The University of Manchester
Alliance Manchester Business School

Evaluation of the NHS Leadership Academy Mary Seacole Local Programme

Final Evaluation Report (Phase 2)

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Original Thinking Applied

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For more detailed biographies, see Appendix 1.

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We would also like to thank all colleagues at the NHS Leadership Academy for their participation, engagement and cooperation, which have added great value to this evaluation.

Finally, we thank the project managers and administrators who gathered and collated all the documents we needed, set up the focus groups and interviews, sent out the surveys and were extremely helpful throughout.

Executive Summary

The Mary Seacole Local Programme (MSLP) is a national leadership development programme that is being taken up and implemented locally within an organisation or system, via a 'licensing' approach offered by the National Health Service Leadership Academy (NHS LA).

The initial phase of the evaluation consisted of diagnostics and engagement with three case study sites. The outputs of this initial phase informed the more extensive fieldwork in Phase 1, after which followed focussed fieldwork in Phase 2, with a specific exploration of impact and return on investment.

There was a significant amount of learning captured from the evaluation of Phase 1, focussing on the following thematic areas:

- Deciding to take up the local programme,
- Contracting and negotiation,
- Getting started, the role of leadership,
- Developing and maintaining relationships.

In the interim report (p48-49), it was evident that all of the sites were able to move from initial idea, through the process of mobilisation to successfully deliver the programme. The findings of the evaluation provide evidence of both demanding and challenging experiences during the phases of mobilisation, although overall each site was positive about their learning, and recognised the potential for this national leadership development programme being delivered locally, taking into account local contextual factors and developing leadership at scale.

The findings in the first phase of the evaluation helped to identify the impact of mobilising to deliver the programme on organisations/systems. Within the second phase of the evaluation, we balance this by better understanding the impact of the programme on participants, teams and organisations. In this way, a fuller picture of the return on the investment and leadership intervention can be presented.

For the second and final phase, we report on the following impact themes:

- Increased collaboration and partnerships,
- Team engagement,
- Increased reflection and reflexivity,
- Enabling innovation

- Changes in behaviours

The stories included here highlight a 'line of sight' from participation in programme activities, into insights, learning and applications in work settings that have a range of impact, at different levels (individual, team and organisation/system).

Recommendations to optimise the return on the investment in MSLP as a leadership development intervention are focussed on the importance of planning and engagement.

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Abbreviations

CQC	Care Quality Commission
CSS	Case study site/s
LAS	London Ambulance Service
LMT	Local mobilisation team
MSLP	Mary Seacole Local Programme
NHS LA	NHS Leadership Academy
ROI	Return on Investment
STP	Sustainability and Transformation Partnership
SWFT	South Warwickshire NHS Foundation Trust
VC	Virtual Campus

1 Purpose of the Report

This is the second and final report relating to the evaluation of the MSLP. The evaluation overall spans the time period ranging from when the case study sites decided to become early adopters during the initial months of 2016 to July 2018. At the point of the final phase of fieldwork, several cohorts of participants had already completed the programme. The findings described herein can be used for wider discussion and to inform immediate and future practice.

1.1. Evaluation Aims: Phase 2

- Build on the findings of the diagnostic phase and Phase 1 to get a deeper and clearer understanding of impact resulting from implementation of the MSLP.
- Assess the value that the local Mary Seacole Local Programme provides in the early adoption sites involved, through illuminating the return on investment (ROI).
- Make connections between process and impact evaluation, with emphasis on the interplay between elements of development and local delivery.
- Make recommendations that will optimise return on investment from the MSLP for other potential license sites.

1.2. Evaluation Design

A longitudinal multi-case study approach framed the evaluation, which facilitates in-depth understanding in the early adopter sites from:

- multiple perspectives
- a range of data points/types
- the levels of self, team/service, and organisation.

The longitudinal aspect of the approach is illustrated in the following diagram:

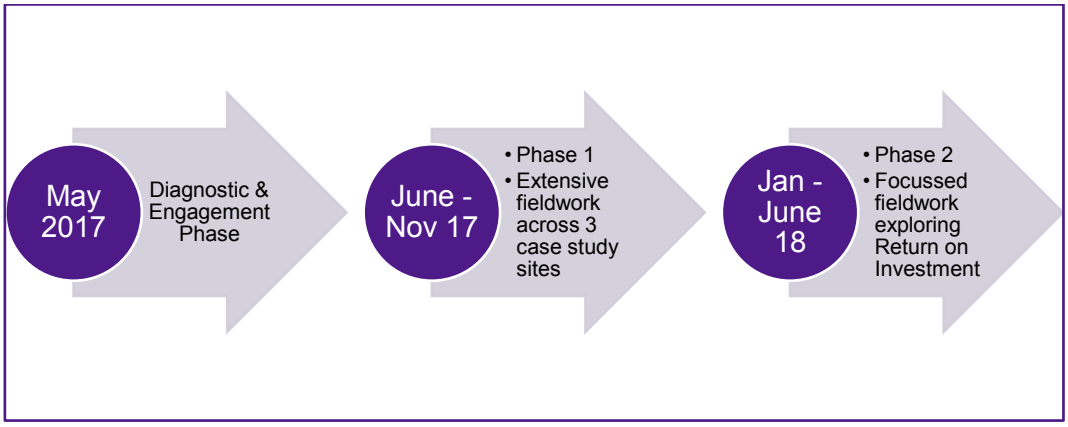

Figure 1 showing evaluation points as part of longitudinal design

We returned to each site to gain deeper insights into the experiences of leaders and participants at each of the case study sites. During interviews, we were particularly interested in identifying and charting:

- changes to individual leadership practice that stemmed from participation in the programme and that have made improvements and/or resource efficiencies, for patients and services
- the impact individual participants have had on their colleagues in relation to 'spreading the word' and the participants' potential to improve the level of staff engagement as a result
- alignment of leadership approaches and impact on organisational culture, involving the perspective of senior leaders.

2 Contextual Overview

2.1. The case study sites

The three MSLP Early Adopter sites were selected for their differences in organisational form and geographical location; their characteristics are summarised below (further detail in Appendix 2):

Figure 2 Summary of Case Study Site Characteristics

2.2. Implementation in each site

The evaluation team were provided with participant data from the NHS LA on the number of participants and cohorts across each of the sites. The data describes the number of participants enrolled, number of participants who completed the programme, and the number who withdrew. The evaluation did not consider data at different time points during the roll-out of MSLP therefore this 'snapshot' data needs to be treated cautiously. Further, supporting qualitative data, explaining reasons for withdrawal, for example, was also not available. As this is essentially background data, and is incomplete over the period of mobilisation and license period, it is not offered as part of the evidence identified as part of the evaluation, however, it may serve as a useful source of data for

future lines of enquiry (discussed in more detail at the end of the report). The snapshot data is summarised visually in Appendix 3.

As outlined in the Interim Evaluation, the three case study sites differed and the data provided does suggest potential differences in mobilisation. A MSLP license enabled a site to deliver 300 participants over a 2.5 year period, although an extension to this delivery period was possible. The Essex case study site was a Sustainability and Transformation Partnership[1], it was comprised of multiple organisations, and as such had the greatest workforce at approximately 32,314 employees. LAS was the second biggest employer with approx. 5,000 staff, and SWFT was the comparatively smaller site with approximately 4,321 staff. The attrition rate for Essex was much higher than for the other two sites at 23%, compared to 12% for SWFT and 8% for LAS. The snapshot data also suggests that all sites had significant work to do to deliver the 300 participants enrolled in the programme within the 2.5 year contractual period.

The relationship between the organisational and system context appears important, as suggested by this data and revealed in qualitative data. For Essex, the complexity of working within an STP area appeared to influence the engagement and completion of participants. For the LAS site, significant operational demands during 2017 appeared to influence the engagement and completion of participants. Furthermore, a more geographically disparate workforce was a feature of both sites. In contrast SWFT was reported to be in a relatively stable period, expected operational demands.

The MSLP requires a monetary and human resource investment from participating trusts, consequently, the NHSLA and trusts are interested in quantifying the value obtained from this expenditure (ROI). One of the ways to maximise return ion the investment by trusts is to ensure optimal use of the license (in terms of cohorts and participants). Whilst the scope of this evaluation does not include investigation of attrition and completion rates, there is potential for further evaluation to understand factors influencing this specific element of implementation and return on investment.

ROI emphasises the importance of planning and mapping against quality indicators/outcome measures/improvement targets, understanding costs, benefits and

[1] https://www.england.nhs.uk/integratedcare/stps/view-stps/

whether the return is worth the investment (Phillips 2013). In the Interim Report, the findings suggested how the take up and implementation of the MSLP could be described as an 'organisational development (OD) intervention', to develop leadership at the level of individual, team and system in participating trusts. In this evaluation, we examined and report on the ways in which the sites experienced both ROI and the OD intervention.

3 Evaluation Findings: Phase 2

Findings are presented in two areas. Firstly, five impact themes are described that have emerged from the interview material collected during Phase 2, as well as evaluator observations about the different organisational cultures of the three case study sites. These impact themes are connected to evidence to substantiate the significance for individual, team and organisational performance. Following this, individual stories are presented that illuminate both the potential ROI and the process by which impact is achieved. Impact themes are; increased collaboration and partnerships, team engagement, increased reflection and reflexivity, innovation and changes in behaviours.

3.1. Impact themes

3.1.1. Theme 1: Increased collaboration and partnerships

Several of the interviewees in phase three talked about how they worked in a much more collaborative and empowering manner as a result of participating in the programme. In addition to this, increased evidence of networking and partnership working were also reported:

> *"I am networking more and that is how we are progressing so well with the functions that require cooperation and change inside (the organisation) and externally"*

As these leaders in organisations 'let go' of their own need to make decisions alone and instead work with others both within and outside of their own teams, they not only demonstrate increased transformational leadership behaviours by inspiring and engaging others but they also instigate collective leadership:

'…. a new way of sharing power, ensuring that leadership and expertise are correlated at every level in relation to every task. It also represents a strategy for integrating leadership collectively across the organisation' (West et. al., 2014, p.7).

This shared sense of leadership creates a different kind of culture that can spread not only throughout the organisation but across a whole healthcare system and can lead to improved patient safety and care (Richardson & Storr 2010).

For some of the participants of the MSLP, it appeared that they found or re-ignited an emotional connection with their peers and colleagues across the organisation:

> *"I'd pretend to listen before, but I'd already made up my mind. ...our relationship wasn't brilliant, we didn't pull together well…..So during the MSP when she said, 'how shall we do this?' – I said, 'let's have a conversation'. 'Tell me your feelings about this' … We're now much more equal and that's beneficial."*

This emotional connection links to Ballatt & Campling's (2011) notion of 'intelligent kindness': these authors state that the more attentive leaders are to the emotional dimensions of caregiving, and thereby authentically demonstrating that they value the emotional labour involved in caring for patients, the more their staff will help them to find creative ways of achieving objectives. Again, this impacts on the culture of the organisation, by creating a 'ripple effect' (Riley & Weiss, 2016).

3.1.2. Theme 2: Team engagement

All the stories presented in section 3.2 (below) involve a tangible sense of higher levels of team engagement. All participants described how their changes in cognition and resulting behaviours impacted on increased team engagement.

Research by Sharma & Bhatnagar (2017) explored teams working under time pressure and found that such teams use their social resources as a coping mechanism, developing into highly engaged teams. In such situations, leader's behaviours include emotional agility, use of humour, efficient delegation and quality of feedback. The leaders participating in this phase of the evaluation stated that they applied most of these behaviours. For example, the testimonies cited in 3.1.1 show that, as a result of team feedback, Shirley improved team communication and Julie delegated more to her team. NHS and Social Care leaders are of course under constant time pressure, as well as being short of other resources but the leaders that were interviewed for this evaluation demonstrated that the changes they made as a result of the MSLP had a positive impact on team engagement.

There is a strong evidence base for effective team working and team engagement in relation to patient satisfaction and this is something that could be measured in future in relation to the return on intervention of the MSLP. Effective team working was found to be a key predictor of patient satisfaction in the analysis of NHS staff surveys from 2014 & 2015. In the most recent analysis, Dawson (2018) found that the higher the effectiveness of team working reported by staff (in terms of the clarity of

objectives, interdependence of team members, and reflection by the team), the more satisfied patients were.

3.1.3. Theme 3: Increased reflection and reflexivity

The impact of the significant increase in reflection and reflexivity for the participants we interviewed was substantial:

> *"One thing I am definitely doing more of as a result of the programme is reflecting more – thinking more widely about things, thinking about the impact for others and how I can take that into account?"*

> *"Have I slipped back? What difference have I made?"*

> *"I now recognise the importance of leadership development, and I would have liked this early in medical career. MSLP has given me a change of perspective, a much broader perspective, and seeing how things work in other non-clinical specialties….it has improved my interactions with other colleagues because I now have more understanding of how my behaviour is received by others"*

According to Castelli's (2016) literature review on the topic of reflective practice in leadership, this involves: self-awareness, mindfulness and personal wisdom. All of these components have been found to increase leadership effectiveness and the outcomes of reflective practice lead to a more motivated workforce, renewed interest and effort and improved performance. It was clear from MSLP participants' statements that they gained new insights about themselves and others as a result of being provided with the space, time and ability to reflect during the programme. For example, as a result of their reflective practice on the programme the participants interviewed had become more aware of their need to:

- listen to others
- empower their teams and peers
- listen to feedback effectively
- allow others to make decisions and changes.

The resultant changes in these reflections and increased levels of reflexivity appeared to make a difference to confidence levels, team working and patient care.

3.1.4. Theme 4: Changes in behaviours

As a result of their reflections, increased self-awareness and reflexivity, participants interviewed reported numerous changes to their cognitions, emotional states, attitudes and subsequently changes in their behaviours: These changes included:

- Increased assertiveness
- Higher confidence levels
- Continuous and conscious reflexivity and curiosity
- Changes in communication mediums and behaviours
- Realising when and how to challenge more effectively
- Working 'smarter' and taking a less defensive, more pro-active approach
- Delegating more, 'letting go' of control and empowering others, and a sense of stepping into one's own authority

> *"I feel the o*rganisation is more encouraging about taking responsibility*"*

> *"Felt it was some things already knew, but gave it formality and credibility, linking to evidence and leadership thinking"*

Behaviour change is seen as central to NHS policy implementation and development, with potential for impact on organisational cultures and performance (CQC 2017, NHSI 2017, NILDB 2016).

3.1.5. Theme 5: Innovation

When leaders and teams practice reflexivity on a regular basis their levels of burnout diminish significantly (i.e., exhaustion, cynicism and inefficacy) (Chen et al, 2018). In addition to this, reflexivity enhances innovation and this relationship is mediated by the high degree of involvement experienced, which, in turn, motivates team members and their engagement levels (Farnese & Livi, 2016; Litchfield et al, 2017). During Phase 2 of this evaluation it was found that innovative practice became more evident, likely brought about by the increased reflexivity levels alongside increased engagement of MSLP participants. Examples include:

- The development of a Smartphone App to connect emergency and non-emergency resources together in real time across multiple sites
- Evidence based reporting measures
- New ways of working around skill mix to alleviate staffing pressures

So far the impact themes described appear as leadership and team influences that taken together can improve overall performance. The various cognitive and behavioural components were evidence in the narrative captured from MSLP participants (see Figure 3 below).

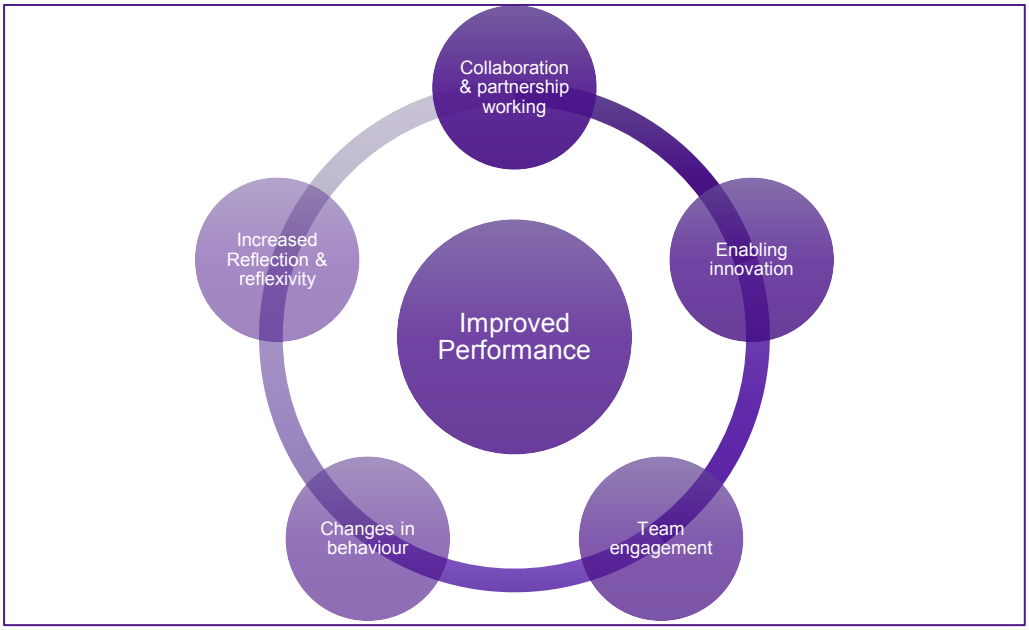

Figure 3 MSLP impact themes

3.2. Implications for organisational culture

The interim evaluation report (section 9.2, p.44) asserted that an intention of the MSLP would be to support a shift in organisational culture in the NHS through changing the practices and behaviours of a significant number of people who have some power and authority in the NHS system culture. As a reminder, Schein's (1992) model of organisational culture is presented in Figure 4 below.

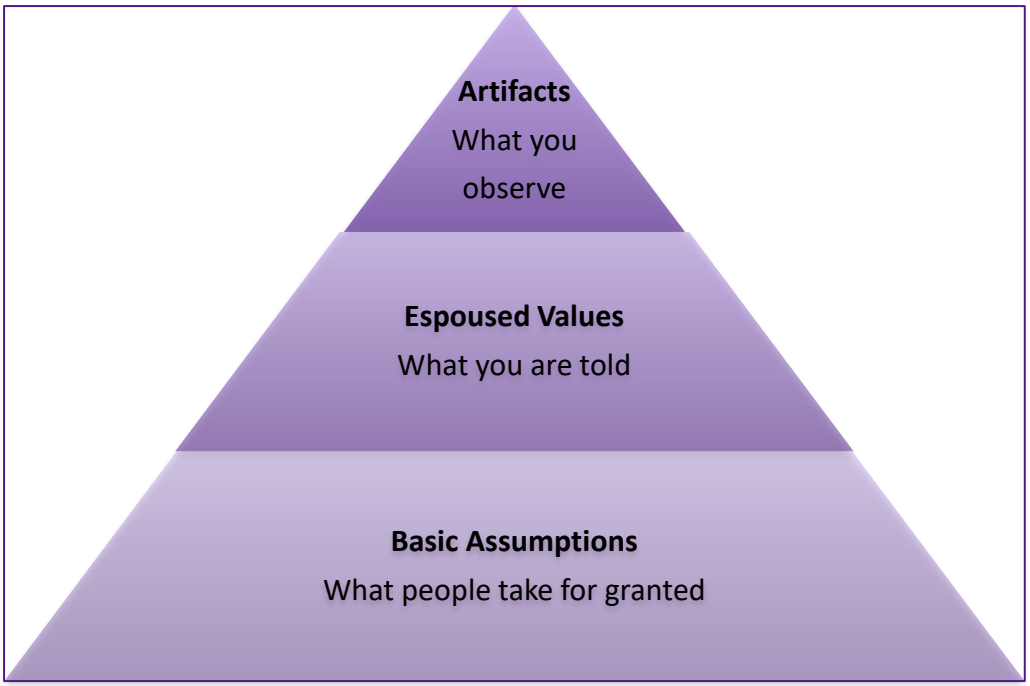

Figure 4 Schein's Triangle Model of Organisational Culture

From the interviews conducted during Phase 2, there is evidence to suggest that changes have occurred at all three levels, at least at a leadership and team level and that these changes could have a ripple effect (Riley & Weiss, 2016) across the rest of the organisation and system. For example, the creation of a Smartphone App and new styles of reporting could be considered to be artefacts; espoused values may remain the same in the leaders interviewed but the application of these values have become more visible to others they work with; and basic assumptions have changed as leaders have become more self-aware and reflective.

Also observed by the evaluators was the instigation and impact of the programme on the differing cultures and contexts of the case study sites and how the programme was and could be further 'used' to impact on culture. This became particularly noticeable as the different case study sites underwent various organizational changes and as situations arose within their geographical context. For example, the LAS had to cope with the Grenfell Tower fire and various terrorist attacks, emphasizing the challenge of creating a culture where leaders can flex their style depending on the focus: from harrowing emergency situations to the more developmental tasks of improving the efficiency and adaptability of emergency services. This was described as moving away from only a 'tell and do' command style to incorporating a more collaborative leadership approach that empowers leaders at every level to enable and engage staff to contribute to wider developments. There was mention of

"resetting the culture" and ensuring the new behaviours were articulated and woven into all development activities, with MSLP being one element.

Essex, as a multi-organisation system appeared to find cultural change more challenging: it appeared difficult for the programme to gain traction at the beginning of the licence period and the system also experienced a series of mergers during the evaluation period. Hence getting started in larger healthcare systems may be a more cumbersome process. However, the benefits for participants of learning about a wider system and how this might impact on their leadership behaviours and the system culture could be invaluable.

Senior leaders involved in the inception and roll out of the programme stated the following in the phase two interviews:

> *"And so, the delivery of the programme has been like a microcosm of system leadership…… The dynamics of different organisations wanting different things from the programme and trying to find a common way forward."*

And also:

> *"It has been difficult, at the beginning it was quite challenging, but I do feel now that …there is some benefit from doing this. One of the ethos' of the programme locally and one that we continued is that, actually, we get that enriched learning from having different…your people on the coalface having an understanding of other systems, other organisations and where they may be coming from and, yeah, just having an understanding of how the whole system works."*

Conversely, SWFT began the evaluation period as one relatively small organisation and appeared to find it easier to set up and begin the MSLP. Then, towards the end of the evaluation period the trust entered into partnership with two other organisations and began to see and use the MSLP as a vehicle for culture change across the three organisations.

Senior leadership at SWFT commented that he felt the MSLP could function as an opportunity to share and disseminate best practice with other organisations moving into a 'group hospital structure' to mitigate the potential for clash of cultures.

It would appear that size and complexity matter when setting up and implementing leadership development programmes across organisations and systems. Learning more about this in full could be the basis for a separate evaluation project and highly valuable for future roll-outs along with perhaps a wider comparison of different organisations and systems.

4 Stories of Impact

We now present four stories that exemplify the kinds of impact identified through this phase of the evaluation. Names have been changed to maintain anonymity. Each example of ROI is organised using a sequential framework.

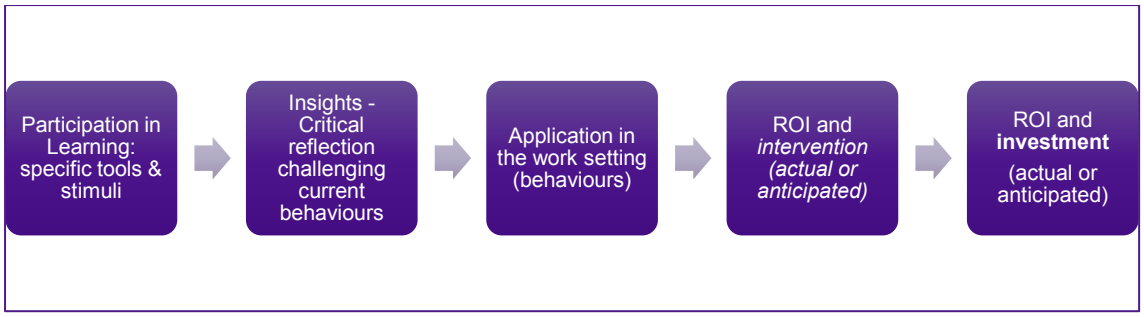

Figure 5 diagram illustrating how learning leads to impact

The theories of learning and personal change that underpin this framework are based on the literature describing the pivotal role played by the theories of Transformative Learning (Mezirow, 1997) including critical reflection (Finlay and Gough, 2008) and Planned Behaviour Change (Ajzen, 1991, 2015). In summary, the framework begins with the stimulus for learning (MSLP materials and interaction) creating the conditions for critical reflection. Based on that reflection, current assumptions and attitudes are challenged which in turn drives changes in behaviour (applications in the work setting), leading to impacts (or 'returns'). This 'chain of events' informs the framework used here to capture the stories emerging from the participant interviews.

4.1. Technological Innovation

Figure 6 illustrating programme participation to ROI

Managing a team of six operational managers, Shirley had assumed the levels of job satisfaction and engagement were reasonably good. However, via the Team Survey and the 360 Healthcare Leadership tool her assumptions were challenged:

> *"We thought we were doing well so it really shocked me when I read the feedback. The team wanted more frequent, open and two way communication" (Shirley)*

Shirley had a preference for communicating via email and had assumed that this method was the more efficient, particularly as the operational managers were based in different places. She also tended not to take the time to explain purpose or context to team members who were not sited with her:

One thing I am definitely doing more of as a result of the programme is reflecting more – thinking more widely about things, thinking about the impact for others and how I can take that into account" (Shirley)

Shirley had a strong and supportive relationship with her line manager, which meant she was able to talk through this unexpected feedback to help gain a constructive view of what to do next. The feedback was discussed with the team in a positive manner with a focus on what she was proposing to do differently. As a result, the team members have renewed enthusiasm and feel they are using their strengths and interests more effectively.

Understanding of their potential contribution to improving response times has led to innovative solutions being progressed more quickly e.g. the development of an App to connect emergency and non-emergency resources together in real time across multiple sites. In addition, Shirley has found herself changing the way she communicates more generally:

"The other thing I'm doing more of – which I don't like – I am networking more and that is how we are progressing so well with the functions that require cooperation and change inside (the organisation) and externally - in that I'm out there proactively - not happily, although it is becoming easier." *(Shirley)*

The factors that optimised the impact were:

- Shirley had a pre-existing relationship with her line manager where she felt comfortable sharing information that potentially reflected her weaknesses.

<u>Potential further actions to improve the identification of ROI</u>

The team survey could be repeated to identify any changes in satisfaction and engagement, and also emergency response times recorded as pre and post measurements.

4.2. New Reporting Mechanisms

Figure 7 illustrating programme participation to ROI

Susie described how she is beginning to work smarter as a result of reductions to her budget. During the MSLP programme she began to realize, through a process of learning from peers and self-reflection, that her line manager has challenges coming from elsewhere and that she needed to get smarter at providing her line manager with a clear business case that could be taken forward. So now she thinks:

> *"This isn't personal, whatever happens it comes down the line. I've got smarter at thinking how the challenge goes back up. We're the ones delivering the service and know what the impact is going to be. We are therefore in the best place to challenge back up and provide good, relevant information." (Susie)*

A specific example of how Susie has achieved this is via reports prepared for the CCG in relation to targets they set for joint multi-disciplinary team (MDT) meetings held in GP surgeries; these meetings include: practice managers, social care workers, community matrons, voluntary agency and charity staff, an MDT administrator and health navigators. The meetings are held monthly or bi-monthly and the attendance of these meetings are measured by the CCG who have awarded the contract. They pay Susie's organisation a small amount for this, which covers the MDT administrative role. The target is 95%

attendance and the CCG look at the data. For January to March, 76% attendance was maintained, which was a breach. Rather than react in a defensive manner, which Susie might have done before the programme, Susie now writes a detailed, evidence based breach report that explains the rationale for lower attendance rates such as winter weather, recruitment, staffing and sickness issues. Having collated this information, which also includes looking at the organizational RAG[2] system, Susie's report is then passed to her line manager and the CCG. This approach is much smarter and looks at the detailed information pertaining to the situation in more depth. Susie has also begun to look at what she needs to do as a team leader in order for her team to evidence this detail:

> *"'We look at what do we need to do, why do we need to do it and how we need to do it. Before the MSLP there would have been a constant flow of emails backwards and forwards, in the midst of which people would have got cross, peoples' emotions would have run high. Now there is a much more considered process with information that is evidence based." (Susie)*

The factors that optimised the impact were:

- Susie's levels of self-reflection and reflexivity – i.e. an evolving understanding during the programme of insights about herself but also her impact on others.

Potential further actions to improve the identification of ROI

A 360-degree feedback tool across the MDT and CCG staff could be used, pre- and post-programme, analysis of communication time, quality and content pre- and post (e.g. email analysis, time spent communicating, reporting mechanisms), and recording of attendance at MDT meetings.

[2] Red/Amber/Green coding system

4.3. Empowering others

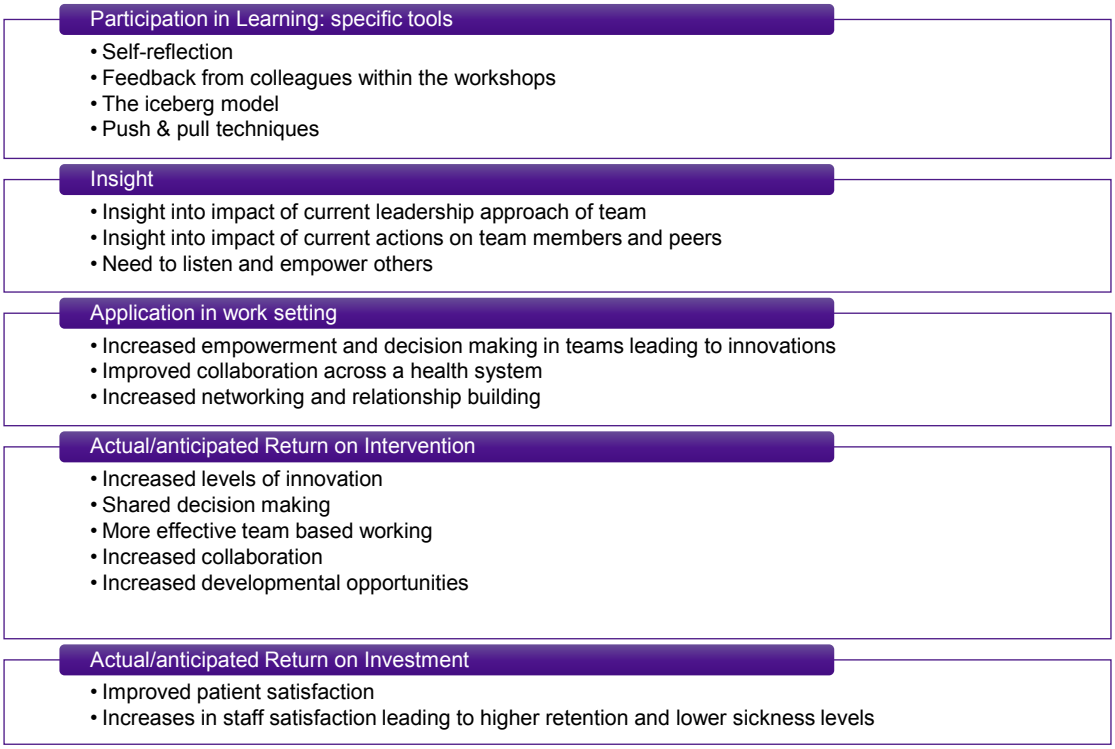

Figure 8 illustrating programme participation to ROI

Participants on the programme related stories about how their leadership behaviours changed such that they began to empower others and foster much more collaborative ways of working rather than 'telling', or acting as the sole decision maker:

> "*How I work with my line reports when they come to me with a problem, instead of saying you need to do this, this and this, I'm trying to get them to provide the answers rather than doing it for them. It's easy to think you've got to impart your knowledge. Instead, how do I support and facilitate them to come up with the answers themselves?" (Julie)*

One participant, Julie, compared this different way of partnership working with what she observed in others and as a result now constantly double checks herself, asking:

> "*Have I slipped back? What difference have I made?" (Julie)*

Julie's has significantly changed her approach to team working as a result of the programme and now actively listens to what people have to share. She has chosen to develop the team so they don't always rely on her. She described how, as a result of becoming more empowered, the team created and implemented new ways of working with the skill mix to alleviate staffing pressures and how this innovation then impacted on patient care.

Another participant, Dina, shared:

> *"The top thing I learned was curiosity, this has changed specifically. I interact and listen a lot more and realize it's not just about having your own agenda. I never really listened before, I did listen to patients but not to colleagues….it was all about control." (Dina)*

Dina said that the iceberg model really helped her with this and she explained how she used to come across as agreeing with someone but was actually quite controlling:

> *"I'd pretend to listen before, but I'd already made up my mind. It's my relationship with another team member that has changed the most…..our relationship wasn't brilliant, we didn't pull together well. In our service you have to motivate people and have to be creative in how you do that. So during the MSP when she said 'how shall we do this?' – I said 'let's have a conversation, tell me your feelings about this', and now when she comes to me I say 'what do you think we should do?' I learned the push and pull technique. She has brilliant ideas – we motivate the clinical care workforce. We're now much more equal and that's beneficial. I don't feel like I'm carrying the weight any more. She now runs an important integrated care group. That's hers now and …the impact is that those staff are now better equipped to deal with patient care. Her confidence was low but she's now actively there and role modelling. This has all come from the MSP because she's now empowered." (Dina)*

The factors that optimised the impact were:

- Self-insights; becoming more curious; learning how to actively listen and empower others; tools and techniques learned on the programme.

Potential further actions to improve the identification of ROI

Data from pre- and post- team surveys could be collected, appraisal meeting feedback about developmental opportunities that staff have been provided with Pre- and post-patient surveys.

4.4. Diversity and Broadening Perspectives

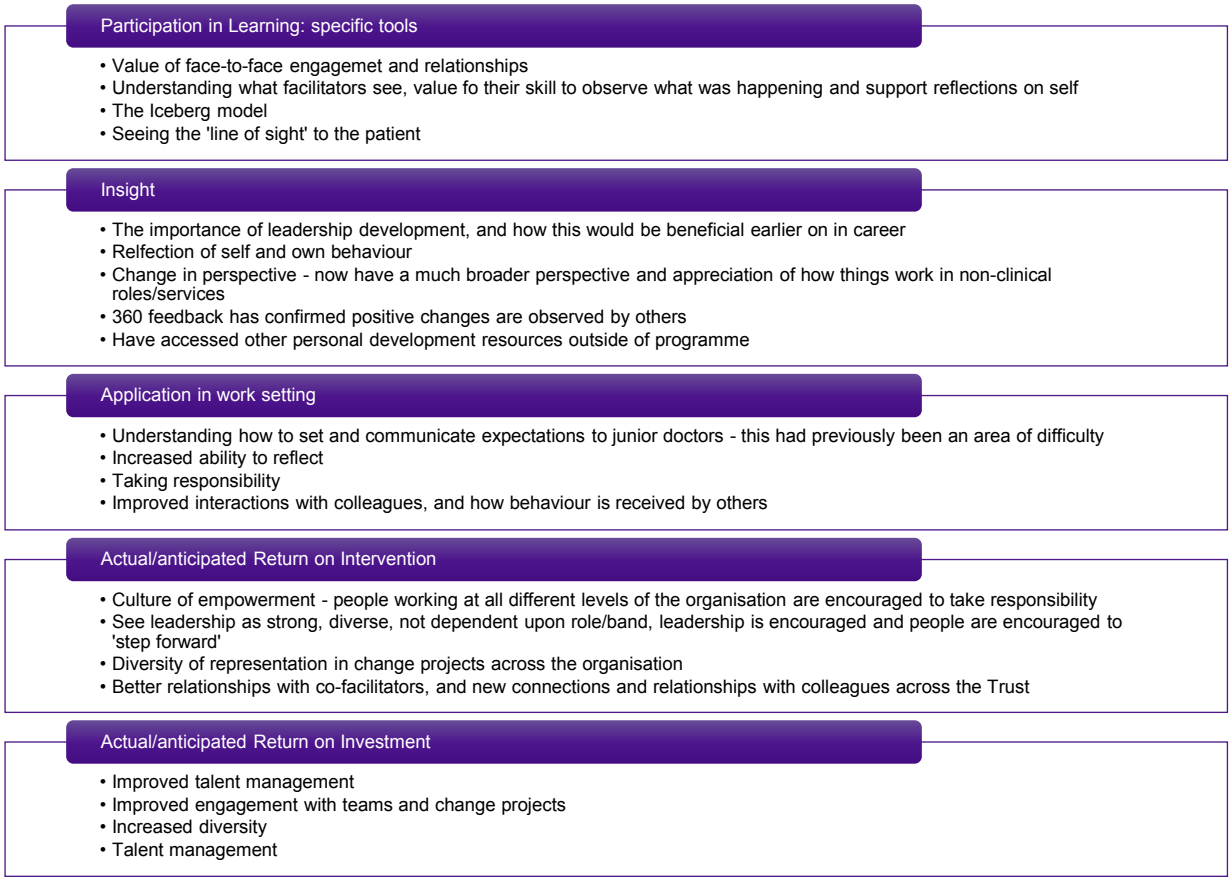

Figure 9 illustrating programme participation to ROI

There was a purposeful blend within each of the MSLP cohorts at SWFT to include clinical staff, medical staff and non-clinical staff; this has led to 'different kinds of conversations' and enabled participants to gain a wider perspective on their organisation, their role within it, and a greater understanding of their own personal impact in their role. There have also been some indications of increased empathy between participants across different types of role, as participants understand more clearly the struggles and problems of others. A diversity of

relationships and connections across the organisation also enabled wider networking, both for participants and facilitators.

A participant in a senior medical role felt that the MSLP programme had provided a completely different perspective that contrasted with much of their medical training, but which offered new insights into how to optimise working with others. The programme enabled the participant to reflect on their own behaviour, something which was not necessarily encouraged thus far in their medical career. Another participant in a non-patient facing role, described how the MSLP programme had "really opened my eyes about how the trust works". Further, the programme enabled participants in non-clinical roles to understand, appreciate and feel confident about their impact on patients; one participant commented:

> *That they had…"a line of sight to the patient. This felt really important, as being in a non-clinical role I can feel quite distanced from the patient, but there is a connection, and this helps, and it is important".*

Blending the cohorts gave the participants and facilitators at SWFT the opportunity to make connections across the Trust, broadening their perspectives on their own role, as well as that of others, and providing a greater depth of insight into the work of the trust, moving beyond their own area. Furthermore, the participants and facilitators then 'became known' to the senior management team, and as a consequence, were invited to become involved in other pieces of work, adding a greater diversity to the influencing voices on change and innovation. What was important to the participants and facilitators was that they were;

> *"recognised by the Top Team, and became known as someone who embraces this kind of work"*

The broadening of perspectives therefore operates in two dimensions: firstly, for the participants/facilitators, and secondly, for the senior management team, by getting a better understanding of 'who is out there' and facilitating them to become engaged in wider programmes of work. This talent management opportunity was an unanticipated benefit of the MSLP.

The factors that optimised the impact were involvement of a diverse range of staff, building relationships and increased understanding of one another.

Potential further actions to improve the identification of ROI

More data on talent management monitoring and reporting could be collected, improved engagement with teams and change projects, and increased diversity in participation.

5 Conclusions & Recommendations

5.1. The potential for impact

There is strong evidence of impact within each of the case study sites as a result of implementing the MSLP. In the final phase of the evaluation, we 'looked for impact' and in doing so, were able to identify supportive and enabling conditions for maximising return on the investment and intervention. As evaluators, we were struck by the congruence of the findings with larger published studies and leadership theory (included in the section 3 discussion) about impact and this should give confidence in the qualitative findings of this study. The 'how' of leadership development as an intervention is highlighted: at its best, the individual learning process matched with the organisational processes, in support of each other and ultimately, the best possible care for people using services.

The data from the second phase of the evaluation describes impact in the following areas:

- the process of learning and application through the MSLP resulted in changes in individual leadership behaviours
- increased collaboration and partnerships across organisational and role boundaries
- increased team engagement, strengthening of team relationships and increased delegation
- increased reflection and reflexivity as key to gaining leadership insight that informed applications to work based problems and issues;
- greater innovation as a result of participation in the programme;
- the potential for areas of impact to come together and support changes in organisational culture.

The capacity for impactful changes to result in a shift in culture, 'the way we do things around here' appears to have potential. In the interim report we noted that, one of the advantages of the MSLP is that the impact from participants is within and across an organisation or system. James (2011) describes how "*Leadership development 'in context' does not just mean individual leadership development adapted to a specific locale but means people from that locale coming together to learn to lead together and to address real challenges together*." (pg 1). In this sense, leadership development can function as an 'organisational intervention' permeating through leadership practice at all

levels, creating a cultural impact that can then help to embed and sustain the new type of leadership practice. This report illustrates the ways in which change as a result of leadership development happens in different organisational contexts and supports the kinds of leadership practices that are essential in today's NHS.

5.2. The role of planning, contracting and negotiation

In all evaluation stages, taking time to plan for the local programme has been key to optimising the potential from taking up the MSLP in systems. The case study design enabled the evaluation team to look closely at how contextual factors impacted on the mobilisation, implementation and impact of the MSLP. Linked to this, we suggest that the area of planning and organising is an area with the richest potential for maximising impact as a result of taking up the MSLP.

The findings of this evaluation suggest that the take up of the MSLP is more than buying leadership development 'off the peg'; trusts and sites can enter into a process of learning and improvement and it is commitment to this process that sees the optimal return on the investment. Greatest impact is possible through committing resource through the life of the license, both in practical terms and in giving space for senior leadership to regularly reflect on intentions and impact. Considering the best way to organise and co-ordinate MSLP across each organisation or system is a key opportunity to optimise impact against the cost of the licence. For example the selection and allocation of facilitators to ensure availability to the maximum number of cohorts; the involvement of line managers as informed sponsors (to positively increase expectations and support for MSLP participants to apply their learning); and the integration of organisational expectations e.g. for a specific project to be delivered by participants as a focus for MSLP.

5.3. Planning and measuring for improvement and return on investment

Whilst the evaluation findings identify impact through insight, learning and change at the levels of self, team and system, quantifying this was more difficult. We noticed a pattern of describing change qualitatively, more than seeing or measuring the return from a monetary or numerical perspective. There is rich potential to surface increased efficiencies and effectiveness through explicit mapping of individual goals to measures and to make explicit correlations with performance measures for a whole organisation intervention. Making that data available would require planning for measuring ROI being built into programme implementation locally, and within the pre-mobilisation phase. This

is illustrative of the overall challenge discussed in the literature of evaluating the impact of development interventions (Hartley & Hinksman 2003 and Hannum & Craig 2010).

In Section 3, we outlined a sequential framework or chain of events that typified the journey from learning to impact on the MSLP programme. Using this framework, there are opportunities to optimise planning for measurement of return on intervention and investment:

Participation

Consider intentions for change and what 'good leadership' looks like in the organisation and how you would like the MSLP to contribute to that. Map what you hope to gain from the programme against key indicators of performance and development. Ensure diversity in participation (particularly for people with protected characteristics) and gather data to monitor this inclusion. Ensure there are adequate support systems in place, for example, having a dedicated co-ordinator for the programme.

Insights

Creating space for participation and reflection for participants (including attendance at programme days and study time) to optimise the potential for learning and application. Encourage critical reflection in teams to share learning and at a senior level to model leadership behaviours and consider feedback 'from the ground' and alignment with direction and priorities.

Application

Planning for measurement to be incorporated in change and improvement activities carried out using tools and approaches from the programme. For example, encourage and facilitate numerical data collection on cost savings using improvement and ROI methodology. Support changes to processes so that measuring for improvement is worked through and made possible. Create opportunities for learning to be shared across the system.

5.4. Investing in relationships and engagement

Much of what we heard from case study sites across the evaluation pertained to the importance of relationships across the systems. A recommendation from the interim report is to use early conversations between the NHSLA and sites to understand the

local context (nature of pressures, opportunities and barriers) and how this might impact on implementation. The findings in the second phase support this recommendation as an early opportunity to optimise potential for impact and alignment with organisational priorities and leadership direction.

The important role of senior leaders in optimising impact from the programme is highlighted. In this study, where there was stability of leadership in case study sites, impact was optimised: through alignment with culture of senior leaders and openness to a collective approach that encourages individuals to take up their authority in-role.

Today's NHS has a highly diverse staff and patient population and involvement created opportunities for the broadening of perspectives as a result of the process of learning and application within the organisations. That investment in engagement rippled across the organisation through reflexive and team applications, resulting in change and innovation.

5.5. Recommendations

- Senior leadership clarity in Trusts (both at the start and ongoing) on what 'good leadership culture' looks like locally, identifying the key values, behaviours and experiences (from staff and customer perspectives) and how they are measured. and how implementing MSLP aligns with strategic plans.
- NHS LA in the contracting stage to signpost ways in which return on investment and intervention could be measured.
- Individual sites could facilitate the integration of ROI measures into planned change activities completed during participation in MSLP.
- Leaders at sites to ensure ongoing commitment to and resourcing of the programme through; dedicated co-ordination, involvement of a diverse range of staff, release of staff for development activities and recognition of success.
- Different packages of support from the NHS LA might serve to sensitise both parties to the specific needs of their context, underline what is involved in implementation of MSLP locally and optimise return on the intervention and investment.

5.6 Potential Avenues of Further Enquiry

The role of context: it is noted that one of the features of MSLP is its focussed delivery in an organisation or system; this is in contrast to a national offer for other

NHSLA programmes. The license to develop 300 participants within a 2.5year time period, and within a specific system may lead to a specific Return on Investment that could be quantified further. However, a note first on context. Bate (2014) discusses the role of context from a quality improvement perspective. He discusses the tendency to refer to context as a concrete, objective phenomena (i.e. a more positivist stance) which can be described using specific contextual factors. However, context can also be conceptualised as a process (therefore reflecting a more constructionist approach), and may be described more appropriate by an evaluator as seeking to understand the 'contextualising process'. Why does this matter, and how is this relevant to MSLP? It may be that the different license sites offer an opportunity to understand the contextualising process in a deeper way, through enquiry using a longitudinal approach, capturing data on patterns and relationships. (Bate advocates this as an improvement on the current descriptive methods of understanding context.) The 'Account Manager' approach now employed by the NHSLA to deliver the MSLP, and the recommendations from the Interim report, to establish relationships through the 'contracting cycle' could lend itself to a better, deeper understanding of the context. Further insights could be gained into what creates receptive conditions for a leadership development programme, such as MSLP; this would all serve to secure and optimise the ROI for license sites, by beginning to connect work on leadership with broader cultural change.

Optimising participation: monitoring the engagement, uptake and completion of the programme to maximise the investment made is of benefit to each site. There is scope to better understand the interactions between mobilisation, implementation and context and how higher rates of participation and completion can be achieved to gain maximum benefits of the license, linking into measures for ROI.

Understanding difference, diversity and inclusion: there is some evaluation evidence gathered which has demonstrated a 'broadening of perspectives', relating to appreciating difference in roles (clinical, administrative and managerial) and across different sectors and services. However, perhaps of note is any data about individual diversity, such as gender, sexuality, race and culture. There are notable gaps in the representativeness of NHS workforces, which is particularly apparent in management and leadership positions (Kline, 2014). The diversity gap may then perpetuate prevailing attitudes and inhibit diversity, difference and inclusion. Further lines of enquiry could specifically track diversity through the pre-mobilisation and contracting phases, to consider any impact on inclusion and diversity, again, optimising the ROI through creating a positive and diverse culture which leads to better quality care (Nath, 2016).

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Appendix 1 - Detailed Biographies of Evaluation Team

Jackie Kilbane, Lecturer in Leadership MA, MA (Econ), BA (Hons), RN (LD)

Jackie leads the evaluation team from Alliance Manchester Business School. She brings a wealth of experience in designing and delivering local and national leadership and organisational development programmes in the NHS and Third Sector. Her work has included systems improvement in NHS 'turnaround' organisations and most recently Jackie led the design and delivery of a training and development programme for Integrated Care in Manchester. This experience is complemented by Masters level qualifications in Applied Research Methods and a passion for creating meaningful change with individuals and groups. Jackie is a Cohort Director of both the Elizabeth Garrett Anderson and Nye Bevan NHS leadership development programmes, where she leads on tutor development for both group facilitation and equality and diversity.

Karen Shawhan, **Associate Lecturer, MSc (Health Psychology), MA (Health Service Management), PGCert Education, BA (Hons) Psychology, RGN.**

Karen is a lead evaluator, having collected data at the South Warwickshire case study site, and is also project manager for the team. She has significant experience in NHS management, consultancy, project management, evaluation skills, and teaching and development, including being a tutor on the EGA Programme, and was part of the evaluation team from Alliance MBS for the Intersect Leadership Programme Evaluation. Karen was also a tutor on the original Mary Seacole Programme working with the Open University. Karen's recent projects include: leading the Evaluation Team for the Leaders in GM Leadership Programme, developing the primary care workforce and education strategy and implementation for Manchester Health and Social Care, and mapping of Organisational Development capacity and capability, and engagement needs across Manchester. Karen also has significant experience of working with senior teams in developing solutions to 'wicked' problems within the NHS, and has worked with NHS providers, social care, independent providers and third sector providers.

Sue Jones, **Associate Lecturer, MSc Occupational Psychology (Distinction); MPH (Public Health); PGD (Clinical Communication); BA (Hons) Psychology; Currently studying for a PhD in Organisational Health & Wellbeing, University of Lancaster.**

Sue has collected the data for this interim report at the London Ambulance site and is a lead evaluator in the team. She is an organisational psychologist with a particular interest &

experience in the design, delivery and evaluation of complex organisational interventions across health and social care. This has included a national evaluation looking at the effectiveness of integrated working (DoH/SSI) and more recently the evaluation of a new preventative role with primary care (with AgeUK). In addition, Sue has delivered a range of leadership development interventions across both the commercial (e.g., Deutsche Bank) and public sectors (e.g. as an EGA tutor). She is currently delivering an action learning intervention focused on developing high quality, performance focused conversations between line managers and staff members across a large NHS Trust & evaluating learning transfer. Originally working as a speech and language therapist Sue completed the NHS general management training scheme and subsequently worked in an extensive range of leadership positions, including a number of executive Board member posts.

Dr Penny Cortvriend, **Associate Lecturer, PhD Organisational Psychology, MSc Organisational Psychology, BSc (Hons) Psychology**

Penny is a lead evaluator in the team and has conducted the data collection process at the Essex case study site. She is a chartered organisational psychologist with a particular interest and wide ranging experience in leadership development. Penny conducted a process evaluation of the Darzi Review and an evaluation in local government of the impact of leadership development coaching on performance. She also has significant experience of conducting qualitative, case study research both in her PhD and in a large-scale research project in the NHS exploring the links between HRM and performance. Penny was recently a tutor on the Elizabeth Garrett Anderson (EGA) programme and is currently working with the Health Service Leadership Academy in Ireland as they roll out the Leading Care II programme.

Appendix 2 – Case Study Site Overviews

Case Study Site – South Warwickshire NHS Foundation Trust (SWFT)			
STP AREA - Warwickshire			
SIZE	**FOCUS**	**CQC RESULTS**	**NHS STAFF SURVEY RESULTS (2016)**
Covering population of 536,000. There are 441 inpatient beds within Warwick Hospital and 50 inpatient beds throughout the community hospitals. 4,321 members of staff	An integrated organisation that provides acute, rehabilitation and maternity services for the people of South Warwickshire and community services for the whole of Warwickshire, and School Nursing Services in Coventry. The Trust is comprised of five divisions; Elective Care, Emergency Care, Out of Hospital Care Collaborative, Women's and Children's and Support Services.	March 2017 - Overall: Requires Improvement • Safe - Requires improvement • Effective - Requires improvement • Caring - Good • Responsive - Good • Well-led - Requires improvement Identified Issues • Medicine storage and security • Patient records and risk assessments • Staff understanding of mental capacity and duty of candour • Some governance weaknesses • Lack of oversight for babies, children and young people across the Trust • No strategy for end of life care • Safeguarding training	Higher than average scores for: • Organisation and management interest in and action on health and wellbeing • Staff satisfaction with resourcing and support • Percentage of staff feeling unwell due to work related stress in the last 12 months • Recognition and value of staff by managers and the organisation • Staff motivation at work Worse than average negative score for: • Percentage of staff / colleagues reporting most recent experience of harassment, • bullying or abuse • Percentage of staff experiencing physical violence from patients, relatives or the • public in last 12 months • Percentage of staff working extra hours • Percentage of staff / colleagues reporting most recent experience of violence • Percentage of staff experiencing harassment, bullying or abuse from patients, • relatives or the public in last 12 months

Case Study Site – London Ambulance Services			
STP AREA - London			
SIZE	**FOCUS**	**CQC RESULTS**	**NHS STAFF SURVEY RESULTS (2016)**
Population: 8 million over 620 sq. miles; from Heathrow in the west to Upminster in the east, and from Enfield in the north to Purley in the south Staff: About 5,000 across 70 ambulance stations & 5 HQ bases	Emergency and urgent care (EUC) service. 999 calls, which are received and managed by the emergency operations centre (EOC). Resilience and hazardous area response teams (HART). Key role in the national arrangements for emergency preparedness, resilience and response, (EPRR), There are two LAS Hazardous Area Response Team (HART), based in Hounslow & Tower Hamlets. Patient transport services (PTS)	Nov 2015 Overall: Requires Improvement • Safe - Requires improvement • Effective - Good • Caring - Outstanding • Responsive - Good • Well-led - Requires improvement Identified Issues • Incident reporting • Learning from incidents • Mandatory training & tracking • Infection prevention& control • Quality of ambulances • Staff engagement • Rostering flexibility • Bullying & harassment – linked to variable leadership in local stations	Higher than average scores for: • Staff satisfied with opportunities for flexible working patterns • Staff reporting good communication between Senior Managers and staff • Staff believing that the organisation provides equal opportunities for career progression • Fair and effectiveness of procedures for reporting errors, near misses and incidents • Support from immediate managers Worse than average negative score for: • Staff agreeing that their role makes a difference to patients/service users • Staff/colleagues reporting most recent experience of harassment, bullying and abuse • Staff experiencing discrimination at work in the last 12 months • Staff satisfaction with the quality of work & care they are able to deliver • Staff satisfaction with level of responsibility & involvement

Case Study Site - Essex					
NAME	**STP AREA**	**SIZE***	**FOCUS**	**CQC RESULTS**	**NHS STAFF SURVEY RESULTS****
Basildon & Thurrock NHS University Hospital Foundation Trust	Mid & South Essex Success Regime/STP	Population: 405,000 Staff: 4,500 Patients: 480,500 Budget: 288m	Acute healthcare X-ray and blood testing facilities Dermatology Tertiary cardiothoracic services	Overall - GOOD • Safe Good • Effective Good • Caring Good • Responsive Good • Well-led Good Identified Issues Mandatory training rates Updated equipment competency training Reduce the delayed discharges over four hours from the critical care unit to the main wards Reduce the number of transfers out of hours between 10pm and 7am (July 2016)	Higher than average score for; • Staff reporting errors, near misses or incidents witnessed in the last month • Staff motivation at work • The quality of non-mandatory training, learning or development They have a worse than average score for; • Staff feeling unwell due to work related stress in the last 12 months • Staff believing that the organisation provides equal opportunities for career progression or promotion • Staff experiencing physical violence from patients, relatives or the public in last 12 months
Mid Essex Hospital Services NHS Trust	Mid & South Essex Success Regime/STP	Population: 350,000 Staff: 5,000	Acute & community services A & E Elective & non-elective surgery	Overall - GOOD • Safe Requires improvement • Effective Good • Caring Good • Responsive Good	Better than average score for; • Staff able to contribute towards improvements at work • Fairness and effectiveness of procedures for reporting errors, near misses and incidents • Staff reporting errors, near misses

		Patients: 416,630 Turnover: 315m	Maternity services Paediatric services Plastics, head & neck, GI services Burns services	• Well-led Good Identified Issues Secure records in orthopaedics Clear prescribing of paracetamol Staff appraisals Mandatory Training rates Rapid discharge re end of life patients (December 2016)	or incidents witnessed in the last month Worse than average score for; • Staff appraised in last 12 months • Effective use of patient / service user feedback • Staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
Southend Hospital University NHS Foundation Trust	Mid & South Essex Success Regime/STP	Population: 351,614 Staff: 5,000 Patients: 746,931 Income: 300m	Acute medical and surgical specialities General medicine General surgery Orthopaedics Ear, nose & throat Ophthalmology Cancer treatments	Overall – REQUIRES IMPROVEMENT • Safe Requires improvement • Effective Good • Caring Good • Responsive Requires improvement • Well-led Requires improvement Identified Issues Medical care Services for children and young people End of life care	Better than average score for; • Staff experiencing physical violence form staff in the last 12 months • Staff/Colleagues reporting most recent experience of violence • Staff experiencing physical violence from patients, relatives or the public in the last 12 months Worse than average score for; • Staff motivation at work • Staff satisfaction with the quality of work and care they are able to deliver • Staff recommendation of the organisation as a place to work for receive treatment

			Renal dialysis Obstetrics Children's services	Outpatients (May 2017)	
East of England Ambulance Service Trust	Mid & South Essex Success Regime/STP	Population: 5.8m Staff: 4,000 Patients: 1.14m emergency calls 531,614 non-emergency journeys Income: 247m	A & E services Non-emergency patient transport	Overall – REQUIRES IMPROVEMENT • Safe Requires improvement • Effective Requires improvement • Caring Outstanding • Responsive Requires improvement • Well-led Requires improvement Identified Issues Improve performance for emergency calls Staffing Appropriately mentored staff Mandatory training Consistent incident reporting Safeguard training Medicines management Cleaned and maintained vehicles	higher than average score for; • Staff attending work in the last 3 months despite feeling unwell • The quality of non-mandatory training, learning or development • Staff witnessing potentially harmful errors, near misses or incidents in last month worse than average score for; • Staff appraised in last 12 months • Staff agreeing that their role makes a difference to patients / service users • Staff believing that the organisation provides equal opportunities for career progression or promotion

				Mental Capacity Act 2005 awareness Duty of Candour awareness Secure records storage on vehicles. (August 2016)	
Colchester Hospital University NHS Foundation Trust	Suffolk & North East Essex STP	Population: 370,000 Staff: 4,314 Patients: 611,262 Income: 301.6m	Wide range of acute, in patient and outpatient services including surgery, maternity, physiotherapy	Overall - INADEQUATE • Safe Inadequate • Effective Inadequate • Caring Requires improvement • Responsive Inadequate • Well-led Inadequate Identified Issues Safeguarding Information recording completion of DNACPR forms Mental Capacity Act Training Availability of Syringe drivers Emergency department care & treatment Emergency department streaming (July 2016)	better than average score for; • Staff experiencing physical violence from staff in last 12 months • Staff motivation at work • Effective use of patient / service user feedback worse than average score for; • Staff / colleagues reporting most recent experience of violence • Staff / colleagues reporting most recent experience of harassment, • Bullying or abuse

Essex Partnership University Trust	Mid & South Essex Success Regime/STP	Population: 2.5m Staff: 7,000 Patients: Not available Income: not available	Community, mental health and learning disability services	Not available yet (organisations merged 2017)	Not available yet
The Princess Alexandra Hospital NHS Trust	West Essex STP	Population: 350,000 Staff: 2,500 Patients: Not available Income: 209m	General acute A & E ICU/NICU Maternity	Overall - INADEQUATE • Safe Inadequate • Effective Requires improvement • Caring Good • Responsive Inadequate • Well-led Inadequate Identified Issues Risk Management Ward to board Escalation Safeguarding children's processes Appraisals Mandatory Training	higher than average score for; • Staff experiencing physical violence from patients, relatives or the public in last 12 months • The quality of appraisals • Staff experiencing physical violence from staff in last 12 months worse than average negative score for; • Staff satisfaction with resourcing and support • Staff appraised in last 12 months • Staff agreeing that their role makes a difference to patients / service users

				Mental Capacity Act 2015 Training Cleaning of public areas Mortuary Refurbishment (October 2016)	

- Size is based on information presented on organisational websites November 2017; patient numbers are patients seen during previous year and budget/turnover is 2016 budget.
- ** Top three highest and worst scores

Appendix 3 – Cohort Statistics

The following graphs illustrate the engagement across each site, for each of the cohorts, at a point in time.

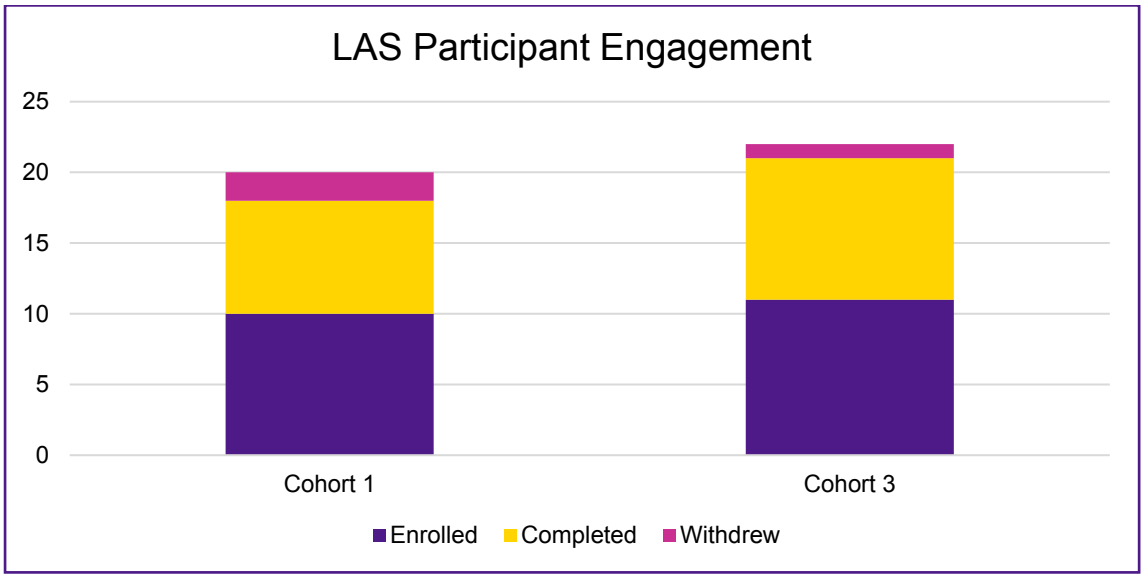

Figure 10 graph showing the number of participants engaged with the programme in LAS, in two of the three cohorts (note Cohort 2 data was unavailable at the time of writing)

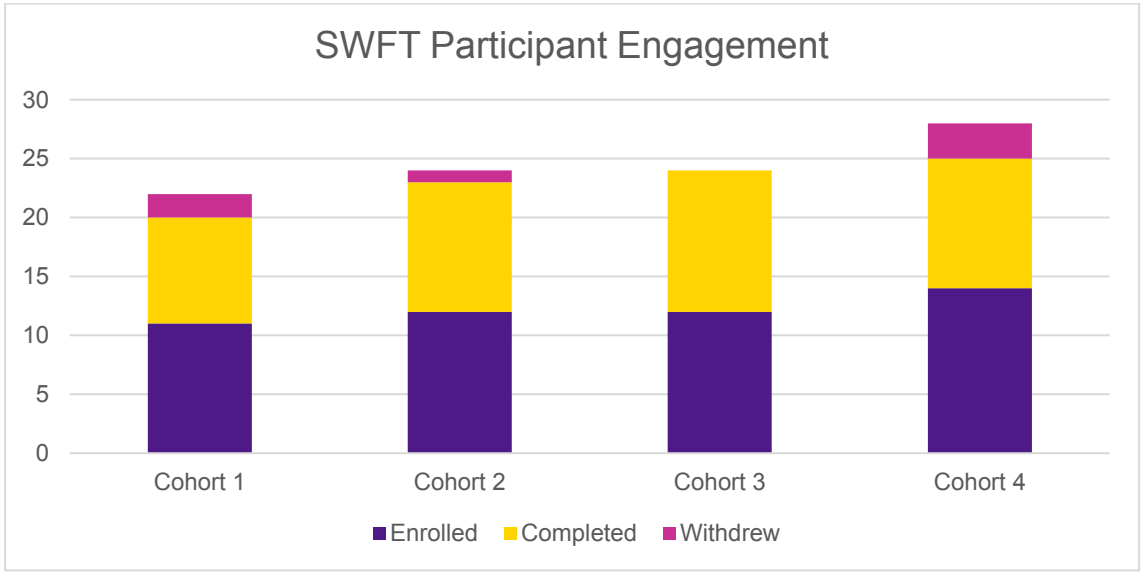

Figure 11 graph showing the number of participants engaged with the programme in SWFT, across four cohorts

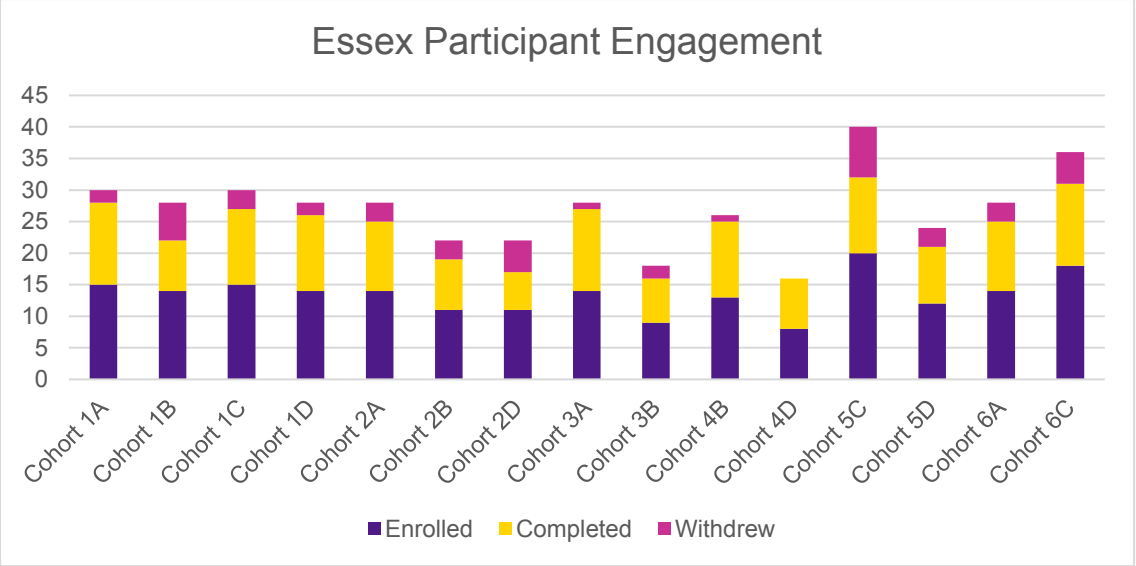

Figure 12 graph showing the number of participants engaged with the programme in Essex, across 15 cohorts

Monitoring the engagement, uptake and completion of the programme to maximise the investment made is likely to be important for each site. Presented below is an analysis of the participants who engaged and completed the programme as a proportion of the overall workforce that interestingly shows there was potentially a more concentrated effect in SWFT than in other sites. It is possible that SWFT achieved a 'critical mass' which might be necessary to optimise Return on Investment (ROI).

Table 1 showing proportion of staff who enrolled on and completed the programme in each of the three sites

	LAS	Essex	SWFT
Proportion of staff through programme (enrolled)	0.74%	0.63%	1.13%
Proportion of staff through programme (completed)	0.36%	0.48%	1.00%
Proportion of staff who (through the license) can access the programme	6.00%	0.93%	7%