The Nye Bevan Programme

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Final Full Evaluation Report   
for the NHS Leadership Academy

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Executive Summary

The evaluation

The Nye Bevan Programme is the NHS Leadership Academy’s intensive, one-year development intervention aimed mainly at people who hope to be in executive teams or equivalent roles within the next one to two years. It requires high levels of commitment and a willingness to hold peers to account and be receptive to challenge, albeit within the relatively safe confines of a learning set, thus removing participants from their ‘comfort zone’. The Programme has a focus on staff engagement for patient care, with service users at its heart.

The external evaluation of the Nye Bevan Programme was carried out by the Institute for Employment studies on behalf of the NHS Leadership Academy. The evaluation team based the evaluation approach on a stakeholder map, starting at the centre with the Programme participant, and rippling outwards through other stakeholders: colleagues, patients and service users, the organisation, and the wider health and social care system. The evaluation team put particular emphasis on participant’s impact on and beyond their organisation, as a key aim of the Nye Bevan Programme is for its graduates to make a substantial difference for the better via a new style of leadership.

The Nye Bevan Programme

The NHS Leadership Academy launched the Nye Bevan Programme in October 2013 together with three other leadership development programmes, all developed in response to a need for culture change within the NHS to be affected from the top level. The programmes aim to produce a new senior leadership cadre (clinical and non-clinical) with the necessary skills to lead the desired culture change at regional, national and organisational levels.

A collaboration of national and international health care experts – including, importantly, the representation of the patient voice – designed, and continues to deliver, the Nye Bevan Programme:



The Programme runs for 12 months. It is an annual programme with one intake a year however, this was expanded to include a spring and autumn intake in 2016 and is based in the Leeds NHS Leadership Academy and online. There are 18 face-to-face days, including four residential workshops, with participants also dedicating additional time to studying; it is a requirement that participants provide evidence of applying learning in their workplace. Each cohort of 49 is formed into seven learning sets, facilitated by a dedicated learning set adviser. There are seven learning set meetings and three assessment points.

The eight Programme learning outcomes focus on effective leadership skills, diversity and inclusion, and engagement with patients and staff in line with the NHS Constitution. Throughout the evaluation, stakeholders (the design and delivery team, Programme participants, learning set advisers, and staff and patients in participants’ organisations) were asked about the extent to which the Programme is meeting these learning outcomes.

Programme experiences

The evaluation team conducted in-depth interviews with 40 Programme participants; these included those who had successfully completed, those who were part-way through, and a small number who had failed or withdrawn.

Many of the 40 had actively selected the Nye Bevan Programme to develop their career and their leadership skills; others had been encouraged to apply, usually by someone in their organisation. At the outset, many were open-minded about exactly what to expect from the Programme, although most were clear about what they wanted: to develop self-awareness, extend their networks, gain new knowledge and skills, advance their careers, or develop within their current role.

When describing their **journey** through the Programme, participants on the whole spoke positively – although it was clear that many had experienced lows and highs, and found some aspects both unexpected and challenging. As one participant commented, *“It is unlike anything I have done before – really quite unique”.* Some participants clearly loved the Programme and described themselves as fans, others struggled but persevered, while a few realised it was not quite for them. The first residential made a big impression on many participants, and took some of them well beyond their comfort zone – partly because they were not expecting to meet patients right at the start of the residential, and partly because they found the self-selection into learning sets daunting.

**High points** related to interactions with others, such as opportunities to develop deep relationships within the learning sets and to network more broadly. The learning set processes were also highly valued, as were the simulations. More broadly, the space, time and opportunity to think, reflect and discuss issues in ways that are not normally available in the workplace were valued.

**Low points** mostly revolved around two issues. The first issue was around assessment and challenging their peers in the set, handling failure and providing support; the second was the time and effort required to complete the Programme, especially the assessments, especially as there was a perceived lack of flexibility around attendance and deadlines.

When asked about the **most valuable learning**, responses were grouped into:

* intra-personal learning: increased self-awareness, enhanced awareness of self in relation to others, increased self-confidence, resilience, drive, questioning of assumptions, and thinking differently
* inter-personal effectiveness: understanding personal impact and extending the sphere of influence via new approaches and techniques
* enhanced system awareness
* greater understanding of leadership
* the learning processes themselves, notably reflection which some had integrated into their work lives.

Most of the words used by participants to describe the Programme were positive, sometimes extremely so. The positive words and phrases are illustrated in this word cloud:



The role of Set Advisers

The learning set experience was very important to participants. The evaluation team interviewed a sample of six set advisers to explore their perceptions of the Programme; between them, these set advisers had facilitated twenty learning sets as part of eight different cohorts.

The set advisers were all enthusiastic about the Programme, and its impact:

“It is a brilliant programme … Some of the people who come out of it at the end, I feel WOW I am really glad they are going to be leaders in the health service … they have become people you can really trust to make a difference.”

Advisers identified a design tension, in that the Programme combines two approaches – self-managed learning and competency development/assessment – and set advisers seemed to identify themselves philosophically more with one approach or the other. Almost all of the advisers had experienced changes in the design and delivery of the Programme since it started, and their views of these changes depended on their approach. In general, those with a preference for a structured competency approach regarded changes perceived as clarifying the requirement and assessment component as positive, whilst those with a preference for a ‘pure’ unstructured self-managed learning approach perceived the same changes as negative.

* The increase in learning set meetings from six to seven, with each meeting having a specific defined purpose, was seen by all as beneficial and helpful to participants.
* The addition of diversity, inclusion and power as one of the objectives on which participants had to be marked was also welcomed by all, as this aspect was considered insufficiently emphasised during the early cohorts (although it is worth noting here that some of the design and delivery partners expressed an opinion during their interviews that diversity was, though a welcome addition, too narrowly defined).
* Increased clarity was introduced about different aspects of the Programme, including recruitment criteria and assessments; opinions were divided about these, depending on the adviser’s overall approach.

The learning sets were considered to work well, in three ways: as a forum for effective information exchange and networking; as a microcosm of how people are in their relationships; and as a group setting which mirrors the workings of a board (especially as each set contains a mixture of professions and of clinical and non-clinical roles). Another aspect of the Programme considered to work well was the self-managed learning element, because it pushed participants towards self-reliance and helped them come to terms with ambiguity.

Suggestions for improvement were:

* Greater clarity about overall purpose of the Programme, as some advisers were encountering participants arriving with little idea what to expect (although it might be argued by Programme designers that the element of surprise is a key aspect).
* Review the viva experience, as currently this was too inconsistent.
* Improve communication: between the Programme leads, set advisers, participants and participants’ organisations.

Most set advisers identified the same two learning objectives which they felt the Programme is particularly strong at delivering: ‘A critical awareness of your personal approach to leadership’, and ‘Your ability to work constructively within a team’.

Set advisers were keen to describe the individual transformations they witness over time. One commented,

“I see changes in orientation and mind-set” while another said, “There is a powerful ripple-out effect. I see individuals being more action-orientated, doing more listening and less talking, and being more cognisant of the emotional temperatures of colleagues. From set meetings I hear about this resulting in wider engagement, more productivity and better conversations with patients. The impact comes from them being different.”

Set advisers also believed that the Programme was having a wider impact on the health system, in two main ways. Firstly, it was contributing to succession planning within the NHS by “*delivering* *individuals who can move into a different space”.* Secondly, it was delivering high quality leaders who champion the patient voice.

Assessment of the Learning Outcomes

The evaluation team asked participants to provide examples of how they personally were demonstrating achievement of the eight learning objectives. Most participants were able to produce examples for most of the objectives, although they sometimes had issues with them – for example, feeling that they already demonstrated a particular objective, or that it was too challenging to evidence, or that it was too early to say as they were only part-way through. It was rare for participants to take issue or disagree with any of the learning objectives, although some pointed out that they could be difficult to evidence and sometimes needed to be broken down.

* **Your ability to lead with confidence and take courageous decisions and actions that make the aspirations of the NHS Constitution a reality.** Participants spoke of more consciously including the Constitution in their leadership style and decisions, for example   
  *“Although I had read the Constitution before, the course made me re-look at it and this changed me as a leader. Nye Bevan encouraged me to consider how I will take courageous decisions. When I went back to the workplace I revisited one section of the Constitution as part of all my team meetings and as a team we explored how we can make it come to life in practice.”*Several participants focused on courageous decision-making as their key ‘takeaway’, for example in dealing with a difficult situation, or showing resilience in the face of complex and long-term activity.
* **Your ability to create the right conditions for frontline staff, irrespective of their background, to deliver good quality, patient-centred, co-ordinated and cost-effective care.** Here, participants spoke of being encouraged to think about how they came across to their teams, and take action such as to seek feedback from their direct reports or colleagues; examples were also given of participants engaging more actively with staff to improve their workplace conditions, ask their opinions about services, and encourage them in their development.
* **System leadership; as an enabler of change within the wider health economy.** This objective inspired several participants to behave differently and instigate change programmes – often, things that they would never have done without the Programme. Some participants also spoke about engaging with the wider health economy through networking with external stakeholders, or even taking on new roles outside their immediate organisation. This objective seems to have made people really think about the positioning of their roles, as they had previously considered themselves as operating solely within the boundaries of their organisation.
* **Readiness to operate successfully at executive (or national equivalent) level, as part of the board team.** This objective seemed to be one of the more challenging for participants, possibly because this objective focuses on personal ambition whereas others are more outward-focused:   
  *“My set adviser said I hadn’t exhibited that enough but it is very difficult to show that you are ready.”*   
  However, some were very confident that they were now ready and were taking active steps to apply for promotion or to position themselves within their organisation as appropriate candidates:   
  *“Nye Bevan gave me the confidence to step up to the interim MD role and apply for the MD post.”*
* **Your ability to engage with patients, service users, carers and families of all backgrounds, and use this perspective to foster person-centred care in a complex environment.** This objective was easy for interviewees to discuss as the learning and relevance were so clear, and they were comfortable giving examples – although some felt their clinical roles meant that they had relatively little to learn. Participants spoke of listening better to patients and carers, involving them in decisions about services, consulting them about changes to service and even, in some instances, making them part of the change process. Participants in behind-the-scenes or corporate roles had taken big steps to involve themselves and their teams with frontline services to gain familiarity with the issues and provide a clear line of sight.
* **Your attainment of a solid foundation of knowledge and networks that will support you in your leadership now and into the future.** The majority of participants spoke far more about networks than about knowledge, and were particularly keen to stress the importance of their learning set and their wish to remain in touch with other set members in the future:   
  *“The biggest part of this was the learning set. I have always had good nursing and community links but I got most from the friendships of the learning set and we are still meeting, which is testament to the Programme output.”*Some participants also gave examples of networks they had joined or in some cases set up within or outside their organisation, or said they were now playing a much more active role in external networks. When they did mention knowledge (sometimes after prompting), they tended to speak about particular tools or techniques or models, or publications, or approaches that they had found very useful.
* **A critical awareness of your personal approach to leadership, your biases, blind spots and attitude to diversity, and how you will continue to develop your leadership after the Programme.** Participants were enthusiastic about this aspect, which they felt the Programme had delivered very well; they spoke about the Programme encouraging them to reflect more about themselves:   
  *“I was strong on this already but Nye Bevan has shifted me from ‘unconsciously competent’ to ‘consciously competent.’” “This is the most direct hit – the Programme is very strong on challenging us on how we are, how we perceive things and how others perceive us.”*
* **Your ability to work constructively within a team, offering and receiving feedback, support and challenge to improve individual and team performance.** Participants spoke of thinking much more deeply about their teams and their colleagues:   
  *“I always thought I was aware and I think on a superficial level I was but I didn’t have the insight to understand the interactions in the wider team. I can now tease out the way they are interacting and help colleagues understand what is going on, which I would never have thought to do before.”*In addition, several people said that their view of what constituted a ‘team’ had broadened, and they were now looking more critically at interactions at different levels within and across organisations.

Making an Impact on the Wider System

The Nye Bevan Programme is unusual in the particular emphasis it places on the impact of leaders on the wider health and social care system. The nine case studies provided specific examples of the ways in which participants made an impact, both within and outside their organisations. The areas of impact seem to cluster in four key areas:

* **Applying new skills and perspectives to enable participants to work more confidently across the system***:* One of the key benefits reported about the Programme was the broadening of horizons through bringing together people from all parts of the NHS – for example, commissioners and providers, clinical and non-clinical staff, and people from different types of trusts as well as social care professionals and some non NHS staff working for organisations providing care directly into the NHS The case study participants gained an understanding of the importance of leaders influencing across boundaries, and beyond the limits of their positional authority. Much of their work was values-driven and patient-centred, leading to high staff engagement.
* **New approaches and meaning given to patient-centeredness:** Non-clinical interviewees had been the most impressed by patient involvement in the first residential, but some clinicians also discovered through their feedback that although they were *patient-facing* they were not always *patient-centred*. Participants found many different ways to make their practice more patient-centred through embedding values, moving to genuine co-production with service users, and recognising patients as experts in their own conditions. Although it was considered easier for those in patient-facing roles, others made opportunities to shadow people on the front line and to make explicit the links between their own roles and patient outcomes and experience, prioritising indicators of direct relevance to patients.
* **Enhancing the general quality of leadership:** The case studies provide very positive stories about leadership development. For some this had led to promotion, but in several cases there were flat structures, or simply limited turnover in senior posts, and participants instead found opportunities to lead on new projects or cross-system roles. Several reported improved standing and higher visibility with their boards, and had a greater appreciation of board activities and responsibilities, enabling them to contribute more effectively. In two of the case studies, however, senior leaders expressed concern that other Nye Bevan graduates had not been able to find promotions and felt disillusioned. Where this was the case, senior level support in finding opportunities to use new talents was vital.
* **Increased confidence to push the boundaries, through firstly innovation and secondly stepping up to take on new challenges:** A key impact from the Programme is demonstrated where case study participants have gained the confidence and inspiration to drive new pieces of work or develop ideas through their teams. In several cases, Nye Bevan was an incubator in which participants could try out new ideas and experiment with new skills within their learning sets before implementing them ‘for real’; this enabled them to gain a more systemic perspective.

The nine case study participants represent some of the Nye Bevan Programme’s many ‘success stories’. However, their critical perspective led them to offer some observations about the Programme that, in their opinion, needed to be tackled. Firstly, they did not like being told, by the NHS Leadership Academy, that they were the ‘crème de la crème’: they found this uncomfortable and thought it might lead to unrealistic expectations. Secondly, they experienced too much of an emphasis on ‘failure’ rather than constructive challenge, and were concerned that some people could be ‘absolutely destroyed’. One case study participant argued strongly that better guidance on how to deliver very difficult feedback would have been helpful. Finally, there were some issues with the expectation of the NHS Leadership Academy that they should quickly gain a director role; in many cases these roles were not available locally, and in others people did not aspire to those roles but wanted to learn how to be a good leader. They were disturbed that promotion appeared to be *the* key indicator of success.

The Nye Bevan participants were busy people with demanding jobs, requiring them to constantly re-balance their priorities during the intensive Programme. Analysis of the nine case study participants has enabled the evaluation team to identify the factors that led to successful completion of the Programme:

1. Personal resilience and determination
2. Willingness and receptivity to new learning
3. Realistic expectations
4. Support from the learning sets
5. An understanding of role variety
6. Organisational support
7. Support from teams and immediate colleagues.

Conclusions and recommendations

The Nye Bevan Programme aims to have features that set it apart from the many leadership programmes that exist within and outside the NHS: the creation of a new style of leader, which, as it gains critical mass, will have a major impact on how the NHS does things; impact, in terms of better services, more satisfied patients, and more engaged staff; and wider impact on the health and social care system. The evaluation evidence confirms that, to date, the Nye Bevan Programme is making considerable inroads into achieving these objectives. The majority of participants interviewed by the evaluation team spoke very positively about the Programme, felt their leadership style and practice had benefited considerably, and were able to evidence their success. Even those who had failed or withdrawn mostly felt they had gained some positive benefits.

The following **recommendations** are made in the belief that they will strengthen the Programme and help the NHS Leadership Academy to achieve its aspiration with regard to leadership across health and social care. These recommendations are based on those issues arising from the evaluation that were raised on several occasions by interviewees in different stakeholder groups.

1. Provide more clarity to prospective applicants about what to expect, and ensure they understand the factors that need to be in place for them to succeed.
2. Liaise better with the sponsoring/supporting organisations, to enhance their understanding of the Programme and enable them to provide good opportunities for Programme participants to put their learning into practice.
3. Ensure the Programme is geared to people in national organisations as well as those in trusts (especially as some people in national roles have huge potential to spread their influence widely across the system). Although a briefing along these lines already exists, it does not seem to be consistently understood and applied.
4. Assess the (possibly erroneous) perceptions that there is an emphasis on failure, by providing better guidance to participants on how to assess success or failure and how to convey it, together with a better briefing to set advisers. The issue appears to relate to the interpretation of the objective of encouraging participants to hold each other to account, rather than the moderation process.
5. Give better support to those who withdraw and fail, and try to gain a better understanding of the aspects of the Programme that brought about their withdrawal or failure – this is considered further in the recommendations, in that several interviewees who had withdrawn or failed told the evaluation team that they still valued their learning on the Programme and had been able to put it into place.
6. Consider the presentation of ‘diversity’ beyond ethnic diversity, to embrace other aspects such as age, gender, disability, nationality, responsibility for dependants, background and personality.
7. Track success and impact over time:a key aspect of the Nye Bevan Programme is the development of leaders who will make a major difference as the NHS goes forward. However, it is currently hard for the NHS Leadership Academy to assess how well they are doing. A more systematic approach to keeping in touch with graduates should pay dividends, as it would enable the NHS Leadership Academy to track what people are doing, what moves (if any) they have made, and – most importantly of all – how they are continuing to implement their learning to make a difference.

# The Evaluation

## Background

This external evaluation of the Nye Bevan Programme has been carried out by the Institute for Employment Studies (IES) on behalf of the NHS Leadership Academy. IES is an independent, not-for-profit research and consultancy institute with expertise in both HR management and development, and employment policy. The Nye Bevan Programme is the NHS Leadership Academy’s intensive, one-year development intervention aimed mainly at aspiring executive directors – people who hope to be in executive teams or equivalent roles within the next one to two years. It requires high levels of commitment and a willingness to engage in self-managed learning and reflection; participants must practise, but also be receptive to, peer review. It contains challenging and deliberately disruptive elements, which are designed to remove participants from their ‘comfort zone’. The Programme has a focus on staff engagement for patient care, with service users at its heart.

Any leadership programme will have a personal impact on those taking part; they will learn new things, meet new people, tackle assignments, and gain insights into themselves and their management style. The Nye Bevan Programme, however, attempts to do far more than this. Participants are required to produce evidence to demonstrate not only their increased knowledge and self-awareness, but also the wider impact they are making:

* On their immediate colleagues
* On frontline staff in their organisation
* On patients and service users
* On the wider health system.

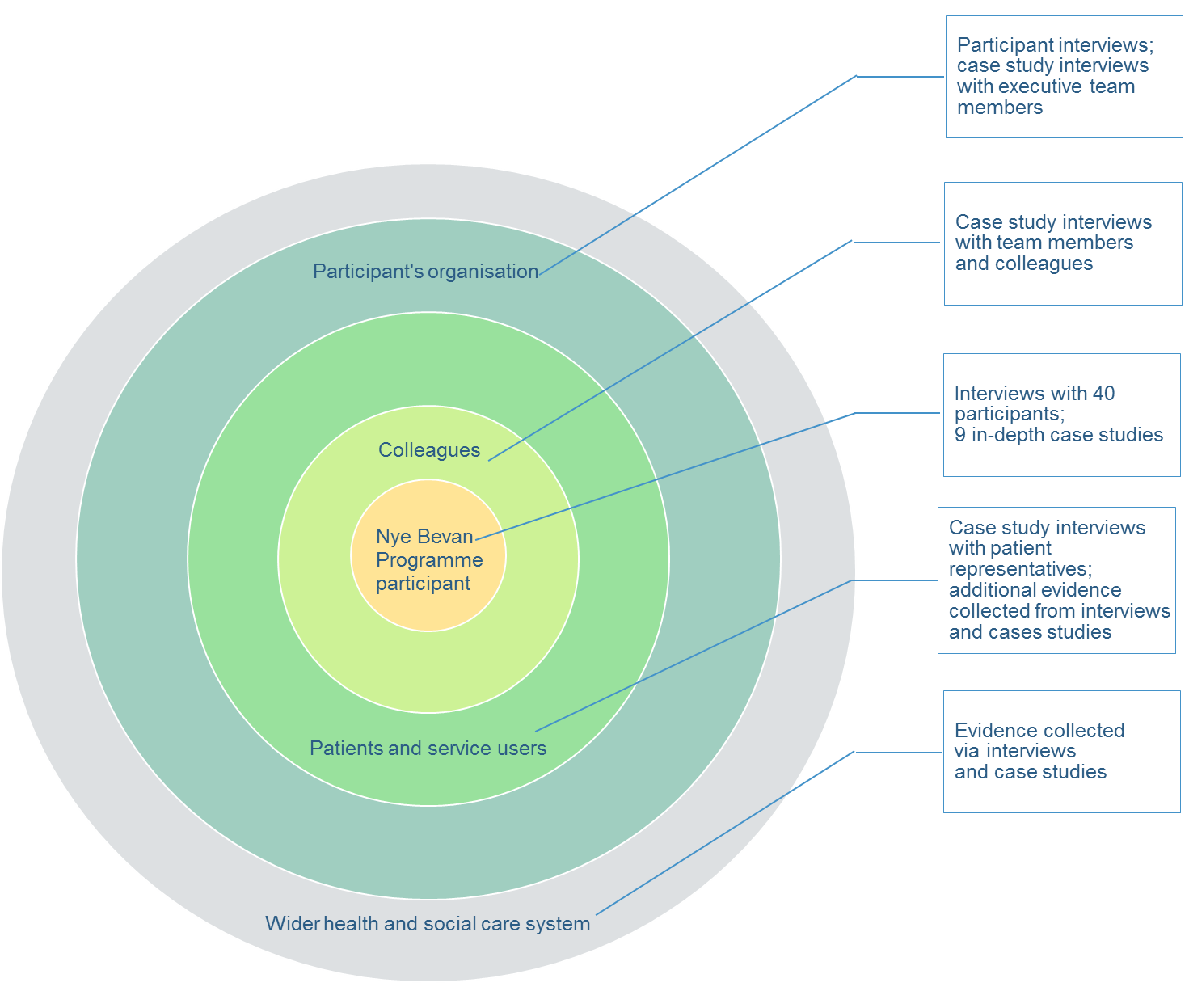
## Evaluation approach

The evaluation began at the end of 2014 and continued throughout 2015 and the early part of 2016. It has involved a range of activities:

* Stakeholder interviews with eight of those responsible for the design and delivery of the Programme
* Interviews with 40 Programme participants at various stages of participation or completion, including some who failed or withdrew before completion
* An analysis of internal evaluation material
* Interviews with nine Local Delivery Partners
* Interviews with six learning set advisers
* In-depth case studies of nine participants, focusing on wider impact.

The conceptual model underlying the evaluation is captured in diagrammatic form at Figure 1. The evaluation team used a stakeholder map, starting at the centre with the individual Nye Bevan Programme participant, and rippling outwards through the other stakeholders: colleagues, patients and service users, the organisation, and the wider health and social care system. The aim of the evaluation was to identify changes in the individual (behavioural and attitudinal), and assess how these changes impacted on other stakeholders, in terms of the changed relationships, different approaches, and actions taken that can be attributed in whole or part to the Programme.

Figure : The ripple effect: assessing impact via a stakeholder map



## This report

This document is the final full report of the evaluation findings. Previously, the evaluation team has produced an interim report (in June 2015) and a summary final report (in February 2016).

* The interim report provided: an overview of the findings from internal evaluations; a review of participation data to highlight where participants come from and how this varies by geography and organisational characteristics; a summary of discussions with Local Delivery Partners; and a flavour of the findings of the interviews in two main areas, namely the degree to which Programme participants felt the eight learning outcomes were met, and a summary of participants’ views regarding the main impact of the Programme on them.
* The summary report focused on positive responses to the Programme, and success stories. The impact analysis carried out for the summary report looked for examples of wider impact (on the participant’s organisation and health system), as this emphasis on wider impact is one of the things that sets the Nye Bevan Programme apart from other leadership development programmes.

The rest of this report comprises:

Chapter 2: The Nye Bevan Programme

Chapter 3: How Participants Experienced the Programme

Chapter 4: The Role of Set Advisers

Chapter 5: Assessment of the Learning Outcomes

Chapter 6: Making an Impact on the Wider System

Chapter 7: Conclusions and Recommendations

Appendix: Case Studies

Chapter summary

The Nye Bevan Programme is the NHS Leadership Academy’s intensive, one-year development intervention aimed mainly at people who hope to be in executive teams or equivalent roles within the next one to two years. It requires high levels of commitment and a willingness to hold peers to account and be receptive to challenge, albeit within the relatively safe confines of a learning set, thus removing participants from their ‘comfort zone’. The Programme has a focus on staff engagement for patient care, with service users at its heart.

The external evaluation of the Nye Bevan Programme was carried out by the Institute for Employment studies on behalf of the NHS Leadership Academy. The evaluation team based the evaluation approach on a stakeholder map, starting at the centre with the Programme participant, and rippling outwards through other stakeholders: colleagues, patients and service users, the organisation, and the wider health and social care system. The evaluation team put particular emphasis on participant’s impact on and beyond their organisation, as a key aim of the Nye Bevan Programme is for its graduates to make a substantial difference for the better via a new style of leadership.

# Nye Bevan octagon.pngThe Nye Bevan Programme



## Development

The Nye Bevan Programme was launched in October 2013 by the NHS Leadership Academy together with three other leadership development programmes: Edward Jenner, Mary Seacole and Elizabeth Garrett Anderson. Each programme is named after a historical healthcare leader who made a significant contribution to the health service. The four leadership programmes were developed in response to a need for culture change within the NHS to be affected from the top level, with the objective of creating high-performing and continuously-improving healthcare organisations. The programmes therefore aim to professionalise leadership across the NHS in order to produce a new senior leadership cadre with the necessary skills to lead the desired culture change at regional, national and organisational levels.

### Why ‘Nye Bevan’?

Aneurin or ‘Nye’ Bevan was the Minister for Health in Clement Atlee’s post-World War II government, a role in which he notably spearheaded the establishment of the National Health Service in Britain. Nye Bevan (see figure 2) was passionate, sometimes outspoken in his beliefs, and not afraid of making himself unpopular; the combination of his force of will, his ability to influence and inspire others and his vision of the ‘big picture’ of the NHS enabled him to bring his plans to fruition. In a similar way, the Nye Bevan Programme aims to produce leaders who are not afraid to adopt new and innovative approaches, take a different approach, challenge themselves and others with regard to changing the established way of doing things, and occasionally take unpopular and difficult decisions.

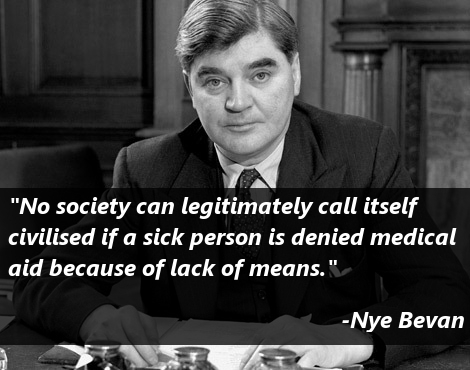
Figure : The man himself

We know what happens to people who stay in the middle of the road. They get run down.

Aneurin Bevan (1897 to 1960), quoted in the Observer, 6 December 1953

He is one of the few people I would sit still and listen to.

Winston Churchill



The Nye Bevan Programme has been developed in collaboration with national and international experts in health and organisational performance to help prepare current NHS leaders into executive roles; the logos of the design and delivery partners are shown at the start of this chapter. In addition to this, the Programme gives participants an opportunity to view leadership from the perspective of private sector organisations, such as FirstGroup, BT and Microsoft.

The Nye Bevan Programme, like the other three leadership programmes, was designed with the NHS Constitution and its principles of equality of access, professionalism and patient-centric care at its heart. One of the partners is National Voices, a coalition of health and social care charities, which seeks to ensure that the voices of patients, service users, carers and families remain in focus.

## The Programme

The Nye Bevan Programme is aimed especially at those seeking to apply for board level roles in the near future, and those generally interested in a challenging programme of professional development. It is aimed at individuals in both clinical and non-clinical healthcare roles who aspire to lead large and complex projects, departments, services or systems of care. Applicants are required to have a degree qualification, an equivalent professional qualification or more than three years’ relevant experience leading teams or services; and the ability to demonstrate a commitment to making a fundamental difference to the quality of care in their respective organisations and in the healthcare system as a whole.

There are eight learning outcomes in the Programme that focus on effective leadership skills, diversity and inclusion, and engagement with patients and staff in line with the NHS Constitution. In addition, participants set two personal learning goals. Staff and patients are present throughout the Programme, sitting on the viva panels to give feedback on each participant’s credibility to operate as a director. Moreover, the Programme is based on the principles of reflexive awareness, self-managed learning and peer assessment. Participants are required to take responsibility and accountability for their own learning and to assess and be assessed by their peers in learning sets. They submit evidence to each other, therefore holding their peers to account for their impact as leaders, and making pass or fail decisions on each other’s work.

### Structure and assessment

The Programme does not result in an academic qualification; it is an applied executive leadership programme that leads to a post-masters executive leadership award. To pass the Nye Bevan Programme and to achieve the ‘NHS Leadership Academy Award in Executive Healthcare Leadership’, participants have to demonstrate their readiness to make the principles of the NHS Constitution a reality for patients, carers and staff; and that they are ready to lead in a system and take action that actively promotes equality.

The fee-paying Programme runs for over 12 months with two intakes per year; spring and autumn. It is based in the Leeds NHS Leadership Academy and is also online. It consists of 18 face-to-face days over the period of 12 months (including four residential workshops) but it also requires participants to dedicate time outside the residential activity and to apply learning in the workplace. Participants are divided into cohorts of 49 individuals, and each cohort is additionally formed into seven learning sets, each facilitated by a dedicated learning set adviser. There are seven whole day learning set meetings and three assessment points during the Programme.

### Learning outcomes

The eight key learning outcomes for participants of the Programme are designed to create a senior leadership cadre with the skills to lead culture change at regional, national and organisational level:

1. The ability to lead with confidence and take courageous decisions and actions that make the aspirations of the NHS Constitution a reality.
2. The ability to create the right conditions for frontline staff, irrespective of their background, to deliver good quality, patient-centred, co-ordinated and cost-effective care.
3. The development of system leadership; as an enabler of change within the wider health economy.
4. Readiness to operate successfully at executive (or national equivalent) level, as part of the board team.
5. The ability to engage with patients, service users, carers and families of all backgrounds, and use this perspective to foster person-centred care in a complex environment.
6. The attainment of a solid foundation of knowledge and networks that will support participants in their leadership now and into the future.
7. A critical awareness of participants’ personal approach to leadership, their biases, blind spots and attitude to diversity, and how they will continue to develop their leadership after the Programme.
8. The ability to work constructively within a team, offering and receiving feedback, support and challenge to improve individual and team performance.

Underpinning and running throughout all eight learning outcomes is a commitment to diversity and inclusion, recognising that the only way of delivering the right care to everyone who needs it is to understand and, where necessary, challenge existing power imbalances and to tailor support to people’s individual circumstances and situations.

quotation_marks[1] ***If there’s a ‘golden thread’ that runs through the Programme and the impact of the work it asks you to do, then it’s cultivating more effective staff engagement in service of ever-better patient care, experience and outcomes. Staff and patients (carers and service users) are present at the start and throughout the Programme – indeed, they will sit on your viva panels to give you feedback on your credibility to operate as an executive director.*** C:\Users\DR\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\8OOBXDUQ\quotation_marks[1].png

NHS Leadership Academy

Chapter summary

The NHS Leadership Academy launched the Nye Bevan Programme in October 2013 together with three other leadership development programmes, all developed in response to a need for culture change within the NHS to be affected from the top level. The programmes aim to produce a new senior leadership cadre (clinical and non-clinical) with the necessary skills to lead the desired culture change at regional, national and organisational levels.

A collaboration of national and international health care experts – including, importantly, the representation of the patient voice – designed, and continues to deliver, the Nye Bevan Programme:



The Programme runs for 12 months with two intakes per year, and is based in the Leeds NHS Leadership Academy and online. There are 18 face-to-face days, including four residential workshops, with participants also dedicating additional time to studying; it is a requirement that participants provide evidence of applying learning in their workplace. Each cohort of 49 is formed into seven learning sets, facilitated by a dedicated learning set adviser. There are seven learning set meetings and three assessment points.

The eight Programme learning outcomes focus on effective leadership skills, diversity and inclusion, and engagement with patients and staff in line with the NHS Constitution. Throughout the evaluation, stakeholders (the design and delivery team, Programme participants, learning set advisers, and staff and patients in participants’ organisations) were asked about the extent to which the Programme is meeting these learning outcomes.

# Programme Experiences

This chapter draws on the interviews with 40 Nye Bevan participants, and focuses on participants’ experiences as they applied and progressed through the Programme.

## Programme participation

### What motivated people to apply?

The evaluation team found motivations for applying to the programme clustered into three broad groups. In the first and largest group, the initiative came from the participant who actively selected the Nye Bevan Programme, either for career development reasons (the majority), or for more general leadership development. A second group was recommended to apply by managers, development professionals or their Board. Some applications were more opportunistic in nature, with a less clear rationale given.

Table .1: Motivations to apply for the Programme

|  |  |  |  |
| --- | --- | --- | --- |
| Initiator | Reason | No. | Examples |
| Participant | The participant actively chose it and saw it as relevant for their (career or leadership) development | 24 | “[I was] keen to plan for a Director level post and the Programme is applicable to where I am in my career”  “I finished my formal education with an MBA and was looking for something to develop my leadership practice”  “I was interested in taking a national leadership role”  “I saw the flyer and thought it was an opportunity to develop myself towards a more senior role” |
| Other | The participant was recommended by others to apply (e.g. line manager, mentor, Human Resources (HR), Learning and Development (L&D), Board) | 12 | “My mentor… recommended me to apply”  “The HR Director [and] the Board felt it was… appropriate for me to do it and I felt quite touched”  “It was only my manager who told people about it, no-one else did” |
| Unclear | A more opportunistic application | 4 | “It was not a considered decision. I could have done with some advice”  “I thought it would benefit my career but not a lot of thought went into it”  “An email flew around the organisation… I thought it might be fun: useful for the Trust, clients and me” |

### Hopes and expectations prior to the Programme

Many people arrived with few expectations (11 mentions), either because they had little information about what to expect, or because they were open-minded about the Programme. When participants articulated clearer expectations, many talked about wanting to develop self-awareness (10), or more extensive networks (9). There were expectations for new knowledge (7) and skills (6). Some were looking for career advancement (6) and others were focused on development within their current role (5). A few were seeking an experiential approach to learning (3), while others expected a structured programme (2). Table 3.2 summarises the hopes and expectations mentioned at interview, illustrated with some examples.

Some people commented on where the Programme departed from their prior expectations. Generally, this mismatch related to the personal development work:

“I didn’t expect there to be so much on yourself and for it to be so experiential”

“I was aware Nye Bevan Programme focused on me as an individual leader and there’s been more of this than expected – but it’s a good thing”

“It’s completely introspective, we’re having to unpick ourselves and rebuild ourselves”

One person commented on the written assessments:

“I did not expect to do any written submissions, and certainly not do them over and over again”.

Table .2: Hopes and expectations

| Hopes and expectations | No. mentions | Examples |
| --- | --- | --- |
| Few expectations | 11 | “I was just excited and my expectations were limited”  “I hoped it would be interesting and enjoyable”  “I had no expectations of it, I just wanted some NHS development”  “I didn’t know what I didn’t know. If I had would I have done it?”  “I didn’t know anyone who’d done it before”  “I had no idea what to expect”  “It was quite nebulous in the information given”  “I had no expectations. There are no set agendas”  “I arrived without massive expectations” |
| Developing self-awareness / self-managed learning | 10 | “To be personally stretched”  “I did have deficits in management style… I wanted to assess different approaches”  “Better self-understanding as a leader”  “How to function differently”  “[I] wanted to understand my leadership style and have the capacity to adapt it to different situations”  “I wanted to explore myself more deeply as a leader”  “I wanted a safe place to look at my own skills [and] benchmark myself against a cohort”  “I wanted something that would take me out of my comfort zone and let me take some risks in terms of learning”  “To have more inner reflection on what drove me” |
| Networking | 9 | “My biggest expectation was to network outside my locality”  “Meeting others and developing a peer network… across the whole country”  “The relationships were important”  “I thought it would be multi-disciplinary and national… that is what appealed to me”  “You can get siloed and parochial. I wanted to be pushed”  “Speak to people from across the country as they were no other opportunity for me to do that [in current role]”  “Wanted a peer group outside the Trust who you could discuss confidential issues with”  “I hoped it would help me increase my network… at Director level” |
| Gaining additional knowledge/theory/ insight/tools | 7 | “[I] expected a high calibre of inputs from the faculty”  “Opportunity to gain cutting edge knowledge and skills to enhance my leadership – in terms of my toolkit, personal style and leadership qualities”  “I wanted a detailed knowledge of the NHS, particularly of things outside my immediate sphere”  “To work with professionals and the best in the business to get leadership input” |
| Developing (leadership) skills | 6 | Handling being overstretched  Managing change  Managing conflict  “To get more out of the team I manage”  “I wanted to be one of the people doing it [leadership] well”  “More political nous… with less personal angst” |
| Career advancement | 6 | “The course was badged as the gateway to Exec Boards so that in order to have credibility and be able to take [the] next step up you needed the Programme”  “To gain that extra edge to become a director”  “I wanted something to clarify for me whether to go for a Medical Director role”  “I hoped it would… prepare me for a Board level post”  “I wanted to take the next step” |
| Better performance/confidence in current role | 5 | “I need more confidence in what I am doing”  “To be as good as possible” |
| Experiential learning | 3 | “The opportunity to test out some ideas and initiatives”  “Support and challenge”  “Information gathering and sharing about how to tackle the difficult challenges we face” |
| Structured programme (structured residentials, portfolio, assessment) | 2 |  |

### How the Programme met participant expectations

Participants were asked how the Programme met their expectations and delivered what they hoped. While we did not ask them to rate the Programme, we found people responding in this way, so we were able to cluster the responses into different groups (see Table 3.3). Of those who responded, 25 (76%) said that it met or exceeded their expectations, six suggested it partially met expectations (18%), as some were met and some not. It did not meet expectations for one participant and one was unclear.

Table .3: Meeting expectations

|  |  |  |
| --- | --- | --- |
| Hopes  and expectations | No. mentions | Examples |
| Exceeded expectations | 7 | “Any expectations that I had have been exceeded – the overall quality was outstanding”  “I wanted to be inspired and feel that this was a brilliant course that would inspire me to be a better leader”  “More than!”  “Yes, it surpassed my expectations”  “My satisfaction was higher than expected – at every stage I was challenged, I was learning and I was supported in my learning” |
| Met expectations | 18 | “Yes… there’s a variety of learning materials which keeps it engaging”  “Definitely met expectations”  “I got so much from it”  “Absolutely. I’m a Nye Bevan Programme fan and really enjoyed the experience”  “It’s been very challenging and personally rewarding – a stretch”  “I think it has”  “Yes. It’s fairly tough”  “Yes, but not in the way I expected”  “Yes and it came at a perfect time for me. It was a really important part of my induction into that new role”  “So far yes. And my expectations are also changing as a result of the Programme” |
| Partially met expectations (some met,  some not) | 6 | “It was a missed opportunity although some elements were valuable”  “The bulk is delivered through the learning set and the 6 colleagues will be a network… [but] I am unlikely to build much more of a relationship with other people in the cohort”  “It has and it hasn’t. The residentials have been very good… [but] I didn’t want to get into essay writing”  “Yes to the patient side… [but] I felt quite sad – I’d achieved so much and no one knew or cared I passed”  “I expected more on how the NHS works… I learned a lot through conversations with peers on the Programme”  “To some extent... I’ll probably see the benefits over time” |
| Did not meet expectations | 1 | “Content poor. Behaviour and attitudes of lecturers, facilitators and some participants was poor” |
| Unclear | 1 | “I didn’t go in with clear expectations” |

## Programme experiences: personal

### Participant journeys

Everyone has their own journey through the Programme. One participant commented:

“It is unlike anything I have done before – really quite unique… but it’s a bit like marmite, you love or hate it”

Some participants clearly got lots from it, while others suggested it was not quite for them. Either way, first impressions counted. People’s experiences at the beginning set the tone and experiences at the end stayed with them. Some vignettes are offered below as illustration.

I got lots from it…

“I remember hearing from someone a couple of days before the first residential that it was more experiential and I wasn’t sure I wanted to go. But it was really fantastic. I was worried about the learning set and the simulation sessions, but I loved them. They were the best parts of the Programme for me. I’m a mental health nurse by background, so there were elements from that that made it OK and enjoyable”.

“Very positive. I like working independently at home. I’m enjoying the online learning between the modules. I’m getting a lot out of creating a development plan and collecting evidence. I’m now seeing everything I do as a learning opportunity”.

“I started with no expectations and had never worked in learning sets, but got loads out of it. I had worked in quite a narrow field before so it enabled me to see different kinds of people, I liked having to deliver on personal and learning outcomes, you were pushed and challenged not to hide away and to do things you wouldn’t have done before”.

It wasn’t for me…

“I am broadly disappointed. I don’t feel I will come away having learned anything. It is a touchy feely approach which isn’t me naturally. A colleague of mine did it previously – she loved it but came from a mental health background”.

“It was painful… Even registering was hard – when I was given a log-in they had already assigned that to someone else so I couldn’t register. I had to have quite a lot of dialogue to resolve that. When it came to diagnostics, they booked it and you couldn’t change it. When I came to speak to the person about the results, the diagnostics hadn’t been sent to them”.

“I found it extremely frustrating... the course and the focus of the delivery staff was totally geared towards getting onto the executive Board. I, and my fellow participants from… national organisations, wanted something a bit different. We don’t necessarily want to be on a Board, but need to be able to negotiate and influence at that level; I give advice and guidance to Chief Executives… I stayed the course because of a really good set adviser and another [participant]… a couple of colleagues… pulled out. Nye Bevan is too rigid and narrow-minded for people from national organisations”.

It’s up and down…

“It’s gone from positive to very frustrated to positive. Partly it’s where I’ve been mentally, the Programme expects you to put time aside but we don’t have time… Part of my frustration is understanding that I can’t do this in a rush and you need to give yourself time…. I understand where I am now and the changes I need to make. But I don’t understand where this is taking us and everyone is at different stages”.

The beginning was valuable…

“The first residential was an extraordinary experience, highly anxiety-producing, which was resolved partially but not fully. It shook everyone up in a good way, and a very unexpected way”.

“I wasn’t sure what to expect from the first week – it is a long time to spend away. There was a good balance between high level leadership topics and the process of sharing and forming learning sets. Most found that quite challenging”.

“The first residential though was a real eye opener – it got people interacting and thinking in a way that I hadn’t seen people being challenged before. Day one people got hit with the diversity session that got them thinking about things in a way they hadn’t before. Forming groups was really interesting and there was a lot of discussion around it as well. Telling life story in small groups was really emotional. By Wednesday we were emotionally exhausted. I felt I am extremely glad I am here - it was terrific in so many ways”.

“The first week was very enjoyable although odd because it kicked off with meeting with patients and patient stories. That wasn’t new to me as a clinician but obviously made a big impression on those who didn’t meet patients. That was interesting for me, to see the impact on them”.

“The first day was fabulous – the introduction to patients – it knocked you off your feet!”

“The first module was exhausting but excellent. It was very searching personally. Going in to meet patients straight away was very sound. The emphasis on the Constitution was sound as well to remind us why we are in the NHS. It chimed with my values. I liked the session on gender, race and getting a richer group of managers if we paid attention to diversity. It reinforced my values although I didn’t learn anything new, I felt I was in the right place”

The beginning was a shock…

“Turned up in Leeds on day 1 with a suitcase and was thrown together with 49 people in a room – all strangers. It was scary and I wondered what I was letting myself in for and what am I doing here? On Day 1 the biggest shock was putting ourselves into action learning sets… everyone was watching how you behaved and it was uncomfortable”.

“I found the initial residential very difficult, I didn’t enjoy it and I came away feeling quite flat. It was designed to be intensive and a rigorous look at self but I missed the inspiration/aspiration side of it. I would have liked to see some stories that really valued people from clinical backgrounds and how they made a difference”.

“The course organisers did a bit of game playing letting the Programme evolve – they hadn’t thought it all through. I thought that was a naïve way to deal with senior people. Had they been honest and had good discussion as a cohort about reflective practice – that would have been great”.

“The first [residential] was nerve-racking in terms of not knowing what to expect in a room with 49 people you don’t know. It is quite full-on the first residential – a bit of a shock. The first day you are faced with patients who have had bad experiences in the room directly challenging you”.

“The first day was very weird. I am a clinician and will remain that. I see patients every day and am constantly involved in pathway redesign and the concept of being in a room with a group of managers who didn’t seem to know what a patient was, was a real worry. I had never thought that people who manage a hospital wouldn’t understand the impact on patient experience…. I didn’t like the assumption was that none of us in the room understood about patients. I felt demeaned by that”.

The ending was disappointing…

“There were points all the way through where I thought I’d drop out. At the residential last May our cohort became quite polarised. The super-confident, extravert and dominant ones in the group were ready to coast to the end. Others of us were feeling we were being told that the NHS wanted different sort of leaders and that resonated. But the old heroic command and control were still taking control and people were still not listening to my different voice”.

### Programme highs and lows

We asked participants about their high and lows points. Many high points (summarised and illustrated in Table 3.4) related to interactions with others on the Programme – opportunities to develop deep relationships within the context of the learning sets and opportunities to network more broadly. The learning set processes were also highly valued, as were the simulations. More broadly, the space, time and opportunity to think, reflect and discuss issues in ways that are not normally available in the workplace were valued. For some, achieving the award was a particular high point, while others found that confidence building was a Programme high. Participants also mentioned a variety of specific sessions that were high points for them.

Table .4: High points

| High points | No. mentions | Examples |
| --- | --- | --- |
| Learning set | 18 | “I loved my learning set and we’ve stayed in touch”  “Working with my learning set – I’m excited about seeing them next week and sharing what’s going on”  “Learning set facilitator was very good, especially in getting the group to hold each other to account”  “When the course finished on the Friday I had instant support from my learning set”  “Outstanding learning set with a collective hunger to learn”  “A brilliant set facilitator”  “Forming a learning set after a very tricky time previously”  “The learning sets had a lot of high points – seeing my peers exceed what looked possible, and the privilege of getting to know them and their challenges”  “The learning set and the depth of self-understanding that you go into. It takes you into places I would never have been otherwise”  “We organised ourselves into a learning set, it was a real social commentary. You learn more than by being told”  “That has been very helpful as a safe space and we have continued to meet and intend to meet every 6 months” |
| Specific sessions | 17 | “The Michael McCormack workshop and the Director of Public Health from the Dana-Farber Institute – was such a well-run session” (x3)  “I was impressed they brought someone over from Harvard” (x2)  “Enjoyed the formal teaching sessions, but they come behind the learning set and independent learning”  “We had a video with Dutch and Americans – you got a broad worldwide perception of health” (x3)  Sessions by Jon Glasby  “The patient focus on the first day was brilliantly grounding” (x4)  “The best inputs were having service user engagement in the inputs and in the final assessment; the viva”  “The topics chosen and the themes have been very relevant”  “Elements of the course were fantastic – like knowing yourself to influence others”  The KPMG session on global trends (x3)  “The material from National Voices about patient involvement is very relevant to me and the job I’m in”  “The second residential when we did change models - it was fantastic and I would have been grateful to have had this earlier”  “The speakers – around BME diversity especially” (x3)  “Looking at different framings and change models”  “Looking at the international elements and how others do it – this really challenged ingrained thinking”  “The first residential, especially cohort forming and doing a timeline of my career to date; this was a bit of an epiphany for me”  “The first residential was outstanding” (x3)  “The knowledge and resources on the website were excellent” |
| Simulations | 13 | “What I loved most was that, although we struggled, we worked as a team, we stuck together and it worked out well”  “Simulations were very difficult”  “The case study simulations… and the way they were set up”  “The simulation days were excellent especially the stakeholder one at the penultimate residential”  “Success in the simulations – and individual moments where you think ‘I’ve got this!’ It’s like attending an extended interview for a job and feeling it does fit”  “The live stuff and surviving or coming a cropper was really amazing” |
| Networking | 13 | “Meeting people was good and I met people locally as well who I now know better”  “Meeting people with passion, keen to develop services, discussing theory”  “Meeting colleagues you know you’ll remain in touch with forever”  “We sometimes feel a bit of an outsider… Finding that like-minded group was one of the best things”  “Mixing us up in different combinations and permutations, there’s been a good mix”  “Definitely meeting all the fantastic people and the wealth of experience and knowledge”  “You just have a group of senior managers who are there to learn which is very valuable”  “The people I met were amazing from all walks of life”  “Growing cohesion within the group was a gentler high – feeling much more confident and able to be ourselves”  “I kept in touch with six or seven people who are going to be amazing leaders”  “Ability to meet people in similar roles has been a real high point. All the hierarchy is stripped off so other people can challenge” |
| Time/space/opportunity for discussion/reflection | 10 | “The passion and enthusiasm and the discussion was invaluable. At work you are just inside a ball”  “Every exercise involved deep reflexivity – where you’d come from, where you were going, and what we’ve learned from it”  “Broadening horizons, learning and sharing from others”  “”To be able in a non-judgemental environment to explore what... [people] think and feel. You haven’t time in your day to day job and you worry that you sound stupid if you ask some questions”  “Going up there [to residentials in Leeds] was exciting… it was big buzz”  “Getting permission to think differently”  “Meeting the others, a nice hotel and being invested in. It made me feel worthwhile”  “It was a good opportunity to have time away from work to reflect on what we had learned”  “The environment – building and facilities” |
| Achieving the award | 4 | “Completing and passing and getting the award. Not everyone did”  “I felt competent in viva and got great feedback”  “The graduation! Because it was so well organised, so well run and there were good speakers”  “When I ended up getting the certificate! I was determined to finish and not be beaten by it” |
| Building greater confidence | 3 | “Helped build self-esteem”  ”Getting confidence and believing that I could go for Director posts in the future” |

Many of the reported low points (summarised and illustrated in Table 3.5) revolved around two issues. The first issue was around assessment, handling failure and providing support. We heard that failing people, and being failed, was a shock and was difficult to handle. Furthermore some people felt there was inadequate support for people who needed additional help in working through issues arising for them from their experiences on the Programme. There were also niggles about the process of assessment.

The second major issue arising was the time and effort required to complete the Programme. There was a lack of understanding of just how much time would be required for assessments. Questions were raised about the value of time spent revising and tweaking documents for assessment. Perhaps related to this issue, some people questioned the academic stance of the Programme and its value. Another issue in relation to time and effort required was a perceived lack of flexibility; it is all or nothing.

Other low points related to specific sessions that were felt to be below par, or particular approaches to course design and organisation that participants felt could be better. The beginning and ending were mentioned by some.

Table .5: Low points

| Low points | No. mentions | Examples |
| --- | --- | --- |
| Assessment, handling failure, inadequate support | 15 | “It was a bit of a shock for people who have successful careers not to pass something. We use the F word, the Fail word, and it’s not something we like doing”  “There was confusion as to whether you were being assessed”  “There was no consistent approach and I questioned whether I was being fair”  “The learning sets are given too much responsibility”  “We had to fail somebody, that was really hard”  “It was difficult to fail a piece of work when I’d put so much effort in”  “One lady who failed has been affected emotionally and needs help and support. That isn’t available from the Programme”  “Having to re-write my first submission. It was a brief low point”  “It was quite emotional and there wasn’t the support here…some might thrive on it but I didn’t”  “I was sent back to revisit my work to make things more explicit. But I learned that what seems obvious isn’t always obvious to those with different backgrounds”  “I was very upset after the last learning set because they decided that my element one needed revising… I went home and didn’t sleep. I felt not listened to”  “How the feedback was delivered was quite damaging for some people”  “The process completely deconstructed me in a way that I had not experienced before and at that point in time I didn’t have direct support mechanisms in place to work through that”  “We had to fail someone from our learning set who took it to appeal so it felt like a tribunal”  “The viva - I enjoyed it, but some people were bursting into tears” |
| Time/effort required (and the value of it) | 13 | “The longer weeks i.e. four days where you’d just had enough of it”  “Keeping up with the recommended working hours… it feels great when I’ve finished it”  “There was a low point [a bereavement]… The problem is that you have to complete everything – there’s no opt out. It’s a really big issue”  “The evidence gather for the portfolio was tough… for most that is a Saturday/Sunday and it did take some time to demonstrate all the evidence”  “It’s a very intensive programme. You’re told to expect 8 hours a week reading and it takes that”  “It is very intensive in terms of what we have to do but it isn’t academically validated”  “We are required to spend hours and hours tweaking documents. I understand the need to accept ambiguity but what is required for the Element 1 submission is very confusing”  “I also spend hours marking other people’s work. What is the standard?”  “It’s about making the opportunity fit with the day job, making sure it is interwoven with the working life”  “It is a whopping task asking for a medic to take a week out”  “The amount of written work has come as a surprise, and it’s [hard] getting the time to do that” |
| Course design | 7 | “Client perspective should have been embedded in the course… It felt as though clients were parachuted in and out”  “The megatrends – I understood why we were doing it, but not the whole day”  “It sets itself up very high and we are expected to be executive standard by September so I would have expected a lot more input”  “I would have expected more one-to-one or coaching”  “Because I had moved into a new role I needed something more flexible around attending some of the sessions but it was all very rigid”  Did not see the point or the value in the simulations beyond “seeing if we can take a beating and keep our cool… [it was] a pointless and unpleasant experience”  “The self-managed learning sets contained too much introspection and naval gazing” |
| Specific sessions/issues | 6 | Values session – “I sat next to someone who was offended by a couple of points he [the facilitator] made… He tried to download his values rather than create them”  “We did a session facilitated by actors. I was crap at it and got quite upset afterwards. I really took it to heart and felt I had failed myself”  “Access to the website was problematic. The system couldn’t be accessed from NHS computers”  “When people challenged the lecturers they didn’t handle it well. Frustrating students is not a good way to teach people”  “There were one or two sessions where the calibre was below par for a future senior leaders programme… some [facilitators] were less inspirational and just hearing about the importance of their role wasn’t helpful”  “There were points… where some of the issues around race became raised. I wasn’t directly involved but we all knew something was going on. There was a lot of chatter among ourselves but there was no clear message from the Academy. It was difficult for the whole group” |
| Academic expectations | 5 | “The Programme is pitched at self-directed learning but it isn’t that at all – it is academic”  “The essay writing bit. I’d prefer assessments based on projects”  “There no limit to the word count or structure of the work on my cohort – it’s been changed now – so there was a lot of work tweaking and we put undue pressure on ourselves”  “[The facilitator] made everyone constantly re-write until they were all the same academic standard he wanted to see” |
| First residential intimidating | 3 | “It was like the early days in the Big Brother house or The Apprentice. It takes a while to find your feet. Some people want to be noticed”  “The group dynamics of 50 plus people in an open forum was difficult for me” |
| Learning set formation | 3 | “The self-selection into learning sets has been my lowest point… it was very uncomfortable and very stressful”  “It was traumatic. There was lots of grumpiness. The medics all headed for each other. It was ridiculously time-consuming” |
| (Dis)organisation | 3 | “Programme details for the first residential week in Leeds were very sketchy”  “We are not given an agenda about the residentials beforehand. One could argue that it is about us dealing with ambiguity. But I get the impression it is just disorganisation. Sometimes the admin is shambolic”  “The Programme felt a bit put together at the last minute” |
| Final residential/ graduation/closure | 3 | “The final residential was quite low [energy]”  “After we finished and before we graduated, it felt like it dropped off”  “Member of the learning set leaving on the last day, which was difficult for everyone. As a result closure could’ve been better” |
| Expectations for promotion | 2 | “It was a shock to get there and hear that the next expected step was Director level”  “The whole thing of the focus on executive director ambition, and having to constantly say, that’s not why I’m here” |

### Most valuable learning

Table 3.6 summarises the most valuable learning reported by interviewees. We found five clusters of learning: intra-personal, inter-personal, system awareness, leadership and learning process.

Perhaps unsurprisingly, several aspects of intra-personal learning were cited as most valuable; such as increased self-awareness, enhanced awareness of self in relation to others, increased self-confidence, resilience and drive. Some people talked about questioning their assumptions – particularly around diversity – and thinking differently, taking different angles and perspectives into account.

A second group of learning relates to various aspects of inter-personal effectiveness such as understanding impact and extending their influencing repertoire. Some found aspects of enhanced system awareness or leadership most valuable.

Yet the learning processes themselves were also highly valued, with reflection notably being something that some had integrated into their work lives.

Table .6: Most valuable learning

|  |  |  |
| --- | --- | --- |
|  |  | No. mentions |
| **Intra-personal learning** | Increased self-awareness and understanding your impact on others | 9 |
| Increased self-confidence | 7 |
| Challenged assumptions and awareness e.g. around diversity | 5 |
| Personal change which others have noticed | 2 |
| Increased resilience | 2 |
| Increased drive/motivation | 1 |
| Feeling set up well for the future | 1 |
| **Inter-personal learning** | Impact in (difficult) meetings | 3 |
| Extended influencing repertoire | 3 |
| Ability to challenge / be challenged | 2 |
| Giving negative feedback | 1 |
| Different ways of working with patients | 1 |
| Effective communications | 1 |
| Negotiating skills | 1 |
| Understanding tribalism and group dynamics | 1 |
| **System awareness** | International aspects of healthcare | 1 |
| Leadership in NHS not positional authority | 1 |
| Making a difference as part of leadership community | 1 |
| Future trends in healthcare | 1 |
| **Leadership** | Working effectively with diverse team | 2 |
| The Holland example – empowering clinicians | 1 |
| Leading for patients and delivery of care | 1 |
| The softer side of leadership | 1 |
| Issues around rural leadership/isolation | 1 |
| **Learning process** | Discussions/thinking through with other participants (support and challenge) | 4 |
| Reflective learning | 4 |
| Experiencing new situations/scenarios  (in safe & challenging environment) | 3 |
| Viva presentation | 1 |
| Seeking feedback | 1 |

### Descriptions of the Programme

Participants were invited, at the end of their interview, to provide some words and phrases to describe the Programme. The vast majority of these descriptive words were positive, but some were less so. The word clouds below, which provide a neat illustrative picture, have been created from these descriptions; the less positive word cloud has been included for balance.

Figure : How did participants describe the Nye Bevan Programme? Positive words



Figure : How did participants describe the Nye Bevan Programme? Less positive words



Chapter summary

The evaluation team conducted in-depth interviews with 40 Programme participants; these included those who had successfully completed, those who were part-way through, and a small number who had failed or withdrawn.

Many of the 40 had actively selected the Nye Bevan Programme to develop their career and their leadership skills; others had been encouraged to apply, usually by someone in their organisation. At the outset, many were open-minded about exactly what to expect from the Programme, although most were clear about what they wanted: to develop self-awareness, extend their networks, gain new knowledge and skills, advance their careers, or develop within their current role.

When describing their **journey** through the Programme, participants on the whole spoke positively – although it was clear that many had experienced lows and highs, and found some aspects both unexpected and challenging. As one participant commented, *“It is unlike anything I have done before – really quite unique”.* Some participants clearly loved the Programme and described themselves as fans, others struggled but persevered, while a few realised it was not quite for them. The first residential made a big impression on many participants, and took some of them well beyond their comfort zone – partly because they were not expecting to meet patients right at the start of the residential, and partly because they found the self-selection into learning sets daunting.

**High points** related to interactions with others, such as opportunities to develop deep relationships within the learning sets and to network more broadly. The learning set processes were also highly valued, as were the simulations. More broadly, the space, time and opportunity to think, reflect and discuss issues in ways that are not normally available in the workplace were valued.

**Low points** mostly revolved around two issues. The first issue was around assessment and challenging their peers in the set, handling failure and providing support; the second was the time and effort required to complete the Programme, especially the assessments, especially as there was a perceived lack of flexibility around attendance and deadlines.

When asked about the **most valuable learning**, responses were grouped into:

* intra-personal learning: increased self-awareness, enhanced awareness of self in relation to others, increased self-confidence, resilience, drive, questioning of assumptions, and thinking differently
* inter-personal effectiveness: understanding personal impact and extending the sphere of influence via new approaches and techniques
* enhanced system awareness
* greater understanding of leadership
* the learning processes themselves, notably reflection which some had integrated into their work lives.

Most of the words and phrases used by participants to describe the Programme were positive, sometimes extremely so.

# The Role of Set Advisers

The learning set and the influence of learning set advisers were frequently mentioned by participants in the context of their overall experience of the Programme, so the evaluation team interviewed a sample of six set advisers to explore their perceptions of the Programme. At the time of the interviews, these set advisers had facilitated twenty learning sets between them as part of eight different cohorts. Key aspects of a set adviser’s role were described thus:

“The set process may seem very procedural and task-orientated to some participants who describe it as ‘jumping through hoops’. But at an interpersonal level what they should be focusing on and questioning is ‘what am I learning?’ and then gather evidence about that. It is a journey they each need to make. My role is to hold the space safely while they make that journey. They all take a different amount of time to get there.”

Set Adviser 5

“At element 2 stage some list achievements against the capabilities that you might provide as evidence for a promotion and others provide something very reflective and ignore the learning contract and part of the set adviser’s role is to make them do a bit of both.”

Set Adviser 6

## Views on the Programme

### The Programme as a whole

Generally set advisors were very positive about the overall effects of the Programme. Comments included:

“It’s a bloody good programme. The first Academy programme I think to specify in such detail our expectations. It gives people confidence in how to be a leader.”

Set Adviser 4

“The Programme does a lot on personal approach to leadership… All of them struggle with it and I have noticed an incredible sea-change to be open to looking at themselves. It is an intense year and it gets into the DNA of how they think of themselves and their practice.“

Set Adviser 1

“It is a brilliant programme. It is in my nature to be a bit critical but it is fantastic…Some of the people who come out of it at the end, I feel WOW I am really glad they are going to be leaders in the health service…they have become people you can really trust to make a difference.”

Set Adviser 6

### Design of the Programme

Whilst participants tended to describe the Programme as having two key elements – five experiential residentials plus six (or seven) learning set meetings – the set advisers tended to also describe a third element: the time in between residentials and set meetings for personal self-directed learning (including using virtual campus, key readings and reflections from implementing new ways of working).

Three advisers identified a design tension, because the Programme combines two approaches – self-managed learning and competency development/assessment. One set adviser described this tension thus:

“There are two things going on here – one is an aspiration for a pure self-managed learning programme where participants identify what they need to work on to build their strengths and to become a better leader. There is a tension with something that is more like an extended assessment and development centre with a set of criteria or competences that people have to learn about and show their achievements of. So there are two types of programme going on at the same time. Sometimes it’s a really rich, creative and positive tension and other times it’s like a pantomime horse with the front legs of a horse and the back legs of a camel. Some participants find it very confusing and others find it part of the richness of the Programme.“

Set Adviser 6

Set advisers seemed to identify themselves philosophically more with one approach or the other and this was the lens through which they conducted set facilitation and evidence review. In general, the lens of the set adviser also seemed to affect their reactions to changes to the Programme. Changes perceived as clarifying the requirement and assessment component were regarded as positive by those with a preference for a structured competency approach whilst the same changes were perceived as negative by those with a preference for a ‘pure’ unstructured self-managed learning approach.

## Changes to date

Five out of six set advisers interviewed have been involved with the Programme for some time (since cohorts 1 or 2) and were therefore well placed to comment on the evolution of the Programme over time. Three types of changes were described relating to programme structure, content and clarity about expectations.

### Programme structure

Three advisers described a structural change whereby the number of learning set meetings had been increased from six to seven, with each meeting having a specific defined purpose. This change was described as “*wholly beneficial”* and “*working much better*”. The benefits of the change were said to be: reduction in the anxiety and stress of participants; giving participants more time to develop as people and practise new ways of thinking before submission; providing the opportunity for more formative assessment as participants go through the process; and less reliance on the summative assessments. One adviser, however, pointed out that there was no accompanying change in the quality of written submissions since the extra session was introduced.

### Programme content

Set advisers identified as a major change the addition of the criteria of diversity, inclusion and power as one of the learning objectives participants had to be marked against. Most advisers welcomed this move. Comments included:

“It was felt to be core to the NHS and previous cohorts hadn’t discussed or engaged with these issues in papers they had submitted. It was to force participants to pay attention to these issues.”

Set Adviser 1

“Nye Bevan is now very strong on helping people identify their unconscious attitude to diversity but not yet good enough at insisting they translate that into engaging with the issues and securing change back in their own organisations.”

Set Adviser 3

### Programme expectations

Two set advisers noted that the Programme’s designers have provided clearer expectations over time about the level prospective participants needed to be working at, and what the standards of achievement required were, and this increased clarity has helped participants understand Programme expectations and what it is they are meant to be doing. For instance we were told:

* The recruitment process has been tightened to ensure that no-one too junior is admitted to the Programme, and this is believed to have reduced the numbers failing to cope and dropping out.
* Several iterations of the Programme handbook have specified the definition/competences of leadership required and provided guidelines on how to evidence them.
* Participants are now given maximum word counts and clarity about what is needed from each assignment.
* Pieces of the residential elements have been re-framed to provide a clearer rationale to participants about why they are there.
* The importance of reflexivity and what that means is now clearer.

One adviser was extremely supportive of these changes saying “*This is a direction of travel which I hope will continue.”* However for the other adviser it was a source of concern saying “*Over time I think the Programme has shifted more to the assessment centre approach and away from the self-managed learning ethos”.*

## What works well

### Learning sets

The learning sets were mentioned by all the advisers interviewed in the context of what works well in the Programme. The sets were considered key in three different ways:

* As a forum for effective information exchange and networking both about participants’ own development and learning about elsewhere in the NHS, providing the opportunity to think more systemically about what is happening.
* As a microcosm of how people are in their relationships, so others can see and feel what is like to be with them and feed that back to the individual(s).
* As a group setting which mirrors the workings of a Board, providing a relevant context for Director-relevant skills development.

Specific comments included:

“The mix of people in each set is really good. Although the process of determining the groups is deliberately cryptic, each group has two doctors, two nurses and three non-medical staff. This balance allows for lots of challenge.

Set Adviser 3

“The set is also a proxy for a Board and plays a critical role in a way that results in big shifts in mind-sets. Set members have to collectively pass or fail other members and when they do not agree they have to do more work to come to an agreed position. This mirrors executive life where you do not get to a consensus but if you feel valued and listened to you have to stand by the decision made even if you personally did not advocate it.”

Set Adviser 5

“The sets are complex, difficult and emotional. It is where people make a leap in their learning. It is a safe place to say things they wouldn’t say anywhere else.”

Set Adviser 2

“One of the key leadership requirements if you are aspiring to be a Director is holding others to account. They were really tentative when they started, wanting everyone to do well ... They can now give quite difficult messages but in a way that is caring. Some have a real need for being liked by others but it holds them back in other ways such as at work not being able to say no. They hadn’t thought like that about themselves before. The set gives you the freedom and also the expectation to do that. If you are not doing it, you are not being an effective set member.”

Set Adviser 1

### Self-managed learning

Self-managed learning was described by one of the advisers as ‘*the best part of the Programme’*, and others agreed that it was important to the success of the Programme. Specific comments included:

“The self-managed learning approach is good. An average delegate is stressed but the combination of lack of clarity and the open environment encourages them to learn.”

Set Adviser 3

“Ambiguity is held throughout the process and leaders need to understand how it feels and how they can deal with it.”

Set Adviser 5

“Most self-managed learning is open but in Nye Bevan the Programme outcomes that they have to focus on are really clear. The role of the leader in the NHS is not a job, it’s a purpose. They need to achieve a philosophy and a way of being and do something to make an impact on equality in society. They are part of a social as well as a medical movement. The questions they must address in the Programme are fascinating.”

Set Adviser 4

Other aspects of the Programme also mentioned as excellent by at least one adviser were:

* Some of the residential modules
* Broadening participants’ broader knowledge and networks e.g. through giving participants the excuse and the privilege of talking to CEOs, Heads of Social Services etc.
* Supervision of set advisers which ensures constant learning and feedback loop to the Programme leads
* The opportunity to meet other faculty.

## Areas for further improvement

### Improve potential participants’ understanding of the Programme

Three set advisers suggested it would be a good idea to re-state and better communicate the overall purpose of the Programme. This was raised in the context of ensuring that there is no mismatch between participant expectations when they sign up and later experiences of the Programme, as currently there are said to be participants arriving with little idea what to expect. Specific suggested improvements for considerations were:

* More time invested up front to explain what working in learning sets is like and how self-managed learning works, to help people decide if the Programme is right for them
* Clarify whether the Programme goal is to make people ‘more effective’ at board level or to get people ‘ready’ to work at board level and ensure programme materials reflect the goal
* Introduce reflexivity earlier in the Programme.

### Selection and briefing of viva panel members

Two set advisers identified the opportunity to improve the viva experience for participants. Vivas were considered an extremely useful opportunity to practise the skill of pitching to others. Feedback from participants, however, was said to be too variable at present with some having a ‘great’ viva experience and others a ‘terrible’ one. Suggested improvements for consideration included:

* Increase time allocated from five to fifteen minutes
* Select patient panel members who are also a leader on a board of some kind to improve credibility
* Provide a thorough briefing on diversity for panel members so they understand that Nye Bevan is not seeking to train people to exhibit stereotypical attitudes
* Introduce a development activity for panel members to ensure NHS leaders from the ‘old’ system have the right lens through which to judge the people being trained to lead the ‘new’ system.

### Further improve communications between all parties

Potential improvements in communication were thought desirable – between the Programme leads, set advisers, participants and participant’s organisations. Specific suggestions were to:

* Increase the visibility of changes to learning objectives or revised guidance about what they mean
* Highlight the importance of the personal development goals so they are not just another learning objective but rather something personal to the participant – technical or a skill or a mind-set change – and that it will not be enough to just reflect on an issue, participants need to actually *do* something
* Achieve a greater connection between the Programme and participants’ workplaces. Whilst organisations do not necessarily offer opportunities – and participants have to find opportunities themselves – the possibility of a local mentor who has closer ties with the Programme was considered worth exploring
* Continue clarity for participants about how they can improve the quality (and reduce the quantity) of the evidence they provide
* Ensure consistency between set advisers e.g. in how self-managed learning is applied within the Nye Bevan Programme setting
* Improve the connection between those working on the residentials and the set advisers e.g. by exposing set advisers to the rest of the Programme and getting them to go to a residential.

## Outcomes and impact

At the point at which participants pass the Programme, they will have successfully described and convinced their set members, set adviser and viva panel that their leadership practice has improved and made a positive impact on patients, staff and NHS system. So whilst set advisers do not see impact first hand, they hear examples of outcomes shared within set meetings and presented as written evidence of achievement against learning objectives.

### Where the Programme is strongest at delivering outcomes

Most set advisers identified the same two learning objectives which they felt the Programme is particularly strong at delivering against. These were:

* A critical awareness of your personal approach to leadership, your biases, blind spots and attitude to diversity, and how you will develop your leadership after the Programme (learning objective 7)
* Your ability to work constructively within a team, offering and receiving feedback, support and challenge to improve individual and team performance (learning objective 8).

Specific comments included:

“Participants see the causal relationship between what they do, creating a culture which enables people to feel good enough to give a fantastic service. What they do as leaders impacts on how staff treat each other and patients.”

Set Adviser 4

“The Programme is stronger in the areas that are more personal, especially in delivering a critical awareness of personal approaches. They are the qualities which participants can witness in each other. The set work is very powerful on delivering those.”

Set Adviser 6

“The greatest impact comes when participants can articulate what they did and how it touched all eight learning objectives and their two personal learning goals. Good learning should touch on all of the outcomes all of the time.”

Set Adviser 5

“Everyone has gained enormous insights into their behaviour and impact. One example is a participant whose 360 showed she was highly controlling and morale in her team was low. She explored with the set her fear of stepping back. Then she held some team events, told staff about her feedback and discussed with them how they could work differently with her and only referring things that were absolutely essential. Later we heard about the difference that has made to the team.”

Set Adviser 2

### Individual level transformations

Set advisers were keen to point out that the Programme is all about impact and that, in order to pass the Programme, participants will have to changes in their practice and be able to demonstrate the impact of this. What the set advisers see first-hand, and were keen to describe, is the individual transformations they witness over time. Specific comments included:

“They [participants] come as subject experts. But human systems are complex and adaptive, not at all like medical systems. They need a better set of skills. And I see them get it.”

Set Adviser 4

“I see changes in orientation and mind-set. One board member began to see himself in the service of patients. Another Director of Nursing now sees her role as supporting board performance in many different ways, not just on matters involving nursing.”

Set Adviser 2

“There is a powerful ripple-out effect. I see individuals being more action-orientated, doing more listening and less talking, and being more cognisant of the emotional temperatures of colleagues. From set meetings I hear about this resulting in wider engagement, more productivity and better conversations with patients. The impact comes from them being different.”

Set Adviser 5

### Impact on wider health system

Three set advisers spoke about the contribution the Programme makes to succession planning within the NHS by “*delivering* *individuals who can move into a different space”.* Some participants were said to have become more focused on their own career progression with over a third of ‘aspiring’ directors (according to one Adviser) having been promoted within the period of the Programme itself. The Programme was also said to help participants already in director roles, but operating within a narrow technical focus, to acquire the mind-set and skills to go back and succeed in contributing to the wider challenges locally. In addition ‘reluctant’ clinical leaders with little previous leadership training are said to grasp what leadership means and have the determination and knowledge of how they can make the NHS work better for patients.

Three advisers also mentioned the impact of higher quality leaders who champion the patient voice. As one explained:

“Some participants say that their bosses don’t live the NHS values. It is a good outcome for the NHS as a whole when [Nye Bevan participants] move into more senior jobs.”

Set Adviser 3

Chapter summary

The learning set experience was very important to participants. The evaluation team interviewed a sample of six set advisers to explore their perceptions of the Programme; between them, at the time of interviewing, these set advisers had, to date facilitated twenty learning sets as part of eight different cohorts.

The set advisers were all enthusiastic about the Programme, and its impact: *“It is a brilliant programme … Some of the people who come out of it at the end, I feel WOW I am really glad they are going to be leaders in the health service … they have become people you can really trust to make a difference.”*

Advisers identified a design tension, in that the Programme combines two approaches – self-managed learning and competency development/assessment – and set advisers seemed to identify themselves philosophically more with one approach or the other. Almost all of the advisers had experienced changes in the design and delivery of the Programme since it started, and their views of these changes depended on their approach. In general, those with a preference for a structured competency approach regarded changes perceived as clarifying the requirement and assessment component as positive, whilst those with a preference for a ‘pure’ unstructured self-managed learning approach perceived the same changes as negative.

* The increase in learning set meetings from six to seven, with each meeting having a specific defined purpose, was seen by all as beneficial and helpful to participants.
* The addition of diversity, inclusion and power as one of the objectives on which participants had to be marked was also welcomed by all, as this aspect was considered insufficiently emphasised during the early cohorts (although it is worth noting here that some of the design and delivery partners expressed an opinion during their interviews that diversity was, though a welcome addition, too narrowly defined).
* Increased clarity was introduced about different aspects of the Programme, including recruitment criteria and assessments; opinions were divided about these, depending on the adviser’s overall approach.

The learning sets were considered to work well, in three ways: as a forum for effective information exchange and networking; as a microcosm of how people are in their relationships; and as a group setting which mirrors the workings of a board (especially as each set contains a mixture of professions and of clinical and non-clinical roles). Another aspect of the Programme considered to work well was the self-managed learning element, because it pushed participants towards self-reliance and helped them come to terms with ambiguity.

Suggestions for improvement were:

* Greater clarity about overall purpose of the Programme, as some advisers were encountering participants arriving with little idea what to expect (although it might be argued by Programme designers that the element of surprise is a key aspect).
* Review the viva experience, as currently this was too inconsistent
* Improve communication: between the Programme leads, set advisers, participants and participants’ organisations.

Most set advisers identified the same two learning objectives which they felt the Programme is particularly strong at delivering: ‘A critical awareness of your personal approach to leadership’; and ‘Your ability to work constructively within a team’.

Set advisers were keen to describe the individual transformations they witness over time. One commented, *“I see changes in orientation and mind-set”* while another said, *“There is a powerful ripple-out effect. I see individuals being more action-orientated, doing more listening and less talking, and being more cognisant of the emotional temperatures of colleagues. From set meetings I hear about this resulting in wider engagement, more productivity and better conversations with patients. The impact comes from them being different.”*

Set advisers also believed that the Programme was having a wider impact on the health system, in two main ways. Firstly, it was contributing to succession planning within the NHS by “*delivering* *individuals who can move into a different space”.* Secondly, it was delivering high quality leaders who champion the patient voice.

# Assessment of the Learning Outcomes

This chapter presents the results of an analysis of the 40 in-depth interviewees carried out by members of the evaluation team with 40 Nye Bevan Programme participants, with a particular focus on the eight learning outcomes.

## The interviewees

The 40 Programme participants are be broken down as follows: 12 in clinical and 28 in non-clinical roles; 17 completed, 18 on-going, five failed/withdrew; 11 community/mental health, 21 acute, eight others; 20 female, 20 male. The dates next to participants’ comments relate to their start-date on the Programme.

## The learning outcomes

In this section we explore participants’ views on their achievements against the Programme’s learning outcomes.

Your ability to lead with confidence and take courageous decisions and actions that make the aspirations of the NHS Constitution a reality

#### Deconstructing the objective

Like many of the outcomes this is a multiple objective, which some of the participants unpacked in answering the degree to which their participation on the Programme helped them meet it. One commented on the fact that this objective was in itself multiple:

“This is not a SMART objective!”

Participant, October 2014

This particular participant had raised this with the Leadership Academy and had received advice to break it down to make it more manageable.

One participant pointed out that part of this objective is about knowledge whilst the confidence bit is quite different:

“The Constitution bit is knowledge but the confidence and courage is more complex.”

Participant, started November 2014

Others revealed an irritation with the evidence needs of the Programme when they felt they had demonstrated capability but were being asked to present their evidence in a particular (and bureaucratic) way.

“Part of problem was trying to fit experience around what the objectives were rather than highlight what we had done and articulate how it fitted in. I evidenced it through procurement for another hospital’s path lab that I was leading… Irrespective of the course, I had done a major piece of work on values and vision ... This vision was in line with the NHS Constitution. I tried a half-baked attempt to provide evidence by ticking boxes in the NHS Constitution but I struggled with that. What I would rather have done is a presentation to the group so that they could decide that it did reflect the NHS Constitution. I organised a workshop and stood up in front of another acute trust and said ‘This is what we stand for’. That should have been sufficient but I had to send minutes of meetings and presentations and describe the learning from the process.”

Participant, November 2013, withdrew

#### Evidence on meeting the objective

For some participants the NHS Constitution was not well known and so one of the outcomes of the Programme was to make this more obvious to people and for participants to reflect on it. The following participants describe how since completing the Programme they have actively incorporated the Constitution into their leadership:

“It brings the Constitution into your consciousness but the delivery of the objective is how I then work it into the work I do each day. The decision to lead the task force on the 4 hour wait came from the thinking I did around this learning objective ... I felt something different had to be done so I put a proposal forward to the Exec Team and I took up the leadership with the emergency pathway director. That decision and interaction has come about to some extent through my awareness of the Constitution and the Programme objectives. The Programme has brought that to life for me in a way that I wouldn’t have had in my thinking had I not been on the Programme.”

Participant, September 2014

“Whistle-blowers get chastised – people know what the right things in the NHS are but the culture doesn’t lead us to do some of that. I am looking at challenging the Exec teams I am working with in terms of the Constitution and diversity and looking to encourage them to meet all of those standards .... I need to distinguish between reassurance and assurance – so people telling me that things are fine and showing me that they are fine are different things. In my own organisation, however, it is more difficult to challenge beliefs. There are some clear unwritten rules about how we influence and things that we are expected to say and do. We are not always encouraged to be as open and honest as we would like to be.”

Participant, November 2014

“Although I had read the Constitution before, the course made me re-look at it and this changed me as a leader. Nye Bevan encouraged me to consider how I will take courageous decisions. When I went back to the workplace I revisited one section of the Constitution as part of all my team meetings and as a team we explored how we can make it come to life in practice.”

Participant, October 2014

Several participants focused on courageous decision-making as their key ‘takeaway’. This may have been about dealing with a difficult situation or showing resilience in the face of complex and long-term activity:

“For me it reinforced the importance of why we work in the NHS. E.g. dealing with a colleague who was demonstrating difficult behaviour and ending up in a Tribunal where I was cleared. It took courage but also the belief that this is the way to do things in the NHS and following due process.”

Participant, November 2013

“My leadership of that programme was the goal to be achieved for a number of the learning objectives. It involved 20 weeks of planning, including patients, service users, Exec Directors and Non-Exec Directors. I had to take courageous decisions and lead from the front. I was influencing, challenging, and communicating things that could be challenging [for senior people] about their services.”

Participant, November 2013

“I’ve focused on the courage aspect in terms of taking forward the leadership development agenda at the Trust. It’s very complex and ambiguous – lots of disparate pieces of work across the organisation and we need to bring that together.”

Participant, October 2014

Others highlighted the importance of leadership. For some this meant leading with more confidence and for others it was about making decisions or taking a stand on something. This might be about being braver or simply being more assertive when previously individuals may have stepped back and let others take the lead.

“I’ve always managed with confidence – now I’m leading with confidence. I’m better at Board meetings because I approach these differently, for example I talk to more people beforehand to explain to them. At the meeting itself, I don’t go into detail, but try to sell the vision; it’s the operational teams who will need the detail.”

Participant, September 2014

“Confidence – you model anxiety-producing situations in learning sets. Real life sometimes mirrors them. I lead in a completely different way now, with less positional power and more influence and autonomy. I am now able to structure the agenda and influence the agenda better, rather than just using it to keep track.”

Participant, Autumn 2013

*“In terms of courageous decisions, an example is putting forward a sizeable purchase to help frontline services. I put it on the table, I believed in it, represented it, and saw it through. The Programme equipped me to do it, rather than getting someone else to do it. I felt a sense of achievement. It’s not without its critics but I’m able to look at it objectively. It’s not about ego.”*

Participant, October 2013

“It gave me the confidence to knock back a proposal from the Radiology Service at my trust because I felt that the clinical governance issues were not all in place to the extent they should have been. It has all gone ahead now: my decision just delayed it until those issues were put in place.”

Participant, October 2013

“I have reorganised the clinical leadership structure below me to align it better with the aims and needs of the organisation... It has taken time to get colleagues on board. If I hadn’t been on the Programme I would probably have bowed down to their judgement. But I have argued my case but I have learned that you can’t get everyone to agree all the time and they need to understand where you are coming from and that is a big change for me.”

Participant, September 2013

The following two examples from participants feature courageous leadership with regards to their patients and service users:

“A concrete example is with the Better Care Fund. The manual refers to mental health and service users, so I arranged to meet the programme director and took a service user with me to the meetings. I didn’t ask if I could because the answer would’ve been, “we’re not ready for that yet”, but they would’ve said yes if I’d asked if I could take a colleague. So only in the introductions did it emerge [that her colleague was a service user]. I thought it’d be my one and only opportunity to do it [involve a service user] so I didn’t want to postpone.”

Participant, January 2014

“My organisation was poor at patient involvement. I was chairing a group in my director’s absence and I managed to get a patient representative on that group who was highly skilled. Also on all my services I got patient-related outcome measures agreed and implemented.”

Participant, September 2013

Another participant spoke of engaging colleagues more in decision-making:

“It’s the determination that has gone up and the patience to try and gets others engaged and motivated. Sometimes I would’ve been more judgemental about colleagues who are difficult to engage. Now I give them a small task and keep a check. I’m getting more people involved now, rather than giving things to the same people, or doing them myself. And I’m getting people to work together as a team.”

Participant, November 2014

Others felt that as a result of the Programme they were now more confident when it comes to networking with external stakeholders.

“I’m seeing a personal evolution. I’m now taking decisions within and outside the organisation, and talking to colleagues and to people in outside organisations such as CCGs – previously, I wouldn’t have approached CCGs. I’ve been co-opted onto the Trust Operational Board and, as part of this role I’ve approached CCGs to find out if they’re interested in taking on, for primary care, a model of improving care that is in the acute trust: it involves service development with physician associates.”

Participant, November 2014

For others still the Programme has encouraged them to get more involved in areas that they would not have previously attempted to engage with. This suggests that the Programme expands individuals’ understanding of their own sphere of influence.

“I have started to lead on executive lead meetings more... I am leading on a couple of strategies now that I wouldn’t have done without the Programme. I am doing those alongside the Chief Finance Officer who is now my internal mentor. He has my learning outcomes and helps me with that.”

Participant, September 2014

One participant highlighted how the Programme had raised their ability to see the bigger picture and engage with it. This was especially true of those who had previously held quite narrow and inward focused roles.

#### Difficulties with the objective

Some participants admitted they had struggled with this objective.

“This was quite hard because of how the organisation was. I had locality boards, I worked alongside a GP and I needed to think how to bring them along and focus, my job was picking up areas of work that helped delivery. They got rid of the Chief Operating Officer; it became difficult to know where to find outcomes.”

Participant, October 2013

“To start with I am surprised that the Leadership Academy has a framework which is different to the learning outcomes for this course and it doesn’t even map directly. I tried to do that and it seems odd. It shows a lack of thought and this has turned into an academic exercise. I don’t think I will know any more that when I started.”

Participant, November 2014

One participant recognised the value of this learning outcome but felt it was still a work in progress for them.

“It is taking me on a journey but I’m not there yet. Feel a 100% that it is going in the right direction and I’m feeling braver and doing what I had not done before and on making the decisions. My own journey has been about understanding what holds me back, what is derailing me when I understand that I can know what I avoid and face it. That was really useful. There is always a bit of me that does that.”

Participant, September 2014

The participant above specifies they had struggled to fit the learning outcome with their goals and expectations, but that they still felt they had still gained something from it:

“I found it difficult to tailor my goals around this. It is more about how I represent myself and the Constitution rather than what I do. For example when I am interviewing it is about challenging my prejudices and those of others.”

Participant, September 2014

Your ability to create the right conditions for frontline staff, irrespective of their background, to deliver good quality, patient-centred, co-ordinated and cost-effective care

#### Evidence on meeting the objective

There were several examples of how participants felt the Programme had encouraged them to reflect on how they come across to their teams, and which had prompted them to act in some way. For some these actions were to seek feedback from their direct reports or colleagues.

“The organisation invested more than £20,000 and supported me to take six weeks out of the organisation last year. My team were aware and were part of that because I needed that feedback. If I had a team meeting, or if I chaired a meeting, at the end I’d give everyone a reflection form [for feedback]. It was a powerful tool. Some people were not confident or comfortable about doing it, so they’d send me an email, or have a chat.”

Participant, November 2013

“I did something on team development and making sure I listened a bit more. I talked about developing appraisals and providing feedback centring around them and their performance. We have a 360 process so my direct reports rate me before my appraisal on how I deliver for them. My latest one was 44.8 out of 48 and that is about being open and fair, supporting development and wellbeing.”

Participant, October 2013

“A lot is down to the appraisal we did at the start of the Programme and getting feedback from staff about the impact I have on them. Also I have asked my mentor to give me feedback at the new meetings I go to – he gives me immediate reaction on how I present myself – am I confident, relevant, the level of my contribution. He tries to give me opportunities to speak at meetings. Finance and HR don’t always see eye to eye so that dynamic is useful.”

Participant, September 2014

“Used the Gibbs Reflective Cycle before and after meetings that were going to be difficult. Asked the team to feedback on my leadership and my impact.”

Participant, January 2014

Many of the participants had instigated changes in their workplace involving greater engagement with staff.

“I came away and made changes. Now I start each team meeting with a patient story to engage them [the staff]. And I’m getting close to patients e.g. listening into a few complaint calls. I’ve changed my working day. We’re an out-of-hours service, so now I come in at 7ish and catch up with the supervisor. I know that six patients passed away last night and I wouldn’t have known that otherwise.”

Participant, December 2014

“The team meetings have been very good. We’ve listened into patient calls that have gone wrong. You need to make space for it. And it’s affected what we’ve done as a finance team e.g. we’ve released some money for customer service training as a direct result. The team absolutely love it and we do it every other week. It’s amazing how quickly they embraced it. I was worried there wouldn’t be any conversation, but that hasn’t been a problem because it’s something that matters to everyone.”

Participant, November 2014

“I was trying to build on these. We had a ward meeting on a regular basis and also for the clinical leads and consultants I established a monthly medical managers meeting to share and discuss issues from the clinicians on the ground. I ensured everyone had individual job plans and I instigated a move towards adopting a model for consultants who had previously been split between community and in-patients, so they would be working into one clinical area.”

Participant, November 2013

“Focus groups with people using the community nursing services were much more enlightening than the Friends and Family Test scores and patient surveys, which were both frustrating in indicating the services were all lovely. Focus groups found that people disliked waiting around all day for the district nurses to arrive. This was a real challenge to the team whose initial response was “They are housebound: what difference does it make what time we arrive?” A combination of electronic patient records and the recent move locally to a caseload approach is enabling us to move to a scheduled appointment system which, with the support of staff, we hope will improve the patient experience.”

Participant, October 2013

“I really liked the creative thinking methodology about encouraging people to come up with ideas so I am running my meetings like that to enable people to speak up. We also have a large group of staff working with challenging customers so I am trying to meet both staff needs and encourage good customer care. I try to model that too so when people make mistakes we work on it together. There is a big challenge for me at senior level as the provider/commissioner split has led to volatility and a hostile environment. So I am maintaining a positive attitude and create those conditions for senior staff. I try always to link it back to patient outcomes.”

Participant, September 2014

To this participant, the learning outcome was about creating a space where frontline staff can have their voices heard.

“I’m a clinician by background. I see this as being about creating an environment for people to have a voice – at forums, staff meetings etc. – an open, trusting environment in which people can have a say. It should be an adult relationship, with plenty of listening. I do a weekly walk-round with the Director of Nursing; we can’t always solve problems but can ensure that some sort of action is taken.”

Participant, November 2014

Others emphasised the importance of patient-focused care, providing examples of how the Programme had changed their engagement with patients.

“Now I go into the waiting room and ask patients how the services feel for you. I advertise that I’m doing that and have a chat with them – having more face-to-face contact with patients. Now I’m getting out from behind the desk and looking for conversations – previously would have avoided doing that.”

Participant, October 2013

“The Programme was really focused on the needs of patients and staff. It helped me introduce staff stories at one of our committees and ensuring staff voices were heard at that level. And about challenging myself in the director’s role about how much time I spend at the frontline with staff so that I get feedback from them.”

Participant, November 2013

For one participant (started in November 2014 but considering withdrawing for lack of time*)* the opportunity to reflect on *‘how I am with the team’* created the opportunity to consider new ways of interacting with the team, including a new meetings structure and mechanisms for staff feedback and doing more on diversity awareness with them – in this case through a new training and development programme. Another participant undertook a specific project around delegating authority; one of their personal objectives which chimed with this particular Programme objective.

One participant went on to describe how she had set about integrating the approach more widely into practice.

“Slowly it is going into our practice. For example we have set up a ‘Supporting Patient Independence Project’ and one of my team is the organisational lead for it. We got staff trained up in motivational interviewing. I set up a patient involvement group. We are co-creating all this with staff. I challenged myself to take something to the governing body about a homeless centre. I did the presentation with a nurse and GP to present how we support front line staff, I became more involved than normal and got so much out of it and the opportunity to stand up for what is right. The governing body aligned with why we needed to do this, it made me think how I can influence other people to take advantage of that.”

Participant, October 2013

One participant questioned the way she thought about staff and how she worked with them. She had a team that had been with her for a long time and a new team, the integration of which was much harder. She felt she was friends with her staff and needed to move to become a leader and help them grow. This was traumatic for everyone and did not go very smoothly. Reflecting back on what was clearly a difficult time, she felt she did the right thing but it did not go particularly well.

Some participants felt the learning had been helpful but were less clear about what had changed as a result. For some it would seem to have been a reminder of the importance of this area and a useful emphasis on what they should be doing.

“I went into the Programme to explore new ways of leading and I constructed something around delegating authority and how I could use different management styles. That was a huge piece of work.”

Participant, November 2013, withdrew

“…the session on diversity and the feedback on what it is like to work with us were important. There should be a direct link.”

Participant, November 2014

“This is something I always aspired to. What I realised is how difficult it is to do in a new complex, large, challenged organisation. In my previous organisation it would have been easy. I used my learning to be better rather than perfect.”

Participant, November 2013

“We did some diagnostics before the course. The conditions I created were rated highly effective by colleagues. I get on well with people and manage conflict well. I’ve maintained that but [I] also subconsciously try and engage with people more who don’t engage with a concept at the outset. That has happened, so it is not completely stagnant [i.e. has moved on since starting the Programme].”

Participant, November 2014

“What I’m particularly interested in is unconscious bias and micro inequalities – it’s a new term for me and very interesting. I’m reminding myself to reflect on conversations and meetings and asking if I’ve done that [shown unconscious bias]. I’m going to set reminders in my phone to do that.”

Participant, October 2014

#### Already a strength

Others felt this objective was already an area of strength and therefore change in them was more limited.

“One of my key strengths has always been building a strong team and I’ve worked in many high performing teams. However it was useful to be reminded that lots of positive feedback is important, not just negative feedback.”

Participant, October 2013

“That was already integrated in my practice so I have always been used to process mapping and dealing with and including every individual as a key part of the journey.”

Participant, September 2013

“This is something I’m passionate about anyway. Not sure the course particularly influenced me as I’m aiming to do this anyway. Some of the patient-centred stuff in the first workshop was important to those not in the front line, for some of those who work alongside clinicians it has been and will be useful. Less so for me.”

Participant, autumn 2014, withdrew

This last participant highlighted that the course did not necessarily add value to this objective for them as this was something they were acting on anyway. We also had comments from other participants that they did not see the course particularly influencing this objective.

“I can’t see anything the course has done so far to impact that.”

Participant, November 14

“Over the last 18 months I did a couple of big tenders and part of that was to ensure the staff were trained. I was a Trade Union Officer so have always made sure staff were looked after. I am not sure there was enough emphasis on this in the Programme though.”

Participant, September 2013

System leadership; as an enabler of change within the wider health economy

#### Evidence on meeting the objective

This is an objective that inspired several of the participants to behave differently and instigate change programmes. For some of them the changes were very significant and catalysed them to do something that they would never have done without the Programme.

“That has been massive – now this is about working with commissioners and the healthy futures team and it covers our three main CCGs working together to completely change the way we deliver healthcare services across our county. For me it is providing the conduit for discussions between clinicians who are naïve but trying to use their ideas and translate them into the language the commissioners will understand (I didn’t know they had a different language before the course). I’m trying to bring these ideas to fruition in a way that will work for the healthcare community. I couldn’t have done that 18 months ago.”

Participant, September 2013

“I got myself on AUKUH [Association of UK University Hospitals] which meets in London quarterly. My Director of HR said I could now go and I got involved in a national piece of work on a management accountability framework on workforce KPIs. I did that with five HR directors across the country for NHS Employers. They have asked me back in July to speak on efficiency programmes. It’s good for my CV and the proposals hope to save a few million pounds – it saved £200k in our Trust alone. We are hoping to see if that can be replicated.”

Participant, September 2014

“Because of our performance, we were summoned to the GDA as a system. That led to a very uncomfortable conversation with GDA Directors that I led because I was responsible for the acute hospitals’ contribution but we are delivering because of internal changes and external changes by other community and CCG partners who are pulling people out of the system. That system leadership has been significant there and is growing in significance because of what the external world is seeing of what is being done internally. They are looking to us to also help shape the wider system’s response.”

Participant, September 2014

“Working with NHS organisations I am looking at that organisational level and with wider stakeholders. I ask organisations to demonstrate how they are working with stakeholders. For example, I am doing some work with an Ambulance Service and there is nothing in their strategy about stakeholder engagement. I reflected that back to them.”

Participant, November 2014

For others this learning goal was about engaging with the wider health economy through networking with external stakeholders.

“I have been broadening my horizons by exploiting links with a public health consultant. I have been to a ‘Warm and Well’ steering group, health and wellbeing board, sexual health, chair the GP pathology forum and things like that. I am becoming the ‘go to person’ for public health within pathology and am certainly building a relationship with people outside the Trust. I have also been to some GP meetings.”

Participant, October 2014

“I worked with commissioners in the CCG, local health watch, and patient groups. You get to bring your leadership skills to the fore in co-producing solutions. The Programme did well on this.”

Participant, November 2013

To this participant, the concept of system leadership had even evolved into a new role within their organisation.

“Before the Programme had an utterly superficial understanding of system leadership and I would’ve been completely wrong. Now you could call it my role. There’s been some serendipity in it. I was invited to do this System Transformation Programme and I thought you bet! I leapt at it and it’s gone really well. I’ve been asked to carry on for another year with the system transformation work.”

Participant, Autumn 2013

For others the changes may not have been quite so dramatic but the Programme has shifted thinking. One participant commented that she was doing lots of personal research on system leadership in addition to the inputs on Nye Bevan so her knowledge overall was much improved in this area. Another felt she was thinking much more widely about connectedness as a result of the Programme and another felt that her understanding of change had deepened. This participant said:

“I felt I knew a lot about what happens during change but, because of the theory about change on Nye Bevan, I now understand why it happens.”

Participant, October 2013

“This is the one where I would never have done this without the course - I went to the urgent care board and presented primary care impact and this allowed me to be recognised as a system leader. This was when I was most uncomfortable and this pushed my comfort zone. I pushed myself forward which is not like me! I had that element of confidence that I was there as an equal and allowed myself to accept that.”

Participant, October 2013

#### Too early to say

Others felt the Programme was providing insights into this area but that they were probably too early in their personal learning journey to see any ideas or activities to fruition.

“The content has been good and timely. The philosophy is right and getting different people on the course has been good. We have organisations that have incentives to operate as institutions not systems. In my current role I am working with institutions to help them chart a way forward for the system so I will be able to provide some reasonable evidence.”

Participant, November 2014

“It’s helped me to lead by example and to get others to pull their weight and come along. We’re going through a difficult and rough phase with the merger – take over really… Each time you go forward one step you feel like you’re going back two steps. We’re getting there but not as quickly as hoped. Colleagues have had the same experience. So yes, it has helped me in engaging with difficult colleagues, or engaging with colleagues in difficulty. It’s about broadening horizons and seeing things from their perspective and being flexible to their needs.”

Participant, November 2014

One participant mentioned that they had learnt something even if what they were trying to do had not succeeded.

“I applied the change model but discovered the health care economy isn’t yet confident or sophisticated enough to work as a system. We didn’t progress things as you would in a text book but I learned through the process.”

Participant, November 2013

#### Already a strength

Others felt that this was an area of personal strength before they attended the Programme and were therefore less convinced that the Programme itself has added to their capability.

“I had already done that by creating a network – creating an organisation that spans three systems – it works across organisations and survives eight years later. However I couldn’t include that as it was already in place.”

Participant, November 2013, withdrew

“There have been some elements, e.g. the simulated exercise, which introduced some of the systems elements which was interesting. But probably given the work I do, community health has to interact with all systems anyway unlike hospital; I come with a lot of knowledge on systems.”

Participant, November 2014

“I’m confident in this area already as I’m involved in patient and public engagement work. The Nye Bevan Programme hasn’t yet really helped with this area, but I expect it to in the next residential.”

Participant, October 2014

The following participant felt already comfortable with system leadership, but felt the learning objective was not developed to its full potential.

“This was the easiest one for me to articulate as it was most relevant to me. I felt there probably wasn’t enough emphasis on this. One member of my set had only ever worked in a trust as an operational manager, but when I worked with her I thought she’d be great in a system role, such as commissioning. The Leadership Academy should think about the need for crossover between operations and commissioning.”

Participant, January 2014

Others, however, noted that while this was an area of personal strength they had gained a better understanding through the Programme, or that they had been inspired to research it more on their own time.

“This is one of the things I’m good at and I’ve got more confident – through simulations, and good feedback from colleagues about my interaction with political leaders. Baroness Browning asked a question in the House of Lords for me. Other people asked ‘How did you do that?’ I became more aware of my personal assets in that domain and I’m mindful of the political structure.”

Participant, January 2014

Readiness to operate successfully at executive (or national equivalent) level, as part of the board team

This objective seemed to be one of the more challenging for participants to engage with or to feel that they had met through attendance on the Programme. Perhaps, in part, this is because this objective focuses on personal ambition whereas others are more outward focused, and also because several participants seemed to struggle to pinpoint what ‘functioning at board level’ might mean.

“My set adviser said I hadn’t exhibited that enough but it is very difficult to show that you are ready. Our medical director recently moved on and although I don’t want it at the moment, because there is too much I want to do, I have been approached by lots of board level people and clinicians to suggest I apply – so I am now showing collaborative leadership across the organisation.”

Participant, September 2013

“When we discussed this in our set people are not quite sure what is required to operate at that level. It is a bit of an unknown but through my work I think I can use the tools on the course to navigate an effective way to work at that level. I think the tools without the practice won’t necessarily work. If people have sponsorship the organisation should be giving them opportunities to practice or shadow.”

Participant, November 2014

#### Too early to say

We heard from several participants who did not feel quite ready to move on from their existing role, especially if they felt they were trying to achieve something or because they were clinicians and somewhat ambiguous about a move to a managerial role. Arguably, this may say rather more about selection criteria for the Programme than it does about the delivery of the Programme itself. It does suggest that the desire to operate at board level cannot be taken for granted in those who apply for the Programme, as some participants were quite open that they did not yet feel ready to move to board level. It may be impossible to fully select for this, as some participants suggested that this realisation developed during the Programme.

“I wanted to get to a point where I felt ready to apply and I am still pretty conservative so I haven’t yet applied. Some [are] personal reasons and I am focusing more outside work as I have had some personal changes. But even being aware of that is something I wouldn’t have been before.”

Participant, October 2013

“Most were aspiring to this. By most accounts my learning set was different to others – it had a midwife and two doctors and the midwife and I had the biggest identity crisis. We became less sure that a director level role is what we wanted. … I should have been weeded out. I could have been asked last August if I wanted a board level role within a year and I would have said no, possibly yes in five to ten years but not so soon.”

Participant, autumn 2014, withdrew

“Not one of my favourites. For me, it was more about system leadership and having to work at more senior levels [i.e. operating at a more senior level and influencing others at senior levels]. I was asked two months back about the Deputy Director of Nursing role as part of a succession planning process. I decided not to apply.”

Participant, November 2013

“I questioned whether this was clear from the beginning… I never thought of myself as a Chief Executive although most Directors stand in at some point at that level. I was the oldest person on the course so it isn’t an ambition.”

Participant, September 2013

“I did a lot of tussling with myself that I didn’t want the same thing as others [in the Programme]. I want to stay in the trust and to stay local because I’m quite strategic so I want to see things through. If it was the right Board position and the right trust and the right time in life, I’d apply for it. I have now got a place on a Board as a Trustee. It’s through my professional body and when it came up I thought ‘Yes, I’m ready for that’ – the Programme had an effect on that.”

Participant, October 2014

#### Evidence on meeting the objective

Others commented that they believed the course had moved them nearer to a role on a board team. One participant believed that whilst being on the course had made no difference to her decision to apply for a new Director-level job (or to the strength of her CV) she believed it made her think about the differences she would encounter in a Director level job. This in turn meant she showed more confidence and understanding and as a result became more likely to be appointed.

Others also believed that the Programme had instigated behaviours that would place them better:

“I attend public board meetings – anyone can go but few do, but it signals my interest and it gives me more insight into what is going on. It also gets me noticed by execs. “

Participant, September 2014

“I think it helps you to think two steps higher. To think about what are the challenges at Director level and what will the board see. It gives you the insight you need to move up and helps you to understand the challenges they see.”

Participant, November 2014

“I found it helpful as I was exposed to so much more than children’s health and I felt more confident sitting at the exec table not just coming from a corner of the organisation.”

Participant, November 2013

“The exercises where we’re acting into an executive position are good. And it [the Nye Bevan Programme] gives [us] permission to have conversations with colleagues about what helps and hinders in terms of personal impact. The session on how boards work was useful. I had a conversation with the Board Secretary before and after observing a board meeting. The Board Secretary said execs leave their hats at the door and are all acting completely in the room. I felt this was a powerful message.”

Participant, October 2014

“I would’ve been behind a door on this one – now I feel I can engage with anything. If others get out of the Programme what I did, it can only be better for the health service. I didn’t have the aspirations to develop my career path, but I’ve got a lot to give and now seek more opportunities to do that.”

Participant, October 2013

A few participants commented that they had either achieved a move to board level or were ready to do so, and felt this had been as a result of the Programme.

“I’ll be more confident in applying for a job if it comes along. Having had time with people [i.e. different levels and from different organisations] gives you an idea where you are in the general scheme of things. I understand the wider picture a lot more. I’m meeting managers from NHS England I wouldn’t meet otherwise and recognising the importance of influence and politics. [The Programme has enabled me to do] the kind of informal information and knowledge gathering that you don’t get the opportunity to do otherwise.”

Participant, October 2014

“Yes I’m ready. I’ve met with my Chief Executive and Director of OD. The Chief Exec wants to bring me into the Executive team more – on the external environment and partnership working – but not in a board post. I’m already involved in leading development on the Board.”

Participant, January 2014

“I sat on a locality board and on an exec board too so I used my line manager [for coaching] and learnt about being more concise (I blabber), talked about when people walk, which ones do you notice, you need to walk in and make that presence felt, walk in like you belong here – Wouldn’t have thought about it before.”

Participant, October 2013

“Nye Bevan gave me the confidence to step up to the interim MD role and apply for the MD post.”

Participant, October 2013

One participant who had withdrawn was frustrated by the perceived need to demonstrate evidence *from* the Programme when they had already operated at this level.

“Again I was already doing that – but that wasn’t adequate. It was always phrased that it had to come from the Programme so it excluded what had been done. I think past record needs to come into it. I would suggest it is about ‘why is it important’ and the learning around that.“

Participant, November 2013, withdrew

Your ability to engage with patients, service users, carers and families of all backgrounds, and use this perspective to foster person-centred care in a complex environment

It would appear that this particular objective was easy for interviewees to discuss as the learning and relevance were so clear.

“This was good – the patient was often there to work with us. You got real hands-on experience from a patient perspective. They bring you down to earth. You have to stop talking about it and do it. It concentrated on making sure the clinicians were a key focus of change, empowering them to make the right decisions for the patient.”

Participant, September 2013

“Found this one quite easy, I had monthly patient groups, and thought how could I engage with the wider population and this has shifted to a wider linkage. I do a lot more now and have continued in my new job.”

#### Evidence on meeting the objective

This was an objective that chimed with many of the participants, who felt it was central to what they were there to do. There was special significance for those who had not previously been in a role that enabled much direct patient contact, whereas others (often clinicians) felt this was something they did anyway. Even where patient contact was a regular occurrence in the participant’s role, some had shifted their behaviour and taken action as a result of changing perceptions of agency. There were many excellent examples of changed practice:

“As a nurse, one of the values I have is around passion and care. The Nye Bevan Programme has given a boost of confidence. I don’t ask for permission (which I used to) because support from the Exec team to do the Nye Bevan Programme gave me permission. I did a ‘compassion and care’ day where I invited GP practices to come together and talk about it. We went back to basics with nurses and doctors and said ‘Don’t assume people know who you are’. Now GP practices introduce themselves in person, on their letter heads, in the email signatures, on Twitter etc. And we’re getting feedback from patients that it’s made a difference.”

Participant, November 2013

“We are building a new unit and have run focus groups and made around 30 patient videos to use with staff to explain how and why we need to change. We have also used patient diaries. We still need to make sure we are really listening but it is really exciting. In another building project we have mixed up staff and patients together into three co-design groups. In the last six months we have engaged more with patients than over the previous ten years.”

Participant, October 2014

“It has helped me to think more laterally. I’ve gone out to the Diabetes Forum for help and I think we should engage with them more. We’re getting feedback from relatives and patients after they’ve left hospital after their investigation. We’re trying to avert complaints by giving staff dedicated time to talk to relatives. It’s working well and we can see a fall in the number of complaints because it’s the simple things that make up the bulk of the complaints.”

Participant, November 2014

“I focused on end-of-life care and doing some different… the committee I chair has introduced a family feedback form for people who have used palliative care services – on how we have managed. We are hitting three times the normal level of those kinds of surveys. We will look at the themes coming out of them to focus on and improve this coming year.”

Participant, October 2013

“Slowly it is going into our practice. For example we have set up a ‘Supporting Patient Independence Project’ and one of my team is the organisational lead for it. We got staff trained up in motivational interviewing. I set up a patient involvement group. We are co-creating all this with staff.”

Participant, October 2013

“I’m coming at this from a perspective of being a white female. I’m doing two things: Firstly, some specialties, for example maternity and critical care, have a debrief service for patients. This used to be nurse/doctor led, but for critical care I’m now looking at the post-traumatic stress element and have brought in some psychologists. Secondly, I’ve commissioned a virtual tool on the Internet, plus open days, for the maternity unit. Both of these are a direct result of Nye Bevan; I’ve been thinking about them for a long time but have been stirred into action by the Programme.”

Participant, November 2014

“For me, we are a community trust and it was about how I used the learning on the course to think about how we were gathering systematic patient feedback and engage with patients in the design of services. For example, in our 0-19 service we have engaged young people in how we have set up that service – that is a very different approach for us.”

Participant, November 2013

For others there had been a shift in perspective that was changing participants’ approaches and attitudes towards how they might improve patient-focused care.

“I have realised the need to develop more relationships with external partners. For instance I realise now that GPs are not just ‘tiresome’. They need to be brought on side so that our local health economy works for our patients.”

Participant, October 2013

“Patients usually seek me out because they’ve got a complaint, and I would’ve shied away from more patient contact. But I now believe that every conversation has the opportunity for learning and that no one needs to leave the room unhappier than when they came in. I enjoy it now.”

Participant, October 2013

“I work as an HCA half an hour a week for the past six months. I put my pinafore on and feed patients who haven’t got relatives. It gives me insight into how the staff feel. I learn about what is going on and I can give them feedback too. It is insight into what is going on for patients and how little time they get and the importance of the HCA to patient care.”

Participant, September 2014

“The parameters we use at the moment to see how well Trusts are doing from staff survey reports to family and friends tests are not perfect. We are doing some work at the moment with Trusts on how we assure ourselves that the quality of services is good. We have lots of measures about mortality indices and the numbers of complaints but I want to do some work on getting a more sensitive approach that shows us that Trusts are really engaging with service users across the spectrum.”

Participant, November 2014

Others have been particularly motivated by hearing patient stories and have integrated them into their own practice.

“Patient stories, where patients and service users share their stories, had sometimes been tokenistic. Now I’ve made sure it’s not tokenistic and do it in real time. As a result of the Programme – I’m the lead for cancer services – and I asked patients to speak to our board. It was very powerful because it hadn’t happened before. I’m also the lead for maternity. But we’d never had mothers coming in to tell their stories, and I was able to bring some ladies to the board. Now there is a patient story [in real time] at every board meeting, with consent and support. I’ve got another day on 22nd June with all the organisations we commission. We now expect all our commissioning providers to have core values of care and compassion. Patients are coming along to tell their stories.”

Participant, November 2013

“It was particularly good having patient stories at the start of the workshops which was very powerful. I’ve done lots in this area: I talked to people who are already Directors and reflected about this. I have also implemented divisional awards based on staff feedback, been instrumental in sharing success stories, wrote a document setting out a vision for engaging with patients and run sessions with staff on patient engagement.”

Participant, November 2014 (considering withdrawing for lack of time)

#### Already a strength

We did hear from some participants (usually clinicians) who did not feel that the Programme had particularly enhanced these skills for them.

“This was already integral to my work.”

Participant, September 2013

“This is my raison d’être – it is what I have always done. I was the only clinician in my learning set and they said they learned a lot from me and really benefited from having someone at the front line delivering care. In my leadership role I have to take that to other people – it is the ethos of our specialty. We can always do it better and I did some case studies around that. My peers who weren’t at the front line really appreciated it.”

Participant, November 2013

“[I] had this in spades but not sure if [the training] altered it in me. The course gives exposure to what patients are thinking but it takes years of exposure and practice to get the skills and you are not going to get this on a course. It is designed to go and get the experience you need.”

Participant, autumn 2014, withdrew

#### Difficulties with the objective

Others were finding the application of these principles to their particular role quite difficult because of the lack of engagement with patients.

“Tricky for me as my current role is non-patient facing but there are some discussions as to how patient facing the role should be and we are encouraging it. I am definitely encouraging that and we have chosen a piece of work internally to engage patients. I should be able to evidence it by the end of the course.”

Participant, November 2014

“As a pathologist there are limited opportunities but I introduced something about patient complaints and a process where I wrote back and offered them the opportunity to meet with me and discuss their concerns. That is taken up by around four a year. But having to reflect on what the patients said to me was a challenge. The tone from the learning set was how it made me feel and how my feelings change practice.”

Participant, November 2013, withdrew

“As we are arm’s length this is harder but we can engage with service users and we are trying to get press attention for the service and get a change management process where we consult with customers. The customers are keen to come in and micromanage but the service is less keen. I am pushing for transparency but it is a hard sell to the service team. Where we can we will make sure front line staff can meet and consult with customers (clinicians and managers).”

Participant, September 2014

Your attainment of a solid foundation of knowledge and networks that will support you

When commenting on the achievement of this objective, the most frequent comment focused on the formation of **networks**.

#### Networks: Evidence on meeting the objective

On the whole the course was seen to provide access to new networks. In large part this was most immediately felt through the learning sets.

“A lot of that is the amazing people I met on the course and we do keep in touch. Three of the set came from organisations under scrutiny so we had a lot in common. I have now started working with GPs – I didn’t realise what they did, commissioners. I haven’t gone national and international yet but as my knowledge improves I know how to make contacts if needed.”

Participant, September 2013

“The learning set and the whole Bevan community became a network. I started to use Twitter differently and it helped me find resources and put me in touch with people with shared interests in a situation. I don’t find it difficult to ask for help – I’ve got a coach, I’ve got a mentor, I’ve put in place support structures. I asked who in my organisation could be helpful in my development and asked them for feedback. It’s made it less lonely than in the past.”

Participant, October 2014

“It is quite a mixed group so as a peer network there will be many I stay in touch with but not all.”

Participant, November 2014

“The biggest part of this was the learning set. I have always had good nursing and community links but I got most from the friendships of the learning set and we are still meeting, which is testament to the Programme output.”

Participant, October 2013

“Networks – the learning set, [I now have] six friends around the NHS system.”

Participant, November 2013

“Networks – yes, definitely, within the learning set and the wider cohort. Found it particularly valuable meeting people who work for commissioners.”

Participant, October 2014

Although the sets were often used as an example of greater networking, there was evidence that these had spread beyond the set for many participants.

“Inspired by the course I now subscribe to a variety of online fora from UK and overseas which I consistently read and feed it into what I do here at the Trust.”

Participant, October 2013

“The reading and the work in the residentials helped me realise I needed a network locally.”

Participant, November 2013

“[I]… set up a local health and wellbeing forum, and challenge myself to go meet new people. Now I go and find people and make them find me. I wouldn’t have done that without the course. It is partly confidence, and asking myself what can I do to do that. It becomes a norm now, it is about thinking about it and also shifted my view on my job, this is much wider now, I know people and I know who I can connect with.”

Participant, October 2013

“I did a network map before the course and one towards the end. The first one helped me to reflect in which areas of my new role I already had a good network and which areas I needed to develop more. The areas of safeguarding and infection control were identified as areas where I needed to do more networking. I have done that and have got more confidence in doing that, having been through the Programme.”

Participant, November 2014

#### Networks: Difficulties with the objective

The large majority of respondents had formed close relationships with those in the learning set and the general tone of comments was that these relationships were expected to endure for a reasonable period of time beyond the course. Two respondents however, were slightly less positive about the likelihood of a long term relationship:

“One of the positives was working with people from different backgrounds which was good. It probably won’t endure to be honest. It was a positive environment and you can be very honest with people as you’re not close to them. It felt safe and secure but I didn’t connect with them particularly.”

Participant, autumn 2014, withdrew

“I am not sure the cohort will function as a network in the future. I felt that everyone would go back into their lives.”

Participant, November 2013

One participant who failed said that it was hard to contact people when you knew you had failed the Programme. Another participant commented that networking with those who have not been through the Programme may be more difficult because they do not fully understand some of the approaches and may not practise some of the principles that the Programme encourages.

“It has increased – but how far it is practically feasible [to network] I don’t know. Clinical management teams [i.e. senior levels] haven’t been through the Nye Bevan Programme and are very rigid in their thoughts. This can be difficult to tackle because you can be seen as obstructive... It’s not easy to tackle that different generation without risking personal loss or damage.”

Participant, November 2014

#### Knowledge development: Difficulties with the objective

There were fewer comments regarding increased **knowledge development** through the Programme, and a small number said they would have liked more time given to this:

“Some things are still shaky due to the intensity of the Programme. I would’ve preferred to spend more time reading, e.g. about [clinical] micro-systems. I would’ve liked a week on that rather than a day… So much time is spent writing and tweaking – for writing’s sake. I’m sorry I didn’t have the time to spend on core/key skills, e.g. looking into service improvement methodology.”

Participant, January 2014

#### Knowledge development: Evidence on meeting the objective

Others mentioned specific knowledge that they felt they had acquired.

“Knowledge – I’m carrying it around with me. The change module was very powerful for me as change is part and parcel [of everything]. I now have a more structured way of doing it, a better understanding of the layers and what it means for the individuals. I have the technical tools to break it down and understand how it’s uncomfortable for people. With so much change coming down the line, people are terrified of change.”

Participant, October 2013

“Regarding knowledge then it was the simulations, and the reading, e.g. ‘Embodied Leadership’ by Pete Hamill, all of it is serving me in the future.”

Participant, November 2013

“The reading and learning for the Programme. I have picked up quite a few business paperbacks that I wouldn’t have before, e.g. about personality, resilience, mindfulness.”

Participant, October 2014

A critical awareness of your personal approach to leadership, your biases, blind spots and attitude to diversity, and how you will continue to develop your leadership after the Programme

#### Evidence on meeting the objective

On the whole, participants believed that the Programme had encouraged them to reflect more about themselves.

“Learning objective 7 was also covered well by Nye Bevan. There were lots of sessions around oneself and what one’s skills were. I was strong on this already but Nye Bevan has shifted me from ‘unconsciously competent’ to ‘consciously competent.’”

Participant, October 2013

“This is the most direct hit – the Programme is very strong on challenging us on how we are, how we perceive things and how others perceive us. At an everyday level in meetings I am much more likely to be the person who will go round the table to get people’s views. Previously it tended to be the assertive people who speak so I have a sharper eye out for that now.”

Participant, November 2014

“That was quite a new thing for me to reflect and look at myself critically. That was very effective with the challenge of the new role I am in. I learned not to do the same things I did before in the new role. I couldn’t just do more of the same.”

Participant, November 2013

“I’m quite a reflective person. I have team away days, we get away from the office. I look at personal outcomes and autonomy; think about how I can support my team on autonomy. What I do a lot more of is I build relationships with my peers, previously I would focus on my team but now it is with those within and outside the organisation and think about what I need to do and what I do now.”

Participant, October 2013

“It’s key. People were arriving thinking they knew who they were and how they lead. But learning how you are coming across to others really improves during the Programme. If you take it seriously, it works.”

Participant, November 2013

For some this reflection was particularly attributed to some of the diagnostic instruments used in the Programme.

“The diagnostics at the start were helpful. Asking for feedback at work from different colleagues is helpful. I’m doing more reflection and am more reflexive about own impact. I wasn’t writing it down before [but is now]. I’m now more objective about what’s gone well and I have used it appreciatively to be even better. It has also helped me work on my resilience goal. Now when I feel that something has not gone well, I challenge myself to look at the positives and the intention of the other person, rather than taking it personally. This is really important because if I put my head above the parapet [in an exec role] I’m likely to have more criticism and stress to deal with.”

Participant, October 2013

“The 360-degree and Hogan psychometrics we did were very interesting in thinking about styles. I had never done anything like that before. It is about consciously knowing how you are behaving and honing your ability to tailor your style. I got a colleague to repeat this after nine months to identify changes within the teams. It made me think about whether we should have a talent management programme here at the Trust. As a result we have started up a management development programme which is making this kind of thinking available more widely.”

Participant, October 2013

“I used the Gibbs reflective learning cycle for my learning objectives and modified it to record feelings about what’s difficult, what I could’ve done, what I could’ve done differently. It really helped me stick with things when I was a bit discouraged, for example if a meeting hadn’t gone well or I felt my voice [and the voice of mental health] was not heard.”

Participant, January 2014

“The diagnostics showed nothing surprising. One helpful one is how you perform under pressure. I become quite introverted so I have been making myself go out to visit staff and patients more. From a self-awareness point of view that was helpful. There were a couple of workshops to expand on this work**.”**

Participant, September 2013

Some participants described how the learning outcome had helped change their attitude towards diversity in the workplace.

“I used to think that managing diversity was more about bureaucratic processes, but it is now much more on the emotional side of how it feels. It has a relevance in health and isn’t something that stops at the boundary of your job description.”

Participant, October 2013

“The attitude to diversity has made me stop and think about the make-up of the senior leadership team where I work. We have eight divisions across a large Trust and over seven years I have been involved we have only had white male directors so it has made me stop and think and the need to consider the diversity agenda in a way I hadn’t before.”

Participant, September 2014

For one participant, the self-reflective aspect was as about awareness of others in the team.

“This has been very much part of my journey. It is very useful to know what are the bits I’m doing that I should be doing [differently] and how to address that, and also to also see people coming at things in a different way. There have been some crises where some of the team won’t offer support and I know they are not that busy. I avoid them and am frustrated that they are not a team player; I increasingly recognise this is my bias and not theirs and have made an effort to understand them more.”

Participant, September 2014

Others mentioned the role of others such as peers, direct reports or mentors as particularly impactful.

“This is going back to the mentor, people I manage and peer group to give me feedback. We are doing a new approach to job planning using one of the leadership frameworks we learned about at the second residential – Kotter's 8 Step Change Model.”

Participant, September 2014

“I have a critical friend (not a coach) inside the Trust who gave me feedback throughout Nye Bevan on the way I work within the Trust. We have continued to meet beyond Nye Bevan for personal feedback but also include discussion of how to operationalise changes within the Trust.”

Participant, October 2013

One participant felt that the self-reflection elements of the Programme were not very sophisticated but still felt they had learnt something.

“I have a psychology degree so I find a bit of what they do a bit twee but I have learned more about self-reflection and I have learned more about encouraging others to reflect rather than just telling people what to do, so that has been beneficial and I have picked up hints and tips.”

Participant, November 2014

Your ability to work constructively within a team, offering and receiving feedback, support and challenge to improve individual and team performance

#### Evidence on meeting the objective

Several participants commented on how the Programme had encouraged them to think more deeply about how they work with others.

“The 360s and the Hogan analysis were very useful. Because things that I thought were strong points can be negative points to people who report to you. It said that I don’t sell myself well [which I see it as a strength], but maybe my reports want me to be more arrogant and to sell them. My views of my positives may not be what my reports think. I need to sell the people who report to me.”

Participant, October 2014

“I’ve done a lot of leadership programmes and I’ve used the psych leadership team. This team [the focus for her Nye Bevan Programme work] was a virtual team across Trusts and organisations. I learned how I could lead and deliver outcomes where there wasn’t performance management to fall back on. I learned a lot about system leadership.”

Participant, January 2014

“There was a heavy emphasis on that and coaching. I started to delegate more and get feedback to allow managers to make decisions but also push that out to the clinicians. I visited most of my teams as part of this course to give them authority to treat patients where it was justified clinically**.”**

Participant, September 2013

“I was able to reflect on feedback from the learning set and one thing is dispelling the myth of doctors underestimating their impact in a team. I was humble but with some expertise. I have also looked at how I support and mentor others. I delegate more and give people more opportunities. If we want an empowered approach you have to give others opportunities and feedback.”

Participant, November 2013

“I really enjoyed this aspect. I have a small number of direct reports and peers but need to influence other teams and peers. A ‘team’ can be seen as being made up of a number of people and roles, and can be seen as very broad. I understand that being asked for advice and guidance is very important.”

Participant, January 2014

For some the Programme was felt to have produced changes in this capability, which had affected others in turn.

“I am in an unusual situation when it comes to teamwork because structurally I am not part of any one team. In practice however I am part of a variety of different teams: some long term and some short term when they are struggling ... My role also involves being brought in to help struggling teams to help sort out their services. Before Nye Bevan I was sometimes asked but post-Nye Bevan I get used more widely for this. I can be asked to help by the team themselves or by their managers. So it was really helpful on Nye Bevan to understand how individuals in teams can feel more supported to develop their own capacity. I need to leave them ready and able to take their services forward themselves.”

Participant, October 2013

“There was an opinion in the network that different management styles could be more inclusive. As a consequence the board adopted a completely different approach and had more engagement as a consequence.”

Participant, November 2013 (withdrew)

One participant applied the learning outcome in a new role, and felt the concrete tools given on the Programme supported and motivated them to build a new team.

“I had a poor experience of the last team I worked in and at the start of this role, no-one around me worried about building a team. I set up objectives to develop the team. Because of the Bevan Programme I kept going and kept going. It was a useful objective – otherwise I might have given up and thought this collection of individuals isn’t going to form a team.”

Participant, October 2013

Other participants commented that the Programme had helped them think about team dynamics with better insight and to tackle aspects that need to be changed with greater confidence.

“I always thought I was aware and I think on a superficial level I was but I didn’t have the insight to understand the interactions in the wider team. I can now tease out the way they are interacting and help colleagues understand what is going on, which I would never have thought to do before. If you are going to achieve change everyone has to drive change forward and I will now address it if one person is not helping.”

Participant, September 2013

“I am giving much better feedback than before and we have set up a system to get people to give feedback more, including training and opportunities. You can give people the tools but you need to increase the level of trust so we are doing more to build that. Being able to articulate the benefits has been helpful. I had some helpful feedback at the start of the Programme that I was selective and wouldn’t bother with some people whereas I was good at supporting others. I am now much more inclusive and jump to conclusions less quickly.”

Participant, November 2014

Some participants spoke of learning how to be more careful in dealing with others and the specific impact of their learning set.

“Not formally but because you are on the course you become more conscious about giving and receiving feedback and trying not to take it too much to heart. On one occasion I gave feedback to someone who didn’t take it well and I had to discuss it with her. They gave us a building coalitions paper about understanding colleagues and how to manage relationships. We have used that to get the team to be more savvy when dealing with people. We think more about how to manage different characters.”

Participant, September 2014

“We found that our relationships in the learning set were very good for modelling that and I took that learning into my team at work where we are doing a development programme.”

Participant, November 2013

“Our learning set created a strong sense of team right away. My learning set is fantastic. It’s very diverse – people from different walks of life, different sectors, and ages. They forced us to be a diverse. It was absolutely hilarious. You form your tribes very quickly and become very possessive about your people. It’s just like the NHS – a massive learning experience.”

Participant, December 2014

For others the real learning was less about working with their current team in the ‘here and now’ but about working with future teams and contemplating what they would need to do differently.

“Thought about this long and hard. I work with people I know and they know me and we have a very good rapport. At the next level I’ll work with people I don’t know – how will I do it? I’ve been four and half years in this role and it takes time to get things going [and running very smoothly]. Sometimes it makes me feel a bit uncomfortable [to think of losing that]. It all depends on your credibility, need to extend sphere of influence.”

Participant, November 2014

“I did this with my previous team and the new team to try and take them to a different place and seek to broaden those relationships. It felt quite insular in a way. I felt responsible for those who work for me but now realise people who work with you are important too and you can have constructive conversations.**”**

Participant, October 2013

#### Too early to tell

For some of the participants who had only recently started the Programme this objective was not achieved as yet. One commented that although she acknowledged that she was thinking about teams more than before it had not made a difference to her practice yet, although she expected this would come later on in the course.

## Wider Programme impact

Participants were specifically asked if their participation on the Programme had benefited their organisation including patients, staff, or services in any way. A wide variety of comments were made in response and we have pulled out some of the recurring themes below.

### Changed self and changed ways of working

For some participants, it was the changes they had seen in their own understanding of themselves (and from that, understanding their sphere of influence and impact on their organisation) which stood out for them.

“I have a better understanding of self – what I want to do and hope to do. One of the challenges was developing a greater outward looking look at management. [I’ve] been very acute-focused. Now I’ve got better understanding of how hospital works and CCGs etc. It encouraged me to open my eyes and work beyond my comfort zone.”

Participant, autumn 2014, withdrew

“Yes because it made me understand more about my personal impact through 360 degree feedback. I have become a different person. I have volunteered to do jobs in order to meet my objectives – things that would never have got done. Good ideas are now getting done, e.g. the job planning strategy looking at the effectiveness and efficiency of consultants throughout the hospital. I wouldn’t have volunteered to lead that had it not been for the Programme.”

Participant, September 2014

“It has made me more aware of myself in that leadership role. I stand up and do quarterly Q & A with all the staff and I do get out more and talk to people. We did win that tender and that was because of the values we espoused. The board reconfigured itself.”

Participant, November 2013, withdrew

“There are three Nye Bevan graduates at my level out of two and a half thousand staff. I am a better balanced individual, more self-aware, I have a good network of colleagues. The wider NHS benefit is positive. Some of my blind side was about being softer where I need to be, recognising leadership styles and pay loading those as required. Some theoretical frameworks come back in flashbacks when they are needed.”

Participant, October 2013

“I am more confident and assured in myself. I used to have a bit of an inferiority complex. I feel differently now. I know my opinion is as valid as theirs. I feel able to contribute and challenge. This has now become part of my core.”

Participant, October 2013

One participant feels they are now more effective generally and therefore more strategic in meetings, performing better in board meetings and looking for the wider agenda. They give the following example of how the change manifests itself in their leadership:

“I created a glorious mutiny locally on leadership training. Before going on Nye Bevan I would have announced that I was not happy and sat back. These conversations can become quite personal and confrontational. Instead [after Nye Bevan] I engaged other colleagues in a constructive discussion beforehand about the problems and potential solutions. In the end they did all the work in the meeting. Having general agreement beforehand gave a very clear message to the HR Director and the whole thing was less confrontational and more constructive.”

Participant, November 2013

One participant felt that there had been many strong points in the Programme, including the co-ordination side of person-centred care and getting participants to articulate what it could actually look like. She also felt the Programme *‘really helped’* on creating a culture of quality, helping participants to deconstruct what it takes to achieve this in terms of structure, context and techniques. Similarly it helped with patient experience, helping to see it is partly an individual issue, partly about approach and partly about having a vision of how things can work better. The most impressive bit however was around understanding self:

“It is really easy to assume that because we are at that level we are deeply self-aware already. It was brave of Nye Bevan to take us down this path. It was the key for me. I was finding being a manager very frustrating, it was taking a long time to get things done. I can deal with that better now but the test will be when I get back to the Trust. Being able to influence and manage frustration will also be in the best interest of patients.”

Participant, November 2014

### Patient-focused care

Others spoke of bring about change in patient care with strong benefits for patients.

“From a patient perspective there has been far more collaboration in the patient pathway. I wanted to that anyway but the Programme has helped facilitate it and open doors.”

Participant, September 2013

“The commissioner put a five-year contract out to tender which included the need to look at services up to 2022/3. I thought we needed to be innovative and include information on patient-centred care and direction of travel. It was not really down to me, our ex-Director of Nursing was meant to be doing it, but I said ‘No. It must be patient-centred. We need to think about this, this and this.’ I gave reasons and evidence to support my view. The focus of our entire bid was eventually based on working towards a patient-centred co-ordinated care patient-led approach. We have not won the tender yet - it is still on-going - but we have got through every round so far. I used the course materials: they were really helpful.”

Participant, October 2013

“The main direct benefit has been more patient involvement and engagement through the strategic team… the third and fourth key principles – patient experience and understanding self … it has definitely delivered.”

Participant, October 2014

“With regard to patients it is about connecting to the organisation, the governing body now hears patients’ stories first thing. I hope that’s made a difference. In my old role I linked the business case to what it means for patients as the first thing – I hope that has continued since I left. With regard to services, e.g. the homeless centres, we connected those services into other networks so they would know what is available and make sure we can continue and be sustainable.”

Participant, October 2013

“They did benefit from more patient involvement, more staff empowerment, decision making for clinicians and patients... I also got patients involved – this guy onto the strategic group – my Director wouldn’t have done it – but I got it written into the terms of reference and got him appointed. Then I left but he is still there.”

Participant, September 2013

However some felt that while they in principle agreed with the Programme’s focus on patient outcomes, it was not always realistic in the day-to-day management of the NHS.

“My only caveat is that in the real world you can be a lone voice because the environment is about saving money and cost improvements and not much about quality. It is trying to make us the yeast to go back into the bread.”

Participant, September 2014

### Staff engagement

The Programme’s emphasis on developing and utilising good relationships and networks to bring about change has changed the way some participants work with and through others.

“Staff-wise it has helped me and my general manager change the way we deliver messages and collaborate with colleagues. We have had the most constructive discussions with commissioners which wouldn’t have been as fruitful without the understanding I gained from the Programme. I didn’t know that they existed and I didn’t understand that they didn’t understand so it has changed the conversation and has made things more fruitful.”

Participant, September 2013

“I’ve allowed nurses to take more assertive decisions through a criterion-led discharge project. Nurses actually do the discharge now and senior nurses feel empowered. It gives them the flexibility to make arrangements with ambulance, relatives, pharmacy. Others have followed the lead. It’s better than a verbal agreement because nothing gets missed off. Senior nurses feel valued and empowered with the tool.”

Participant, November 2014

“I think it made a difference to others within the team. In some ways I look beyond the team [more] than before so perhaps I’m less focused on them and on their needs. I’m also more challenging to them so my direct reports may not say I’m a better leader for them but the care I give patients might benefit.”

Participant, Autumn 2014

“On the train home from a residential I reflected on a change piece on the management structures of our divisions. I looked again at the change models from the course and applied the 9-step model, especially the step about guiding coalitions. I realised we hadn’t done any of this. When I got back I told the CEO ‘We are starting from the wrong place. We are not having a dialogue with staff.’ So we put it on hold and took a different tack.”

Participant, November 2014

“A couple of my operational managers left, which led to distress in the team. We went out to advert to get a good team fit, but with diversity. I approached the interview differently: less structured, more values-based rather than all scenario-based. The person who arrived is different – a male in a sea of females! I approached induction differently, too – we invited him to a social event first (bowling), so he could meet the team.”

Participant, November 2014

“It’s not always tangible, it’s the softer stuff – staff retention and attendance and making the place feel happier. I’ve introduced breakfast meetings – it’s a lot less mechanical than it sounds. It’s with other practices in place to improve [staff engagement].”

Participant, October 2013

Some participants provided examples of steps they had taken to empower and engage staff.

“I have taken over a role where the engagement scale was quite poor and last month I fed that back to a medical committee. I asked what we could all do to improve that and have taken up two of the main concerns about administration and accommodation and facilitated a meeting for those concerns to be heard and suggested an improved position.”

Participant, November 2013

“When I proposed the task force for the 4 hour wait, we took a hand-picked group of six people from across the organisation who had been involved in the emergency care pathway for some time. At the first meeting they all described feeling disempowered, frustrated and very low on energy. We turned that round so that at the second meeting people were saying that they hadn’t felt so empowered for a long time, they were part of something that was going to make a difference and they wanted to make a difference. That was the start of a major change in belief across the organisation.”

Participant, September 2014

One participant held two big meetings for demoralised staff members in their trust. Inspired by the Programme, they made sure to use inclusive language and to familiarise themselves with material on staff engagement in preparation:

“The difference in energy and positivity was huge. It was about me and how I led it and being relentlessly positive – it was infectious!”

Participant, October 2014

One participant felt that while the Programme did not directly result in improved staff engagement, it had helped them to understand the issues:

“Staff engagement tends to fall by the wayside during mergers, so there has been no improvement in engagement levels. However, indirectly it may have had some impact as I had more awareness of the problems with mergers and what was likely to come up. I anticipated the staff issues and tried to mitigate them.”

Participant, November 2013

### Cross-boundary working

Two participants felt the Programme had facilitated them taking a more active role in bringing together teams, or working on an organisational interface, to help things operate more smoothly.

“The operations team in the Trust is seen as ‘management’. I have been bringing clinicians and operations teams together to understand the other’s perspectives. It’s opened up the floodgates between the two groups who are used to seeing each other as opponents – now there is much better understanding of the pressures the other team faces. The only person who can do it is me because I’m linked to both teams. I felt I’ve achieved something.”

Participant, November 2014

“As an example I have done quite a lot of work looking at [the] GP admissions unit. I’ve tried to smooth the pathways for those not coming through A&E, important in itself but also reduces the pressures on A&E. These are relatively marginal gains, difficult to measure and describe to others. I’ve been to board meetings and hospital strategy meetings and talked about A&E and other areas and how it impacts. I’ve developed a network. Over a longer period I’ve developed greater awareness of our issues and better understanding of the wider pressures faced.”

Participant, autumn 2014, withdrew

“I have used my networks to see if we can get new business in and we have the potential for other new business. So I have tried to use my influence to help us become a more robust organisation and I am starting to give examples.”

Participant, September 2014

### Skills

One participant felt they had gained a particular skills set – in this case media skills – which enabled them to engage with the media very successfully:

“In the last six months I had to front two health overview scrutiny committees and talk about the CQC inspection. These were webcast events with journalists in the gallery. Had I not had the opportunity to test that out in the simulation, to test out what I did well, to get the feedback relating to embodied leadership etc., I wouldn’t have been able to handle those situations with the same level of confidence. There’s been lots of media interest recently. I’ve been able to engage with them on Twitter and through local papers. I’m more confident and was able to contain the situation. It [the Nye Bevan Programme] really does prepare you for real life situations.”

Participant, November 2013

Similarly, another participant felt the skills they had gained were crucial in their new role:

“Yes I think so through the skills I have developed. When I got the second director role, because of the skills I had developed, I was able to put forward proposals about how we could manage that in a different way, make changes in my role and be able to meet our strategic objectives in a better way.”

Participant, November 2013

Chapter summary

The evaluation team asked participants to provide examples of how they personally were demonstrating achievement of the eight learning objectives. Most participants were able to produce examples for most of the objectives, although they sometimes had issues with them – for example, feeling that they already demonstrated a particular objective, or that it was too challenging to evidence, or that it was too early to say, as they were only part-way through. It was rare for participants to take issue or disagree with any of the learning objectives, although some pointed out that they could be difficult to evidence and sometimes needed to be broken down.

* **Your ability to lead with confidence and take courageous decisions and actions that make the aspirations of the NHS Constitution a reality.** Participants spoke of more consciously including the Constitution in their leadership style and decisions, for example *“Although I had read the Constitution before, the course made me re-look at it and this changed me as a leader … When I went back to the workplace I revisited one section of the Constitution as part of all my team meetings and as a team we explored how we can make it come to life in practice.” “Although I had read the Constitution before, the course made me re-look at it and this changed me as a leader. Nye Bevan encouraged me to consider how I will take courageous decisions. When I went back to the workplace I revisited one section of the Constitution as part of all my team meetings and as a team we explored how we can make it come to life in practice.”* Several participants focused on courageous decision-making as their key ‘takeaway’, for example in dealing with a difficult situation, or showing resilience in the face of complex and long-term activity.
* **Your ability to create the right conditions for frontline staff, irrespective of their background, to deliver good quality, patient-centred, co-ordinated and cost-effective care.** Here, participants spoke of being encouraged to think about how they came across to their teams, and take action such as to seek feedback from their direct reports or colleagues; examples were also given of participants engaging more actively with staff to improve their workplace conditions, ask their opinions about services, and encourage them in their development.
* **System leadership, as an enabler of change within the wider health economy.** This objective inspired several participants to behave differently and instigate change programmes – often, things that they would never have done without the Programme. Some participants also spoke about engaging with the wider health economy through networking with external stakeholders, or even taking on new roles outside their immediate organisation. This objective seems to have made people really think about the positioning of their roles, as they had previously considered themselves as operating solely within the boundaries of their organisation.
* **Readiness to operate successfully at executive (or national equivalent) level, as part of the board team.** This objective seemed to be one of the more challenging for participants, possibly because this objective focuses on personal ambition whereas others are more outward-focused: *“My set adviser said I hadn’t exhibited that enough but it is very difficult to show that you are ready.”* However, some were very confident that they were now ready and were taking active steps to apply for promotion or to position themselves within their organisation as appropriate candidates: *“Nye Bevan gave me the confidence to step up to the interim MD role and apply for the MD post.”*
* **Your ability to engage with patients, service users, carers and families of all backgrounds, and use this perspective to foster person-centred care in a complex environment.** This objective was easy for interviewees to discuss as the learning and relevance were so clear, and they were comfortable giving examples – although some felt their clinical roles meant that they had relatively little to learn. Participants spoke of listening better to patients and carers, involving them in decisions about services, consulting them about changes to service and even, in some instances, making them part of the change process. Participants in behind-the-scenes or corporate roles had taken big steps to involve themselves and their teams with frontline services to gain familiarity with the issues and provide a clear line of sight.
* **Your attainment of a solid foundation of knowledge and networks that will support you in your leadership now and into the future.** The majority of participants spoke far more about networks than about knowledge, and were particularly keen to stress the importance of their learning set and their wish to remain in touch with other set members in the future: *“The biggest part of this was the learning set. I have always had good nursing and community links but I got most from the friendships of the learning set and we are still meeting, which is testament to the Programme output.”* Some participants also gave examples of networks they had joined or in some cases set up within or outside their organisation, or said they were now playing a much more active role in external networks. When they did mention knowledge (sometimes after prompting), they tended to speak about particular tools or techniques or models, or publications, or approaches that they had found very useful.
* **A critical awareness of your personal approach to leadership, your biases, blind spots and attitude to diversity, and how you will continue to develop your leadership after the Programme.** Participants were enthusiastic about this aspect, which they felt the Programme had delivered very well; they spoke about the Programme encouraging them to reflect more about themselves: *“I was strong on this already but Nye Bevan has shifted me from ‘unconsciously competent’ to ‘consciously competent.’” “This is the most direct hit – the Programme is very strong on challenging us on how we are, how we perceive things and how others perceive us.”*
* **Your ability to work constructively within a team, offering and receiving feedback, support and challenge to improve individual and team performance.** Participants spoke of thinking much more deeply about their teams and their colleagues: *“I always thought I was aware and I think on a superficial level I was but I didn’t have the insight to understand the interactions in the wider team. I can now tease out the way they are interacting and help colleagues understand what is going on, which I would never have thought to do before.”* In addition, several people said that their view of what constituted a ‘team’ had broadened, and they were now looking more critically at interactions at different levels within and across organisations.

# Making an Impact on the Wider System

Leadership programmes typically have an impact on participants themselves, due to improved self-awareness, which then translates into improved leadership behaviours. The Nye Bevan Programme, however, is unusual in the particular emphasis it places on the impact of leaders on the wider health and social care system. This chapter traces the impact of participants’ learning on their organisation, via the activities or projects they have undertaken because of the Programme. It then assesses the impact participants have had at a regional and wider NHS level. Specific examples have been chosen across the nine case studies to illustrate impact.

## Impact Analysis

The areas of impact seem to cluster in four key areas:

1. Applying new skills and perspectives to enable participants to work more confidently across the system
2. New approaches and meaning given to patient-centeredness
3. Enhancing the general quality of leadership
4. Increased confidence to push the boundaries, through firstly innovation and secondly stepping up to take on new challenges.

### Working across the system

One of the key benefits reported about the Programme was the broadening of horizons through bringing together people from all parts of the NHS – for example, commissioners and providers, clinical and non-clinical staff, and people from different types of Trusts. The case study participants gained an understanding of the importance of leaders influencing across boundaries, and beyond the limits of their positional authority. Much of their work was values-driven and patient-centred, leading to high staff engagement.

Table .1: Embedding values and principles around involving people and respect for multiple perspectives

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Individual behaviour** | **Output** | **Team** | **Region** | **Wider NHS** |
| The case study participant recognised, due to Nye Bevan, the difference between consultation and co-production. | Cross-system work on ‘Right First Time’ recognised the vulnerability of people with serious mental health problems.  Care planning template across primary and secondary care. | Good preparation and agendas ensured high attendance at project meetings and excellent ideas generated. | Model incorporated into the city’s integrated commissioning plan for Keeping People Well.  Has become a commissioning priority in Sheffield. | National award for integrating physical and mental health.  Multiple methods of disseminating learning with a wider group of GPs. |

Table .2: Leading system transformation

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Individual behaviour** | **Output** | **Team** | **Organisation** | **Region/wider NHS** |
| Participant invited to work (50%) in the System Transformation Programme (STP). Nye Bevan gave him knowledge and confidence to connect and influence across the system, relying less on positional power and challenging others on NHS values. | He got the mental health element of the STP agreed and was involved in developing proposals for a new model of care and gaining consensus from all chief executives. A colleague described his as a ‘brokering’ role. | Colleagues see him checking back with people to ensure their views are heard. They value the ‘creative conversations’ they have had. | His chief executive believes Nye Bevan has been good for the participant, the Trust and the wider NHS. | He continues to build networks and bridges between organisations and stakeholders in order to influence strategy across organisations involved in the STP. |

Table .3: Enabling change

| **Individual behaviour** | **Output** | **Team** | **Organisation** | **Region/wider NHS** | **Measures** |
| --- | --- | --- | --- | --- | --- |
| Participant’s arrival in post was key in enabling the people element of change during a major transformation programme, keeping the focus on patient care, role modelling staff engagement and embodying the organisational values. | Made a major contribution to informatics regionally and nationally.  Key player in the NE Emergency Care Vanguard. | Instrumental in his team’s development of a bottom-up clinical dashboard.  Seen now as listening more, but also sharing and creating an environment where people feel valued. | Described as ‘a Group Medical Director who hit the ground running with ease’.  Enhanced the trust’s reputation through publicising its work and inviting visitors.  Medical management is seen to have improved.  His good networks help the trust to influence policy changes and to explain the national picture locally. | Described as instrumental in convincing the Secretary of State to spend more resources on informatics – ‘an exceptional contribution’.  Network of local health services working better, and benefited when participant helped get acute mental health services included. | Through Vanguard work, participant improved: patient care; profile of mental health services locally; profile of trust.  Just seconded to NHS England as National Clinical Adviser for Mental Health Informatics. |

Table .4: Influencing and engaging people through changing dynamics

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Individual behaviour** | **Team** | **Organisation** | **Output** | **Region** | **Wider NHS** |
| As Chair of a monthly Emergency Prevention, Preparedness and Response (EPPR) network, participant instigated a rotating monthly chair, making him an equal around the table. | It enabled others in the network to develop, and changed the dynamic to promote dialogue. | Participant seen as acting as a buffer between the regions and the demands of the centre. | Enabled outcomes to be achieved in a better way. | Reduced the regional and local divide. | Helped area teams understand the application and relevance of policy outside London. |

Table .5: Developing a wider portfolio

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Individual behaviour** | **Team** | **Organisation** | **Output** | **Wider NHS** |
| Participant now draws on a wider network, deeper knowledge and a broader view of the NHS. | Supporting a direct report to attend a course on emergency planning and build her own network. | Participant has developed his ability to influence others where NHS England has no direct authority. | Involvement with the development of 111 and winter preparedness. | Now stepping up to lead on national pieces of work such as ‘on-call guidance’ and with the national ambulance resilience unit. |

### Patient-centred care

Non-clinical interviewees had been the most impressed by patient involvement in the first residential, but some clinicians also discovered through their feedback that although they were *patient-facing* they were not always *patient-centred*. Participants found many different ways to make their practice more patient-centred through embedding values, moving to genuine co-production with service users and recognising patients as experts in their own conditions. Although it was considered easier for those in patient-facing roles, others made opportunities to shadow people on the front line and to make explicit the links between their own roles and patient outcomes and experience, prioritising indicators that directly impact on patients.

Table .6: Working with values of care and compassion

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Individual behaviour** | **Team** | **Output** | **Region** | **National** | **Measures** |
| Participant seen to ‘set the culture for compassion’ and ‘lives the values’. | Patient-centredness has become part of the team/ organisation culture. | She led a compassion and care initiative with engagement days in 5 localities, going back to basics with nurses, doctors, primary care staff and stakeholders. | She took the national nursing strategy and aligned it with CCG values, galvanising staff in nursing homes and GP surgeries to embed it. GPs now introduce themselves on letter heads and social media.  CCG expects all commissioned providers to have core values of care and compassion. | First CCG in the country to adopt ‘hello, my name is..’ badges. Seen by someone from Boots who are adopting it nationally in their pharmacies. | Patient feedback shows it has made a difference.  Staff engagement is also higher. |

Table .7: Patient as expert

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Individual behaviour** | **Output** | **Team** | **Organisation** | **Wider NHS** |
| Participant’s belief is that patients become experts in their own condition. | He set up a monthly patient panel for inflammatory bowel disease (IBD) and is working on a patient-led app for IBD involving patients and staff.  He is also working to roll out similar panels for other chronic conditions eg diabetes, asthma. | His two specialist IBD nurses attend the panel. | Trust has pledged support for the IBD app.  He is seen as ‘a great ambassador for the clinical leadership model’. | Hoping to achieve national funding for the app.  Spoken at seminars and conferences. |

Table .8: Co-production with service users (SUs) and being more explicit about stakeholder involvement with greater confidence in spotting the gaps in whole system

|  |  |  |  |
| --- | --- | --- | --- |
| **Individual behaviour** | **Team** | **Organisation** | **Region** |
| Participant resolved practical issues eg wheelchair access and ensured full SU briefing before meetings. | Involved SUs in bid, meeting to talk about gaps in mental health. | SUs will be taking the lead, with support from participant, in the trust’s event as part of Sheffield’s CCG’s 2020 consultation. | City secured £9 million funding for a consortium of GP practices. Participant pressed for high citizen involvement. |

Table .9: Making opportunities for self and others to shadow the front line staff

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Individual behaviour** | **Output** | **Team** | **Organisation** | **Region** | **Wider recognition** |
| Although no longer in a patient-facing role, during the commissioning of 111 participant spent time in call centres listening to patients. | He built the learning into design, e.g.in one region 90% of calls were for dental pain. | Ensures direct report has time to shadow front-line services e.g. going out with ambulance crews. | Feedback suggests he has more confidence to stand up and assume authority in a senior forum, respecting authority but seeing where he can add value. | He shared learning with other 111 providers and facilitated changes in access to out of hours dental services. | Director of a voluntary organisation acknowledged participant’s work to put people at the heart of emergency planning. |

### Enhancing the quality of senior leadership

The case studies provide positive stories about leadership development but most interviewees agreed that they had developed greater self-awareness, and even those who withdrew or failed had taken something from the Programme. For some this had led to promotion but in several cases there were flat structures, or simply limited turnover in senior posts, and participants instead found opportunities to lead on new projects or cross-system roles. Several reported improved standing and higher visibility with their boards, and had a greater appreciation of board activities and responsibilities, enabling them to contribute more effectively.

In two of the case studies, however, senior leaders expressed concern that other graduates had not been able to find promotions and felt disillusioned. Where this was the case, senior level support in finding opportunities to use new talents was vital.

Table .10: Greater self-awareness of leadership style

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Individual behaviour** | **Output** | **Team** | **Organisation** | **Wider NHS** |
| Nye Bevan helped participant to be ‘more in the present and mindful in day-to-day leadership’. | She applied key learning on transition to a change programme, which involved bringing together all the trust’s remaining emergency and in-patient care onto the redeveloped hospital site, affecting 3,000 staff. | Colleagues see a greater breadth of vision. | ‘Lots of tiny things add up to a big impact on staff and patient, so the organisation has benefited several-fold from her participation’. | Put forward for NHS Health Education East of England leadership award. |

Table .11: Becoming braver and developing confidence

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Individual behaviour** | **Output** | **Team** | **Organisation** | **Region** | **Measures** |
| Participant felt the peer review process on Nye Bevan had developed courage in challenging and holding people to account while offering support.  Her knowledge grew around the political agenda and she was more prepared to take a lead on issues. | Led an HR project on agency and bank nursing, delivering a contract cap on agency spend.  Established a different function for the bank team, managing the agency supply and making it easier for clinical staff. | Good at growing front line HR managers through confidence in coaching and organisation development (OD).  Enabled the team to think in a more disciplined way and think outside the box to modernise its approach. | More able to hold her own in the executive management team, e.g. pushed on statutory mandatory training.  Sat on a number of senior panels and appeals, offering confident and sound advice. | Developed good relationships with the Association of Care Organisations and networked with NHS Employers. | Now have better data from the agency to accountants. |

Table .12: Greater awareness of board concerns on risk, assurance and strategy, and insights into sub-committee structure and board climate and culture

|  |  |  |  |
| --- | --- | --- | --- |
| **Individual behaviour** | **Output** | **Team** | **Organisation** |
| Participant observed board meetings and interviewed execs and non-execs. | Her presentations and contributions to board now have a sense of purpose to enhance board effectiveness. | With other Nye Bevan graduates, there are better conversations on views of the board and awareness of tensions across the system. | Board receives high quality information tailored to their needs. Enhanced participant’s reputation.  Chief executive reports a more consistent, higher level contribution. |

#### Building a critical mass of leaders across the trust

The participant’s trust is one of the organisations aiming to develop a critical mass of leaders and has three Nye Bevan graduates with four current participants. With only four key executive director roles in the trust, there is less opportunity for promotion than in larger acute trusts.

Table .13: Widening the role and taking on external responsibilities

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Individual behaviour** | **Team** | **Organisation** | **Region** | **Wider NHS** |
| The participant does not have a new job but has taken on more leadership roles within the whole system. | With other Nye Bevan graduates they apply a co-consulting model to share thoughts and feedback . | Chief executive reports a bolder contribution – informed, skilled, considered and with a clearer focus. | Participant has greater involvement with other health, social care and third sector organisations at a strategic level across the city and spots new partnership opportunities. | Invited to be an expert reference group member on a national body. |

### Undertaking new challenges

A key impact from the Programme is demonstrated where participants have gained the confidence and inspiration to drive new pieces of work or develop ideas through their teams. In several cases, Nye Bevan was an incubator in which participants could try out new ideas and experiment with new skills within their learning sets, as well as gaining a more systemic perspective on wider implications.

Table .14: Confidence to re-negotiate a role to put in practice ideas from the Programme

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Individual behaviour** | **Output** | **Team** | **Organisation** | **Region** | **NHS** |
| Participant negotiated a split role to spend 2 days weekly supporting the nursing agenda.  She ensures patient stories are told in real time at every board meeting. | Her work has had a huge impact on the CCG. As well as the ‘compassion and care’ initiative (see above), she re-designed the care pathways locally with patients and clinicians. | Compassion days and patient stories have led to a ‘whole shift’ in team behaviour. | Executive director says that the CCG has benefited from her growth and confidence during and since Nye Bevan. | Negotiated a way through a dispute between a local community organisation and GP practices about location of Sure Start Centres. | Promoted to Chief Nurse with strategic responsibility for safeguarding quality and the nurse agenda. Staff stories on YouTube about the difference made to patients. |

Table .15: Using social media

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Individual behaviour** | **Team** | **Organisation** | **Region** | **Wider NHS** |
| One of participant’s personal learning objectives was to transform leadership practise by using social media. | With other participants, she set up ‘Reflection of the Day’ on Twitter. In 12 months they reached 2.5 million impressions. | Broadens the horizons of Trust eg found out about Vanguard work in Manchester. | Helped CCG with innovation e.g. an app to support service users and Facebook support for new mums and women who have lost babies. | Shortlisted for national safety awards because of changes made through Twitter.  Trust has become more visible to others. |

Table .16: Innovation

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Individual behaviour** | **Organisation** | **Output** | **Region** | **Wider NHS** |
| Participant was instrumental in introducing and developing the role of ‘Physician Associate’ within the trust. | Seen as an ambassador for the trust, whose reputation has been enhanced in the wider health economy. | Helped make a YouTube documentary about ‘a day in the life of’ Physician Associates which has had over 21k viewings. | Contacted CCGs and local GPs to suggest the use of Physician Associates in primary care. | Created considerable interest in the NHS and participant hosts visits from around the country.  Met with Coventry University which is considering delivering a course for Physician Associates. |

## Less positive aspects of the Programme

While the nine case studies were chosen to illustrate some of the positive impact the Programme is already having at many levels, there were sometimes suggestions from the case study participants – who were mostly very positive – that certain aspects of the Programme had the potential for a long lasting negative impact for individuals. These are summarised below, and, given that they come from people who are ‘success stories’ for the Nye Bevan Programme, should be taken seriously.

* Participants being told they were the ‘crème de la crème’: some found this uncomfortable and thought it might lead to unrealistic expectations. One described it as ‘patronising’.
* The emphasis on ‘failure’: there was a fear that some could be ‘absolutely destroyed’. Anecdotal examples given were of an existing director who was at risk of failure and concerns over the message it would send to this individual’s organisation, and in another example the distress caused when someone failed unexpectedly and was sent away from the Programme with no further support or contact. One case study participant argued strongly that better guidance on how to deliver very difficult feedback would have been helpful.
* The expectation (which participants felt had come from the NHS Leadership Academy) that they would leave the Programme and quickly gain a director role: in many cases these roles were not available locally, and in others people did not aspire to those roles but wanted to learn how to be a good leader from the Programme. Some were disturbed that they had been contacted by the NHS Leadership Academy to find out if they had been promoted – the implication being that this was the key indicator of success.

## Success factors

The Nye Bevan participants were busy people with demanding jobs and commitments at home; this meant that they were constantly re-balancing their priorities during the intensive Programme, and were often under considerable pressure. Analysis of successful participants, notably the nine case studies, has enabled the evaluation team to identify the factors that led to successful completion of the Programme:

1. **Personal resilience and determination:** Successful participants were highly capable, resilient and ambitious, and had considerable potential – both to improve in the current role, and to gain promotions to executive team level should they wish to do so.
2. **Willingness and receptivity:** Those who were open to new learning – which in many cases was very different in style to anything they had experienced before – tended to feel they had travelled the furthest in their leadership journey.
3. **Realistic expectations:** Although some participants were uncertain of exactly what to expect from the Programme, those who gained the most tended to have reasonable expectations; they knew they would have to work very hard and would have to both accept a lot of personal challenge and give it to others. The intense, disruptive nature of the Programme therefore did not take them by surprise.
4. **Support from the learning sets:** Participants spoke approvingly of the support they had received from the other members of their sets, which had enabled them to test ideas and grow in a safe, but challenging, environment. The relationship with the set adviser was crucial, in that a good rapport was associated with success; participants who did not have this positive relationship found the Programme much more of a struggle.
5. **Role variety:** Gaining a really good understanding of the varied roles (clinical and non-clinical) of their fellow participants was identified as a real strength of the Programme. Those who used this understanding to collaborate more fully with their colleagues from other disciplines back in their workplaces and in the wider health and social care system reported considerable success at effecting change.
6. **Organisational support:** It was very important for participants to have the backing of their organisation. This included practicalities such as negotiated time off to attend learning events but also (and more importantly) opportunities to discuss their learning with the senior team and put it into practice via gaining permission to effect change.
7. **Support from teams and immediate colleagues:** it was very common for participants to have teams and peers in their workplace who were interested in the Programme and wanted the participant to succeed; this led to a willingness to be flexible and accommodating around work organisation; and receptivity to new ideas and ways of working.

Chapter summary

The Nye Bevan Programme is unusual in the particular emphasis it places on the impact of leaders on the wider health and social care system. The nine case studies provided specific examples of the ways in which participants made an impact, both within and outside their organisations. The areas of impact seem to cluster in four key areas:

* **Applying new skills and perspectives to enable participants to work more confidently across the system***:* One of the key benefits reported about the Programme was the broadening of horizons through bringing together people from all parts of the NHS – for example, commissioners and providers, clinical and non-clinical staff, and people from different types of Trusts. The case study participants gained an understanding of the importance of leaders influencing across boundaries, and beyond the limits of their positional authority. Much of their work was values-driven and patient-centred, leading to high staff engagement.
* **New approaches and meaning given to patient-centeredness:** Non-clinical interviewees had been the most impressed by patient involvement in the first residential, but some clinicians also discovered through their feedback that although they were *patient-facing* they were not always *patient-centred*. Participants found many different ways to make their practice more patient-centred through embedding values, moving to genuine co-production with service users, and recognising patients as experts in their own conditions. Although it was considered easier for those in patient-facing roles, others made opportunities to shadow people on the front line and to make explicit the links between their own roles and patient outcomes and experience, prioritising indicators of direct relevance to patients.
* **Enhancing the general quality of leadership:** The case studies provide very positive stories about leadership development. For some this had led to promotion, but in several cases there were flat structures, or simply limited turnover in senior posts, and participants instead found opportunities to lead on new projects or cross-system roles. Several reported improved standing and higher visibility with their boards, and had a greater appreciation of board activities and responsibilities, enabling them to contribute more effectively. In two of the case studies, however, senior leaders expressed concern that other Nye Bevan graduates had not been able to find promotions and felt disillusioned. Where this was the case, senior level support in finding opportunities to use new talents was vital.
* **Increased confidence to push the boundaries, through firstly innovation and secondly stepping up to take on new challenges:** A key impact from the Programme is demonstrated where case study participants have gained the confidence and inspiration to drive new pieces of work or develop ideas through their teams. In several cases, Nye Bevan was an incubator in which participants could try out new ideas and experiment with new skills within their learning sets before implementing them ‘for real’; this enabled them to gain a more systemic perspective.

The nine case study participants represent some of the Nye Bevan Programme’s many ‘success stories’. However, their critical perspective led them to offer some observations about the Programme that, in their opinion, needed to be tackled. Firstly, they did not like being told, by the NHS Leadership Academy, that they were the ‘crème de la crème’: they found this uncomfortable and thought it might lead to unrealistic expectations. Secondly, they experienced too much of an emphasis on ‘failure’ rather than constructive challenge, and were concerned that some people could be ‘absolutely destroyed’. One case study participant argued strongly that better guidance on how to deliver very difficult feedback would have been helpful. Finally, there were some issues with the expectation of the NHS Leadership Academy that they should quickly gain a director role; in many cases these roles were not available locally, and in others people did not aspire to those roles but wanted to learn how to be a good leader. They were disturbed that promotion appeared to be *the* key indicator of success.

The Nye Bevan participants were busy people with demanding jobs, requiring them to constantly re-balance their priorities during the intensive Programme. Analysis of the nine case study participants has enabled the evaluation team to identify the factors that led to successful completion of the Programme:

1. Personal resilience and determination
2. Willingness and receptivity to new learning
3. Realistic expectations
4. Support from the learning sets
5. An understanding of role variety
6. Organisational support
7. Support from teams and immediate colleagues.

# Conclusions and Recommendations

## Conclusions

The Nye Bevan Programme aims to have features that set it apart from the many leadership programmes that exist within and outside the NHS. All leadership programmes will have an influence on the individual participant, notably in terms of increased self-awareness and knowledge, but the Nye Bevan Programme aspires to much more:

* The creation of a new style of leader, which, as it gains critical mass, will have a major impact on how the NHS does things – seen as necessary in view of the many existing and future challenges faced by the NHS.
* Impact, in terms of better services, more satisfied patients, and more engaged staff.
* Wider impact on the health and social care system – so that services become more ‘joined up’ and are receptive to change and innovation.

The evaluation confirms that, to date, the Nye Bevan Programme is making considerable inroads into achieving these objectives. Interviews with, and case studies of, Programme participants clearly demonstrate that many of these individuals are approaching their leadership roles differently and are finding themselves better able to effect change in their organisations and beyond. Participants provided many examples of actions and improvements that they attributed wholly or in part due to being on the Programme, and team members and colleagues spoke positively and enthusiastically about personal changes and their impact. There were several examples of increased patient satisfaction and staff engagement, although these tended to be reported anecdotally (for example, by colleagues and patient representatives) rather than confirmed by data such as patient feedback or scores achieved in the annual NHS staff survey. Some interviewees also pointed out the difficulty of attribution; many of the Nye Bevan participants are ambitious and highly capable individuals, and it is hard to know whether the successes they reported were entirely down to the Programme. Individuals, however, often gave credit to the Programme for giving them the motivation and courage to initiate change.

In organisations with several people on the Nye Bevan Programme and other leadership development programmes run by the NHS Leadership Academy, there is some evidence that these individuals are meeting to discuss their ideas and approaches. However, these meetings were described to the evaluation team as informal and unstructured, designed more to support people going through the programmes and act as a sounding-board. In addition, the numbers of participants and graduates in each organisation so far is fairly small and has not yet approached the critical mass required for ‘tipping’ the organisation’s leadership team into adopting a different mind-set and approach.

The Programme is intended to be disruptive and challenging, and to remove people from their comfort zone. However, some people – including some successful participants – felt that this might have gone a little too far, and were uneasy about this. They felt the emphasis on holding to account their fellow set members, and occasionally find them wanting, was reasonable, even though personally challenging. However, this could sometimes be translated into what they experienced as pressure to fail people, even if they did not think this was deserved. The ‘how’ of failure was also discussed, with some feeling that it could be handled better. There was also concern that not enough support was provided by the NHS Leadership Academy for those who withdrew from or failed the Programme, and not enough explanation given to their organisations.

The focus of the Programme is, appropriately, on the individual. However, during several of the case studies, interviewees who were members of the trust’s executive team expressed concern that they did not feel involved with the NHS Leadership Academy and had not been sufficiently informed about the nature of the Programme and the demands on its participants and on the organisation. Releasing senior people for a week at a time for the residentials, for example, was a big ‘ask’ for many organisations, especially when the participant was a senior clinician whose work would need to be covered. The executive team members felt that this lack of consultation was more understandable when the organisation was not funding the individual to attend, but was much less acceptable when funding had to be found from within the organisation’s own budgets; it was leading some trusts to consider alternative, less expensive (and often more local) options. The perceived distance between NHS organisations and the NHS Leadership Academy, and the lack of understanding of the Nye Bevan Programme, led to the occasional use of adjectives such as ‘arrogant’ and ‘excluding’, and, in one case, even to a degree of suspicion about the sort of leaders that the Programme might be producing. These concerns contrast markedly with the enthusiasm and belief expressed by the Programme participants themselves, most of whom were great fans – even if several conceded that the Programme ‘wasn’t for everyone’.

A stated aim of the Nye Bevan Programme is to equip participants for a post at executive level. Although several participants interviewed by the evaluation team were indeed achieving these promotions, several people pointed out that not everyone wanted to be an executive director of an NHS trust – indeed some (notably but not exclusively those in national organisations) felt that their influence might be curtailed if they occupied such a role. The primary motivation for the majority of participants was a desire to understand and improve their leadership styles and behaviours, and to make a difference in the roles they were in, with some hoping that promotion might be an added bonus. In addition, in smaller trusts, and in some parts of the country, promotion opportunities were very limited, so it might be difficult for geographically-constrained people to achieve an ambition to be on the executive team; this led to a concern, expressed by several interviewees, that the Programme might raise expectations that could not always be met. When challenged by the evaluation team about why they had chosen the Nye Bevan Programme if they did not aspire to promotion, a small number responded that they had probably chosen the wrong programme, or had been encouraged to apply before they were really ready. However, the majority of participants believed the Programme to be right for them, their roles and their organisations, and felt that their achievements represented great advertisements for the Programme even if they had not been (or did not want to be) promoted. The main issue, therefore, is that some participants feel that the NHS Leadership Academy is placing too much emphasis on promotion as an indicator of success.

Finally, those in national roles (rather than in trusts) felt that the Programme was not designed for them and did not understand their roles and the ways in which they needed to approach making an impact, and sometimes experienced considerable frustration due to this. A good set adviser could help, by facilitating these individuals to explain their roles and thus enhance understanding within the set; however, some individuals in these national positions felt that they had achieved graduation by sheer determination in the face of adversity.

## Recommendations

These recommendations are based on those issues arising from the evaluation that were raised on several occasions (i.e. were not isolated mentions). Some of these recommendations are ‘quick wins’ while others will take more time and effort.

* **Provide more clarity about what to expect:**Although the Programme is intended to introduce a degree of disruption by confronting people with the unexpected, several interviewees commented that they had little idea of what to expect and might, with hindsight, have opted for a different programme. Some were surprised about the amount of time they had to spend on assignments, and most had not taken on board the centrality of the learning set. It might help if potential participants understood the success factors that would help them to succeed; if they felt that several of these success factors were not in place, a different programme might be more suitable.
* **Liaise better with the sponsoring/supporting organisations:**An organisation that is enabling one or more of its senior employees to participate on the Programme is entitled to some consideration. Working in collaboration with these organisations – for example, by informing them about the aims of the Programme and what to expect – could bring dividends, as it will bring the organisations on board rather than keeping them at arms’ length, which appears to be the current situation. It would also help the organisations to provide good opportunities for Programme participants to put their learning into practice. Finally, it would be an excellent opportunity for the NHS Leadership Academy to help individual organisations to leverage the advantages of having several graduates or participants in its various leadership programmes in the same organisation; currently, executive team members said they would be prepared to work at this, but did not know how they should go about it in practice, due to not fully understanding the programmes and their aims. These executive team interviewees did not appear to be in communication with the NHS Leadership Academy’s local delivery partners, suggesting that there is scope for better communication here.
* **Ensure the Programme is geared to people in national organisations as well as those in Trusts:**This does not require a major effort, but rather an increased emphasis that the Programme should not be aimed entirely at those wishing to achieve an executive post at trust level. Some people in national roles have huge potential to spread their influence widely across the system – much more so than if they were based in a single trust. Having a mix of people within each set – not only a mix of professions, but also of trust/national roles – is hugely beneficial to enhancing mutual understanding, and it would be a shame to miss out on this potential by adopting a narrative of ‘success equals promotion to a trust executive director role’. Although a briefing along these lines already exists, judging by the interviews and case studies, during which participants described inconsistent messages, it is not being taken on board by all.
* **Assess the perceptions of emphasis on failure:**It is entirely appropriate to encourage participants to confront the possibility of personal failure, and to take on the uncomfortable role of challenging their peers. However, according to some interviewees, this aim might have gone a step too far – possibly leading to people being judged unfairly as having ‘failed’, due to perceived pressure on the set members in some learning sets. Better guidance to participants on how to assess success or failure and how to convey it, together with better briefing to set advisers, would be helpful. The NHS Leadership Academy has a moderation process designed to ensure consistency of standards across the set adviser body, so the issue here appears to be related to the interpretation of the objective of encouraging participants to hold each other to account. Interviewees spoke of inconsistent practice in the different sets, with some participants experiencing what they described as an intense pressure to assess a peer’s assignment as having failed, even when they did not believe this to be deserved.
* **Support those who withdraw and fail:**Inevitably, there will be some failures, and there will also be people who choose to withdraw for different reasons – including the fear of failure, but also due to personal or workload pressures that are outside their control. Interviewees expressed concern that these individuals are unsupported when they leave the Programme, and are left to their own devices to come to terms with a lack of success and to explain this to their sponsoring organisations. The evaluation team was told, anecdotally, of some individuals being ‘in pieces’ and losing confidence in their ability to fulfil their roles in their organisation – which suggests that some of those who withdraw or fail have been quite badly harmed by their experience. It is important for the NHS Leadership Academy to engage with these individuals, both to help them manage their personal and organisational issues and to gain understanding of the aspects of the Programme that brought about their withdrawal or failure. There is also a positive side to this recommendation, in that several interviews who had withdrawn or failed told the evaluation team that they still valued their learning on the Programme and had been able to put it into place.
* **Consider the presentation of ‘diversity’:**Diversity became more important as an aspect of the Programme after the first few sets of cohorts had gone through, when there was a review by the Programme deliverers. However, some interviewees – including some senior stakeholders – felt that ‘diversity’ was being conceptualised almost exclusively as ethnic diversity. Interviewees suggested that other aspects of diversity, such as age, gender, disability, nationality, responsibility for dependants, background and personality should also be considered under this umbrella term.
* **Track success and impact over time:**A key aspect of the Nye Bevan Programme is the development of leaders who will make a major difference as the NHS goes forward. However, it is currently hard for the NHS Leadership Academy to assess how well they are doing. The proceedings of the learning sets are confidential, which means that major success stories are not necessarily shared beyond the set, and are unavailable to the NHS Leadership Academy, meaning that it is difficult to prove that the Programme is making an impact. Some Nye Bevan graduates reported that they are sometimes contacted to ask how they are doing, but that the main question seems to be ‘Have you been promoted yet?’ A more systematic approach to keeping in touch with graduates would pay dividends, as it would enable the NHS Leadership Academy to track what people are doing, what moves (if any) they have made, and – most importantly of all – how they are continuing to implement their learning to make a difference. Suggestions about which metrics to consider collecting are given below:
* As a critical mass develops of NHS Leadership Academy graduates, a judgement can start to be formed regarding the impact of these programmes on metrics such as patient satisfaction and staff survey scores. Although precise attribution will not be possible, due to other developments and issues in the organisations concerned, higher scores in those areas managed by Nye Bevan and other graduates will suggest that these programmes are having a major influence.
* Some graduates, if contacted at regular intervals, may be able to produce other ’hard’ evidence, such as cost savings and winning awards.
* Promotions are, of course, important, as the NHS Leadership Academy wishes to demonstrate to individuals that career progression is one benefit of coming on the Programme. However, the context needs to be considered, in that it is much easier to identify promotion opportunities in larger trusts and/or in urban areas where several NHS organisations exist, than in smaller trusts in more remote areas. Another way of identifying success would be to find out, from HR directors or executive teams, whether Nye Bevan graduates were being considered for future executive director posts, for example by being identified on a succession plan as a possible successor. Executive teams could also be invited to comment of the quality of leadership.

Chapter summary

The Nye Bevan Programme aims to have features that set it apart from the many leadership programmes that exist within and outside the NHS: the creation of a new style of leader, which, as it gains critical mass, will have a major impact on how the NHS does things; impact, in terms of better services, more satisfied patients, and more engaged staff; and wider impact on the health and social care system. The evaluation evidence confirms that, to date, the Nye Bevan Programme is making considerable inroads into achieving these objectives. The majority of participants interviewed by the evaluation team spoke very positively about the Programme, felt their leadership style and practice had benefited considerably, and were able to evidence their success. Even those who had failed or withdrawn mostly felt they had gained some positive benefits.

The following recommendations are made in the belief that they will strengthen the Programme and help the NHS Leadership Academy to achieve its aspiration with regard to leadership in the NHS. These recommendations are based on those issues arising from the evaluation that were raised on several occasions by interviewees in different stakeholder groups.

* Provide more clarity to prospective applicants about what to expect, and ensure they understand the factors that need to be in place for them to succeed.
* Liaise better with the sponsoring/supporting organisations, to enhance their understanding of the Programme and enable them to provide good opportunities for Programme participants to put their learning into practice.
* Ensure the Programme is geared to people in national organisations as well as those in trusts (especially as some people in national roles have huge potential to spread their influence widely across the system). Although a briefing along these lines already exists, it does not seem to be consistently understood and applied.
* Assess the (possibly erroneous) perceptions that there is an emphasis on failure, by providing better guidance to participants on how to assess success or failure and how to convey it, together with a better briefing to set advisers. The issue appears to relate to the interpretation of the objective of encouraging participants to hold each other to account, rather than the moderation process.
* Give better support those who withdraw and fail, and try to gain a better understanding of the aspects of the Programme that brought about their withdrawal or failure – especially as is recommendation, in that several interviewees who had withdrawn or failed told the evaluation team that they still valued their learning on the Programme and had been able to put it into place.
* Consider the presentation of ‘diversity’ beyond ethnic diversity, to embrace other aspects such as age, gender, disability, nationality, responsibility for dependants, background and personality.
* Track success and impact over time:a key aspect of the Nye Bevan Programme is the development of leaders who will make a major difference as the NHS goes forward. However, it is currently hard for the NHS Leadership Academy to assess how well they are doing. A more systematic approach to keeping in touch with graduates should pay dividends, as it would enable the NHS Leadership Academy to track what people are doing, what moves (if any) they have made, and – most importantly of all – how they are continuing to implement their learning to make a difference.

Appendix: Case Studies

Acosia Nyanin

Visit date 6th October 2015

The organisation: Camden and Islington NHS Foundation Trust

Camden and Islington NHS Foundation Trust provides care to patients in the community, in their homes or in hospital. The trust provides Mental Health services for adults of working age, adults with learning difficulties, and older people. The trust delivers the majority of its care to residents in the London Boroughs of Camden and Islington; however, it also provides substance misuse services in Westminster, and a substance misuse and psychological therapies service to people living in Kingston. In addition, there are specialist programmes to provide help and treatment for:

* [Veterans living in London](http://londonveterans.nhs.uk/)
* Young people caught in the cycle of gang culture and in transition
* [Older people suffering from dementia and other age-related mental health conditions](http://www.candi.nhs.uk/services/ageing-and-memory)

Services are split into five divisions:

* Acute and Crisis
* Recovery and Rehabilitation
* Services for Ageing and Mental Health
* Substance Misuse Services
* Community Mental Health and Primary Care.

The trust is also a partner of the University College London (UCL) Academic Health Services Network. The trust is proud that it is recognised internationally for the quality of its research and innovation; over 40 per cent of its consultants hold joint academic posts. In addition, it is a lead provider for educational placements in north London.

Acosia’s background and role

At the time of the case study visit in early October 2015, Acosia’s role was Associate Director for Governance and Quality Assurance; she received an internal promotion part-way through the Nye Bevan Programme, having previously been Head of Quality Assurance and Regulation. She gained her Nye Bevan place after successfully participating in the NHS Leadership Academy’s ‘Ready Now’ Programme for Black and Minority Ethnic leaders; she was sponsored by the Inclusion Department at the NHS Leadership Academy, and supported throughout by her trust.

Acosia began her career in the trust as an administrator and was sponsored into a Mental Health Nurse training programme after her ability was recognised; she was later spotted as having the talent to be a potential future leader. A member of the executive team described her as having ‘done everything on her own merit’ and now being on a ‘rapid career trajectory’.

From mid-October 2015, Acosia took up a new role as Head of Adult Social Care Inspection for the Central Region of the Care Quality Commission (CQC).

Programme participation

Acosia was part of cohort 6, so she had graduated in March 2015 (some six months before the case study visit) and had been able to reflect on her experiences on the Nye Bevan Programme. She applied for the Programme because she wanted to prepare for her next career step – a more externally-facing role; she was encouraged to apply, and supported throughout, by her line manager, who is a Director of the trust. There are several others from the trust on different stages of the Programme, but Acosia was the first to complete.

Impact since the Programme

#### Personal impact

The biggest thing that the Nye Bevan Programme gave Acosia was ‘the confidence to do what I thought needed to be done’. It also provided her with the informal networks to assist her in this.

#### Wider impact

Acosia has taken action in several areas which she attributes in whole or in part to her learning from the Nye Bevan Programme, and which have benefited her organisation and its staff and patients. These are particularly apparent with regard to four of the Nye Bevan learning objectives: 1 (ability to lead with confidence), 2 (ability to create the right conditions for frontline staff), 3 (system leadership) and 5 (ability to engage with patients, service users, carers and families).

#### Ability to lead with confidence

As Acosia started the Programme, her trust found out that it was to be the first mental health trust in London to go through the new Comprehensive CQC inspection. Her leadership of this inspection on behalf of the trust involved 20 weeks of planning which included patients, service users, Executive and Non-Executive Directors. Acosia had to do a lot of influencing, communicating and above all challenging; she found herself having to challenge senior people about the services for which they were responsible.

#### Your ability to create the right conditions for frontline staff

Acosia developed a Quality Assurance (QA) Framework which, underpinned by clear methodology, provided the trust with a ‘barometer’ for what is happening across the organisation. The QA Framework is a formally ratified approach, comprising three parts: a balanced scorecard, data on the patient experience, and an online dashboard. These indicators influence which services are to be given attention, impacts on the annual plan regarding which services are to be inspected, and influences the trust’s training and development programmes. It represents a big overhaul of the governance framework, which (in Acosia’s words) ‘has moved from counting to a quality focus’. There is now a peer review approach to reviews, which also involves service users.

Due to the involvement of staff in these reviews, they are now seen as helpful, because they are owned locally; people no longer feel that they are ‘having things done to them’. Indeed, teams sometimes actually ask for a QA review. Often, this is because they feel they are doing well and want this to be recognised; alternatively, the manager sometimes has concerns and wants support in tackling these.

#### System leadership

The Nye Bevan Programme encouraged Acosia to see the wider system, and take a leading role in bringing together different organisations. Inspections and reviews carried out under the QA framework take a systems approach: CCG commissioners, local councillors, patient groups and Health Watch (HW) community representatives from both Camden HW and Islington HW are engaged and involved with inspections. Previously, CCG people were involved only in the formal quarterly reviews. Acosia felt that her approach to other organisations, to get buy-in and involve all the right people, ‘was very much influenced by Nye Bevan’.

#### Ability to engage with patients, service users, carers and families

Serious incidents can occur relatively often in mental health trusts, and it is very easy to adopt a defensive attitude. Influenced by the patient representatives that she met at the first residential for the Programme, who were unhappy at the complaints processes they had encountered, Acosia encouraged her trust to be more open and to work with patients and families to improve things together. External personnel now come in to support investigating serious incidents to provide independence and challenge; there is engagement with the patient’s family up front; and the family is kept updated throughout. In addition, the trust holds a ‘learning the lessons’ workshop, to identify what went wrong but without blaming. The task of the group is to come up with, and own, recommendations that have a practical, local focus. Finally, the trust worked with CCG and Public Health to carry out a thematic review, and pledged to publish the report.

Acosia said that she had been helped by the ‘subtler aspects’ of Nye Bevan: knowing who to approach, and how to gain leverage (eg by identifying the interests of other people) without being confrontational and alarming. She and her colleagues who were interviewed for the case study felt that this serious incidents thematic review has encouraged the organisation to be more public-sharing and more outward-facing, and importantly, has included families and service users in the process.

Perceptions of others

An executive team member who was also Acosia’s line manager, a colleague, and a team member (one of Acosia’s direct reports) were interviewed as part of the case study.

Their perceptions are summarised below, under each of the eight Nye Bevan learning outcomes.

#### Ability to lead with confidence

Acosia’s direct report and colleague felt that she was a confident leader whose confidence had grown through being on the Nye Bevan Programme. One said: ‘She’s very good at this, including making difficult decisions. She has cordial relationships but can make unpopular decisions and have a different viewpoint’.

#### Ability to create the right conditions for frontline staff

Although Acosia is in a corporate role, her work with frontline staff in the trust (the QA reviews and subsequent action plans) was mentioned by all interviews as impressive and effective. A colleague pointed out that when Acosia started working in Business Performance, a key focus was to understand the link between the key performance indicators and the quality of care: ‘We successfully made those links – so now, when negotiating with CCG for contracts, we can be very confident that the data actually represent the quality of care’.

#### System leadership

Here, Acosia was felt to ‘promote the sharing of good practice’ and ‘develop relationships with stakeholders and understand how to approach them’. The thematic review of serious incidents, and the new QA framework, were both evidenced as examples of success.

#### Readiness to operate successfully at executive level

Interviewees felt that the trust’s executive team considered Acosia to be a trustworthy ‘key player’ on whom they relied; the team actively sought her advice and guidance. Examples were also given of Acosia having to present papers to the Board and fight for resources – where the ‘robust confidence’ built up via the Nye Bevan Programme has paid dividends.

#### Ability to engage with patients, service users, carers and families

Acosia was described as being ‘very focused on service users.’ Although her role meant that she was not in such frequent contact with service users as in previous roles, Acosia had actively promoted patient/family engagement via two means: a new service user strategy, and the creation of a new patient and public involvement role within the team.

#### Attainment of a solid foundation of knowledge and networks

Interviewees mentioned Acosia’s confidence in working in a lot of different settings: clinical and operational, but also the corporate and strategic area represented by governance. She has been helped by the Programme, which has given her a close-knit circle (her learning set) of peers with whom to discuss ideas and approaches. One interviewee said that Acosia ‘mentions other Nye Bevan people a lot’ and added that ‘she wasn’t previously a networker, now she is’.

#### Critical awareness of personal approach to leadership

Here, Acosia was described as ‘very self-aware’ and open about her personal style; in addition, she was considered to reflect on her interactions with people in a conscious way, and to think carefully about how to approach issues and people. One colleague said that she was ‘firm but conscious of other people’s feelings and thoughts and perspective’. Another appreciated Acosia’s willingness to encourage people in her team to be more self-aware, via individual conversations.

#### Ability to work constructively within a team

Acosia was described as an excellent team player/leader, who maintained an open culture and encouraged constructive challenge, while retaining the ability to make decisions. One interviewee said that she ‘helps people to get there, with no panic or fire-fighting’ while another remarked that she was never dismissive of people.

Regarding the specifics of **staff engagement** and **stronger team working**, Acosia has strengthened these via establishing clarity of roles in the department – distinguishing them and eliminating overlaps. On a personal level, both Acosia’s direct report and her colleague felt supported and helped in their jobs. As one said, ‘She’s willing to focus on making it feasible for staff to do their jobs’.

With regard specifically to stronger team-working, Acosia has completely restructured the team dealing with governance and assurance. The new QA model is unique and powerful, and the methodology engages staff; Acosia was a key driver in this.

Success factors

A variety of factors seem to have contributed to Acosia’s successful progress through the Nye Bevan Programme.

1. Her personal level of commitment was high, and has gone hand-in-hand with persistence and resilience. Acosia focused strongly on getting the best out of the Programme: ‘People should stop giving it such a hard time. What I’d say to people is that, as a senior person you’re responsible for yourself. The reason I’m so upbeat and positive is because of what I put into it. What you get from the Programme is your responsibility’.
2. Acosia has received support from the top of the organisation, with her line manager – a member of the executive team – being fully committed to her participation, despite some reservations about the Programme which are described at the end of this case study. The support was particularly willingly given to Acosia because of her drive and determination to get the best out of the Programme. As one interviewee put it, ‘Acosia has a very demanding, unpredictable role, and works like a train’.
3. In addition, Acosia has received support and encouragement from colleagues and her team, who have been pleased that she is on the Programme and interested in her progress and the learning she has shared.
4. Acosia herself particularly valued the support and challenge she received from her learning set, and the opportunities it offered to sound out new ideas and approaches: ‘Senior roles are quite lonely and the networks is the thing I’ll take the most from. The learning set is great when it works well. We continue to meet for set meetings. We’ve moved beyond the set to supportive, beneficial friendships – key relationships across the NHS system.’
5. Finally, relationships with other organisations in the wider health economy (the CQC, Health Watch, patient groups) are positive and collaborative, due to a considerable extent to Acosia’s own leadership. This has helped Acosia to demonstrate her impact as a driver for change.

The combination of these factors, and notably Acosia’s own persistence, hard work and drive, seem to have worked together to produce a successful outcome for both Acosia and the trust. It was pointed out that the combined demands on Acosia of her job and the Programme constituted a heavy load, but that she had kept going without complaining.

Where next?

#### For Acosia

Acosia felt she would start her new role equipped with a variety of tools and approaches gained through being on the Programme, and with the valuable support of a network of trusted contacts. There was considerable goodwill in evidence towards her, even though there were anxieties about how the trust would manage without her. This did not mean that she had no more learning to do; the executive team member felt that Acosia had grown impressively although she ‘still has more learning to do around different approaches … She’s developing more strings to her bow.’

#### For the Programme

The member of the executive team expressed misgivings that the NHS Leadership Academy had not engaged more with the trust (for example, to find out about their expectations and the leadership work that they were already doing). This was contrasted to Middlesex University, the trust’s partner higher education institute, which works closely with the trust; symbolically, an executive team member attends all the graduation ceremonies.

There was also concern that the NHS Leadership Academy was not providing any advice to the trust regarding the best ways of taking advantage of the shared learning from programmes such as Nye Bevan and Elizabeth Garrett Anderson: ‘It needs facilitation’. Compared to other Programmes, Nye Bevan was considered to be ‘in a special and privileged class’, but there was a danger that it would not retain this position and would lose its cutting edge because other, rival programmes were becoming available – including high-quality internal offerings. Despite these reservations, the trust has supported the next cohort of the Programme and paid for another senior manager to go on it.

As far as Acosia is concerned, there is a belief at executive team level that the Programme has met expectations, but this is not an entirely confident belief due to a lack of understanding about its theoretical underpinning and a lack of information regarding how sponsored people were doing; there were, for example, no seminars or webinars for sponsoring organisations.

Most valuable learning

There was general agreement that both Acosia and the trust had benefited from the Programme, and that it was hard to separate one from the other. Acosia herself explained:

“I’ve benefitted greatly ... In the last six months I had to front two health overview and scrutiny committees and talk about the CQC inspection. These were webcast events with journalists in the gallery. Had I not had the opportunity to test that out in the simulation, to test out what I did well, to get the feedback relating to embodied leadership etc., I wouldn’t have been able to handle those situations with the same level of confidence … The Programme really does prepare you for real life situations ... If you take it seriously, it works ... The one thing it does is help you to think.”

The executive team member interviewed for the case study was very positive about the impact Acosia had made, and felt this was at least in part down to the Programme. In particular, the trust’s performance has improved: ‘Everything is on track. Acosia really has a grasp on performance. With regard to system leadership, she’s a real credit to the Programme’. Acosia’s understanding of the ‘big picture’, and of wider system relationships, had been particularly strengthened by being on the Programme. She has also made the organisation reflect: ‘At one point, she did a Board exercise and demonstrated powerfully how it feels to be a mixed race woman, with a lack of role models in senior positions. It made me thoughtfully consider how powerfully she was demonstrating this aspect of leadership’.

A colleague believed firmly that the organisation had benefited considerably: ‘The structure of the team and processes work better across the trust. She’s led lots of working groups, like the serious incidents review group, to engage clinical managers’. Another stressed Acosia’s ability to improve other people’s performance, stating that she had improved staff’s confidence and ability to deliver, and involved her teams and colleagues in a very effective way: ‘A good leader brings people along in a very positive way – Acosia really has this. Not all NHS leaders are like this – there are threatening bullies who blame others … she helps her team to be part of a big picture’.

#### A final word from Acosia

When asked to describe the Programme from her perspective, Acosia used the following words:

* Experiential
* Valued
* Essential
* Patient-centred.

She added that it was particularly good for really committed and conscientious leaders in the NHS:

‘Our stories are different, but the NHS attracts people who really bust a gut.’

Carolyn Fowler

The organisation: East and North Hertfordshire NHS Trust

The East and North Hertfordshire NHS Trust has over 5,000 staff and treats around 600,000 people a year at its four hospitals in Hertfordshire and north west London. These are Hertford County hospital, Hertford; The Lister hospital, Stevenage; Mount Vernon Cancer Centre, Northwood (one of the country’s top five cancer treatment centres); and the New QEII hospital, Welwyn Garden City.

The Trust’s vision is ‘to be amongst the best’ across its range of general and specialist services. Between 2009 and 2014 the Trust completed the Our Changing Hospitals (OCH) programme at the Lister Hospital, one of the most complex recent service reconfigurations in the NHS. The OCH programme invested £150m to transform emergency and inpatient care for local people. The New QEII hospital in Welwyn Garden City was also designed and built during this period, by the local Clinical commissioning group. The new hospital opened in June 2015.

Carolyn’s background and role

Carolyn Fowler is the Deputy Director of Nursing, Education and Patient Experience for the Trust and is based at The Lister hospital, where she has worked for the past two and a half years. Her wide-ranging role encompasses legal services; patient advice and liaison; complaints; chaplaincy; the nursing and patient experience; resuscitation; nurse research; as well as nurse development and learning.

Before joining The Lister hospital, Carolyn was Nurse Director for the Mount Vernon Cancer Network, and has a masters’ degree in education to support her in that role. She then moved to The Lister in an interim role as Assistant Director heading up education before being appointed as Assistant Director of Nursing, Education. The opportunity of a secondment to the more senior Deputy Director of Nursing role came up shortly afterwards, but Carolyn decided not to apply at that time because she was relatively new into her post and wanted to deliver on that first. When the permanent position came up the following year, however, she applied and was promoted into that role.

Programme participation

Carolyn embarked on the Nye Bevan Programme in November 2013, when she was Assistant Director of Nursing, Education. She had not previously been involved in formalised leadership training and wanted to understand the theory better and to be clear on where she sat in leadership terms by understanding better what she was good at and where she needed to grow. Carolyn completed the Programme a year later in Autumn 2014. In July 2015, she was promoted to the Deputy Director of Nursing role. She is now actively participating in a development programme for aspiring directors in Hertfordshire and Bedfordshire.

Impact since the Programme

#### Developing as a more confident, compassionate leader

When Carolyn embarked on the Nye Bevan Programme she was concerned that her style of leadership might be different to what is traditionally expected. She is not an authoritarian, directive style of leader, so she warmed to messages she picked up from the Programme about moving away from those old models of leadership to a more compassionate approach to leadership. Of key importance for Carolyn was being able to maintain who she is while being effective in a Director role.

As Carolyn worked through the Programme, staff saw her gaining the confidence to develop her own style of leadership. Staff and colleagues felt she had developed a greater breadth of vision and more exposure during the Programme. One member of her current team commented; *“At the end of the course, I could see the Director of Nursing in her”*.

Carolyn has since been put forward for an NHS Health Education East of England leadership award in 2015, a nomination that was supported wholeheartedly by a wide range of staff groups at the Trust. She was selected from 202 nominees as one of just 15 finalists.

#### Adding value every day

For Carolyn, the Nye Bevan Programme has enabled her to be *“more in the present and mindful in day to day leadership”*. Her colleagues agree. Rather than pointing to big projects, they highlighted the ways in which Carolyn adds value every day through her interactions:

“If you look at every interaction with every single person every day, there’s a quality that she’s added to every one of those interactions”.

Lots of tiny things add up to having a big impact on staff and patients and so the organisation has benefitted several-fold from her participation in the Nye Bevan Programme, we heard.

A specific project where she has applied key learning from the Programme was the OCH change programme which, last year, involved the brining together of all of the trust’s remaining emergency and inpatient care onto the redeveloped Lister Hospital site, affecting 3,000 staff. Knowledge about transition, that Carolyn gained on the Programme is embedded in her now and helped her to recognise where staff are still in the process of psychological change.

#### Authentic, approachable leadership – creating the right conditions for frontline staff

There is no smoke and mirrors with Carolyn, she is consistent and people respect that. She is seen as fair and reasonable, ready to take others’ views on board in making decisions and ready to give credit where it is due. She also takes time to explain why she has made a decision and how she came to it.

Carolyn has a very high profile with nurses in the Trust. She has done a lot of work on expanding nurse education and raising its profile, as well as being a powerful advocate for recruitment into nursing generally and, more specifically, into the Trust.

People suggested that she is not influenced by status and that her values are true. A colleague said poignantly:

“I’d follow Carolyn into the abyss, because if she was going into the abyss it’s because it would be the right thing to do”.

She was described as having retained her approachability and humility as she’s risen through the hierarchy. People know she will listen if they go to her with a problem. They feel safe to admit a mistake, to share emerging ideas or to *“have a wobble”*. Carolyn remains someone who can engage with anybody at any level, including with families, patients and support workers.

#### Fostering strategic, person-centred care

Carolyn is not at all detached from frontline clinical work in her Deputy Director role, we heard, although she easily could be, and spends a lot of time on the wards with clinical staff.

She is seen as highly patient centred. An example was coming across a patient who was having difficulty getting from the car park to the hospital. Rather than asking someone else to do it, Carolyn got straight onto it. She got a wheelchair, helped the patient into it and over to the hospital before handing them over to another member of staff. She is also very open in using patient stories where something has gone wrong and took a patient to a conference to tell their story.

Fostering person-centred care is central to Carolyn’s personal ethos, but since the Nye Bevan Programme, she does this at a more strategic level. Although now involved in the high level management of the Trust, a colleague commented that Carolyn has not lost sight of what the whole thing is about (i.e. patient care), which is not an easy to do.

#### Putting the challenge into compassion

Carolyn’s brand of compassionate leadership is no push over. She is quite prepared to tackle difficult challenges and has taken tough decisions on staffing and HR issues.

Since the Programme she feels she is better at holding people to account and confronting poor practice. In fact, as a strong patient advocate, even stronger she thinks since the Programme, Carolyn has no problem challenging poor practice if she feels the patient experience or safety has been compromised. On several occasions she has taken action to rectify patients’ outcomes and now makes sure she uses that learning to ensure the same thing does not happen again.

While it can be harder to tackle intangibles such as someone’s commitment, she does not shy away from those challenges and employs some of the difficult soft skills, such as really good listening, to help her to get results in changing behaviours. The relationships she has developed help Carolyn to ensure she has the communication channels she needs to manage complaints or difficult decisions effectively. The latter was something that Carolyn used to find difficult. But now she has become something of a role model in this area with people looking to her to make decisions when they are unsure. We heard that *“she is able to pick up the hot potato”* and will always deal with a problem*.*

Perceptions of others

#### Resilience under pressure

Carolyn continues to take here development as a leader seriously since completing the Nye Bevan Programme and is willing to put herself in uncomfortable places to do so. In early 2015 she was asked to go forward for a Health Education East of England programme for aspiring directors. On an immensely stressful assessment day for the programme, Carolyn was put under extreme pressure and, according to a colleague, *“displayed a huge depth of character”*. Despite being knocked back during the process, she got through it and performed well, becoming one of 13 out of 20 people who were then put forward for the programme.

We saw this resilience under pressure for ourselves as our case study visit was scheduled hot on the heels of a CQC inspection. It turned out to be a week that was characterised by unannounced visits and a large number of data requests. In short, it was a very busy and highly pressurised period for leaders within the Trust. Yet Carolyn greeted our researcher with a welcoming smile and a calm air; a small, but important act of leadership. Others followed her lead and made time for our conversations amid the pressure.

Despite what is seen as *“an enormous and unremitting workload”* Carolyn maintains her calm and her can-do approach and does not let things fall to the ground.

#### Inspiring others

For staff, the bottom line is *“she’s amazing!”* They really value her supportive style and the way she has helped them to lead difficult projects, such as a big R&D consultation for the Trust, without taking over. Not only is Carolyn approachable, she also makes sure she is available when and where staff need her. She has been described as inspirational:

“It is the way in which Carolyn leads her team and touches everyone she comes into contact with, that makes Carolyn stand out as an inspirational [leader]”.

“She sees the potential in all - I am at my best when working with her, she inspires me to be the best I can be”.

“She makes you want to get up and come to work”.

“When she asks you to do something, you want to do it”.

Success factors

The Trust has supported Carolyn’s continued development and has given her the opportunity to demonstrate her leadership abilities in more challenging roles. Yet Carolyn herself has also created a strong platform for success through her ability to develop strong, trusting relationships with a wide variety of people.

Where next?

Carolyn aspires to a Director of Nursing role. She deputises for the Trust’s Director of Nursing from time to time, which is helping to develop her knowledge in this area. She feels she has the skills needed for a director-level role, such as making difficult decisions, and is working to develop the wider knowledge necessary for this role in an acute trust, so she is ready for a director of nursing role in a year or so. *“She’ll make a great director of nursing”*,we heard, as she has an ability to balance logistics, operations, finances and staffing pressures – *“and doesn’t let it get in the way of patient care”*.

Most valuable learning

For Carolyn, her most valuable learning from the Nye Bevan Programme was learning to be honest with herself, really working out who she is as a leader and what she is really good at. She commented; *‘the Programme had more effect on me than anything else I’ve done because I really faced myself*’. The challenge she experienced in the programme and putting herself out of her comfort zone was invaluable training for her current role, where she does not have a safety net.

Having internalised learning and self-reflection into her everyday practice, she now thinks critically all the time. A colleague explained: *“If you look at every interaction with every single person every day, there’s a quality that she’s added to every one of those interactions”.* Lots of tiny things have added up to having a big impact on staff and patients and so the organisation has benefitted several fold. *“The Trust is a better place for having her”* we heard.

Catherine Randall

This case study is based on interviews and a focus group supplemented by some desk research comprising:

* Two interviews with the Nye Bevan participant (May and November 2015)
* A focus group of five direct reports (November 2015)
* Interviews with two Executive Directors in November 2015
* Interview with CCG Deputy Chair and Lay Member for Quality and Patient Involvement (November 2015)

The organisation: East Lancashire Clinical Commissioning Group (CCG)

East Lancashire CCG is in its third year having been authorised without conditions by NHS England in April 2013. The CCG is one of the largest Groups in the North of England with 58 GP Member practices and 102 staff. It commissions and monitors the quality of healthcare to meet the needs of local 371, 500 people with a budget of approximately £518m. In 2014-15 it met its statutory duty by delivering the target surplus of over 1 per cent.

Four out of the five boroughs in East Lancashire contain high levels of deprivation and child poverty. The CCG describes itself thus,

"We were formed by like-minded general practices concerned with supporting the NHS in providing quality and excellence in cost effective services that are delivered with compassion and care. If, in the words of the NHS Constitution, the ‘NHS belongs to the people’ then patient, public and partner engagement should feature in everything we do. ‘

The CCG was shortlisted for 2015 Health Service Journal Awards in the ‘CCG of the Year’ category.

Catherine’s background and role

Catherine trained and worked as a nurse and midwife before becoming a health visitor. She worked supporting families in some very hard circumstances in a neglectful and deprived area of Preston before becoming named as the designated nurse for safeguarding in Preston. In September 2008 she took on a brand new integrated role leading on the Children’s Agenda working across the local Council and PCT with joint responsibility to the Cabinet and Board.

Catherine currently has a split role at East Lancashire CCG. She reports to the Director of Performance and Delivery for three days a week responsible for a portfolio of areas including Children and Young People, Maternity, Child Mental Health and Cancer. She is also the lead for Hospices, Third Sector work, Primary health workforce development and the placement of doctors in primary care. Her team also works across the neighbouring Blackburn with Darwen CCG (on a shared service basis). This entails working to two Executive Boards and within two organisational structures.

Since April 2014, Catherine has also reported to the Chief Nurse for two days a week working across the 58 GP member practices and the local acute trust leading on revalidation of the nursing workforce, training, education and on the CCGs Compassion in Care Initiative.

At the time of our visit in November 2015 Catherine had just announced her success in achieving a promotion to Chief Nurse at Trafford CCG. This is a brand new post with strategic responsibility on the CCG Board for safeguarding, quality and the nurse agenda.

Programme participation

#### Why the Nye Bevan Programme?

The opportunity came through her Executive Board who went out to everyone in the organisation asking for nominations for all the Leadership Academy programmes. She says the Nye Bevan Programme suited her because of where she was in her career. She says:

“I had done other leadership programmes, a BA degree and masters. I wanted to progress but wasn’t sure what the right programme would be for me. My Directors were very much involved in supporting me.”

Nye Bevan participant

One of the Executive Directors explained that Catherine was already on the Nye Bevan Programme when she became her immediate boss but that she chose to support her attendance by re-designing/’splitting’ her role to allow her to put into practice the ideas she was learning on the Programme:

“At the start of Nye Bevan Catherine knew she needed to develop her nursing leadership role. Aspiring to it is different from demonstrating you can do it. I thought the Programme was helping her understand what a Chief Nurse Role looks like and what she needs to demonstrate to get the next job up. So we gave her two days a week to move away from solely a commissioning role to support the nursing agenda as Deputy Chief Nurse. Among other things, she has led two significant pieces of work which have had a huge impact on the CCG. “

Director of Quality and Chief Nurse

Impact

#### What Catherine has done that she attributes to the Programme, in whole or in part

#### Patient centred care

Catherine says that patients were already at the heart of everything the CCG do and there is a strong patient engagement culture with patients on the governing body and most committees. Nevertheless she feels the Programme has added an extra dimension to this and enabled her to evidence that they are doing so. As she explains:

“I’ve made sure patient stories are not tokenistic and are told in real time. As a result of the Programme – I’m the lead for cancer services – I asked a cancer patient to speak to our Board. It was very powerful because it hadn’t happened before. I’m also the lead for maternity. We had never had mothers coming to the Governing Body before to tell their stories. The mums brought their babies, related their experiences and breastfed. Now there is a patient story in real time at every board meeting, with consent and support. I see them beforehand so they’re ready to come into a committee of 20 doctors and feel supported to tell their story.”

Nye Bevan participant

Her focus on patient-centred care is confirmed by all other interviewees whose observations included the following:

“Catherine went about re-designing primary care pathways locally through real co-design with patients and clinicians. Not just talking to patients about pathways but really listening to them and involving them in making it happen.”

Executive Director

“We are all patient centred here. We are all on the same page. It is our culture. Catherine drives and promotes that”.

Direct report

“Leaders need values to be authentic. Catherine's starting point is the patient being heard and listened to. She inspires people to realise that doing the little things are important to patients.”

Lay Member for Quality and Patient Involvement

#### System Leadership

Catherine describes her impact on system leadership in the context of the Compassion in Care Initiative. She says:

“As a nurse, one of the values I have is around compassion and care. The Nye Bevan Programme has given a boost of confidence and courage to actually do things without always seeking permission. I led compassion and care engagement days in five localities where I invited GP practices to come together and explore the importance of compassion in practice. We went back to basics with nurses, doctors and primary care staff. Explanation re the importance of introducing yourself to patients and the concepts of 'hello my name is ' was highlighted. Now GPs practices introduce themselves in person, on their letter heads, in email signatures, social media etc. I also led another day with our stakeholders including organisations that we commission. Our CCG expect all our commissioned providers to have core values of care and compassion. We are now getting feedback from patients that it's made a difference.”

Nye Bevan participant

Catherine’s pivotal role in introducing the Compassion in Care initiative was confirmed in various ways by all of our other interviewees and focus group attendees. Everyone also referred to the ‘seminal’ visit to the CCG by Dr Kate Grainger, who came at Catherine's invitation, to share her story of being a patient. Specific comments about Catherine's role included:

“Catherine sets the culture for compassion and she lives those values. She took the national nursing strategy aligned it with CCG vales and really galvanised staff in nursing homes and GP surgeries and elsewhere to embed it and really think about what it means in practice. She provided leadership within the local health economy on this and we have seen benefits from this natural progression of going back to basics in terms of staff engagement and patient satisfaction.”

Executive Director

“The NHS looks to data. Compassion in Care did not have data behind it when Catherine first pitched her team’s idea to the board. It was grass roots –led and she supported her team 110per cent. The idea felt radical at the time although it instinctively felt right. It is more than a name badge; it requires working and thinking in new and different ways. Catherine sold it and I helped her. We have had tremendous feedback on increases in the quality patient experience. Other commissioners need the evidence for system-wide change and we now have it.”

Lay Member for Quality and Patient Involvement

She shines as a leader. Her enthusiasm and compassion for patients is evident in everything she does. She made us the first CCG in the country to adopt the ‘hello, my name is…’ badges. Catherine led the work here and rolled it out in other local organisations. Someone from Boots the Chemist came to one of her events and now they are adopting it nationally in all their pharmacies.”

Executive Director

When I had an idea in March about Compassion in Care Week she believed in me, she pitched the idea to the Board and we did it in June. It may not have happened without her.”

Direct report

“We have staff stories on You-Tube from practice nurses and a manager in a care home talking about what they have done and the differences it has made to their patients. The video taken of Melissa O’Rourke (Manager of a Care Home) talking at one of our events has had over 400 views so far.”

Lay Member for Quality and Patient Involvement

Other examples of Catherine's achievements were provided in the context of systemic leadership work. We heard how she has the confidence of all 58 members and wider stakeholders. One example given was when a local community organisation who provides services for children and young people wanted to move services from GP practices across Lancashire and into Sure Start Centres. Local GPs had concerns about safeguarding and patient care and perceived that the plans were driven by financial rather than patient concerns. Comments included:

“Catherine had the confidence and skills to step up and negotiate a way through the dispute.

Executive Director

“Catherine had a difficult job. There were lots of power dynamics going on. She robustly challenged the provider. It could easily have become antagonistic. I first saw Catherine in action four years ago when she was in a PCT commissioning role and she was good then at resolving disputes by sitting down one on one afterwards but now she can do it in public and in meetings in front of everyone.”

Lay Member for Quality and Patient Involvement

#### Use of Social Media

Catherine also identified social media as an area the Nye Bevan Programme had transformed her leadership practise.

“One of my personal learning objectives – something I was not very good at -was to try Twitter. Communication via Social media concerned me and something I was very unsure of. A participant on cohort 6 wanted to try and use Twitter for feedback and reflection, so on April 1st last year, we set up Reflection of The Day on Twitter [#ROTD]. Then there were four of us. We had tweet chats every other Wednesday evening for 12 months and we’d get people from all around the country taking part. Topics were around leadership, compassion, equality, reflection and diversity. We have now reached 2.5 million impressions. The four of us were shortlisted for the national safety awards because of the changes we’ve made through Twitter. It never would have happened without the Programme.”

Nye Bevan participant

Others we interviewed also mentioned the value of Catherine's confidence with social media:

“She broadens our horizons about what’s going on. She picks things up on social media and brings them into our organisation. She found out about the Vanguard work going in Manchester through Twitter. There is also a professional benefit in letting others see what we are doing.

Executive Director

It fits with our values of openness and transparency and patients are getting more involved in the organisation via Twitter.”

Executive Director

“Having people like Catherine tuned into social media has helped the CCG with innovation beyond most commissioners’ comfort zone. Our maternity services provider has got financial and staffing challenges. Nevertheless progress is being made by patient-led groups looking at non-traditional ways of communicating. We have got an app to support service users and Facebook support for new mums and women who have lost babies. At the time people using maternity services, most want to contact family but they couldn’t get a mobile signal or re-charge their phone so we have made a phone available.“

Lay Member for Quality and Patient Involvement

Perceptions of others

Catherine's colleagues all perceive that local services and the wider NHS have benefited from her participation in the Programme as well as Catherine herself benefiting. Specific comments included:

“She has always kept her team in the loop and was always enthusiastic but now she has added a person-centred angle to the CCG. She is a good example of distributed leadership. She listens to our ideas. She doesn’t mind being criticised. She can stand out and be objective.

Direct report

Her confidence in her own abilities and skills has grown. Before [Nye Bevan] she used to think ‘Maybe I can do that’ but now she thinks ‘I can do that’.”

Direct rep***ort***

Being on the Programme has made a big difference to her approach. Nye Bevan has helped her clarify her thoughts, given her the confidence to go ahead and take things forward. Trafford CCG is getting an enthusiastic and competent nurse leader who can demonstrate this. But our CCG has benefitted directly too.

Executive Director

“It is hard to lose someone who has been so good for our organisation. I am glad for Catherine that she has gained increased confidence and is stepping up into another job. This is good for the NHS more widely as we are getting leaders for the future with a new less hierarchical mind-set. And our CCG has benefited from her growth and confidence during her time on the Programme and since.

Executive Director

Success factors

Interviewees reflected on Nye Bevan Programme more widely and identified two organisation factors as important.

#### Supportive leadership

We were told that succession planning is a key responsibility of the Executive team. Within this context, Nye Bevan is seen as a worthwhile time and investment by the Executive team to support leaders across the CCG and this has helped Catherine (and another colleague in a later cohort of Nye Bevan) to make the most of the opportunity that the Programme provided. Other leadership options available locally are also encourages and supported eg Masters or MBA programmes or a suite of other training courses. We were also told that the organisation would be willing to support someone else in future to do Nye Bevan in principle especially if they were a clinician relatively new in a clinical leadership role. However there were some concerns about the cost in the context of an NHS in financial distress. One person suggested the cost per participant simply had to be brought down, perhaps by reducing the ‘taught’ time element. Another suggestion was for more free places or bursaries to be re-introduced in order to get equity of access across organisations as ‘*How can acute trusts in deficit make this kind of investment otherwise?*’

#### Supportive organisational culture

A number of interviewees explained that the CCG is clinically-led with a patient-centred culture. We were told that co-production with all stakeholders is the one and only way that work is conducted within the organisation. This means that Catherine was able to put into practice what she was learning. Whilst some people felt that the good relationships locally with other organisations in the local health system was an important factor in helping all people on development programmes to pursue a patient-led agenda, others were keen to acknowledge Catherine's own contribution to establishing these good relationship in the first place.

Where next?

In the immediate future, Catherine plans to focus on her new job as a first-time Chief Nurse at Trafford CCG getting to know who the team are, understanding the specific issues, strengths and challenges and developing new relationships. She is mindful that, with her past promotions within her present CCG (and PCT before that), some of her success has been down to her insider knowledge and local networks whereas in her new role she will be starting in a new location without these advantages to help her. She says she has other advantages however:

“I am coming from a CCG where the bar is very high. I know what to expect from myself, my team, my organisation. I can transport all of this learning and knowledge to Trafford CCG.”

Nye Bevan participant

Most valuable learning

Catherine says the most valuable thing the Programme has done for her is:

“I was pushed into situations I’d never have done otherwise. It gave me the toolkit, confidence and motivation to apply for the next level.”

The single most important thing Catherine has been able to do for her CCG because of the Programme is:

“…our patients now have been put further at the heart of our decision making through compassion days and patient stories. By delivering and believing in patient core values, I can now see that my whole team are also behaving in the same way. There’s been a whole shift. “

Fiona Goudie

The organisation: Sheffield Health & Social Care NHS Foundation Trust

Sheffield Health & Social Care NHS Foundation Trust provides a wide range of specialist health and social care services, including mental health services for adults and older people, services for people with learning disabilities and services for people with drug and alcohol problems. The Trust works alongside other organisations in the voluntary sector, with GPs and in partnership with Sheffield City Council, providing services on their behalf and has made good progress in developing integrated services. Its vision is to be recognised as world class in terms of co-production, safety, improved outcomes, experience and social inclusion.

Fiona’s background and role

Fiona Goudie is a Consultant Clinical Psychologist and spends fifty per cent of her time as Clinical Director for Strategic Development, which involves both working inside the organisation with the Board (although not as a Board member) and externally with multiple agencies across the city of Sheffield.

Her Chief Executive felt that, having been in a developmental role for a couple of years, it was a good point in her career to attend the Nye Bevan Programme to stretch herself further. He acknowledged the challenges of her senior position, working at an executive level without the positional authority that goes with it and having to exert influence beyond her direct line of authority. He believes that it is outside the organisation that one’s true leadership skills are honed and exercised:

That is the future. Managing what you have control over is relatively easy but a leader’s job is to influence beyond the boundaries of their authority. For so many people that is a huge transition.

Programme participation

Fiona joined the Programme in January 2014. She was already working across the organisation and leading a city-wide whole systems piece of work that was externally facing, and was interested in taking a national leadership role perhaps with the Department of Health, NHS England, or one of the vanguard sites.

Impact since the Programme

#### System Leadership

During the Programme Fiona was leading on a cross-system project on serious mental illness (SMI) and physical health, which involved collaboration with GPs, local authority colleagues, acute trust, service users and the CCG. She was able to focus on this project, known as ‘Right First Time’, as a learning opportunity on the Nye Bevan Programme. Right First Time aims to reduce unscheduled care and build community resilience and self-care, recognising that people with SMI in Sheffield are more at risk of an acute hospital admission than the general population.



The project manager highlights Fiona’s determination to ensure that everyone on the Committee had a voice and, more importantly, she listened to the different perspectives and followed up on every detail. In particular she took care that the Service Users felt well supported and prepared, sharing any necessary information and concerns beforehand and giving them a standing item at each meeting.

As a result, the project manager believes that attendance at meetings remained high, unlike other projects where attendance tended to dwindle over time. She says,

There are always excellent ideas and a lot of that is down to Fiona with well-prepared agendas. After the meetings there was always a full debrief with Fiona and the Project Director to exchange feedback, and support and agree actions.

Although the project has now closed, learning continues to be disseminated with a wider group of GPs to validate the approach, using the risk stratification, the care planning template across primary and secondary care and the learning about how a community development worker might improve access to health screening, interventions and self-managed lifestyle changes. In addition the model has been incorporated into the city’s integrated commissioning plan for Keeping People Well (KPW). Dissemination has involved:

* Running workshops and presenting at a city wide Physical Health Conference event called ‘20 Years Too Soon’
* Contributing to GP master class and PLI events.
* Securing resources to develop an e-learning package for health and social care professionals to raise awareness about reduced life expectancy, provide information about recommended screening, joint working and how their role could improve the health of people with SMI.
* Sharing learning with Public Health England.
* Users attending a service user network to talk about the partnership work.
* Shortlisting as finalists in the Medipex NHS Innovation Awards 2014.
* An article in Your Voice (user-led mental health magazine)
* Providing feedback on Sheffield’s Integrated Commissioning plan about the importance of parity of esteem within integrated commissioning.
* Ensuring mental health user involvement at the outset of the development of Sheffield’s Prime Minister Challenge fund bid (which was successful).

A GP endorsed the project and ongoing learning:

The physical health of those with Mental Illness is now an identified commissioning priority for NHS Sheffield Mental Health Commissioning Team. We are actively engaged in citywide work around this and related topics, and take every opportunity to embed the learning from this project into all areas.

The project was short listed for a Positive Practice in Mental Health award in two categories. It won the Integrating Physical and Mental Health category and was also highly commended in the Partnership Working category.

#### Co-production with service users

One important learning point for Fiona from both Nye Bevan and the Right First Time programme was that there is a difference between consultation and co-production with patients or the public. Fiona recalls,

We had good sessions on that in the Nye Bevan Programme and at the same time I was chairing the steering group and our service users were already saying, ‘we don’t think you get it when we talk about engagement – having us round the table is one thing, but we should be involved right from the start in designing, in co-producing’. The Programme made me realise that this was a challenge about how we do things around here.

A Service User on the steering group felt that Fiona went beyond simply being welcoming and ensuring that everyone’s voice was heard, she also resolved practical issues for steering group members such as the difficulties of wheelchair access around the building where the meetings were held. One Service User believes,

Fiona grew in confidence, becoming more assertive and displaying the values and principles around involving people – not just users – but all the voices and the various sub-groups. She built up the partnerships with respect for the various perspectives. Her attitudes and values are transparent, open, honest and genuine and she quickly inspires a sense of trust.

Fiona realised that what usually passes for a ‘patient-centred’ approach was still too paternalistic and when she was invited to look at the draft bid for the Better Care Fund by the Local Authority and CCG, she recognised immediately that there was no service user input:

I think before the Programme, I would have said ‘we haven’t got any service-user experience or comments’ and maybe suggest that we needed to get someone to make it user friendly and get some case studies.

Instead she felt she took ‘a braver approach’ which she discussed with her learning set and, having a meeting arranged with the person writing the bid to talk about the gaps in mental health, she took along a service user from the steering group. Although the Commissioner was somewhat surprised, the service user went on to hold much of the air time and even asked for a further meeting because there was more to discuss. As a result things ended up in the document that Fiona would not have known about and believes that in order to demonstrate authentic leadership there must be a commitment to genuine patient-centredness.

This commitment is further demonstrated as each provider hosts an event as part of the City’s CCG’s future-focused 2020 consultation. The service users will take the lead on and co-produce the Trust’s event, supported by Fiona, during which they will explore with people who use mental health services and their carers why mental health and social care services need to change. Fiona reflects,

Some of my colleagues would say that I am the nominated Director for that piece of work but actually I am the support to our Head of Service User Experience. That is how I see it. I am probably now more explicit about things like this.

I feel that there are pieces of work I am thinking about and doing differently now as a result of the Programme. It’s about using my knowledge of the system and my authority, where necessary, to enable other people.

The City has also since secured £9 million of funding for a consortium of 86 GP practices in Sheffield and again Fiona pushed for citizens’ engagement in that exercise. She reflects that,

Since the Programme, that is something that I am more confident about doing, spotting the gaps in whole system representation. I am much more attuned to that. Often clinicians will say, ‘I see patients every day, I don’t need to be involved in engagement exercises. That is somebody else’s job’. But I have changed my thinking about that and I think it is important for role models like me to be posing those questions and pitching up to meetings.

#### Working with the Board

Fiona acknowledges that at one time she would ‘rock up and do my presentation without considering the role and purpose of the board’. She is now more aware of their concerns on risk, assurance and strategy and is more mindful of making a contribution with a sense of purpose, which enhances the effectiveness of the board. Having observed board meetings and interviewed both execs and non-execs about their role, she feels that she has more insight into the politics and sub-committee structure and has a greater understanding of Board climate and culture. She is also more aware of the impact of current changes in the make-up of the Board.

Her colleague who is also a Nye Bevan graduate agrees that they share,

An enhanced polish on the functioning of the Board as an entity, its function, its probity, institutional partnerships and the factors and influences that lead it to be more successful or not. It is more of a shared language, a different conversation and we tend to talk more in that space than we would have done previously. We talk more about what the views of the Board will be on a particular conversation or where individuals are at, and some of the tensions across the whole system leadership in a more politically minded way than we would before.

Perceptions of others

Fiona is described as ‘extremely supportive’ and a good listener to ‘different voices’. On the Right First Time project she is seen as ‘driving through change to become business as usual’, as well as inspiring and ensuring the wide dissemination of learning.

A colleague from the Programme sees a real development in her,

She always put a lot of effort into relationships with the outside world but what I have noticed through the Programme is that she engages with that in a more strategic, organisational level way. She will often be connecting knowledge, information, views and opinions from within the Trust and taking that directly to some of the City-wide work and has a better grasp and appreciation of that City-wide canvas than I have seen before. She takes a clearer role in connecting dots and signposting what it means for an individual’s life. She is conscious of how the conversation we are having here will either help or hinder the reality of people in Sheffield.

Her Chief Executive also sees her performance continually improving, although cannot necessarily draw a causal link from the Programme. He does, however, see her growing in confidence, taking more ownership, being more direct and having an increased ability to work with uncertainty and believes the Programme has been a key part of that and has accelerated her development.

The ambiguities of the role cause her much less concern now than they did two or three years ago. She is much more confident in her abilities to do the right thing and get on with it, involving people when and how she needs to.

He also feels she has ‘a natural understanding about what the rest of us need to know’ and believes that people increasingly respect and listen to her.

Success factors

Fiona has had a lot of support from the CE who is a great advocate of partnership working. He chairs a strong partnership group of providers which involves at the CEs and senior leaders from within each organisation. Fiona is one of those senior leaders. Prior to the Programme she had been attending specifically for the Right First Time project but the partnership has since broadened to involve the third sector (suggested and encouraged by Fiona) and the children’s hospital so that it is now a system-wide grouping.

There is now a sense of building a critical mass of leaders within the Trust. Two of Fiona’s colleagues are also graduates of the Nye Bevan Programme and there are a further four participants currently on the Programme. As a result they have more involvement with other health, social care and third sector organisations at a strategic level across the city and Fiona believes that she has brought this back into the organisation by promoting new partnership opportunities to deliver and contract for services differently.

The Chief Executive believes that ‘building a cadre’ of leaders has been an important step for the organisation. They have chosen people at the right stages of their career and he sees it is a ‘deal between them’ to invest in their leadership development in order for them to become leaders within the organisation. So far the experience has been very positive and he values the reflexive nature of the Programme for developing emotional intelligence. Currently the Nye Bevan Programme is the only one the Trust is using at this senior leadership level. Several members of staff are currently on (or have graduated from) the Mary Seacole Programme.

At a personal level, one of the other graduates feels that they all bring ‘more of themselves into conversations’ which leads to a greater authenticity.

The co-consulting model feels safer between the three of us. There is a level of ‘at ease-ness’ with each other.

They are able to share thoughts and feelings and ask for feedback. They also draw on some of the adaptive leadership and co-creation principles and are a lot more conscious when talking about service re-design how change really happens. It is now less about sitting in a room doing a design then micro-managing and more about creating the conditions for front line staff to engage and ‘create their magic’.

In Sheffield there are a number of other Nye Bevan graduates from various cohorts who meet informally and socially in the region. Members of the learning set remain in email contact and occasionally get in touch for practical help and advice.

Where next?

With only four key Executive director roles in the Trust and a long term CE, there is less opportunity than in a larger acute trust for promotion. Nevertheless, although she does not have a new job, Fiona feels that she has taken on more leadership roles within the whole system and her team has had recognition through recently winning a national award( Positive Practice in Mental Health) She has also been invited to be an Expert Reference Group member on a national body - Achieving better access to mental health services by 2020;Dementia Care Services

Most valuable learning

Fiona believes that as a result of the Programme she has become more resilient in turbulent times. Her colleague believes that among the three graduates there has been ‘a subtle but powerful change’ and that the organisation benefits from ‘a bolder contribution – informed, skilled, considered, confident and with a clearer focus’. He also points to emotional resilience and, as a small group of graduates, their ability to better manage themselves and make a more consistent, higher level contribution.

Dr Jonathan Richards on

This case study is based on ten telephone interviews supplemented by desk research and email exchanges. Interviews were conducted with:

* Nye Bevan participant (May 2015)
* four direct reports at NTW (Oct 2015)
* two colleagues/peers at NTW (Oct 2015)
* one NTW Executive Director in Nov 2015
* a national carer representative (Oct 2015)
* a senior national leader (Oct 2015)

The organisation: Northumberland Tyne and Wear NHS Foundation Trust (NTW)

Northumberland, Tyne and Wear NHS Foundation Trust (NTW) was formed in 2006 and is one of the largest mental health and disability Trusts in England employing more than 6,000 staff. It has an annual budget of over £300 million and serves a population of approximately 1.4 million from over 60 sites across a large area totalling 2,200 square miles. Services include Inpatient Care, Community Services, and a number of regional and national Specialist Services.

The Trust’s stated vision and mission[[1]](#footnote-2) is:

‘To improve the wellbeing of everyone we serve through delivering services that match the best in the world. We strive to provide the best care, delivered by the best people, to achieve the best outcomes.’

Its stated values are to be: Caring and compassionate; Respectful; and Honest and transparent.

In line with other NHS organisations, the Trust is currently undertaking the largest transformation Programme in its history. The service model being used was initially developed through the transformation of urgent care pathway which reduced clinician administration (freeing time to care for service users), improved clinical outcomes for people in crisis, reduced harm and improved safety whilst ensuring service users are not ‘bounced’ around the system.

The Trust has a strong tradition of supporting academic research to ensure patients benefit sooner from new treatments, diagnostics and prevention strategies. NTW was listed as the second most research active mental health trust in England by the NIHR annual league table (2014/15) and an NTW nurse was named national lead for mental health and policing by the patient led Positive Practice Mental Health Collaborative. In addition, the informatics team was a finalist in the 2014 National EHealth Insider Awards and in the 2015 Lean Healthcare Awards for its pioneering Mobile Digital Dictation Pilot in the community using 3G technology.

Background and role

Jonathan’s background is in Old Age Psychiatry. He worked at Newcastle General Teaching Hospital for seven years. When he started on the Nye Bevan Programme in 2013 he was Clinical Director for Informatics and, as the Clinical Director for In-patient services, he was accountable for 12 wards. He was also working as a Consultant.

After two years at Clinical Director level, whilst he was still completing the Nye Bevan Programme in 2014, Jonathan was promoted to Group Medical Director for the community services group and was subsequently appointed Deputy Medical Director for Quality and Safety across the whole of the Trust. As Group Medical Director he is jointly accountable in a triumvirate management model with the Group Director and Group Nurse Director for all of the community services (approx. 2000 staff). The role of Deputy Director for Quality and Safety role is changing but currently he takes the medical lead looking at themes across the whole Trust and having action plans in place for each theme e.g. on violence and aggression, use of restraint, falls and physical health.

Programme participation

#### Why the Nye Bevan Programme?

Speaking in May 2015 Jonathan explains what motivated him to apply for the Programme thus:

“When I decided to become a doctor I wanted to help people but the method to achieve that aim has changed. I realised that one way to move from helping a patient to helping a population was to become a leader. I had been on the Clinical Fellowship for Doctors, which was very robust with coaching; and then I did an MSc in Integrated Service Development. “

“My expectation of the Programme was to have more inner reflection on what drove me, to think about my strengths and weaknesses, what I needed to do/not do/ to do more of. To think about how to apply those skills to the patients I serve, the teams I lead and the organisations I work in. which would in turn improve quality and safety ”

Nye Bevan Programme participant

The Executive Director interviewed explained that applying for the Nye Bevan Programme was instigated by Jonathan but that once they became aware of his intentions they were happy to encourage and support his application as well as two other individuals who were also selected onto the same cohort. The organisation’s hopes and expectations of him were, as follows:

“We wanted Jonathan to continue his personal development and to better understand the wider scope of the role of an Executive Director in the current climate. In our experience at the Trust, new Directors often do a good job as a functional lead but find it harder to contribute constructively to the wider corporate aspects of the role. We wanted Jonathan and his colleagues to get the great benefit of time for self-reflection and the deeper understanding of self than Nye Bevan provides so they learn to present themselves and deal with wider corporate decision making.”

Executive Director

Impact

#### What Jonathan has done that he attributes to the Programme, in whole or part

#### Patient-centred care

Jonathan says that the most valuable learning for him from Nye Bevan has been “*keeping the patient at the centre of all decisions as a leader and a manager*” He explains his learning from the Programme thus:

“It reiterates my view on being patient centred; If you are going through transformation, the whole purpose should be about improving patient care. I was able to reflect on myself as an individual that I don’t need to say yes to everything that comes in the door. It has had a big impact on my understanding of the challenges I will face. It has helped me to improve my own abilities and look at the gaps in my knowledge such as finance, short term cost pressures and their relation to quality. I applied for the Group Medical Director to use and apply my learning. It was a close and competitive interview. I am much more aware of my strengths.”

Nye Bevan Programme participant

His focus on patient-centred care is confirmed by several interviewees who made the following observations:

“His focus on patient care shines through in meetings. His slant is always ‘how will what we are doing play through at the level of a patient?’ This contrasts with other managers.”

Direct report

“Jonathan bears people in mind throughout. He makes sure that problems discussed by the doctors are understood and seen from the users’ point of view and that any proposals have to help users and families as well as doctors.”

Carer Representative

“Almost every meeting where I have seen him he puts up-front his personal perspective of what’s important, which is improving services for patients”

Direct report

“Jonathan is good at getting the right people around the table and passes on his understanding of the more sophisticated cultural side of things. He lays out the facts of why change is important but always brings people back to patient-centred care. He is a strong advocate for patients.”

Colleague/peer

#### System Leadership

Jonathan describes his role as an enabler of change within the wider health economy largely in terms of his informatics work. He says:

I continued as Chair of the NE clinical health informatics network – a network of informaticians, clinicians, managers, patient representatives with a remit to act as a forum around informatics issues covering primary and secondary care and the NE ambulance service to influence national initiatives.

Nye Bevan Programme participant

Interviewees all confirm that Jonathan has made a major contribution to informatics across the North East and nationally pointing to his Chairmanship of the Royal College of Psychiatrists’ Informatics Committee. Most interviewees also mentioned Jonathan’s instrumental role locally in developing a dashboard service line reporting system has to improve quality and performance by providing reports of clinical, finance, HR and safety across wards and teams. The dashboards provide a visual representation of where the metrics are for each clinical service at any one time. Work is on-going to embed them in clinical practice within all specialities. One interviewee says:

“Somebody else could not have achieved what Jonathan has in taking a leadership role on informatics nationally. He has huge credibility as he has demonstrated change in his own patch including through his own team’s development of a bottom-up clinical dashboard. He is a very good measured negotiator and was one of two people who convinced the Secretary of State to spend more resources. He has made an utterly exceptional contribution.”

[National Clinical Director (Mental Health)

Although Jonathan himself did not highlight his contribution to the transformation Programme within the Trust since his new appointment a number of interviewees did so when identifying his contribution to system leadership. Some interviewees acknowledged that Jonathan could be said to have come in late to the transformation Programme in community services when the conceptual Model used for new pathways was already developed and a lot of the ballpark ideas were agreed. For others, Jonathan’s arrival in post was a key factor in enabling the crucial people element of the change to come to the fore when everything was in a state of flux. He was described variously as “*clued up, supportive and on-board, going about things in a systematic way*” and “*actively supports the change, takes a sensible line, always makes sure everyone sticks to the principles of the pathway and gives extra resources if needed to support the change*”. One colleague says:

“Ambitious transformations often don’t work – ours seems to be holding – and it is Jonathan who provides the ‘scaffolding-type support’ which has been essential to enabling the ideas to be operationalised in community based services.”

Colleague /peer

Perceptions of others

Jonathan’s colleagues all perceive that local services and the wider NHS have benefited from his participation in the Programme. There are some differences in perception among colleagues regarding who has benefited most – Jonathan or NTW - whilst Jonathan perceives both to have benefited in equal measures. Specific comments included:

“The Trust has definitely benefited. We’ve got a Group Medical Director who hit the ground running with ease.”

Executive Director

“Our organisation has benefitted hugely from Jonathan’s work through the Vanguard. Patient care has improved, the profile of mental health services locally has improved and the profile of our Trust has improved.”

Direct report

“The network of local health services has benefited. Jonathan has helped get acute mental health services included and working better.”

Direct report

“Jonathan is passionate about bringing his own organisation into good repute, publicising what NTW are doing in achieving good clinical care through data and inviting people to visit and see for themselves. “

National Clinical Director (Mental Health)

“Medical management has changed around here. He is improving matters. He role models staff engagement. We know we are high on his priorities and valued.”

Direct report

“Nye Bevan is very expensive. We need to look at the cost and make sure there is enough bang for the organisation for our buck. Jonathan however is a good example of where a Programme has been successful and productive for the individual and for the Trust.”

Colleague/peer

#### Leadership style

Direct reports describe Jonathan’s strengths as his: relationship building; open, approachable, collegiate, enabling and non-directive leadership style; and good networking. Specific comments included:

“Jonathan is a medic/psychiatrist who is prepared to manage. He embodies the new breed of Medical Director we need in the NHS: someone with the right balance of clinical leadership and managerial leadership who can manage difficult issues and support transformation.”

Colleague/peer

“He is extremely corporate in a positive sense: he embodies the needs and values of the organisation… He has enthusiastically embraced the triumpherate way of working and prompted medics to think about how other staff can be used.”

Direct report

“He is good at running with an idea (perhaps not his own) and taking it up to the point of implementation. He can really make things happen.”

Direct report

Most colleagues who know Jonathan well were keen to explain the timing in that Jonathan experienced two significant development opportunities during the period – training and self-awareness through the Nye Bevan Programme and on-the-job learning and experience through his new role/promotion – and therefore they feel it is impossible to assign credit specifically to one or the others for any changes in Jonathan and his achievements during/since. One person added a third development opportunity during the period as being the Vanguard project. As one person explained *“All are bits of the puzzle. Nye Bevan can only have been helpful”.*

#### Networking

The benefits of Jonathan’s networking were outlined as follows:

“He is very good at forming and maintaining networks including with the CCG and other providers within the North East. This does a lot for trust around the table in the outward facing part of his role. He is a good figurehead for our Trust.

Direct report

“His good networks in mental health helps the Trust get linked in early to policy changes, early enough to influence those changes. It also helps local discussions because we can explain the national picture.”

Colleague/Peer

“Jonathan is good at networking and learning from other people. This is good for us as we don’t want to be an insular looking organisation. We get to know how other organisations are taking things forward and what all their hints and tips are.”

Colleague/peer

Colleagues who worked with Jonathan before and since his participation in the Nye Bevan Programme shared their observation of the changes they had observed during this period. These included:

The differences have been subtle but important. For instance in meetings he doesn’t take the stage now, he listens more and chats less.

Direct report

Jonathan used to be quite deferential to Directors. He is now more assertive. He takes a decision and sees it through.

Colleague/peer

The big difference I have seen is the way he leads change. He is a key player in the North East Emergency Care Vanguard and has shared why it is important within the wider health economy in a way other medics haven’t done.

Direct report

I have seen a step up in the level of communication, approachability and emphasis. His one-to-one communication was never a problem before but now it is an exceptional level. He stands out. No-one else has his quality or tone.

Direct report

In terms of staff engagement, all interviewees agreed that Jonathan is very supportive, gives feedback and goes out of his way to create an environment where people feel valued.

Success factors

Interviewees reflected on Nye Bevan Programme more widely, whilst making it clear that their comments did not relate specifically to Jonathan.

#### Support from Executive Team

We were told that the Nye Bevan is held in high esteem within the Trust and that the Executive Team actively supports enthusiastic and ambitious people, wishing to aspire to Director-level posts, to undertake a range of management training. They support people through the NHS Leadership Academy as well as the North West Leadership Academy and local universities. Further, there is a belief among the medical colleagues and direct reports we interviewed from the Trust that, whilst doing some kind of formal management training whether the Nye Bevan Programme, an MBA or something else is not a formal requirement for a leadership role, it is viewed as beneficial. This is because the organisation requires proficiency in wider managerial and political skills beyond expertise in clinical services. Nye Bevan is viewed as ideally set up to deliver on that.

#### Managing expectations

NTW is the only mental health Trust within a very wide geographical area and has low turnover at Executive Director Level. There was some concern about the fourth learning objective within the Nye Bevan Programme (*Readiness to operate successfully at executive level as part of the board team)* as it may unrealistically raise participants expectations that they will get Director posts when they have completed the Programme*.* If Nye Bevan is to continue to meet the needs of wider NHS, there was a request for the NHS Leadership Academy to consider the reality of limited supply of these posts outside large cities and encourage participant’s expectations to be more long term.

#### Supportive corporate culture

We were told by several interviewees that, through the influence of all the Trust personnel who had now completed NHS Leadership Academy Programmes, a positive collective leadership style now has a strong presence within the Trust. This provides a corporate culture within which the four key principles of NHS Leadership Academy Programmes can be successfully implemented by participants. The culture also assists with the transfer of other learning back into the Trust as Programme participants can be open about what they are learning and what they want to implement.

Where next?

At the time of writing in November 2015 Jonathan says his future plans are to consolidate what he is doing as he has just been seconded into a role within NHS England as National Clinical Advisor for Mental Health Informatics.

Most valuable learning

Jonathan says the single most important thing the Programme has done for him is

“Reflection and reinforcement of the reason why I wanted to be a Doctor - at age 14; which was to care for people.”

The single most important thing Jonathan has been able to do for his Trust because of the Programme is in helping NTW:

“…moving towards a clinically led and professional managed service which strives to ensure that the staff who I work for are able to provide the best possible care to the patients and carers who we serve. “

Kelly Angus

December 2015/January 2016

The organisation: Northumbria Health Care

Northumbria Health Care is one of the top performing NHS foundation trusts, and provides services to around half a million people across Northumberland and North Tyneside – one of the largest geographical areas of any NHS trust in England.

It provides hospital and community health services in North Tyneside and hospital, community health and adult social care services in Northumberland. There are three general hospitals – Hexham, Wansbeck and North Tyneside, community hospitals in Alnwick, Berwick, Rothbury and Blyth, an integrated health and social care facility at Haltwhistle, an elderly care unit in Morpeth and outpatients and diagnostic centres at Sir GB Hunter in Wallsend and Morpeth NHS Centre

In March 2015 they were chosen as a ‘vanguard’ site by NHS England – one of eight sites in the country to be tasked with taking a national lead on transforming care for patients.

Northumbria Health Care is one of the largest employers in the North East with almost 9,500 members of staff.

Kelly’s background and role

Kelly described her career trajectory as being up and down the ladder career wise many times for family reasons, her last few years at Northumbria she was in a mainstream HR role. She has worked for the Director of Human Resources for the last 4.5 to 5 years, latterly as Deputy Director of Human Resources.

She is now on secondment to the local authority for two years as HR Director. This was initially part time (from June) but she was made full time in November 2015.

Programme participation

Kelly was in the very first Nye Bevan Programme cohort, which began in Autumn 2013. She was looking for some kind of development that would help her take the next step but knew she did not want any more professional development as she already has a master’s degree and was professionally qualified. She looked at the Nye Bevan Programme and thought it sounded interesting and so applied. She described herself as quite surprised by the level of time out required which meant it was a huge commitment. Her employer was very supportive of her going and doing it but was clear that she still had to do her full time job.

Her expectations were that the Programme would provide her with a networking experience especially allowing peer networking and ‘*that it would offer a critique on my practice that I could reflect on’*.

Impact since the Programme

Kelly highlighted a number of ways in which the Programme had challenged her to become a different kind of leader including building courage to act and acted as an impetus for her to consider a more senior role. Two objectives appear to have been particularly strongly met through the Programme: system leadership; as an enabler of change within the wider health economy and readiness to operate successfully at executive (or national equivalent) level, as part of the board team.

#### System leadership

There were several examples of Kelly creating networks across other potential partner organisations and thereby joining up services; for example Kelly worked closely with the Local Authority and was keen to point out opportunities to move to more shared service type approach. She also developed good relationship with the Association of Care Organisations.

One specific example was some work Kelly did on medical staffing in Cumbria which revised terms and conditions and the use of agency staff in the trust. As part of this project, Kelly made sure individual consultants had legal contracts and that payment rates, job planning appraisals and JV validation all were addressed. This was made more complex as the percentage of consultants on the payroll was relatively low and therefore there was a high percentage of locum doctors which mean that pay and performance issues were especially complicated. Kelly led the project.

Another colleague highlighted some patient centred work Kelly had undertaken. She had looked at staff experience and staff surveys. Kelly worked to triangulate the findings and made a direct link with Michael West’s work on the link to patient satisfaction and patient mortality. She had moved that work forward over the last couple of years and put more emphasis on staff feedback: ‘Without a doubt Kelly played a major role in this’.

Colleagues also spoke of some other changes Kelly had introduced:

* Kelly has worked with university providers to develop front line staff over the last few years: ‘*her ability and knowledge and her ability to access providers and navigate through what is out there and knowing where to challenge has made all the difference*’.
* Another project targeted improving the HR management of nursing agency and bank nursing. Kelly delivered a contract cap on agency spend which therefore meant clinicians didn’t have to manage rates. She developed a good working relationship with the agency too ensuring the trust secures cover within the standards and staff can access agency staff with confidence in their ability. It was said that Kelly was ‘*ahead of the curve on this as it was not a simple project’*. To make it work people needed better data than was available before and that is now available. ‘*I saw Kelly driving the whole project and fronting it. Others were involved but the role crossed clinical, finance and HR boundaries and she absolutely took everyone with her because she had put various structures in place around the project.*’

#### Readiness to operate successfully at executive level

Kelly said she understood the connectivity between HR and its contribution to the business. ‘*The Programme provided a reality check on why I wanted to lead in the NHS and to confirm that the NHS was a career destination for me and the kind of director I wanted to be*’

Kelly said that *‘one thing that the Programme has done is made me braver’*. It has meant she has been able to hold people to account and knows that the way she has delivered that message has been constructive.’

Kelly felt Nye Bevan helped prepare her for a Director role but this was not immediate for her and she needed to consider if such a move would be right for her. Her actual experience was that an organisation came looking for her. She is now in a local authority although she would have preferred to be in the NHS, but opportunities were very restricted in the NE. She felt it took her outside of her comfort zone and gave an opportunity for her to enjoy her leadership and motivated her to move into a Director’s role.

Perceptions of others

Those interviewed for this case study included Kelly’s line manager, two senior colleagues, a peer and three direct reports.

#### Ability to lead with confidence

Each of those interviewed saw Kelly grow over her time in the Programme, in confidence, in courage, in using networks of relationships more and building alliances across the organisation and in terms of making things happen.

‘She was responsible for going to EMT and she started to change the focus of her perspective, understanding and access to information. She made connections and relationships more broadly and stronger than before … She had a very ‘can-do’ approach, if she can find a way to make it happen they she will try and do it …She brought great influence and became the go to person.’

#### Ability to create the right conditions for frontline staff

One of Kelly’s colleagues commented felt that Kelly had developed her hugely and given her a wider perspective and passed on contacts to me, through one to ones and ad hoc discussions. Another highlighted how Kelly found time to help people and offer coaching, support and feedback to colleagues despite her busy role. She said that Kelly takes an interest in anyone who knocks on her door – ‘she was incredibly responsive to me and to others.’ She felt Kelly also created increasing opportunities within her own team offering support to her relatively junior team and delivering very important pieces of work. ‘I can think of three or four others to whom she has given post interview feedback or advice for someone and she picks it up’.

#### System leadership

One colleague specifically highlighted several examples of system leadership in the last two years for example Kelly took forward a project on medical staffing in Cumbria making sure individual consultants had legal contracts and that payment rates, and job planning and appraisals and JV validation all were arranged. A big part of that was problematic as the percentage of consultants on the pay roll was relatively low and therefore there was a high percentage of locum doctors there were lots of issues around pay, performance and systems to monitor and tack action and she led on all that.

Kelly also undertook patient centred work by looking at staff experience and staff surveys. Kelly worked to triangulate the findings and made a direct link with Michael West’s work on the link to patient satisfaction and patient mortality. ‘Without a doubt Kelly played a major role in this’.

#### Readiness to operate successfully at executive level

Colleagues spoke of Kelly’s growing ability to work at a level up, to sit in at board meetings with enough confidence and ability to make a contribution and to understand the politics. Interviewers spoke of a visible growth in confidence and contribution to management team meetings as the course progressed.

One of those interviewed saw Kelly’s knowledge grow around the political agenda where she would ‘pick up and run’ with issues. This individual spoke of a change in approach with Kelly increasingly assuming a leadership role and taking people with her. There was a growth in confidence and greater willingness to direct alongside solid facilitation skills.

The taking on of an HRD role was also seen as requiring significant personal change, with Kelly seen as having developed a wider concept and more strategic view. Colleagues commented that the promotion to Deputy Director was in recognition of the role she had taken on and the work she was doing to cover a larger remit. It was noted that this was a personal promotion in recognition of enhanced contribution rather than an appointment to a vacant role which was unusual. ‘She only got here in 2011 and she made large strides. Her job had grown significantly and she was working way above what she had been doing. ‘

Another colleague felt the course had acted as a catalyst for clearer career focus and increased self-belief: *‘She definitely had bigger belief in herself two thirds of the way into the Programme*’.

#### Ability to work constructively within a team

Several of those interviewed mentioned a shift in the way Kelly worked, highlighting how the growth in confidence was expressed through an increasing willingness and capability to take quite difficult decisions. Interviewers were less certain if this could be attributed to the Programme or whether it was the result of growing experience and maturity, not just of Kelly herself but also her team.

‘What I’ve seen is someone who was very professional with individuals and teams when I first got to know her but I’ve seen her come more to the fore. Her ability to lead has improved without a doubt, she sat on number of senior discipline panels and appeal panels, she offers sound advice and is clear and confident about what is important about that advice.’

Another of our interviewees commented on how Kelly had worked more collaboratively and had encouraged the HR team to do so too; ‘*Kelly was able to not say “no” but to find a way around things and help the team think in a more disciplined way’*. She felt that she had helped HR think outside the box and modernise its approach.

#### Attainment of a solid foundation of knowledge and networks

Several colleagues mentioned that they saw clear evidence of increased networking, one mentioned that she saw Kelly being more externally focused and using contacts and working with other more. Another mentioned:

‘She seemed to start to network an awful lot more including with NHS Employers. …I think now this was down to the Programme’

This activity also involved encouraging others to network more too and to engage the organisation more widely with external initiatives. For example it was said that Kelly participated in an OD programme as an exemplar and supported the equality lead in the trust link into an NHS Employers programme. ‘.

A colleague said she could tell when Kelly had been on the Programme as she talked about her ideas and people she had met, what other organisations were doing and Kelly would introduce others to contacts she had met through the Programme.

#### Ability to engage with patients, service users, carers and families

One colleague was very clear that Kelly put patients at the heart of what she did. Recruitment was given as a good example where she was said to never lose sight of why they were recruiting and what they were looking for. She introduced values based recruitment which was strongly advocated by Kelly as a way of finding those who were caring and compassionate.



Martin Stefan

The organisation: Cambridgeshire and Peterborough NHS Foundation Trust

The Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) provides mental health, learning disability, social care, and community services for adults and older people. It also provides children’s community services in Peterborough. CPFT aims to support people to achieve the very best they can for their health and well-being.

CPFT has a number of inpatient units in Cambridge and in Peterborough providing quality mental health care. It has very recently received a ‘Good’ CQC rating to indicate that the service is performing well and meeting the regulator’s expectations.

However, the wider Cambridgeshire and Peterborough health economy has been identified as one of England’s 11 most challenged health economies and faces a funding shortfall of at least £250 million by 2019. The System Transformation Programme has therefore been established to look at shaping a sustainable health system fit for the future. The Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), the providers of local hospital and community healthcare, Peterborough City Council and Cambridgeshire County Council, and local Healthwatch organisations have joined together in this Programme to address these challenges.

Martin’s background and role

Martin Stefan qualified as a doctor in 1989 and started his postgraduate training as a psychiatrist in 1990. He is currently Consultant Psychiatrist & Deputy Medical Director at Fulbourn Hospital, a role he has held since January 2013. He was also a clinical director there until November 2014, when he dropped that part of his role to undertake a 50% secondment to the System Transformation Programme, hosted by Cambridgeshire and Peterborough Clinical Commissioning Group.

In his Deputy Medical Director role, Martin supports and deputises for the Medical Director. This role allows him to still get his hands ‘under the bonnet’, as he sees it, and deal with organisational issues.

Martin describes the wider Cambridge and Peterborough Transformation Programme as a really complex piece of work. In his System Transformation role, Martin has been focusing on the mental health workstream which aims to develop a coherent mental health strategy across multiple organisations, and also more broadly outside the mental health arena by supporting clinical engagement activity in relation to other clinical disciplines.

Programme participation

Martin was in the very first Nye Bevan Programme cohort, which began in Autumn 2013; and he completed the Programme in Autumn 2014. At the time, he was in a really busy clinical director and operational management role; a complex, overwhelming job. He had just completed the King’s Fund emerging board leaders’ course and was trying to keep his nose above the white water of being clinical director of a complicated community division, so it might be surprising that Martin even applied for the Programme.

Yet Martin’s view is that your personal development doesn’t stop, and that continuing to develop yourself is an important part of developing others. Indeed, he is still continuing to invest time and energy in ongoing developing by embarking on the Improvement Leaders Collaboratives, offered by Health Education East of England.

Impact since the programme

#### System leadership

Martin candidly admits that, before the Nye Bevan Programme, he had an utterly superficial understanding of system leadership. Yet that understanding advanced during the Programme which helped him to develop a more nuanced understanding of organisations, systems and the different lenses that people use to view them. So, when Martin was invited to work in the System Transformation Programme just after completing the Nye Bevan, he says he leapt at it because he felt that it is an area where he can have significant impact because there are some really tough problems to deal with.

In a complex NHS, being at the top of the tree in the Executive Team isn’t necessarily where you get the most impact. I can have more impact doing other stuff.

The Nye Bevan Programme gave Martin both the interest and the confidence to take on this leadership role which relies on his ability to connect and influence across the system.

Within the System Transformation Programme, Martin has been working with the Director of Strategy at Cambridge University Hospitals[[2]](#footnote-3) to develop proposals for a new model of care that stretches beyond mental health, and has been presenting to Chief Executives across the county. This relationship building and collaboration across organisational boundaries is an important part of the work. While it is too early to evaluate the long-term impact of the system transformation work, Martin has achieved notable successes along the way in getting consensus among Chief Executives around a proposed new model of care, so they each felt it was something they could sign up to.

Colleagues see Martin as being particularly good at checking back in with an audience to make sure they feel their views are being captured and keeping them engaged. Martin believes that the way he now influences the format and design of those meetings is a direct outcome of the Nye Bevan Programme.

Having gone from what he saw as a superficial understanding of system leadership before the Nye Bevan, Martin has clearly taken his learning on this topic and applied it. Colleagues now describe him as being really impressive in his system leadership abilities.

#### Working with groups and influencing

Martin leads in a completely different way now. Relying much less on positional power and more on influence, he sees himself as an enabler. He feels he is now able to structure and influence the agenda better, rather than just using it to keep track.

An example is the clinical effectiveness committee which he used to chair. It had become highly process driven and was not engaging staff or delivering real clinical effectiveness because it did not have clinical engagement. Martin was able to construct an argument to help the group to realise that and to reformulate its role.

I’m able to spot what’s not working and to take the action needed to work in a different way, without asking permission. Before the Nye Bevan Programme I would’ve said, ‘you’ve got to turn up to this’ without realising it was the wrong thing to do. They got there by themselves and it feels great.

In May 2015, Martin facilitated a Mental Health Care Design Workshop with the team. He approached it very differently as a result of the Nye Bevan Programme. Being on the programme helped Martin to work well with a range of people with different takes (not just a healthcare provider focus) and it provided some useful tools. More than that, however, Martin feels his attitude and approach to the May meeting were very different as a result of the Programme, particularly in terms of really recognising the importance of service user and employee engagement.

#### Self-awareness

Recognising how you are as a player in the system and understanding that there is a recursive aspect going on is a key aspect of reflexivity. Using this understanding, Martin chose not to intervene in a situation where he previously would have done so, because he recognised that it was the wrong thing to do. Both Martin and his Chief Executive suggested that his decision to take that approach had made a positive difference to the outcome of the work.

Colleagues described Martin as being very resilient, able to see the barriers and difficulties in a system that others do not even see, and finding ways to work around them. They also described Martin as very values driven. Although it can be frustrating if others do not work in that way, Martin will work through any issues by having conversations with people he trusts to help him reframe his view.

#### Applying knowledge and networks to make a difference

Martin felt it was important to build a repository of knowledge from the Nye Bevan Programme and often refers back to course materials. Indeed, he has found and used a framework on coalition building that was added since he was on the programme. He introduced it an OD event of around 30 people ‘*to say we’ve got to stop mudslinging between organisations*’. It did the trick and people still talk about it, in fact some of Martin’s colleagues have also been using it. One participant described it as a light bulb moment and said that she has *‘used it a million times since!’*

Martin is very aware of using networks to make a difference. He has been developing close relationships with people in the System Transformation Programme; using those relationships to build bridges between the various organisations and stakeholders in the system and attempting to influence some of the discourse that happens.

Perceptions of others

#### Thinking and acting more strategically

Others suggested that the Nye Bevan Programme has had an impact on Martin’s confidence and ability to think and act more strategically. The Programme is described as being good at *‘lifting people’s eyes away from local context to a broader horizon’*.

These abilities are vital in his system transformation work, itself an indirect result of the Nye Bevan Programme, where Martin needs to be influencing strategy across the organisations engaged in the Programme. This experience was described as having *‘decentred him from being a psychiatrist, to being a strategic doctor’,* a *‘medical leader’* who is more outward-focused rather than being down and in the services.

Colleagues see Martin as being very capable in this area. He realises that acting strategically is about patience and the bigger picture, recognising that using a non-direct route is sometimes more effective. Martin understands that, in a difficult environment, sometimes a slow pace will help in the longer term.

#### Working collaboratively and courageously to achieve results

Martin has not lost sight of the frontline in taking on a more strategic role. He is still seen as protective of and perceptive about people, and yet he recognises that change needs to happen. He was seen as working well with others in a supportive and collaborate manner; being respectful and a good listener; and understanding about dynamics in teams.

Notable achievements in collaborative working to achieve results come from both parts of Martin’s role. In his role as Deputy Medical Director, he was seen as being able to effectively hold a line with all the consultants in developing an out-of-hours rota for junior doctors and consultants.

In his system transformation work, Martin was described as being focused on the outcomes he wants to achieve, and able to get people *‘to coalesce in a turbulent environment’*. There are three areas where Martin has been able to demonstrate those skills. The first was in getting the mental health element of the system transformation programme agreed. The second involved developing proposals for a new model of care that stretches beyond mental health and gaining consensus so that all the Chief Executives involved were prepared to sign up to it. This was seen as a major achievement. A colleague described Martin’s role in the wider clinical engagement as a brokering role and suggested it is one of the most challenging roles in the system where you are *‘caught in the middle’* in brokering a range of views ‘*to frame, write, describe and present pros and cons back to them’.*

Others appreciate that Martin is *‘not rule-bound, hide bound, or a limited thinker’* but brings a different perspective as a foil to others. This has led to lots of creative conversations as part of the System Transformation Programme, which colleagues have valued, along with his willingness to challenge them. Martin has also challenged some very ‘stuck’ stakeholders while *‘making sure the programme has reached out to everybody*’. In wider groups he can get his point across too. As a colleague put it:

‘It takes guts to stand up and ask difficult questions of a group of GPs and to keep the NHS values underpinning the way you tackle it’.

A colleague described Martin as bringing *‘personal, professional and political sensitivity; a very strong contribution’*.

#### Working knowledgably and through networks

People said that Martin has developed a great deal of strategic knowledge; *‘a wise owl’* as one colleague put it. He has knowledge about NHS politics (and greater confidence in that area since being on the Nye Bevan Programme), knowledge of government policy, national guidance and work on the ground.

Colleagues suggested that people want to engage with Martin. He is seen as working in a way that develops networks and being willing to put colleagues in touch with *‘a different hinterland of people’*. He has spotted opportunities to develop networks and recognises the value of doing so. While Martin had a good network before he took the role on the System Transformation Programme, he has broadened that network further and people outside the mental health world also know who he is now.



Success factors

Martin’s managers have been supportive of his commitment to ongoing development. Indeed his line manager would have welcomed an even greater focus on licensing disruption, perhaps with a secondment to another organisation. Yet Martin has secured a valuable opportunity to apply his learning from the Nye Bevan Programme beyond the confines of his own organisation, with his 50% secondment to the System Transformation Programme across Cambridge and Peterborough.

Where next?

His colleagues and managers agree that Martin would be a strong contender for a Medical Director role. Indeed Martin has been approached several times for Medical Director roles since the Programme. He says: *I can think I could do it, but I’m no longer sure that’s what I want.* For Martin it is now more about opening up opportunities to pursue a different kind of leadership, something he refers to as ‘interstitial leadership’, or the leadership in the space between structures or objects. He is seen as being ambitious *‘in a good way’* to make a difference in the wider health system.

For his Chief Executive, Martin’s ability to lead with confidence (one of the eight objectives of the Nye Bevan Programme) has grown and now he is not out of place in a roomful of Chief Executives. He is not over awed, is willing to interject and does so appropriately.

Other colleagues also suggested that Martin has the breadth of vision to operate at Board level. Yet a question posed for Martin was, *‘if he wants to be on a Board, what does he want to be on a Board as?’*

Most valuable learning

The emerging picture is that Martin’s understanding of organisational strategy and the bigger picture has developed over the course of the Nye Bevan Programme, along with his ability to intervene appropriately in that system to develop a plan that everyone can live with.

In a difficult environment he has secured a plan for mental health that will work… in the long term.

A test for the Nye Bevan Programme is whether there is energy to keep the learning going beyond the confines of the Programme, without further facilitation support. However the learning sets were seen as a positive element and Martin has demonstrated an appetite to stay connected with new materials beyond his own programme.

To sum up, we heard that Martin’s attendance on the Nye Bevan Programme has offered huge benefits for the Trust and to the wider NHS. A final word goes to his Chief Executive who says of the Programme:

‘It’s been good for him, good for the Trust and good for the NHS’.

Phil Storr

The organisation: NHS England

NHS England leads the NHS in England, setting priorities and direction and encouraging and informing the national debate to improve health and care. It is responsible for £100 billion in funds and hold organisations to account for spending this money effectively for both patients and tax payers.

The programme of work referred to as EPPR (emergency preparedness, resilience and response) plans for and responds to, a wide range of incidents that could affect health or patient care, from extreme weather to infectious diseases or major accidents.

Phil’s background and role

One of three deputy directors, Phil leads on EPRR in his role as Regional Head of Resilience for North Region, based in Leeds. Similar roles exists in London, the South, the Midlands and the East but it is an unusual role in that it is an operational role in a commissioning body.

He deals with anything in the NHS in the North that causes significant operational challenges to the delivery of patient services, such as readiness to cope with major incidents, prevention of system failure, troubleshooting and service recovery.

The role requires the ability to work with multiple Boards to solve interrelated problems. He describes it as being ‘about facilitation and influence’. In addition to EPRR Phil is also responsibility for the strategic delivery of NHS 111 across the region, with a focus on the strategic direction of commissioning, brand protection and assurance of local delivery plans.

Programme participation

Phil’s background is in the ambulance service and his line manager wanted to see him broaden his skills from the EPPR specialism. He joined the Nye Bevan Programme in 2014 and successfully completed the following year.

Phil wanted to enhance his capability to enable and influence Boards, which is a key aspect of his role. In addition he has to influence a wide range of people over whom he has no direct authority. For example, although he is head of emergency planning in the Region, he has no direct line management relationship with local (NHS) emergency planners.

He describes his hopes for the Programme,

I wanted to explore myself more deeply as a leader, and understand why I make decisions in the way I do. Originally, I was an Ambulance officer and my training was very mechanistic. Although I’d always challenged the set ways of doing things, I felt I hadn’t really found myself as a leader. I’d had training on technical things like finance, programme and project management but wanted to fill the gap around understanding myself and my approach as a leader.

Impact since the Programme

#### Working with groups and influencing

According to a colleague, small changes have had a big impact. For example, Phil, as Regional Head, had been chairing a monthly EPPR network meeting. He instigated a rotating monthly chair, which makes him an equal around that table and enables others to develop. There is now more dialogue which works well. Previously one member felt there had been an element of ‘them’ (regional level) and ‘us’ (local people) but as more people got involved in chairing, the dynamics changed to more of an ‘us’ situation. He believes that this has enabled the work to be done and outcomes to be achieved in a better way.

A colleague commented that, ‘*Phil used to be a fixer but now he empowers’*.

People also see differences in outcome in situations where they are working with providers and commissioners of healthcare and where they have no real authority or mandate to direct. For example, during the development of the 111 service when they were preparing for a surge in demand at Easter, Phil had to ensure that the service was well commissioned. A colleague notes,

‘I observe his ability to influence others. I can see him applying things he has learned to engage with others in a persuasive way to achieve the right outcomes. We have minimal power but great expectations from ministers to be influential. He has developed and enhanced his style and approach and used some of the models from the Programme to approach a subject or a major piece of work in a different way’.

#### Knowledge and networks

A colleague believes that while Phil was an expert in EPPR, he now takes a broader view of the NHS and has demonstrated this in his involvement with 111 and winter preparedness.

Phil had great EPPR knowledge but now he has new networks, which he maintains and draws on to help in various pieces of work such as 111 and winter preparedness. That is where I have seen a difference. He has a different breadth of knowledge and a wider portfolio.

He supports his direct report to do the same and encouraged her to attend a course on emergency planning which provided her with an opportunity to build her own network on resilience from other Trusts. He also encourages her to shadow and sit in on meetings to deepen her understanding of the subject matter.

#### Broader perspective of the NHS and stepping up to lead

In 2014 Phil’s work across organisations was already recognised in a book entitled ‘Collective Conviction: the story of Disaster Action’. The Director says of him,

There is a picture of Phil in the book. He is highlighted as a figure that has made a difference and there are not a lot of people we have worked with that we pick out in that way. The enabling of patient centred support is the highlight of our work with him. The bereaved, families and carers had no voice. Phil has helped us to maintain and enhance our voice.

Since the Programme, a colleague sees Phil stepping up more to lead on national pieces of work such as ‘on-call guidance’ and with the national ambulance resilience unit and the impact of industrial action. He believes Phil now demonstrates a more ‘rounded opinion’, looking at the wider NHS perspective. For example, when there were challenges in his own region on on-call guidance, he presented a well-reasoned argument within the context of the national picture, having first gathered evidence from other regions.

He has also stepped outside the immediate remit of EPPR by identifying a risk locally and taking the lead to discuss it at a national level to ensure patient safety.

A colleague sees him thinking increasingly strategically about how healthcare is developing and what that means for services and the community, citing the example of a recent exercise to test out a power outage scenario. Phil brought clearly to the discussions his view that community care should be included, recognising that patients in the community would not have the same resilience as a hospital.

Patient voice

Whilst Phil’s role is no longer patient facing, he has gone out of his way during the commissioning of the 111 service to spend time in call centres listening to patients and building their voice into the design of the system. By doing so, he identified that in one part of the region ninety per cent of out of hours calls were for dental pain. Phil worked to share the learning amongst other 111 providers but also with commissioners to facilitate changes in access to out of hour’s dental services enabling better patient care. His manager acknowledges that took him outside his comfort zone but sees the benefits,

We had a view what it (111) should look like but when you listen to patients you realise you were wrong.

He is further seen to work in a patient-centred way when he drills down into performance figures, taking a holistic view and prioritising the indicators that directly impact patients.

The Director of a voluntary organisation he has worked closely with acknowledges,

Phil has worked with us to put people at the heart of emergency planning and to consider what will be the impact on people on the receiving end of my decision.

Phil has also ensured his direct report has the opportunity to shadow front line services and she has been out with ambulance crews and dispatchers, shadowed 111 call handlers and joined hospital staff for major incident training in order to understand patient care principles in practice. She acknowledges,

To be in that scenario and in the back of an ambulance with a patient when you have to spend three hours in a handover queue gives you a new perspective.

#### Getting feedback into the system

Phil was concerned about how NHS England was constantly gathering information but rarely providing feedback back into the system about what they were doing with the information. He has worked with his line manager on that and similarly with his team.

Colleagues value his ability to act as a ‘buffer’ between the regions and the demands of the centre, helping area teams to understand the application and relevance outside of London.

Perceptions of others

Phil received feedback from colleagues, some of whom are Directors from CCGs and really challenged Trusts, that they have seen a change in how he approaches things. He felt there were a number of system issues towards the end of the Programme where he had good feedback from these people, which he might not have had earlier.

A colleague believes he demonstrates more awareness of his role in the wider system and a greater small ‘p’ political acuity. He has a good rapport with staff at all levels from front line to executive level. People recognise that he has more confidence ‘to stand up and assume authority’ in a senior forum, ‘respecting their authority but seeing where he can add value’. He is seen as a leader rather than a manager, inspiring others.

We have seen a different person. What he brings to the team makes meetings more engaging.

One colleague, a former Nye Bevan graduate himself, reports seeing at different stages how he has taken on board learning from the Programme in the way he did business. His style of approach changed on tele-conferences for example, giving people space and listening, not articulating his view above others but retaining a ‘presence in the room’ physically or by telephone. ‘He has gravitas in that meeting that I recognise as a product of the Programme.’ A direct report agrees that ‘he is held in high esteem locally, regionally and nationally’.

In working with the team, colleagues and direct reports see someone who reflects more, takes on board comments and observations and seeks feedback. Whereas previously he might have reacted quickly he reflects more and considers the implications and impact and is more supportive of colleagues.

One colleague who tends to work with Phil mainly during difficult times praises his approach, demeanour and gravitas, the way he relates to people and builds relationships, commands respect and inspires trust. He is seen as very genuine, reflective and able to cut through the superficial to get to the heart of the matter.

His sponsoring manager sees him having ‘*grown in confidence, presentation, influencing, and with more authority and certainty*’.

Success factors

Phil was fortunate to have a line manager who has worked with him to discuss the nature of leadership and transfer his learning to the workplace. He was keen for him to get out into the regions and talk about EPPR in a different way to make it more engaging for others. Together they worked to change the narrative from emergency planning to being resilient.

There was an opportunity to put some of this into practise in Morecambe Bay and later in Cumbria where he worked with both areas on sustainability going forward using an Appreciative Inquiry approach. Phil’s line manager believes it is ‘the approach’ that is different since the Nye Bevan Programme.

Where next?

Phil has to balance his drive to work with multiple Boards at a senior management level with making the change to work at director level in a single organisation. Whilst Phil has no immediate ambitions to become a Director his colleagues and line managers believe he has Director potential. In the flat structure of NHS England, however, the Executive role is not applicable as in an Acute Trust, for example. A former line manager believes that in terms of ‘freedom to act, decision making and delegated authority he is now operating at that level’. His own aim from the Programme was simply to be as good as he could be.

Most valuable learning

Phil describes self-understanding as being the most valuable learning from the Programme.

I notice the trigger points in myself now, and I’m more effective because I can double-think and go down a different track, not necessarily make an instant decision.

I don’t feel I’m different fundamentally but some of my feedback would seem to suggest a change. I’m more reflective, step back more, not so wound-up and task-focused.

An example of how valuable learning from the Nye Bevan course has been is that during the middle of the Programme NHS England launched a major restructuring programme. This resulted in downsizing staff nationally with a significant reduction in EPRR specialists with the region. Coupled with this, the NHS was facing the most operationally challenging winter in a decade, with performance and delivery issues effecting patient services. This also coincided with Phil stepping up to cover the Regional Director of Operations role for three months. Although the timing of all these issues occurred simultaneously, Phil used his emerging learning and newly found skills from the Nye Bevan Programme to approach these issues differently – reflecting on his style more and amending his approach. Phil says,

Although it was not ideal to be dealing with all these issues at the same time as undertaking the course, it allowed me to learn and develop whilst in ‘the eye of the storm’

Having now completed the Nye Bevan Programme I can see how I would do things differently if faced with the same challenges again, but I can also see it helped me personally navigate a very difficult and demoralising time.

Phil attributes much of this to working with an excellent learning set and his Set Leader, who supported him to challenge ingrained thinking and look at international examples of how others countries do things.

Dr Sankara Raman

Visit date 22nd September 2015

The organisation: George Eliot Hospital NHS Trust

George Eliot Hospital NHS Trust provides a range of hospital and community based services to more than 300,000 people across Nuneaton & Bedworth, North Warwickshire, South West Leicestershire and North Coventry. The hospital, which was opened in 1948, provides a range of Accident & Emergency, elective, non-elective, surgical, medical, women’s, children’s, diagnostic and therapeutic services.

In February 2013, following the publication of the Francis report into care at Mid Staffordshire Hospital, George Eliot Hospital NHS Trust was identified as one of 14 trusts across the country with historically high mortality rates that were subject to a review, led by Professor Sir Bruce Keogh, Medical Director at the Department of Health. [The review was published in July 2013](http://www.geh.nhs.uk/latest-news/news-archive/2013/july/trust-reacts-to-keogh-report-publication/). It identified no immediate concerns and praised the work of staff at the Trust, many of whom they described as ‘outstanding and dedicated individuals’ and ‘passionate and loyal’. In September 2013, the Trust published its [action plan](http://www.geh.nhs.uk/latest-news/news-archive/2013/september/action-plan-to-address-review-recommendations-published/) to address the recommendations in the Keogh Review, and in 2014 it came out of special measures. The turnaround has been fast and sustained, with the Trust achieving ‘good’ in its latest Care Quality Commission (CQC) assessment, commendations following the Dean’s visits, and scoring highly in the latest General Medical Council (GMC) national trainee survey, notably for overall satisfaction among Foundation doctors in their first year (F1s), for workload, and for access to educational resources. The Trust is particularly proud of its Physician Associates model, and receives visitors from all over the country to find out more. Sankara himself feels that the Trust ‘punches above its weight’ with regard to facilities for trainees and being receptive to new approaches to the delivery of medical services.



Dr Raman’s background and role

Sankara is a Consultant Gastroenterologist at the George Eliot Hospital NHS Trust in Nuneaton. He joined the Trust in 2003 and this was his first consultant post. Sankara has taken on a variety of wider roles since joining the Trust: he is the Clinical Lead for Gastroenterology, the Head of Postgraduate Education, and the Chair of the Medical Division.

Programme participation

Sankara started the Nye Bevan Programme in November 2014 and was part of Cohort 11. His line manager, the Medical Director, encouraged him to apply for two reasons. Firstly, because of a general belief that leadership is something that needs to be developed within the Trust, and that consultants need leadership development; and secondly, because Sankara himself ‘had done a lot of really good work’ and was ’an outstanding Clinical Tutor’ who would, he hoped, gain a wider insight into the Board leadership perspective. Sankara was also supported throughout the Programme by the Chief Executive. Sankara himself said that he wanted to participate in the Programme ‘to get to grips with the senior vision required to be a Board member’ and ‘to take the next step’.

Impact since the Programme

Sankara has taken action in several areas which he attributes in whole or in part to his learning from the Nye Bevan Programme, and which have benefited his organisation and its staff and patients. These are particularly apparent with regard to two of the Nye Bevan learning objectives: 3 (system leadership) and 5 (ability to engage with patients, service users, carers and families).

#### System leadership

Sankara has been instrumental in introducing and developing the role of ‘Physician Associate’ within the Trust. This role, established in the USA, has only relatively recently in the UK. Physician Associates have relevant undergraduate degrees and undergo training to give them the competence to support doctors in diagnosis and treatment; they typically have high levels of direct patient contact. The Trust’s adoption of this new role in 2010 has created considerable interest throughout the NHS and Sankara has been involved in hosting visits from all round the country. As a result of being inspired by the Nye Bevan Programme, he has also made contact proactively with Clinical Commissioning Groups (CCGs) and local General Practitioners (GPs) to suggest the use of Physician Associates in primary care. A You Tube documentary that Sankara recently helped to make, featuring ‘a day in the life’ of several Physician Associates in the Trust, had received over 21,000 viewings as of December 2015. A Physician Associate interviewed for this case study spoke approvingly of how well Sankara had integrated the new role with the junior doctor role, and also described a meeting that Sankara had set up with Coventry University – a provider of healthcare training that is now considering putting on a course for Physician Associates.

Sankara describes this impact on the wider health economy as “a personal evolution” and reflects that “I’m now taking decisions within and outside the organisation, and talking to colleagues and to people in outside organisations such as CCGs – previously, I wouldn’t have approached CCGs”.

#### Ability to engage with patients, services users, carers and families

Sankara has taken two actions under this heading. Firstly, he has set up a patient panel for the chronic condition inflammatory bowel disease (IBD), motivated by the belief that “patients become experts about their conditions and we need their input regarding what’s best for them”. This panel has been a success and Sankara is endeavouring to encourage the roll-out of similar panels for other chronic conditions such as diabetes and asthma. Two specialist IBD nurses, who report to Sankara, participate in all the monthly panel meetings while Sankara attends specific meetings to discuss medical issues. The chair of the panel believes that the service has improved under his leadership, notably since the appointment of the IBD nurses: “It’s improved tenfold – you really can’t fault it! You feel like an individual”.

Secondly, Sankara is working on the development of a patient-led app for IBD, involving patients and staff. He is hoping to obtain some national funding for this, although the Trust has pledged its support should this not be forthcoming.

Perceptions of others

Those interviewed for this case study (colleagues, direct reports, a patient representative and two members of the executive team) all supported Sankara’s own view that he has grown considerably in confidence since being on the Programme, and that his self-awareness and reflective skills have developed; this has enabled him to approach situations differently and more thoughtfully. In addition, he now understands the ‘bigger picture’ much better, and has far more direct interactions with the executive team. The perceptions of others are summarised below, under each of the eight Nye Bevan learning outcomes.

#### Ability to lead with confidence

Here, colleagues spoke of Sankara’s increased willingness to tackle difficult situations, and to handle them more thoughtfully than might have been the case before he embarked on the Programme: “There are some difficult clinical teams, and he’s not shied away from these … Previously, he could be a bit passionate in a somewhat misguided way; now, he uses his passion to his advantage. He no longer goes in ‘all guns blazing.’”. A member of the executive team had noticed “a change around speaking with confidence as an ambassador for George Eliot” and described him as “a great ambassador for the clinical leadership model”.

#### Ability to create the right conditions for frontline staff

Colleagues and direct reports were unanimous in their praise for Sankara’s day-to-day management style. They spoke of his willingness to involve them and support their development, and his encouragement of a fair, non-judgemental and no-blame culture. This extended beyond his immediate colleagues: “Nursing staff on the ward have the greatest respect for him ... He’s a good role model for juniors and newer consultants. He helps departments to develop their services.” They had also seen a change in him, for the better, since he started the Programme, citing instances where he had handled situations and people well, resulting in an improved outcome. One colleague, for example, spoke of the way in which he had “turned departments round”, while another referred to a specific incident that could have been difficult, but was managed well, adding “A year ago, it might have been different. Now, he took back control and managed the situation”. A member of the executive team spoke of Sankara’s assistance in establishing a better culture in the Trust, due to his ‘positive interactions’ with people.

#### System leadership

Interviewees supported Sankara’s own belief that his understanding of wider system leadership had improved considerably, citing his interactions with other departments within the Trust and with organisations outside. One colleague referred to his willingness to lead change: *“He’s a driver for change and is not frightened by it. He’ll be at the forefront of implementing national things like F1 reports and portfolios.”* Another described Sankara as “*driving the development of the Physician Associate role*”, while a member of the executive team spoke approvingly of the way in which Sankara had taken himself out of his ‘comfort zone’ when liaising with CCGs and GPs.

#### Readiness to operate successfully at executive level

Views here were mixed, although clearly positive. Sankara himself felt that his readiness *“is probably coming together”* and a colleague strongly supported this view, saying that he would be “*a popular appointment*” should the current Medical Director retire. The same colleague stated that, before embarking on the Nye Bevan Programme, Sankara had not felt he was ready for such a move. Several people commented that Sankara has had more dealings with the executive team and the Board since starting the Programme, which meant they were more aware of him and what he was doing; one said that he was much better at taking difficult issues to the Board now, so that they were ‘more receptive’ to him. One member of the executive team spoke of the ‘mutual respect’ that now existed between Sankara and the Board, and another thought that the Programme had definitely ‘brought him on’ in the right way, although it might be too early for him to be a Medical Director yet.

#### Ability to engage with patients, service users, carers and families

Several colleagues spoke of Sankara’s popularity and rapport with patients and their families, and one said that this had increased since he started the Programme. The patient representative supported this, saying she had found him “*a little bit shy but friendly*”, but more recently “*he seems more confident, authoritative and forthright*”. Sankara’s clinical colleagues spoke of how well he involved patients and their families, with one saying he was “*very thorough with patients and families*” and “*involves patients in decisions about their care*”. Another colleague would “*be more than happy to be treated by him*”.

#### Attainment of a solid foundation of knowledge and networks

Here, interviewees spoke of Sankara’s developing relationships with other organisations (Trusts, CCGs, GPs and Universities) and his willingness to take the lead with change, which has led to his speaking at seminars and conferences. Sankara himself spoke positively of the knowledge content of Nye Bevan and the supportive nature of his Nye Bevan set (where he is the only doctor) and set adviser.

#### Critical awareness of personal approach to leadership

Sankara’s belief that the Nye Bevan Programme has increased his self-awareness and understanding of leadership styles was supported by his colleagues, several of whom stated that his already excellent skills had been affirmed and strengthened by being on the Programme. One said that “*He was pleasantly surprised by his 360 degree feedback as he previously wasn’t so confident in his leadership skills - the feedback confirmed he’s doing it right*” and also commented that “*his self-awareness has definitely increased. He’s more measured in his approach; he listens to other perspectives*”. Another volunteered that, since starting the Programme, Sankara “*is more logical and rational and comes over better*”. A member of the executive team compared Sankara’s style before and after the Programme: before, he (along with others) would exhibit “*behaviours around frustration because voices were not being heard – shouting emails*” but now “*knows how to get involved*” and “*mutual trust has developed – he’d come to see me about a problem, constructively*”.

#### Ability to work constructively within a team

Similarly, interviewees spoke warmly about Sankara’s skills and felt these have been strengthened by the Programme rather than changed in any significant way. As an example, one colleague said:

“*One of the Trust’s values is to support and challenge; he used to do a lot of the former, now he’s more mature he does the latter and offers solutions*”. Another added, “*He will encourage the gastro team to come up with solutions – before, he might not have thought they could do this*”. A direct report contributed that Sankara encouraged people to offer ideas and innovation and “*is more expressive about this now*”. A member of the executive team commented that Sankara now has a wider view regarding what constitutes a ‘team’, in that he looks beyond the gastro and education teams, to the Trust more widely and outside. A different executive team member spoke favourably about this aspect, saying that Sankara has “*deliberately pushed himself out of his comfort zone with GPs*”.



Regarding the specifics of **staff engagement** and **stronger team working**, the view was unanimous that Sankara has always had these skills, and that the Programme had enhanced these. The patient representative said that staff seem to be “*definitely engaged*” and “*communicate very well with each othe*r”. An education team member commented, “*He already had strong leadership attributes but this has really rounded him off and smoothed off the rough edges … we’re a tight-knit team which provides a massive safety net for trainees*”. A gastro team member praised Sankara’s commitment to regular team meetings (the team meets weekly, and there are also monthly multi-disciplinary meetings): “*Communication is key. Sankara is very committed to these meetings*”.

Success factors

A variety of factors seem to have contributed to Sankara’s successful progress through the Nye Bevan Programme.

* His personal level of commitment has been high, and has gone hand-in-hand with persistence and resilience. The style of learning has been new for him; he reflected that most of his courses to date had been task-focused, while Nye Bevan was ‘a journey’. He was not daunted to receive feedback, after his first assignment, that he had approached it too much as a task and had been insufficiently reflective, although he remarked wryly that “*clinicians don’t do this very well*!” Instead, as the evidence from interviewees shows, he applied himself without complaint to understanding the skills required for self-awareness and reflection. One of the members of the executive team commented that Sankara was proactive in getting the best out of the Programme: “*being a self-starter and showing the initiative to get things done, make the connections and build on the opportunities to learn from the wider Board*”.
* Sankara has received support from the top of the organisation, with both the Chief Executive and the Medical Director being fully committed to his participation. This commitment has been given despite some reservations about the Programme, described at the end of this case study. The support was particularly willingly given to Sankara because of the interest he showed in the activities and working of the executive team; one of the executive team members considered this to be “*a massive benefit as it enabled clinicians and executives to come together and be on the same page when it came to planning and delivering services*”.
* In addition, Sankara has received support and encouragement from colleagues and direct reports, who have been pleased that he is on the Programme and interested in what he has been learning and the changes that they have observed in him.
* Sankara also specifically mentioned the importance of having a good Nye Bevan set and set adviser. As the only clinician in his set, he sometimes found other people’s roles – especially those working in national bodies – quite hard to understand, so he very much appreciated the support given to him by other set members and the adviser.
* He has also been facilitated by an organisational culture that is open, receptive to new ideas, and willing to take some risks. This has helped him to make a success of integrating the Physician Associate role, and in general be a driver of change.
* Finally, relationships with other organisations in the wider health economy (CCGs, GPs and the university) are positive and receptive – due in no small measure to Sankara’s own efforts. This has helped Sankara to exert an influence and act as an ambassador, in a very positive way, for the Trust.

Any one of the above factors, on their own, are unlikely to have been sufficient for success; this is evidenced by the fact that others in the Trust have received support and commitment, and have been working in a similar culture, but have not succeeded. The combination of factors, and notably Sankara’s own persistence and drive, seem to have worked together to produce success.

Where next?

#### For Sankara

Sankara does not have immediate plans to seek promotion, although since being on the Programme he now believes that an Executive Director post is within his reach. He is being encouraged by his executive team and Board as well as by his colleagues and teams, and the general perception is that he is definitely on the right track. He was described, on more than one occasion, as an ‘asset’ to the Trust, and one direct report described it as “a privilege” to work with him.

#### For the Programme

Although the two executive team members were pleased with the impact of the Programme on Sankara, they pointed out that others had fared less well. They had reservations in recommending Nye Bevan to others, or were selective in their recommendations, partly due to its intensity (which they felt had not been adequately explained) and partly because in future, the Trust would have to pay for it, and was not convinced that it would add value in all cases; Sankara, to date, has been the exception. In addition, the executive team members did not know much about the Programme in terms of content and delivery. They thought it would be important for the NHS Leadership Academy to engage better with Trusts in future, in order to understand Trusts’ perspective on leadership development, and what they were already offering in-house. One executive team member pointed out that, even if the Programme was free to Trusts, there was still an opportunity cost in releasing consultants to go on residentials; this individual suggested that more of the Programme could be delivered at base.

Although several individuals in the Trust were on either the Nye Bevan or the Elizabeth Garrett Anderson Programmes, any attempts to meet to share and spread learning have been informal; mostly, people had applied their learning in an individual way. One executive team member thought that the NHS Leadership Academy should encourage this in more proactively and another felt that the benefits of putting several people on these Programmes “was not massive yet”. However, this individual conceded that everyone on NHS Leadership Academy Programmes ‘gets’ the importance of creating a ‘culture for quality’.

Most valuable learning

Sankara feels that the most valuable learning from the Programme for him was the acquisition of negotiating skills, a focus of the second residential, because he will be able to use these skills throughout his career. In addition, the reflective learning – examining beliefs, values and direction – have been invaluable, especially given that clinicians are not, generally, very familiar with reflective skills.

Colleagues focused on Sankara’s leadership skills as the most valuable learning. One, for example, said “*He’s clearly a leader and these skills have developed and consolidated*”. Another felt that the Programme “*gives him that A\* and has helped him influence other organisations*”, while a direct report thought that Sankara’s flexibility had improved and that being on the Programme had enabled him to “*shine a bit more*”. For one of the executive team members, the most valuable learning has been “*from my perspective, seeing a clinician growing in confidence to proactively go out and do things – with GPs, the university etc*”.

Interviewees found it difficult to decide whether Sankara himself, or the Trust, had benefited most from being on the Programme. On balance, most thought it was Sankara himself, although everybody agreed that the organisation – patients, staff and reputation in the wider health economy and at national level – had seen benefits, too: “*He’s had a positive impact on our (education) team and on the clinical team. Dr Raman has benefited from gaining new leadership skills, the organisation has benefited from his developing services*.” A member of the executive felt that the Trust has benefited “*because he is acting as a role model for clinical leadership and has gained insights*” and “*because of his alignment*”. Another member of the executive team was a little more cautious, feeling that the Programme had brought benefits to both Sankara and the Trust, but that at least some of the improvements were as a result of Sankara’s efforts in getting the Trust out of special measures – which had predated his participation in Nye Bevan. This interviewee pointed out that it was hard to attribute tangible benefits to the Programme alone.

#### A final word from Sankara

When asked to describe the Programme from his perspective, Sankara used the following words:

* Innovative
* Horizon-broadening
* Helped me to see myself and my role in a different light
* Takes me out of my comfort zone.

He added,

“Maybe there should be more clinicians on the Programme – they could do with programmes like this!”

1. <http://www.ntw.nhs.uk/section.php?l=1&p=1179>, accessed 22/10/15 [↑](#footnote-ref-2)
2. Cambridge University Hospitals (CUH) is one of the largest and best known hospitals in the UK. The Trust comprises Addenbrooke's and the Rosie, offering general and specialist and women's and maternity care respectively. [↑](#footnote-ref-3)