. it is always prefaced with equality and diversity, as this helps to signal that the issue of social power is embedded in this concept.

X. The term equality, diversity and inclusion should be used consistently in oral and written communications for CLP work

National and regional EDI leads recommended that the concepts and evidence paper be strengthened by links to an increased number of current and relevant studies, and embed equality, diversity and inclusion more explicitly into the cultural elements and diagnostics phase, for example:

Cultural elements	Values	The way we do things
Vision & values	Constant commitment to quality of care	Everyone taking responsibility in their work for living a shared vision and embodying shared values
Goals & performance	Effective, efficient, high quality performance	Everyone ensuring that there are clear priorities and objectives at every level and intelligent data constantly informing all about performance
Equality, diversity and inclusion	To be defined with input from WRES team and research evidence	To be defined with input from WRES team, and Equality & Inclusion Function of the NHSEI Directorate, and research evidence
Support and compassion	Support and compassion for all patients and staff	Everyone making sure all interactions involve careful attention, empathy and intent to take intelligent helping action
Learning & innovation	Continuous learning, quality improvement and innovation	Everyone taking responsibility for improving quality, learning and developing better ways of doing things
Team work	Enthusiastic cooperation, team working and support within and across organisations	Everyone taking responsibility for effective team-based working, interconnectedness within and across organisations, systems thinking and acting

Table 4 Showing recommended cultural elements, values and the way we do things.

We conclude that WRES and WDES data should be integral to the phase 1 diagnostic tools, so that it is collected, analysed and reported on as part of the assessment of current culture (see above); a series of indicators could be embedded in Culture and Outcomes dashboard, and analysed as a distinct element. In addition, interviewees made helpful suggestions about adding a number of different interventions to address gaps in equality and diversity tools (as above for detail).

XI. WRES and WDES data is included within Discover tools

XII. Equality, diversity and inclusion indicators are embedded in the Culture and Outcomes dashboard

XIII. CLP tools are reviewed to address gaps in equality, diversity and inclusion

6.4 Engagement activity and approach

At the start, dedicated time is needed with the board to focus on the conceptualisation of, and messaging about, the organisation's cultural destination, which should identify the specific cultural change (impacts and behaviours) the trust wants to see. This will not be known fully at this stage (until diagnostics have been undertaken) so the task is about getting started to provide a guide to the change team, enabling further development at the end of discover with a wider group of staff.

Experience from implementing other large-scale change programmes suggest that later success is linked to comprehensive planning and ample resources for implementation. On this basis, we recommend a period of preparation to include:

- undertaking scoping to ensure that the board fully appreciates the depth, scale and focus of the CLP, in order to be clear what they are committing to and their on-going role in engagement and implementation
- developing a branding for the work and defining the different communication and engagement approaches that will be used (take into consideration how integrated CLP will be with the trust's wider strategy and other plans). Credibility related to

the CLP evidence-base was a strong driver for engaging staff to become involved, particularly clinicians. The reputational currency of Professor Michael West's body of work was especially compelling

- adopting a stronger social marketing approach to sustain communications across the phases, celebrate successes and bring to the fore cultural change evident in staff's personal stories and most significant events.

XIV. Branding work is undertaken at the outset to capitalise upon the credibility of the CLP

XV. A strong social marketing and communications approach is agreed and resourced at the outset

6.5 Support for networking and collaboration

An important way in which innovation and change can be supported and refreshed, is to provide opportunities for change team members to see how culture change is being done elsewhere. The creation of new fora e.g. co-coaching, exchange events, regional communities of practice, national development days, etc. will help build peer support and networks and build collaboration.

XVI. Regular developmental and networking opportunities are facilitated to enable trusts to exchange information throughout their CLP life cycles, phases and activities.

In the context of this programme becoming a core programme for NHSEI, we recommend that NHSEI (those involved in providing support whether nationally or regionally located) should provide support throughout all phases (drip-feed support model), but is targeted at specific junctures:

- contracting (formal and psychological) with the board during sign-up;
- facilitating board workshop on cultural destination during sign-up;
- supporting the change team to get started;
- training the change team for the synthesis process;
- supporting the design and facilitation of the synthesis event; and
- helping trusts to translate their cultural destination into impacts and behaviours.

- further additional support needs to be available on a 'call-off' basis, to troubleshoot early issues.

Regional teams currently supporting NHSEI are well placed to support trusts' culture change through use of the CLP, because of their local knowledge and intelligence, and the developmental and processual expertise they bring.

Related to this, we recommend standardising recruitment, selection, orientation of and support for associates across all regions, and for routine events or workshops to be scheduled to focus on and further develop the centre-region collaborative relationship.

XVII. The support from regional teams is targeted to optimise the CLP work and momentum at specific junctures: contracting, supporting work on cultural destination, impact and behaviours, change team initiation, support for synthesis with capacity to provide early support to emerging issues

XVIII. Recruitment, selection and orientation for regional associates are standardised.

6.6 The embedding of change

We recommend that trusts are encouraged to consider at the very beginning or at least at synthesis, where to prioritise their cultural change efforts. This is because trusts are large, complex adaptive systems with multiple sub-cultures, so trying to achieve everything all at once will likely end in failure. Evidence suggests that focusing the change around one area of the organisation like a hospital, or around services or teams will be a more effective of identifying and achieving the desired culture change.

Our findings indicate that external drivers resulting in organisational restructure such as a trust merger or acquisition, significantly detracts strategic attention away from CLP. However, we also recognise that structural changes are a regular feature of contemporary health and social care delivery. We therefore recommend that additional guidance is developed on how to review and renew CLP activity and focus when organisational/structural work is anticipated.

XIX. CLP guidance is developed to address how to support trusts undergoing structural change

The findings on language coupled with the intransigent nature of culture change work, and the need to clearly portray what compassionate and inclusive leadership behaviours are in practice, lead us to propose that additional materials are needed. We recommend collating and disseminating case studies and/or guidance which illustrates to trusts how to embed new cultural norms pertaining to compassionate and inclusive leadership and culture including: re-education and training, new behaviours and expectations into systems, processes and procedures and for which accountability is clearly attributed to individual staff, specific teams, and the trust as a whole.

XX. CLP materials are developed to include guidance and case studies illustrating how new cultural norms pertaining to compassionate and inclusive leadership and culture are experienced in practice.

6.7 Monitoring and evaluating culture change

Further developmental work should be undertaken to iterate and finalise the proposed Summative Impact Evaluation Framework (see supplementary document), which draws on trusts' local culture change implementation processes, including a collection of quantitative data from the outcomes and dashboard used, together with stories and discussions that are shared for learning when applying a Most Significant Change Approach (MSC).

This can be achieved through bringing together a working group comprising NHSEI members (national and regional), academic advisory group members and trust change team members. This membership will ensure the evaluation integrates national, regional, application and methodological perspectives.

XXI. The Summative Impact Evaluation Framework is iterated and finalised with key stakeholders to integrate multiple perspectives

We recommend there is further research on measuring and collecting data on behavioural change, in order to strengthen the sensitivity of indicators that can be tracked more often than those in the annual NHS Staff Survey. The Culture of Care Barometer and organisational pulse checks are very helpful additions here.

XXII. Additional work is undertaken to improve indicators which track cultural change, to include research on evaluating behavioural change pursuant to compassionate and inclusive leadership.

7 Concluding Remarks

The CLP is a courageous programme in that it establishes a practical counter to examples of poor leadership and negative cultures which have become endemic in some organisations. Simultaneously it offers high-performing organisations an approach that can refine, renew and re-energise a focus on compassionate and inclusive leadership and culture. There are some strong foundations to build upon and our evaluative insights are very much generated in acknowledgement of this.

Looking forward, we believe there is rich potential to utilise the CLP across systems. The recommendations for programme design include an engagement phase that would be particularly crucial for senior leaders considering utilising the CLP across a system. The investment in shared thinking and planning around the focus of the CLP and allocation of resources for a change infrastructure across the system would support effective embedding of compassionate and inclusive leadership and culture, which is an attractive prospect.

One of the characteristics of more integrated and systemic working is for organisations providing health and social care to work more closely together for the benefit of patients and people using services. Embedding the CLP across systems, to enable truly integrated systems, could be strengthened by amplifying the patient voice. The future potential to advance compassionate and inclusive leadership and culture with leaders from the patient, carer and community groups constitutes a whole range of exciting possibilities for a further iteration of the CLP.

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