Culture and leadership programme

Phase 1

Discover
How to use this document

This document has been set up to help you navigate your way around. Some text and buttons can be clicked. These will take you to:

- another part of the document, or
- a link to download further resources online.
You will need to be connected to the internet to access these.

Buttons and icons

**Go to previously viewed page**

Sometimes a link will jump you to another part of the document. Clicking this button will take you back to the page you were viewing before the jump.

This icon indicates the sharing of experience and information between trusts.

This icon indicates important notes to consider.
Acknowledgements

NHS Improvement, The King’s Fund and Center for Creative Leadership (CCL) would like to thank the teams from our three pilot trusts, Central Manchester University Hospitals NHS Foundation Trust, East London NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust for their time, creativity and commitment in developing and testing the resources as presented here. Your contributions have significantly advanced this work. We are particularly grateful to Northumbria for co-creating the approach to using patient experience information for culture.

We would also like to thank the following colleagues whose contribution, energy and support has been fundamental to moving this work forward:

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- Colleagues at the Royal College of Nursing, Wrightington, Wigan and Leigh NHS Foundation Trust, Mersey Care NHS Foundation Trust, Frimley Park NHS Foundation Trust and West Midlands Ambulance Service NHS Foundation Trust and everyone who is contributing to the community of practice, for sharing their experiences of culture change; and
- Members of our Steering and Advisory groups.

The King’s Fund and CCL were commissioned by NHS Improvement to provide the evidence base for the programme based on their years of research in this field and the work on the earlier iterations of the collective leadership toolkit.
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Culture and leadership programme

Overview
Introduction

A healthcare organisation’s culture – ‘the way we do things around here’ – shapes the behaviour of everyone in the organisation and so affects the quality of care that together they provide. Research shows that the most powerful factor influencing culture is leadership.

To help NHS providers develop cultures that enable and sustain continuously improving, safe, high quality and compassionate care, NHS Improvement, The King’s Fund and Center for Creative Leadership are developing some practical resources. Three pilot NHS trusts are helping design and test every aspect of these to make sure they have lasting value for you.

The resources are based on national and international evidence that identifies elements and behaviours needed for high quality care cultures. They rest on the principle of ‘collective leadership’, which empowers staff at all levels, as individuals and in teams, to take action to improve care within and across trusts – ‘leadership of all, by all and for all’.

Using the resources, you can run culture and leadership programmes in three phases to:

- **Phase 1**
  - **Discover** any cultural issues you need to address
  - **resources available now**

- **Phase 2**
  - **Design** strategies for developing collective leadership

- **Phase 3**
  - **Deliver** the strategies

The pilot trusts:

1. Central Manchester University Hospital NHS Foundation Trust
2. Northumbria Healthcare NHS Foundation Trust

We would also like to acknowledge the contribution made by Lancashire Care NHS Foundation Trust and Royal Bournemouth and Christchurch NHS Foundation Trust.
Leadership, particularly collective leadership is the key to enabling cultural change that enables NHS organisations to:

- deliver high quality care and value for money while supporting a healthy and engaged workforce. See the concepts and evidence and what good could look like

- enables staff to show compassion, to speak up, to continuously improve and create an environment where there is no bullying, where there is learning, quality and the need for system leadership. This is reflected in several recent reports and reviews (eg the Rose review, the report of the Mid-Staffordshire NHS Foundation Trust Inquiry and the Berwick review)

- help boards assure their governance on the ‘culture and capability’ domain of the well-led framework and improve their results in governance reviews.

Following this programme will help you to create a strategy to develop the culture and leadership of your organisation.
What good could look like

Based on the NHS Constitution and the principles of collective leadership, we suggest that a good result would be where:

- Every person in the NHS, in every organisation, at every level and in every role can flourish and deliver their best for patients – continuously improving, high quality, safe, compassionate care.

Where:

- Everyone working in the NHS is healthy, happy and passionately engaged in improving the lives of people in their communities with commitment to quality of care.

- **Everyone counts**, at all levels, feels inspired and empowered to lead positive change, to constantly learn, and to continuously improve healthcare for patients.

- It is easy to feel compassion for others, because every person working in the NHS is treated with respect and dignity and feels appreciation, compassion and support from their leaders and colleagues – especially during times of stress or difficulty.

- No matter where in the NHS we work, we work together for patients.

Your views

What does good NHS cultures mean for you? You can share your answer and see what other NHS staff said by joining our culture community. Contact us at NHSI.culture@nhs.net
National reports showing the link between leadership, culture and care quality

The resources to support culture and leadership programmes aim to help the NHS achieve the ambitions on culture and leadership set out in recent national reports. They are also intended to help trusts achieve the ambitions of the forthcoming strategy to set the direction for building capacity and capability in improvement and leadership development, including talent management, for the NHS in England.
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<td>Culture change in the NHS, Department of Health (February 2015)</td>
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<td>A promise to learn – a commitment to act: improving the safety of patients in England (August 2013)</td>
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<td>Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report, Professor Sir Bruce Keogh KBE (July 2013)</td>
<td>Sets ambitions for improvement including: listening, engaging, valuing and supporting frontline staff; using transparency for support and improvement and leadership and governance for quality improvement</td>
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<td>Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Chaired by Robert Francis QC (February 2013)</td>
<td>Cultures of putting patients first, openness, transparency and candour, enhancing recruitment and development of nursing and leadership positions</td>
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What are the resources for Phase 1?

The resources for Phase 1: Discover – diagnosing your culture are shown in the figure below. They will help you diagnose your current culture using existing data, board, staff and stakeholder perceptions and knowledge, and workforce analysis. You will then be ready to target the right areas for your collective leadership strategy.

It is not prescriptive but we recommend you:

- use all six sets of diagnostic resources
- use them across your whole organisation for best effect
- adapt them according to what would work best for your organisation

This will help ensure you have the right information on culture, leadership behaviours, and workforce capacity to help develop your collective leadership strategy.

Figure 0.2: Culture and learning programme resources summary

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<th>Outcomes</th>
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<td>Leadership behaviours survey</td>
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<td>Leadership workforce analysis</td>
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<td>Patient experience</td>
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How do the Phase 1 resources work?

The diagnostic resources in Phase 1: Discover – diagnosing your culture enable you to get the information you need to target approaches and interventions in developing your collective leadership strategy in Phase 2: Design.

In Phase 1: Discover you will complete a current state diagnosis. You will have information about each element of the conceptual framework shown in figure 2 to take forward into the design of your strategy. You will understand the perspective of patients, staff, stakeholders and the board on culture.

You will also have initial information to start framing and forecasting your collective leadership strategy.
Figure 0.3: Conceptual framework shows how the results of the different Phase 1 diagnostics work together give you information across all the parts in the conceptual framework outlined in concepts and evidence.
How long will Phase 1 take and what other resources will our organisation need to provide?

Phase 1: Discover can vary depending on capacity, skills and approach. Typically, it takes up to six months to run the diagnostics, build the case for change and establish your ‘change team’. All staff six weeks notice to prepare for interviews and meetings.

The main cost of the programme is staff time. It is helpful to include a programme manager three days a week and a co-ordinator to help set up the interviews, focus groups, etc. Where capacity is lacking, trusts may wish to procure external support, for example for the board interviews.

To find out more see Getting started which includes information on project planning.
How long will Phase 1 take and what other resources will our organisation need to provide?

**Culture and outcomes dashboard**
- Lead analyst: 3-5 days
- Other analysts (e.g., for providing finance, HR, and quality data): 1-2 days

**Board interviews**
- Interviewers: 3-10 days depending on training requirements, number of interviews etc.
- Lead: 8-10 days

**Leadership behaviours survey**
- Staff survey lead: 5-10 days
- Survey support: 5 days
- Communications: 1-3 days

**Culture focus groups**
- Facilitator: 15 days
- Lead: 7 days
- Communications: 1 day

**Leadership workforce analysis**
- Interviews/facilitation: 1-5 days
- Workforce information: 1-2 days
- Lead: 15 days

**Patient experience**
- Patient experience lead: 5-7 days

**Synthesis**
- Facilitator: 2-3 days
- Change team: 1-2 days all members
- Report writer: 2-15 days

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Figure 0.4 Example project plan for Phase 1: Discover
*Bullet points under each diagnostic show the skills needed and number of days required.*
Are the resources useful to organisations already working on culture?

If you are already working on your culture, it’s worth checking to see if these resources can be adapted for your existing programme. They’re based on national and international evidence that identifies key concepts for high quality care cultures. They are tailored to help users identify elements and behaviours for high quality care cultures and approaches and interventions to use in the design and delivery strategies for collective leadership.

However, there are many different resources you can use to develop your culture and leadership. Whichever resources you choose, we’d love to hear about your experiences.

Your views

We are supporting a learning community where people can discuss and share ideas on developing cultures of high quality care.

You can get in touch by contacting NHSI.culture@nhs.net
What does a collective leadership strategy need to do?

The collective leadership strategy designed and delivered in Phases 2 and 3 should answer the question: ‘How do we ensure we have the leadership now and in the future that will nurture cultures which deliver high quality, continuously improving and compassionate care?’

It will:

• be driven by and linked to your business plan (see also Getting started: Identify your purpose.)

• embed the elements of culture and leadership behaviours that lead to high quality care cultures among all staff in your organisation (see the concepts and evidence base)

• set out your plans to ensure that formal leadership ‘key leadership roles’ are filled to effectively support high quality care cultures and ensure your business plan is delivered. This is because leadership is the strongest influence on culture; those in formal leadership ‘key leadership roles’ will be particularly important in influencing the culture of the organisation (see leadership workforce analysis).

It will not address the number, demographics, skills and knowledge of all staff in your organisation. These should be covered in your organisation’s wider workforce strategy and workforce development plans.

The content of leadership strategy design and delivery phases will therefore address

• leadership recruitment and talent management

• leadership development

• wider workforce development

and will need to consider the relationship with:

• wider workforce recruitment and talent management

• organisational design.
What does a collective leadership strategy need to do?

Leadership behaviours

Workforce capacity

Cultural elements

At all levels of the NHS

Key leadership roles

Leadership recruitment and talent management

Leadership development

All other

Wider workforce recruitment and talent management

Wider workforce development (leadership behaviours development)

Organisational design

When will the Phase 2 and Phase 3 resources be available?

The resources for Phase 2: Design – developing your collective leadership strategy and Phase 3: Deliver – implementing your collective leadership strategy are under development. They are expected to be released in mid 2017 and winter 2017 respectively.

Where can I get help or find out more?

If you would like help using these resources, please contact us at NHSI.culture@nhs.net
Culture and leadership programme

Phase 1

Discover

Getting started
Getting started

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This guide covers setting up your culture and leadership programme for **Phase 1: Discover**.

The **overview** will have given you a high level overview of the culture and leadership programme and how it will help you develop a **strategy for collective leadership**.

The following chapters cover three aspects of preparing your programme:

- building the case and identifying the purpose of your collective leadership strategy
- building the team and planning how they will work together
- planning the programme.
Your first task will be to get the support of your senior leaders – particularly your chief executive and chair. This is crucial because the programme will have impact across your whole organisation and will require resources and support from different departments and teams.

If you don’t work in organisational development yourself, you could approach them directly or through the board. They may be able to provide resources and advice.

We have put together a presentation to help you make your case and build awareness and understanding with your board and others:

- introductory slides: you can modify the presentation for your organisation and context. We recommend you read the whole of Getting started to help you prepare your proposal and to help answer questions the board may have.
What did other trusts do? Executive sponsorship

At the onset we identified two executive director sponsors – the chief nurse and the executive director of HR and corporate services. The Organisational Development and Training team led the project but worked closely with our corporate nursing team.

Helen Farrington, Associate Director of Organisational Development and Training, Central Manchester University Hospitals NHS Foundation Trust

A key part of our existing culture and DNA is to be absolutely open to new ideas and so the opportunity to get involved in something which would enable us to improve and enhance our performance, engagement and outcome for patients was not a difficult sell! We ensured that even, in the early days, when there wasn’t a lot known about the programme there were regular mentions and references to it at board and executive meetings so that it was implicitly supported from the start.

Ann Stringer, Executive Director of Human Resources and Organisational Development, Northumbria Healthcare NHS Foundation Trust

The evidence base that The Kings Fund provided ensured credibility to the work programme and supported internal validity.

Since I was appointed as Chief Executive in 2009, we as a collective within the Trust have been doing a lot of work to develop the values and create a positive and appreciative culture. I think it is imperative for all staff to understand the importance of and experience the right leadership culture and its link to compassionate care.

However when our staff survey results arrived in 2014, they did not reflect the extent of the culture change or the level of staff engagement that we had hoped for. Despite the culture work programme we had been doing, there was something hampering the overarching ambition for a positive and engaging culture.

We saw the King’s Fund’s work on collective leadership as an opportunity to build on the cultural change work already occurring within our Trust with someone who had done the research and was committed to and passionate about collective leadership.

Professor Heather Tierney-Moore OBE, Chief Executive, Lancashire Care NHS Foundation Trust
Before starting the diagnostics in Phase 1: Discover, it is important to clarify what you want the programme to achieve – how it can help your organisation’s business plan – and how it fits with your existing work. This will help you target approaches and interventions in Phases 2 and 3 – designing and delivering your collective leadership strategy.

Collective leadership strategies should answer the question:

**How do we ensure we have the leadership now and in the future that will nurture cultures which deliver high quality, continuously improving and compassionate care?**

However, the details of your collective leadership strategy will depend on your organisation’s circumstances and should align with your organisation’s business plan.
We recommend you take time to:

- review your business plan (or organisational strategy) to identify the drivers (or strategic objectives) and their implications for the leadership strategy. The Center for Creative Leadership (CCL) defines drivers\(^1\) as ‘the key choices that leaders make about how to position the organisation to take advantage of its strengths, weaknesses, opportunities and threats in the marketplace’.\(^1\) You can use the [template for linking collective leadership strategy and business plan](#).

- understand your organisation’s current and historical circumstances, particularly anything with significant impact on culture such as mergers, organisational structure and team structures

- identify interdependencies with other initiatives in your organisation such as staff engagement or quality improvement. This will be important in positioning this initiative alongside your wider work, gathering information, avoiding duplication and aligning initiatives to reinforce the programme.

There are a number of ways you can do this such as desk research, and talking to colleagues and your board. Once you have done this, you should confirm with the board that they reflect your organisation strategy and intentions.

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What did other trusts do? Engaging the board

Engaging members of the board in focused conversations about the organisation’s strategy enabled us to explore the implications for the collective leadership strategy. It also meant we got valuable insight into the wider strategic context and key interdependencies.

Kristina Henry, Head of Learning and Organisational Development, Northumbria Healthcare NHS Foundation Trust
Create your change team

The change team should be a multidisciplinary team from across your organisation – championing a collective leadership approach.

It should cover different areas, occupational groups, levels of seniority and demographics. It is important to include operational ‘doers’ as well as influencers and administrative support. A diverse change team may help you capture views of those who feel marginalised in the workforce.

We suggest a team of 10 to 15 people (although the work will involve many others) including:

- at least one executive sponsor (executive director with responsibility for organisational development)
- a project manager or individuals with similar expertise
- organisational development and HR representation
- medical/clinical/service leads
- a communications professional or similar expertise
- analytical resource
- patient experience lead or similar
- administrative support.

Consider including a quality representative, patient/service user leaders, people from estates and facilities, other clinical, administrative or managerial staff or a non-executive director.

Support

Everyone in the change team will need support from the organisation to protect time for this work. Agree upfront how much time will be needed but build in flexibility (see also project planning).

Characteristics

All team members should:

- disseminate learning and influence within the organisation
- demonstrate commitment to exploring ideas and assumptions about the culture of the organisation
- be committed to this work and to involving others
- be resourceful and dynamic
- use this work to support personal and professional development.
What did other trusts do?
Different ways of finding your change team

We asked our directors to identify a number of capable and motivated people as change leaders who will help design and lead on the delivery of the programme. There were no set criteria for getting involved, just an enthusiastic commitment to the programme and a willingness and capacity to get involved. Initially we had 30 volunteers from around the trust and from a range of roles and bands. We have kept the whole group involved but we have had a core group of 16 who have led on this phase of the work programme.

The real benefits of developing the change team in this way have been the fact that we have both capitalised on people’s interest and curiosity in culture and also started to build OD capability in roles who ordinarily would not have been exposed to this. The team has also acted as a real catalyst for communicating and spreading the key messages from the programme.

*Stacy Bullock, Assistant Head of Organisational Development and Training (OD), Central Manchester University Hospitals NHS Foundation Trust*

We found that it is helpful to have a small ‘core team’ of people to undertake the direct work – the change team – and a wider group to engage with.

We identified the roles we needed in our change team and invited people to participate. The change team is crucial as these are the people that will undertake the work. It was not necessarily for them to be in obvious roles (ie it’s not just about your HR and OD team!) At ELFT we have a well established quality improvement programme and we involved members from this team to ensure that learning was transferred and the programmes were aligned. We also wanted to look in depth at particular areas of the organisation so we invited leaders from these parts of the trust to be part of the change team.

We also wanted to engage a wider group of people with an interest. We held a leadership conference in the ‘Getting started’ stage for the programme. After the event we offered participants the opportunity to stay in touch. From this group we formed a ‘reference group’ which became an extension of the change team and we tested out key concepts from the diagnostics and invited them to be part of the synthesis phase of the work.

*Sandra Drewett, Director of HR and OD, East London NHS Foundation Trust*
The change team is one of the things we are most proud of. We developed a set of criteria in order to recruit to the change team. To apply, individuals had to have the sponsorship and support of their line manager, meet the criteria and commit to attend six workshops and to undertake cultural audit work between the workshops. This was in addition to their ‘day jobs’. (See the figure on the next page).

They were shortlisted and assessed by a panel that consisted of execs, non execs, heads of nursing and quality and directors of operations. The board were fully engaged in the process.

We deliberately recruited a diverse section of people in terms of grades, roles, skills and experience. We tried to select a team that was representative of the workforce.

We originally planned to recruit 12 change champions but from a strong field we actually recruited 15 people from a pool of 30, one of the team is a patient/volunteer representative.

The impact has been huge. At the end of Phase 1, they gave a presentation of their findings to the board, and received a standing ovation. The board wanted to know how things really were, and the change champions felt they were doing something really valuable.

Nicola Hartley, Director of Organisational Development and Leadership, Royal Bournemouth and Christchurch NHS Foundation Trust
Nominate a Change Champion

As part of the senior leadership team, we are asking you to nominate individuals from across the Trust who can play a role in developing our new collective leadership approach and driving through cultural change.

We need a multidisciplinary team of change agents who will inform, design and enact the leadership strategy with the support of the board who have agreed to phase 3.

Nominees of the Change Champion:

- What are the gaps between what we have and what we need to deliver?
- Mission, vision, values
- Leading vs. existing capabilities - number of leaders, skills, diversity, multi-cultural
- Review against CEO culture measures

1. Discover
   - Organisational 5-year plan
   - What are the gaps between what we have and what we need to deliver?
   - Mission, vision, values

2. Design
   - Clear and unique Leadership Strategy to drive continuous improvement
   - Engage with the workforce
   - Organisational, design, leadership culture, and development

3. Deliver
   - Talent management
   - Leadership development - programmes and interventions
   - Organization development - culture, learning, boundary spanning, collaboration

We are looking for 12 champions. You have until Friday 19th September 2019 to make nominations using the attached form. Candidates will be shortlisted. Nominated individuals and their immediate line manager.

A panel of senior members of the senior leadership team will interview these nominations against the criteria above and agree one to two change champions.

Who are our perfect Change Champions?

The essential criteria for our champions include:

- Represents a new section of job roles and professions
- Is excited by change and wants to make a positive difference
- Is committed to work beyond current role
- Embraces Trust values
- Seeks to learn and develop
- Demonstrates an inclusive style
- Cultivates leaders
- Demonstrates leadership potential (using stars)
- Is able to role-model collective leadership
- Available to attend first workshop on 5.11.15
- At least one member of the team should have project management skills

Once appointed, the Change Champions will be responsible for:

- Defining the Discovery questions
- Agreeing the process to data collection
- Gathering and processing data including conducting focus groups and interviews
- Capturing the process and ensuring knowledge to the organisation
- Attending project team meetings
- Publishing a high-quality report on the outcome of the discovery process and feedback back with recommendations to the Board
- Nurturing collective leadership and supportive leadership working
- Planning the next steps for Design and Delivery phase of culture change for RBCH

Their commitment will need to include:

- 5 x 1 day workshops over 6 month period
- Working in parallel teams between workshops
- Line Manager support
- An initial term of 6 months, potentially on-going (with reduced time commitment)

To support these individuals in the exciting role, they will be offered development support as part of the workshops. To start, we may need focus groups, building teams, co-presenting skills.

Figure g.1 Recruiting the change team – Royal Bournemouth and Christchurch NHS Foundation Trust
Setting objectives and style of working

Set up a meeting of the change team to determine your project objectives, the change team’s objectives and how the team will work together. This should be aligned to the purpose you have identified.

Objectives:

Broadly the change team’s objectives in Phase 1 will be to:

- define the vision, purpose, mission of the culture programme in your organisation and link these to the organisation strategy, values, good practice and strengths
- agree challenging objectives for the team for each month and individual responsibilities, defining performance measures and monitoring progress against these
- model collective leadership and supportive teamworking in the team and for the organisation
- gain support for and otherwise promote the project and its outcomes to internal and external stakeholders
- produce a timely, high quality summary of the outcomes of the discovery process, enabling significant progress towards a collective leadership strategy
- plan the next steps for the design and delivery phases of a collective leadership strategy

Working together:

Agree how to work together as a change team including:

- frequency of meetings
- activities and timelines
- who does what
- setting personal objectives for the programme
- how you will share information – In particular, use of patient experience data may require approval from your Caldicott guardian. This will depend on the purpose for which the data was originally collected. Similarly with staff and stakeholder data you may wish to seek advice from your Data Protection Officer or information governance team.

Key activities:

- agree how to implement the diagnostics and what to do
- process quantitative and qualitative information gathered with the diagnostics
- communicate with and engage the organisation in the process and share emerging knowledge.
What have other trusts done? Meetings and objectives

The change team meet every two weeks for our ‘culture corner’ sessions which we keep to ½ hr. This is an opportunity for us to keep on top of progress, share learning and support one another with any issues.

In terms of roles, we identified a pair of leads for each diagnostic which helped to ensure ownership and that the diagnostic was designed and implemented effectively.

We did end up running most of the diagnostics concurrently however our culture corner meetings helped to keep us on track and address any issues that arose through this phase of the programme.

*Stacy Bullock, Assistant Head of Organisational Development and Training, Central Manchester Universities NHS Foundation Trust*

We aligned our programme objectives to the trust objectives so that our energy and focus were consistently applied to the diagnostics and associated activities. Our trust priorities related to enhancing high quality compassionate care for our patients, developing our culture to enable our staff to be engaged and accountable.

*Ann Stringer, Executive Director of Human Resources and Organisational Development, Northumbria Healthcare NHS Foundation Trust*

At the first workshop, the team developed their team objectives and progress against these was reviewed at each workshop every month.

*Nicola Hartley, Director of Leadership, Royal Bournemouth and Christchurch NHS Foundation Trust*
Developing your change team

The change team are your ambassadors and champions for the culture and leadership programme so it is important to support them in exhibiting collective leadership.

You can design a programme to support their development throughout the programme.

To support change team development, we have also provided:

- a leadership behaviours reflection questionnaire: change team members can use this questionnaire to self-assess themselves against the leadership behaviours. The top strengths and development areas they identify could be collected and shared or kept personal depending on what is appropriate for the context of your organisation and change team. Similarly, actions at a change team level could be discussed.

- a team working assessment: we suggest you use this once every quarter once the change team is established. You can circulate this in paper or make it available on a survey platform, making sure the results are anonymous. When analysing the results, look for areas of large variation in scores as well as the average score per question. You can review the analysed results as a team and agree actions to improve them.

You may wish to spend time with the change team looking at understanding how to handle sensitive and confidential information. It is important that members working with data which may identify individuals have undertaken relevant training in line with your organisation's policies.

This could cover:

- treating information in line with the Data Protection Action or the Caldicott principles – this is particularly relevant for the patient experience and focus group diagnostics.

- similarly securely collecting, storing securely, and anonymising information collected from staff in the diagnostics so that no staff member or external partner may be directly or indirectly identified – this is particularly important in the diagnostics collecting qualitative information.

- sharing anonymised aggregate findings openly but sensitively to encourage positive culture in the organisation and avoid reinforcement of negative thinking.
What did other trusts do?

Dedicated time is essential and training in the Board interview and focus group diagnostics is definitely recommended. Those members of the change team who led on these were also able to see the benefits throughout the process and in some cases listening and hearing the responses changed their views and facilitated thinking and change.

Helen Farrington, Associate Director of Organisational Development and Training, Central Manchester University Hospitals NHS Foundation Trust

Being in the change team is a development opportunity. We decided to include half a day every other month for structured development programme for the change team see figure below. The development programme included looking at personality types and understanding differences, which was then used to think about how the team members could work effectively together to achieve their aims and objectives. Another session focussed on presenting with impact and we engaged an actor to help facilitate that.

Nicola Hartley, Director of OD and Leadership, Royal Bournemouth and Christchurch NHS Foundation Trust

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**Personal Development Programme for Change Champions**

- Celebrating difference in the team, understanding self and others – Myers Briggs Type Inventory
- What is collective leadership – The King’s Fund evidence base
- The CQC well-led domain – the what and the why
- Models of Organisational Change – including the RICH Quality Improvement Model
- Being a Change Rebel overview
- Willful Blindness – Margaret Heffernan TED talk, what this means for culture change
- Personal Impact toolkit – Amanda Wrischer
- Understanding the role of an NHS Board
- Using social media as an engagement tool – Twitter
- How to run a focus group
- Interviewing the board with confidence
Project planning

We recommend that change team members with project management experience should lead the planning and co-ordinate the project.

We recommend that you:

- establish a governance structure involving regular reporting to the board from your change team (see figure 3 for different governance structures)
- allocate one or two members of the team to each diagnostic. Those members will need to work with the project manager on the plans for each diagnostic and should have associated roles and objectives
- one member to focus on communications across all diagnostics.

Based on our work with pilot trusts, we estimate that running the diagnostic resources will take approximately six months but you will also need time to ‘get started’ – work through the content covered in this chapter.

Although you can run all the diagnostics at the same time we advise:

- implementing the culture and outcomes dashboard, patient experience and the board interview questions first
- running the survey and the focus groups together to maximise staff engagement
- starting the leadership workforce analysis early as this is likely to take the longest time.

Figure 0.4 in the introduction is an example plan showing some rough estimates of time and resource requirements.
What did other trusts do? Establishing the project

Working simultaneously with multiple diagnostics, different stakeholders and resulting activities was quite complex so our advice would be to establish it as a project with the associated tools, stakeholder analysis, project plans, communications plans, milestones, budget, resource allocation, etc. This doesn’t necessarily mean formal project management methodologies such as PRINCE but really clear project principles. If the trust lead has project management experience and is comfortable with project tools too, that will really help everyone’s experience of, and engagement in the programme.

Kristina Henry, Head of Learning and Organisational Development, Northumbria Healthcare NHS Foundation Trust

It is worth spending time to plan your approach. In retrospect it would have been helpful to be able to offer backfill for staff in the change team and be clear about the time commitment. Capacity of team members was a real barrier not least as we were undertaking the diagnostics alongside preparation for a Care Quality Commission visit.

Sandra Drewett, Director of HR and OD, East London NHS Foundation Trust

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**Central Manchester University Hospitals**
- Quality committee of board
- Transformation operational board
- Organisational development and training team
- Change team (16 people)

**Northumbria Healthcare**
- Board
- Executive director of HR
- Co-ordination and programme management
- Change team (15 people)

**East London**
- Board
- Executive director of corporate affairs
- Director of HR
- Change team (≈10 people)
- Reference group (≈50 people)

*Figure g.3: Different governance approaches*
Communications and engagement

It is important that someone in the change team can help raise awareness of the culture and leadership programme in your organisation.

You will also need the help of your internal communications team to plan and prepare your communications, and work out how and when best to inform colleagues.

What did other trusts do? Engaging people

Engagement is particularly important in a culture and leadership programme! In the preparatory phase for the programme, we held a leadership conference which outlined the principles of collective leadership and was open to all alumni of internal leadership programmes, members of the senior management team (which included clinical directors) and anyone who had responsibility for managing others. You can see the visual we captured during the event.

Sandra Drewett, Director of HR and OD, East London NHS Foundation Trust
What did other trusts do? Engaging people

Once the programme was ready to go live with staff, we had a video to describe the programme, regular updates in our newsletter, and posters.

*Kashif Haroon, Organisational Development Manager, Central Manchester University Hospitals NHS Foundation Trust*

It can be difficult to engage staff in new pieces of work because there is always so much going on in the trust so we linked our culture work to a high profile, visible piece of work that was already embedded. We developed key messages that explained ‘what’s in it for me’ and used these consistently in our communication. This helped our culture work to stand out from the crowd. We delivered messages across the trust using tried and tested mechanisms but also identified key forums where we could discuss the programme.

*Yvonne Storey, Communications and Marketing Manager, Northumbria Healthcare NHS Foundation Trust*
Communicating with impact

It is important to consider what sort of communications would most appeal to colleagues across your organisation and work with the other initiatives going on.

You can use the messages in the short guide to help you raise awareness but you will want to adjust this for your trust.

What did other trusts do? Positioning the programme

We decided to create a brand for our culture and leadership programme to make sure staff understand the impact and can see its impact from the diagnostics through to implementation of the leadership strategy. We linked this to the overall Central Manchester branding – particularly the use of the heart etc...

Kashif Haroon,
Organisational Development Manager,
Central Manchester Universities NHS Foundation Trust

Culture was already an important strand of our Northumbria Way programme so we linked this work to that. We carefully crafted messages to explain the importance of culture to us as an organisation and positively positioned the chance for people to input. We were clear staff could shape our culture moving forward and people seemed to genuinely want to be involved. I think being clear what the end goal was helped.”

Yvonne Storey, Communications and Marketing Manager,
Northumbria Healthcare NHS Foundation Trust
Planning evaluation

You will want to plan how you will measure whether your culture and leadership programme has achieved its objectives and how you will capture lessons for future.

To monitor the impact on culture and outcomes you can use the culture and outcomes dashboard. In Phase 1: Discover you will be identifying a baseline which you can review on an annual basis. It may be difficult to update the dashboard data more frequently as many of the indicators are based on staff survey data which is annual. Remember that culture change takes time.

To capture lessons’ learnt and information on the effectiveness on the process, you can:

- review information on each of the diagnostics from the leads. In each of the six guides on the diagnostics we have included a section on improving the process. For the board interview and culture focus groups, we have also provided forms which you can collect and analyse to understand what went well and what could go better.

- conduct lessons’ learnt interviews or focus groups to identify the impact the programme is having on staff. In Phase 1: Discover, the culture and leadership programme will only be well known by the change team so we recommend that you plan to do this evaluation with internal change team members only. In later phases, you can involve other staff and stakeholders. In Phase 1: Discover you can review the process followed against your plan and objectives. You can also discuss any changes in the team working assessments (tool G3) over the phase and review the leadership behaviours reflection questionnaire (tool G2) and see also Synthesis for information and tools for Phase 1 evaluation.
**Tool G1:** Template for linking collective leadership strategy and business plan

[Download resource]

**Tool G2:** Leadership behaviours reflection questionnaire

[Download resource]
Tool G3: Team-working assessment

Tool G4: An introduction for boards
Culture and leadership programme

Phase 1: Discover

Culture and outcomes dashboard

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- Analysing the results 43
- Presenting the results 43
- Improving the process 43

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- Tool 1.3: Exploring variation in culture in your organisation 54
- Tool 1.4: Report template 55
- Tool 1.5: Dashboard templates 55
Introduction

The wealth of data published nationally or collected by your trust can give you a high level picture of your organisation’s culture and related outcomes.

Collecting this in one place can give you an overall sense of your trust as a whole.

Use this diagnostic in your culture and leadership programme as a **snapshot to support development** rather than as an ongoing performance dashboard for the board. It also provides a baseline you can use to evaluate the impact of the programme.

In line with the Health and Social Care Act 2012, quality is assessed by three metrics: clinical effectiveness, positive experience and safety.

The evidence for the use of these specific indicators varies. Some, such as the staff survey overall measure of engagement, the CQC well-led rating and measures on teamwork, have been clearly linked to overall trust outcomes. In other cases the link is not confirmed. See [Improving the process](#) for more details.

The indicators for metric 12 cover all five cultural elements.
Using the diagnostic

The diagnostic has 12 metrics that are measured with indicators, most of which are nationally collected and publicly available. We have listed some recommended indicators (see tool 1.1) to get you started. These draw heavily from the NHS Staff Survey as this is a well-established data source and includes benchmarks. Other indicators, such as your internal pulse surveys, may also help you to measure the metric.

Assign one or two members of the change team to lead the work on collecting the indicators. Once collected, we recommend you facilitate a change team session to examine the data and discuss findings.

We recommend you benchmark the data or compare against your trust’s planned targets where appropriate. For example, for indicators from the NHS Staff Survey you could use the national average or best score for each key finding. Comparing to the best score achieved may be preferable for trusts already scoring above average as it helps to set an ambition towards improvement – which an average may not do. For high performing trusts where even the best national score leaves significant room for improvement the trust’s planned target might be better. We have included some planned targets for the staff survey indicators in the dashboard templates.
In some cases, you will need to use planned targets because benchmarking against other trusts may not be appropriate, for example in relation to the friends and family test. Your trust’s own targets for any indicators should be both achievable and ambitious so it may help to include these in the dashboard.

Whatever benchmarking methodology you choose, you should use the dashboard as an improvement tool. Identify and prioritise areas you can work on to make your culture and outcomes better: flagging up ‘reds’ and ‘ambers’ or other methods that show your development areas as well as your strengths are helpful.

What did other trusts do? Using the dashboard

The culture dashboard is one of the tools we used to diagnose leadership strengths and weaknesses in ELFT. One of the main benefits of using the dashboard, is that you can see a wide range of information presented in a coherent and integrated way. Much of the information is not new, but the focus of the dashboard is very different to a standard performance report. Indeed, perhaps the most important thing is to try to look at the information presented with fresh eyes, and always asking yourself the question ‘what leadership issue is driving this outcome?’, regardless of whether the outcome is above or below your target or national benchmark.

The second key approach is to consider what outcome could be possible, as meeting a national average could divert focus from an area of generally poor outcomes. To address this, we compared our staff survey results to ‘best in class’ scores.

One drawback is that the information is at organisation level, and this masks variation in outcomes across a large trust with several clinical directorates. We therefore completed a further set of analysis for selected areas.

Finally, the dashboard should not be viewed in isolation and must be seen as one of the suite of tools used to diagnose leadership issues. Synthesising the results with the survey, board questionnaire, and focus groups should lead to a much richer analysis for your organisation.

Mason Fitzgerald, Executive Director of Corporate Affairs, East London NHS Foundation Trust
My team produced the culture and outcomes dashboard. The problem we had with the first version was that all of the boxes next to the culture measures were green. This would have been welcomed if we had been reporting on a regulatory requirement, but the purpose of this dashboard was to help with improvement.

The problem was that for the benchmarking thresholds we had used the national median values, and the trust’s performance was above the median value on all the measures. So we changed the thresholds, to make them more challenging. We calculated the trust’s position within the range between the lowest and highest performance values in the country, and we also used the difference between the trust’s position and a stretch target.

This gave us a dashboard that contained some red boxes – it identified where we should concentrate our improvement efforts.

*Alastair Beattie, Head of Information and Statistics, Northumbria Healthcare NHS Foundation Trust*

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**Note: Vision and values**

Not all providers will have strong quantitative indicators for vision and values. Where you have included the optional questions in the NHS Staff Survey on values or vision you could use these answers. Otherwise, we suggest you collect and average scores from other members of the change team. For this high level assessment, you could ask them to provide an overall rating by considering the following:

- What does CQC’s inspection report say under the analysis of the well-led domain – key lines of enquiry vision and value?
- To what extent do staff in the trust know our values and vision? Is there evidence of the values being displayed and staff knowing what they are?
- What is the trust’s vision statement? Is it strong?

You could provide an overall rating based on a five-point scale:

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<table>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Very weak</td>
<td>Weak</td>
<td>Neither weak nor strong</td>
<td>Strong</td>
<td>Very strong</td>
</tr>
</tbody>
</table>
Examples of dashboard results

**Metric 1 – Clinical Effectiveness**

- **CSCI rating: effective**
  - Current Score: Requires Improvement
  - 3 Year Trend: Requires Improvement

- **Mortality rate**
  - Current Score: 52.5%
  - 3 Year Trend: ↓

- **Unplanned readmission rates**
  - Current Score: 9.5%
  - 3 Year Trend: ↓

- **RTT within 16 weeks**
  - Current Score: 34%
  - 3 Year Trend: ↓

- **Cdiff (hospital stay)**
  - Current Score: 30%
  - 3 Year Trend: ↓

- **A&E wait (4 hours)**
  - Current Score: 88%
  - 3 Year Trend: ↓

**Metric 2 – Positive Experience**

- **CSCI rating: waiting**
  - Current Score: Good
  - 3 Year Trend: Requires Improvement

- **CSCI rating: responsiveness**
  - Current Score: Good
  - 3 Year Trend: Requires Improvement

- **NICE test: patients (inpatients)**
  - Current Score: 99%
  - 3 Year Trend: ↓

- **NICE test: staff (care)**
  - Current Score: 77%
  - 3 Year Trend: Requires Improvement

**Metric 3 – Safety**

- **CSCI rating: safe**
  - Current Score: Good
  - 3 Year Trend: Requires Improvement

- **% confidence and security in reporting unsafe clinical practice**
  - Current Score: 3.7
  - 3 Year Trend: ↑

- **% secure in raising concerns on unsafe clinical practice**
  - Current Score: 96%
  - 3 Year Trend: ↑

- **% confident that the organisation would address their concerns**
  - Current Score: 50%
  - 3 Year Trend: ↓

**Metric 4 – Value for money (Financial Efficiency)**

- **Revenue cost cover (RSC) margin**
  - Current Score: 15
  - 3 Year Trend: Requires Improvement

- **Income and expenditure (I&E) margin as % of income**
  - Current Score: 2%
  - 3 Year Trend: ↓

- **Agency worker overall bioderating cost (%)**
  - Current Score: 3%
  - 3 Year Trend: ↓

- **Actual surplus vs planned surplus (%)**
  - Current Score: 2%
  - 3 Year Trend: Requires Improvement

- **% achievement of OSHC plan**
  - Current Score: 1%
  - 3 Year Trend: Requires Improvement

- **Total cost per WGU**
  - Current Score: NA
  - 3 Year Trend: NA

**Metric 5 – Healthy & Flourishing staff**

- **Engagement (total score)**
  - Current Score: 3.6
  - 3 Year Trend: Requires Improvement

- **% saying their organisation actively takes a positive action on health and wellbeing**
  - Current Score: 79%
  - 3 Year Trend: Requires Improvement

- **Sickness absence rates**
  - Current Score: 8.5%
  - 3 Year Trend: Requires Improvement

- **% saying they have felt unwell in the last 12 months as a result of work related stress**
  - Current Score: 30%
  - 3 Year Trend: Requires Improvement

- **Voluntary turnover rate**
  - Current Score: 2%
  - 3 Year Trend: Requires Improvement

**Metric 6 – Continuous Improvement**

- **% able to contribute towards improvement at work**
  - Current Score: 79%
  - 3 Year Trend: Requires Improvement

- **% have opportunities to show initiative in their role**
  - Current Score: 90%
  - 3 Year Trend: Requires Improvement

- **% able to make suggestions to improve the work of their team / department**
  - Current Score: 97%
  - 3 Year Trend: Requires Improvement

- **% able to make improvements happen in their area of work**
  - Current Score: 90%
  - 3 Year Trend: Requires Improvement

- **Number of completed cycle audits with demonstrated clinical impact**
  - Current Score: 79%
  - 3 Year Trend: Requires Improvement
Examples of dashboard results

### CULTURAL ELEMENTS

#### Metric 7 - Vision & Values
- Change team assessment
  - Current: Strong
  - 5 Year Trend: NA
  - Plan: Strong
  - Aim: Good

- Awareness of organisation’s values
  - Current: NA
  - 5 Year Trend: NA
  - Plan: NA

- Managers demonstrating values at work
  - Current: NA
  - 5 Year Trend: NA
  - Plan: NA

- Other colleagues demonstrating values at work
  - Current: NA
  - 5 Year Trend: NA
  - Plan: NA

- Organisation has a clear vision for the future
  - Current: NA
  - 5 Year Trend: NA
  - Plan: NA

- Feeling part of organisation’s vision for the future
  - Current: NA
  - 5 Year Trend: NA
  - Plan: NA

#### Metric 8 - Goals & Performance
- Quality of appraisal
  - Current Score: 3.56
  - Plan: 3.56

- % saying their appraisal ‘helped them focus on their job more effectively’
  - Current: 40%
  - Plan: 40%

- % saying their appraisal ‘helped them improve their work’
  - Current: 60%
  - Plan: 60%

- % saying their appraisal ‘helped them improve their work by setting new objectives or improving current ones’
  - Current: 30%
  - Plan: 30%

- % saying their appraisal ‘helped them improve their work by providing feedback’
  - Current: 30%
  - Plan: 30%

#### Metric 9 - Support & Compassion
- Quality of non-mandatory training, learning at development
  - Current Score: 3.09
  - Plan: 3.09

- % agreeing that training, L&D has helped them to do their job more effectively
  - Current: 75%
  - Plan: 75%

- % agreeing that training, L&D has helped them to set their job more effectively
  - Current: 90%
  - Plan: 90%

- % agreeing that basic and training has helped them to set their job more effectively
  - Current: 80%
  - Plan: 80%

- % agreeing that training, L&D has helped them in their work by setting new objectives or improving current ones
  - Current: 30%
  - Plan: 30%

- % agreeing that training, L&D has helped them in their work by providing feedback
  - Current: 30%
  - Plan: 30%

- % agreeing that training, L&D has helped them in their work by setting new objectives or improving current ones
  - Current: 30%
  - Plan: 30%

- % agreeing that training, L&D has helped them in their work by providing feedback
  - Current: 30%
  - Plan: 30%

- Effective use of patient / service user feedback
  - Current Score: 1.8
  - Plan: 1.8

- % agreeing that organisation asks its concerns raised by patients / service users
  - Current: 80%
  - Plan: 80%

- % receiving regular updates or patient / service user experience feedback
  - Current: 30%
  - Plan: 30%

- % agreeing that feedback from patients / service users is used in more informed decisions within their organisation / department
  - Current: 90%
  - Plan: 90%

- % agreeing that feedback from patients / service users is used in more informed decisions within their organisation / department
  - Current: 10%
  - Plan: 10%
Analysing the results

You can use the **culture and outcomes templates** to help you gather and analyse your data.

You could present your findings alongside your benchmark/organisation planned target to highlight areas your trust may wish to explore using other diagnostics (such as the focus groups) or the strengths and development areas.

You can note your interpretations for discussion in the synthesis workshop alongside the dashboard itself. It is important to note that the dashboard is only one of the diagnostics so the results should be explored alongside those from the five other diagnostics before firm conclusions are drawn.

Presenting the results

Once you have gathered the data, you can present it in any format suitable for your organisation and share a report containing your dashboard and its interpretation with the change team. **Tool 1.4 has an example template.**

Improving the process

You could hold a ‘lessons learnt’ session to identify what worked and how you could improve the results and process of using this diagnostic. You could, for example, review the data to see if there are any areas you want to explore further, any extra indicators you would want to add to dig a bit deeper in certain areas or a different method you could use for benchmarking.

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**What did other trusts say?**

**Presenting information in a familiar way**

Having data in a format that is recognised by leaders in the organisation helps ensure the data is held in the same regard/importance as operational data.

*Stacy Bullock, Assistant Head of Organisational Development and Training, Central Manchester University Hospitals NHS Foundation Trust*

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**Share your learning on the culture and outcomes dashboard with other trusts**

Join our culture community by contacting **NHSI.culture@nhs.net**
### Tool 1.1: Indicators for each metric

<table>
<thead>
<tr>
<th>#</th>
<th>Indicator</th>
<th>Sector</th>
<th>Source/website</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Metric 1: Clinical effectiveness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>CQC rating – effective</td>
<td>All providers</td>
<td>CQC</td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Crude mortality rate</td>
<td>All</td>
<td>NHS Digital/trust data</td>
<td></td>
</tr>
<tr>
<td>1.3</td>
<td>Unplanned readmission rates</td>
<td>All</td>
<td>NHS Digital/trust data</td>
<td></td>
</tr>
<tr>
<td>1.4</td>
<td>RTT within 18 weeks</td>
<td>Acute</td>
<td>Trust data</td>
<td></td>
</tr>
<tr>
<td>1.5</td>
<td>Cancer waits (62 days)</td>
<td>Acute</td>
<td>Trust data</td>
<td></td>
</tr>
<tr>
<td>1.6</td>
<td>C. difficile (national target)</td>
<td>Acute</td>
<td>Trust data</td>
<td></td>
</tr>
<tr>
<td>1.7</td>
<td>A&amp;E waits (4 hours)</td>
<td>Acute</td>
<td>Trust data</td>
<td></td>
</tr>
<tr>
<td>1.8</td>
<td>CPA follow-up within 7 days</td>
<td>Mental health</td>
<td>NHS Digital/trust data</td>
<td></td>
</tr>
<tr>
<td>1.9</td>
<td>Delayed transfer of care</td>
<td>Mental health</td>
<td>NHS Digital/trust data</td>
<td></td>
</tr>
<tr>
<td>1.10</td>
<td>Overall score from national quality reviews</td>
<td>Mental health</td>
<td>NHS Digital/trust data</td>
<td>Specific to forensics</td>
</tr>
<tr>
<td>1.11</td>
<td>Out-of-area treatment</td>
<td>Mental health</td>
<td>Trust data</td>
<td></td>
</tr>
<tr>
<td>1.12</td>
<td>Bed occupancy rate</td>
<td>Mental health</td>
<td>Trust data</td>
<td>(Note: proxy for demand management)</td>
</tr>
<tr>
<td>1.13</td>
<td>Category A response time</td>
<td>Ambulance</td>
<td>Trust data</td>
<td></td>
</tr>
<tr>
<td>1.14</td>
<td>Community services outcomes</td>
<td>Community</td>
<td>Trust data</td>
<td>To be decided by trust</td>
</tr>
<tr>
<td></td>
<td><strong>Metric 2: Positive experience</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>CQC rating – caring</td>
<td>All</td>
<td>CQC</td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>CQC rating – responsiveness</td>
<td>All</td>
<td>CQC</td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>Friends and Family Test score: patients recommending the hospital (%)</td>
<td>All</td>
<td>Trust data</td>
<td></td>
</tr>
<tr>
<td>2.4</td>
<td>Friends and Family Test score: staff recommending the hospital for care (%)</td>
<td>All</td>
<td>Trust data</td>
<td></td>
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<tr>
<td></td>
<td><strong>Metric 3: Safety</strong></td>
<td></td>
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</tr>
<tr>
<td>3.1</td>
<td>CQC rating – safe</td>
<td>All</td>
<td>CQC</td>
<td></td>
</tr>
<tr>
<td>3.2</td>
<td>Staff confidence and security in reporting unsafe clinical practice</td>
<td>All</td>
<td>NHS Staff Survey (key finding 31)</td>
<td>Collect key finding and question level data</td>
</tr>
<tr>
<td>3.2.1</td>
<td>Staff feel secure raising concerns about unsafe clinical practice</td>
<td>All</td>
<td>NHS Staff Survey (Q13b)</td>
<td></td>
</tr>
<tr>
<td>3.2.2</td>
<td>Staff confident that the organisation would address their concerns</td>
<td>All</td>
<td>NHS Staff Survey (Q13c)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Metric 4: Value for money (Financial efficiency)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>Indicator</td>
<td>Sector</td>
<td>Source/website</td>
<td>Notes</td>
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<td>------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>4.1</td>
<td>Reference cost index</td>
<td>All</td>
<td>NHS England</td>
<td></td>
</tr>
<tr>
<td>4.2</td>
<td>Income and expenditure (I&amp;E) margin (%)</td>
<td>All</td>
<td>Trust data</td>
<td></td>
</tr>
<tr>
<td>4.3</td>
<td>Agency workers overall total staffing cost (%)</td>
<td>All</td>
<td>Trust data</td>
<td></td>
</tr>
<tr>
<td>4.4</td>
<td>Care hours per patient day (CHPPD)</td>
<td>All</td>
<td>Trust data</td>
<td></td>
</tr>
<tr>
<td>4.5</td>
<td>Actual surplus vs planned surplus</td>
<td>All</td>
<td>Trust data</td>
<td></td>
</tr>
<tr>
<td>4.6</td>
<td>% achievement of Cash Releasing Efficiency Savings (CRES) plan</td>
<td>All</td>
<td>Trust data</td>
<td></td>
</tr>
<tr>
<td>4.7</td>
<td>Total cost per Weighted Activity Unit (WAU)</td>
<td>All</td>
<td>Trust data</td>
<td></td>
</tr>
<tr>
<td>4.8</td>
<td>Overall financial rating (ie Monitor scale of 1-4)</td>
<td>NHS FTs</td>
<td>Trust data</td>
<td></td>
</tr>
</tbody>
</table>

**Metric 5: Healthy, flourishing and engaged staff**

<table>
<thead>
<tr>
<th>#</th>
<th>Indicator</th>
<th>Sector</th>
<th>Source/website</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Engagement (total score)</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td>(total engagement score)</td>
</tr>
<tr>
<td>5.2</td>
<td>% saying their organisation definitely takes a positive action on health and wellbeing</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td>(Q9a)</td>
</tr>
<tr>
<td>5.3</td>
<td>Sickness absence rates</td>
<td>All</td>
<td>NHS Digital</td>
<td></td>
</tr>
<tr>
<td>5.4</td>
<td>% saying they have felt unwell in the last 12 months as a result of work related stress</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td>(Q9c)</td>
</tr>
<tr>
<td>5.5</td>
<td>Voluntary turnover rate</td>
<td>All</td>
<td>Trust data</td>
<td></td>
</tr>
</tbody>
</table>

**Metric 6: Continuous Improvement**

<table>
<thead>
<tr>
<th>#</th>
<th>Indicator</th>
<th>Sector</th>
<th>Source/website</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>% staff ability to contribute towards improvements at work</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td>(key finding 7)</td>
</tr>
<tr>
<td></td>
<td>% staff that have opportunities to show initiative in their role</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td>(Q4a)</td>
</tr>
<tr>
<td></td>
<td>% staff that are able to make suggestions to improve the work of their team department</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td>(Q4b)</td>
</tr>
<tr>
<td>6.1.3</td>
<td>% staff able to make improvements happen in their area of work</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td>(Q4d)</td>
</tr>
<tr>
<td>6.2</td>
<td>Number of completed audit cycles with demonstrated clinical impact</td>
<td>All</td>
<td>Trust audit office</td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>Indicator</td>
<td>Sector</td>
<td>Source/website</td>
<td>Notes</td>
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<td>----</td>
<td>----------------------------------------------------------------</td>
<td>----------------</td>
<td>----------------------------------------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>7.1</td>
<td>Change team assessment of vision and values</td>
<td>All</td>
<td>Change team self-assessment and rating</td>
<td></td>
</tr>
<tr>
<td>7.2</td>
<td>Awareness of organisation’s values</td>
<td>All (if used in staff survey)</td>
<td>NHS NHS Staff Survey (optional values, Q 23a)</td>
<td></td>
</tr>
<tr>
<td>7.2.1</td>
<td>Manager demonstrating values at work?</td>
<td>All (if used in staff survey)</td>
<td>NHS Staff Survey (optional values, Q 23b)</td>
<td></td>
</tr>
<tr>
<td>7.2.2</td>
<td>Other colleagues demonstrating values at work</td>
<td>All (if used in staff survey)</td>
<td>NHS Staff Survey (optional values, Q 23c)</td>
<td></td>
</tr>
<tr>
<td>7.3</td>
<td>Organisation has a clear vision for the future</td>
<td>All (if used in staff survey)</td>
<td>NHS Staff Survey (optional leadership and development, Q 34a)</td>
<td></td>
</tr>
<tr>
<td>7.4</td>
<td>Feeling part of organisation’s vision for the future</td>
<td>All (if used in staff survey)</td>
<td>NHS Staff Survey (optional leadership and development, Q 34b)</td>
<td></td>
</tr>
</tbody>
</table>

**Metric 8: Goals and performance**

<p>| 8.1 | Quality of appraisals                                          | All            | NHS Staff Survey                              | Collect key finding and question level data                  |
| 8.1.1| % saying their appraisal definitely helped them improve how they do their job | All            | NHS Staff Survey (Q20b)                      |                                                            |
| 8.1.2| % saying their appraisal definitely helped them agree clear objectives for their work | All            | NHS Staff Survey (Q20c)                      |                                                            |
| 8.1.3| % saying their appraisal definitely made them feel their work was valued by the organisation | All            | NHS Staff Survey (Q20d)                      |                                                            |
| 8.2 | Percentage achievement of service line’s strategic or business objectives | All            | Trust data (e.g. collected from each directorate, trust strategy director/chief operating officer) |                                                            |</p>
<table>
<thead>
<tr>
<th>#</th>
<th>Indicator</th>
<th>Sector</th>
<th>Source/website</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1</td>
<td>Quality of non-mandatory training, learning and development (L &amp; D)</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td>Collect key finding and question level data</td>
</tr>
<tr>
<td>9.1.1</td>
<td>% agreeing that training, L &amp; D has helped them do their job more effectively</td>
<td>All</td>
<td>NHS Staff Survey (Q18b)</td>
<td></td>
</tr>
<tr>
<td>9.1.2</td>
<td>% agreeing that training, L &amp; D has helped them stay up-to-date with professional requirements</td>
<td>All</td>
<td>NHS Staff Survey (Q18c)</td>
<td></td>
</tr>
<tr>
<td>9.1.3</td>
<td>% agreeing that training, L &amp; D has helped them deliver a better patient / service user experience</td>
<td>All</td>
<td>NHS Staff Survey (Q18d)</td>
<td></td>
</tr>
<tr>
<td>9.2</td>
<td>Effective use of patient / service user feedback</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td>Collect key finding and question level data</td>
</tr>
<tr>
<td>9.2.1</td>
<td>% agreeing that their organisation acts on concerns raised by patients / service users</td>
<td>All</td>
<td>NHS Staff Survey (Q21b)</td>
<td></td>
</tr>
<tr>
<td>9.2.2</td>
<td>% receiving regular updates on patient/service user experience feedback</td>
<td>All</td>
<td>NHS Staff Survey (Q22b)</td>
<td></td>
</tr>
<tr>
<td>9.2.3</td>
<td>% agreeing that feedback from patients/service users is used to make informed decisions within their directorate / department</td>
<td>All</td>
<td>NHS Staff Survey (Q22c)</td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>Indicator</td>
<td>Sector</td>
<td>Source/website</td>
<td>Notes</td>
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<tr>
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<td>---------------------------------------------------------------------------</td>
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<td>---------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>10.1</td>
<td>Support from immediate managers</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td>Collect key finding and question level data</td>
</tr>
<tr>
<td>10.1.1</td>
<td>% satisfied with support from their immediate manager</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td></td>
</tr>
<tr>
<td>10.1.2</td>
<td>% agreeing that immediate manager encourages those who work for them to work as a team</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td></td>
</tr>
<tr>
<td>10.1.3</td>
<td>% agreeing that immediate manager can be counted on to help with difficult tasks at work</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td></td>
</tr>
<tr>
<td>10.1.4</td>
<td>% agreeing that immediate manager gives clear feedback on work</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td></td>
</tr>
<tr>
<td>10.1.5</td>
<td>% agreeing that immediate manager asks for their opinion before making decisions that affect their work</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td></td>
</tr>
<tr>
<td>10.1.6</td>
<td>% agreeing that immediate manager is supportive in a personal crisis</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td></td>
</tr>
<tr>
<td>10.2</td>
<td>Experiencing harassment, bullying or abuse from staff in the last 12 months</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td>Collect key finding and question level data</td>
</tr>
<tr>
<td>10.2.1</td>
<td>% experiencing harassment, bullying or abuse at work from managers in the last 12 months</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td></td>
</tr>
<tr>
<td>10.2.2</td>
<td>% experiencing harassment, bullying or abuse at work from other colleagues in the last 12 months</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td></td>
</tr>
<tr>
<td>10.3</td>
<td>staff believing the trust provides equal opportunities for career progression or promotion</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td></td>
</tr>
<tr>
<td>10.4</td>
<td>% saying they had experienced discrimination from their manager/team leader or other colleagues in the last 12 months</td>
<td>All</td>
<td>NHS Staff Survey</td>
<td></td>
</tr>
</tbody>
</table>
Key data sources for indicators

- CQC ratings
- National Staff Survey results:
  www.nhsstaffsurveys.com/Page/1006/Latest-Results/2014-Results/
- Friends and Family Test data:
- Summary Hospital-level Mortality Indicator:
  www.NHS Digital.gov.uk/SHMI
- Hospital Episode Statistics (readmissions):
  www.NHS Digital.gov.uk/hes
- Data on Written Complaints in the NHS:
  www.NHS Digital.gov.uk/catalogue/PUB18021
- NHS Sickness Absence Rates:
  www.NHS Digital.gov.uk/catalogue/PUB17903
- Reference costs index:
The table below shows the research findings for those indicators with a strong evidence base. It may help you better understand how some of them predict high quality patient outcomes. The table does not include:

- evidence on metrics 1 to 4 as these are largely well-established national measures of care quality and financial efficiency
- indicators where the evidence is still being collected.

It is important to remember that the dashboard is only one diagnostic. Explore the results alongside the findings from the other four diagnostics and use them to guide discussions in your focus groups.
# Indicator

## Metric 5: Healthy, flourishing and engaged staff

### 5.1 Engagement (total score)

References to support this measure as a predictor of trust outcomes include:


These studies also support the staff wellbeing measure.

### 5.3 Sickness absence rates

This is a well-established measure of organisational health.

The independent NHS Health and wellbeing review published in November 2009 found that NHS organisations that prioritise staff health and wellbeing:

- achieve enhanced performance
- improve patient care
- are better at retaining staff
- have lower rates of sickness absence.


### 5.4 % saying they felt unwell in the last 12 months as a result of work-related stress

The NHS health and wellbeing review also supports these measures as predictors of patient outcomes and financial performance

### 5.5 % voluntary turnover rate

Turnover is a well-established measure of the health of an organisation and is linked to organisation productivity, profitability and innovation

## Metric 6: Continuous improvement

The measures continuous improvement are proxy measures of innovation. We do not have strong evidence for their predictive usefulness but they do predict levels of staff engagement which in turn predict most trust outcomes (e.g. patient satisfaction, CQC ratings, patient mortality and staff absenteeism).
<table>
<thead>
<tr>
<th>Metric 7: Vision and values</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Metric 8: Goals and performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research into high quality care cultures funded by the DH Policy Research Programme clearly identified vision and values understood and embraced throughout an organisation as an important influence the culture.</td>
</tr>
<tr>
<td>Moreover, considerable evidence shows that that clear objectives and helpful, frequent data on performance in relation to those objectives are the most important influences on motivation and performance at work.</td>
</tr>
<tr>
<td>Appraisals are important predictors of outcomes and engagement. Research shows strong association between appraisal and patient mortality in the acute sector.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Metric 9: Learning and innovation</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
</tr>
<tr>
<td>Metric 10: Support and compassion</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>10.1 Leadership and supportive management are important influences on trust performance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Metric 11 - Teamwork</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Much evidence of the importance of team working to outcomes including patient satisfaction, patient mortality (acute sector), staff stress, care quality.</td>
</tr>
</tbody>
</table>
Tool 1.3: Exploring variation in culture in your organisation

Once you have completed the dashboard for your trust you may wish to look at the data at department level so that you can understand the variation in your organisation.

It will be easier to focus on the cultural elements (metrics 5 to 10) rather than include outcomes (1 to 4) in this level of detail.

- For metrics 5 to 12, you can use most of the indicators listed in tool 1.1. You will need to contact your HR department for NHS Staff Survey indicators by department as these data are not publicly available. HR may also be able to provide you with other workforce indicators at departmental level. You may be able to include CQC ratings where service level and departments align.

- If you choose to include outcomes metrics 1 to 4, you will need to select outcomes indicators that are relevant to your organisation at department level. You can look at department business plan targets or objectives for indicators.

The dashboard templates show how you can capture department level data so it can be reviewed by your change teams.
Tool 1.4: Report template

Tool 1.5: Dashboard templates
Board interviews

Phase 1: Discover

Guidance:
- Introduction 57
- Using the diagnostic 58
- Analysing the results 61
- Presenting the results 62
- Improving the process 62

Tools:
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- Tool 2.2: Key messages 63
- Tool 2.3: Report template 64
- Tool 2.4: Feedback forms 65
- Tool 2.5: Interview training resources 65
Introduction

This diagnostic is a set of interview questions for use with board members. The questions are structured around the five key elements which have been shown to be present in cultures of high quality care. They will start your board and change team talking about the board’s role in creating and supporting a culture of collective leadership. They will also give you an insight into how the board perceives culture, helping you identify areas for development or improvement.

Involving the board at this stage ensures they engage early on with the wider culture and leadership programme, take ownership of it and are aware of the key issues in their organisation. Given the influence of the board over organisation culture, we suggest face-to-face interviews rather than an electronic survey as they generate richer data, allow clarification and give an opportunity to probe for more detail.

Individual answers to the questions should remain confidential and each board member should be able to ‘sign-off’ the transcript of their interview to ensure accuracy.

The questions address:

- board perception of organisation culture and performance
- board perception of its own culture and performance
- how the board assures itself of the culture and performance.
Using the diagnostic

The diagnostic has 14 questions designed to address the five key elements present in high quality care cultures. These questions are set out in the interview record sheet (tool 2.1).

The value of the interviews comes from board members talking openly about their organisations so interview individually (rather than as focus groups or workshops), in a secure and confidential manner. Board members should give their personal perspective on the performance and behaviours of the board as a whole.

We suggest you use internal staff members as interviewers because that in itself helps create collective leadership, while improving staff engagement and allowing them to develop transferable skills. If this is not possible, use a peer-to-peer arrangement with staff members from other trusts or even external interviewers.

Regardless of who conducts the interviews, we recommend you:

- ensure they are skilled in interview techniques, including:
  - establishing ground rules (particularly around anonymity and confidentiality)
  - active listening
  - summarising and checking understanding
  - asking open questions when appropriate
  - asking follow-up questions for further elaboration or clarification
  - giving interviewees opportunities to add further comments
  - being resilient and confident in the face of resistance or conflict
- provide support and training where necessary – particularly where junior staff are interviewing more senior colleagues
- try to predict and mitigate any potential conflict of interest or personal issue between interviewer and interviewee.

How does the culture and leadership programme fit with the NHS Improvement well-led framework for governance reviews?

Foundation trusts are required to undertake three-yearly well-led reviews, using the NHS Improvement well-led framework for governance reviews. The culture and leadership programme and the well-led framework are complementary. The culture and leadership programme will help boards assure their governance on the “culture and capability” domain of the well-led framework and improve their results in governance reviews.

Beyond this, the board interview address a broader range of cultural elements than the well-led framework, and delve deeper into the board’s influence on the culture and leadership of the organisation. Thought should be given to the timing of the board interviews in relation to the last governance review to avoid ‘interview fatigue’ amongst board members, and ensure that any changes that occur over time are captured. Data can be shared between the culture and leadership programme and governance reviews, helping to avoid repetition and enabling comparison and cross-referencing between the two.
What did other trusts do?

We chose to use internal employees to conduct our board interviews. We selected this approach because we felt it would strengthen our work to build a model of collective leadership to further improve staff engagement and motivation.

Before undertaking the interviews our change team, who had self-selected for the board interviews and focus groups, underwent an afternoon of interview training. This included discussion of the purpose of the board interviews, confidentiality, note-taking techniques and how to probe effectively. Participants had a chance to practice their newly learnt skills through mock interviews, helping to bring it all to life.

The change team enjoyed the interview training immensely. Not only did the training help bring the team together, but it also provided some excellent transferable skills in interviewing and a thorough introduction to the diagnostics.

Having a number of team members undertaking the interviews meant they were not only able to spread the workload, but also learn together and reflect on the process as a whole. Everyone really enjoyed taking part and commented on how it had positively changed their views of our board. Part of our overall OD plan is to build OD capability across the trust and this process really helped make that happen.

Importantly, the board were very receptive to taking part and it was felt they were open and honest in their responses. This in itself may end up having a positive impact on the culture and leadership of the organisation.

Helen Farrington, Associate Director of Organisational Development and Training, Central Manchester University Hospitals NHS Foundation Trust

“Getting board members engaged was essential to the success of this diagnostic”

Kristina Henry
Before the interview:

- ensure you have appropriately skilled interviewers; internal staff members may need some extra training
- brief the chair and board on the culture and leadership programme and the purpose of the interview
- consider sending the board members the interview questions in advance
- cover any key messages and reassure board members that interviews are confidential and responses will not be linked to particular individuals (see key messages)
- set up interviews with as many board members as possible, ideally all of them, but a minimum of 75%
- allow at least an hour for one-to-one interviews, including time for clarification and elaboration; you’ll need to work with board members’ PAs or diary managers so it is important that the project has enough profile in your organisation to ensure interviews are prioritised
- decide if you will audio record and transcribe interviews, or take notes. If the latter, use two interviewers to enable effective note-taking and sense-checking between interviewers. Individual board members will need to give prior agreement for audio recording.
What did other trusts do?

Getting board members engaged was essential to the success of this diagnostic. Not only did it ensure a high number of participants, but also encouraged honest and open answers to questions.

We made sure that communication with the board was clear and open from the start of the process. Representatives of our change team regularly discussed the project and the diagnostic with the board, explaining its purpose, giving reassurances around confidentiality and outlining use of the data. Regular communication included a combination of face-to-face discussions at board meetings and update emails in the lead up to the actual interviews.

As well as engaging the board directly, our change team ensured they worked closely with the trust management admin support team. This was instrumental in securing time for interviews around tight board calendars and existing commitments.

Using these approaches we were able to achieve a 75% return rate amongst board members, with open discussion generating invaluable data.

Kristina Henry, Head of Learning and Organisational Development, Northumbria Healthcare NHS Foundation Trust

During and after the interview:

- conduct interviews in an open and confidential manner
- ideally, get a response to every question; if this is not feasible you may need to set up another session, or follow-up telephone interview
- at the end, invite interviewees and interviewers to complete a post-interview feedback (see tool 2.4).
- ensure transcripts and notes of interviews are checked and ‘signed off’ by interviewees. Code transcripts so that they do not identify individual board members and redact any comments that are critical of individuals.

Analysing the results

You will need to interpret the responses and conduct your own thematic analysis on the qualitative data. You can use the qualitative analysis guidance to help you with this.
Presenting the results

Present the results of the interviews as a report with both quantitative and qualitative data and share it with your board. See the example template in tool 2.3.

Quantitative analysis

Present summary statistics (mean, mode, range) of the numerical data assessing how well the interviewee felt the board performs in each area.

Qualitative analysis

Provide a summary of the key themes and analysis. The themes may have been raised repeatedly by different board members or have been strongly expressed by only one or two board members. Your report should cover:

- a measure of the board’s current understanding and awareness of its culture and the culture of your organisation
- a measure of the board’s engagement with other staff members in your organisation
- strengths and development areas across each of the five cultural elements.

You will need the express written permission of interviewees to use anecdotes, reflections or examples.

Improving the process

Once the process is complete, you may wish to capture your thoughts on what went well and what could go better in future. You can review the data from the feedback forms in tool 2.4.

Share your learning on board interviews with other trusts

Join our culture community by contacting NHSI.culture@nhs.net
Tool 2.1: Interview record sheets

Tool 2.2: Key messages
Tool 2.3: Report template

Tool 2.4: Feedback forms

“Everyone [the interviewers] really enjoyed taking part and commented on how it had positively changed their views of our board”

Helen Farrington
Tool 2.5: Interview training resources

Download resource

Tool 2.6: Analysing the qualitative data

Download resource

When analysing staff information please ensure you are treating data in line with the Data Protection Act and adhering to your organisation's information governance policy. If in doubt, seek the advice of your Data Protection Officer or information governance team as necessary.

Tool 2.6: Analysing the qualitative data

What is meant by analysis?

Analysis of the board interview data aims to describe, summarise and begin drawing conclusions from responses. Broadly, this entails looking for patterns or themes across the interviews, while considering their frequency and how intensely they are expressed. In doing this, it may be possible to identify relationships between themes and relate ideas or behaviours to elements of the board and organisational culture. The themes appearing in the board interview questions can also be cross-referenced with results from other tools, highlighting consistencies and discrepancies across the organisation.

Having completed the analysis, you will have a set of key themes which form the basis of the final report.

Tips for analysing the data

There are a number of methods for the analysis of qualitative data and there is no prescribed method for doing this. It may be that members of your change team have previous experience of particular approaches, and would prefer to apply these.

There are, however, a number of general tips which may help you analyse your data and ensure accuracy and consistency:

• Try to ensure the interviewer is involved in the analysis – they will be able to give a sense of the 'tone' of the answers, and offer a unique insight into the intended meaning.

• Have at least two people looking at each answer – this should help with consistency, and avoid the potential bias of one person conducting all the analysis.

• If a number of people are conducting the analysis, allocate each person the same few questions across all the interviews, rather than a few whole interviews. This allows one person to start to see the common themes occurring across the interviews.
Leadership behaviours surveys

Phase 1: Discover

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Introduction

These surveys provide information on the 10 leadership behaviours across your organisation.

They tell you about:

- the leadership strengths of individuals at all levels of the trust
- the leadership strengths of the trust’s leadership as a whole.

There is one survey for staff to complete and one for partners in external organisations. Both ask for quantitative responses on 10 leadership behaviours and include optional qualitative questions.

The surveys are designed to be different from the NHS Staff Survey and pulse checks. They help you understand:

- the leadership behaviours of individuals throughout your organisation – not only those in formal leadership positions
- leadership at inter-team and organisational level
- leadership at a systems level including the perspective of external organisations.
What did other trusts say? About the surveys

This is different type of survey to the NHS Staff Survey. It asks people to take time to think about their own behaviour as well as those of their leaders. So it is already encouraging behaviours in people as well as being a diagnostic about staff experience of the leadership they receive.

*Kashif Haroon, Organisational Development Manager, Central Manchester University Hospitals NHS Foundation Trust*

We weren’t sure how people would find the survey and how long it would take to complete because it is quite reflective – so we were glad to see the feedback from staff during the pilot.

*Hasan Cagirtgan, Associate Director of Organisational Development and Learning, East London NHS Foundation Trust*

**How long did the survey take to answer?**

- 15 minutes or more (5%)
- Less than 5 minutes (15%)
- 10 - 15 minutes (20%)
- 5 - 10 minutes (60%)

**Were the questions clear and easy to answer?**

- Agree (75%)
- Neither agree nor disagree (15%)
- Disagree (10%)

*Figure 3.1: Feedback from staff during pilot*
Using the diagnostic

The surveys are online questionnaires available via NHS Improvement’s survey subscription (currently SurveyMonkey).

If you want to host the questions on your own survey provider in house you will need to modify the surveys and communications messages provided in this document to explain to staff and partners who will process the data. This is because hosting in house will affect the anonymity of responders and this would need to be reflected in the communications to make people aware in advance.

We recommend that one or two members of the change team co-ordinate the surveys with day-to-day sponsorship from a member of the senior leadership team to encourage a high response rate.

If you wish to roll out the survey using NHS Improvement’s survey subscription you first need to:

- contact NHSI.culture@nhs.net and sign the data agreement (tool 3.1)
- send us a list of departments, divisions or locations for your staff survey (no more than 12 items)
- send us the names and email addresses of one or two people who will receive access to the survey results
- send us the name and contact details of someone in your trust who can be contacted by staff and partners in case of difficulties with the surveys
- thoroughly test the link supplied by NHS Improvement to make sure it will work in your trust before you release the survey. Let us know if you have any issues and make sure you ask NHS Improvement to delete the test data before you release the survey.

We estimate it takes two to three months to run including three weeks for preparation, six weeks for survey roll-out and two weeks for analysis and report write-up.

Figure 3.2: Allowing time to roll out the leader behaviourship surveys
We’ve included some key messages (tool 3.2) to help you promote completion of the survey, you might also like to review the NHS Staff Survey guidance on improving online response rates.

You then need to:

- co-ordinate the collection of active staff email addresses
- send an email (tool 3.3) explaining the purpose and importance of the survey and asking for participation by x date (2 weeks from the date of the survey)
- send up to three reminders (tool 3.3) one to two weeks after first email. You could also use a ‘count down’ to the deadline.

What did other trusts do? Survey communications

Before releasing the survey we raised awareness of the importance of the culture work by briefing senior leaders. They cascaded this message down through the organisation. We followed this with employee briefings explaining how the survey would be used and why it was so important. The email we used to send out the survey was eye catching and familiar to recipients as it used imagery from our internal campaign, the Northumbria Way. We also incentivised completion with a free prize draw.

Yvonne Storey, Communications and Marketing Manager,
Northumbria Healthcare NHS Foundation Trust

In addition to the standard emails to all staff and reminder emails we used an on-screen pop-up for all staff so that they were reminded whenever they logged in and put messages about the survey in our staff newsletter. This worked well and we had 18% response rate in our census approach.

Hasan Cagirtgan, Associate Director of Organisational Development and Learning,
East London NHS Foundation Trust
We kept an eye on the response rate by demographic group while the survey was running. As not all staff regularly access their emails – particularly support staff and some clinical staff – we printed 100 paper surveys and the patient experience team identified the staff groups, collected the responses and inputted the data online. Alternatives we discussed with NHS Improveme included circulating the survey via iPads or just circulate the link in hard copy – not the whole survey.

*Stephen Hodges, Head of Patient Services, Central Manchester University Hospitals NHS Foundation Trust*

Because junior doctors rotate and because they are on the payroll of a lead trust in a patch it can be difficult to contact them regarding surveys. We used our senior medical personnel and some of the junior doctor representatives. Another option we considered was to circulate an iPad in the mess.

*Leanne Furnell, Human Resources Manager, Northumbria Healthcare NHS Foundation Trust*
Staff survey

Contact NHSI.culture@nhs.net for a link to your survey. Send the link either to all staff in your organisation (a ‘census’ approach) or a sample with a minimum of 850 staff members.

If you select a sample approach, about a quarter of the sample (200 staff) should be in formal leadership positions – band 7 or higher with management responsibilities or consultants with management responsibilities. The rest should be randomly selected to cover all departments, occupational groups and levels of seniority. You can use the NHS Staff Survey guidance to identify which staff to include. This will mean the questionnaire captures both formal and informal leaders, but is weighted to those in positions of formal authority.

Figure 3.3: Example of the staff survey. www.surveymonkey.co.uk/r/CLSSTAFF1
What did other trusts say? Sampling issues

We learnt a lot from this process across the three pilot trusts.

Due to a number of staff being on leave or absent during the survey period, we realised that approximately 12% of employees in our sample wouldn’t receive the survey, so we added another 100 people to the sample. You could anticipate this and over recruit if you use a sample approach or do what we did and wait and see how many bounce backs and out of office notices you get so you only add as many as you need.

All three pilot trusts had relatively few staff responding from bands 8b and above – of course, there are fewer staff at these grades in the organisation – so if you are using a sample approach, I would weight it towards those senior positions. Otherwise, you’ll need to put a lot of effort into those communications.

Leanne Furnell, Human Resources Manager,
Northumbria Healthcare NHS Foundation Trust
External partners survey

Feedback from people in partner organisations is important for identifying strengths in working across organisational boundaries and across local health systems. It is important those who you ask to complete this have personal experience of working with people in your trust.

Send this link with a completion request and deadline to a minimum of 50 individuals covering:

- staff from organisations currently working with the trust, eg commissioners, providers and patient groups
- a sample of stakeholders that avoids selection bias and includes staff in different types of partner organisation and at different roles – senior leaders, managers, and front line.

Your communications team should be able to help you target the survey but you may need to ask key people across your trust to identify those they work regularly with.

Note:

- The survey needs to go to ‘partners’ rather than all external stakeholders as not all external stakeholders will be close enough to the trust to have a sufficiently detailed perspective.
- You can include your governors in the internal staff survey but not in the partner survey.
What did other trusts do? Identifying the partners

We went to our service directors to provide us with the names of all partners that they work closely with because we wanted the views of stakeholders at all levels of our partner organisations not only the senior leaders in the list held in the communication department.

Hasan Cagirtgan, Associate Director of Organisational Development and Learning, East London NHS Foundation Trust

There were significant strategic changes taking place across Manchester and we wanted to learn about what our external partners had to say. We linked in with our executive team to share details of external stakeholders they regularly work with. We also contacted our education teams to share details of people they liaise with regularly.

Kashif Haroon, Organisational Development Manager, Central Manchester Universities NHS Foundation Trust

You can optimise your response rates by taking the partner survey to meetings and events you attend with your partners and asking them to complete it there. We did this using an iPad at our GP education event. The iPad meant GPs could submit the survey themselves protecting the confidentiality of their responses which wouldn’t have been the case if we’d used paper copies.

Yvonne Storey, Communications and Marketing Manager, Northumbria Healthcare NHS Foundation Trust
Closing the surveys and response rate

Email NHSI.culture@nhs.net to let us know when you want to close the surveys (usually after six weeks for the staff survey, and three to four weeks for the stakeholder survey but will this depend on the response rate).

During the collection period, we will provide you with response rate information by demographic.

There is no fixed response rate for these surveys. It is important that you review your demographics for your response rate to ensure you are getting good coverage of your organisation.

For the staff survey a strong response rate would be:

- 20% on census methodology (if the link is sent to all staff in the trust)
- 50% on a sample methodology.

You will not receive feedback for any demographic group where there are 10 or fewer responses so try to get at least 11 responses from each of your occupational group, department and seniority/pay band categories.

For the external partners survey aim to get 50% response rate across your sample.

What did other trusts do? Engaging staff

What we’ve learnt is that the initial email must grab people and be interesting. We modified the standard emails provided by NHS Improvement – but we would do more next time to make our survey more engaging for our workforce. We piloted a campaign tool (‘Mailchimp’) which helped us send out the email to a large number of staff and see if people are opening the email. This combined with data from NHS Improvement on response rates is shown below.

Jo Roberts, Organisational Development Practitioner, Central Manchester Universities NHS Foundation Trust

Figure 3.5
Analysing the results

We aim to send you the results within a week of your survey closing. The data will contain:

**Quantitative information:**
- % scores for each of the 10 behaviours
- % scores for each of the 10 behaviours by each of demographic characteristic
- top and bottom scoring leadership behaviours in each category.

**Qualitative information:**
- full qualitative response for each question including a frequency table of words in the responses

You will need to interpret the responses and conduct your own thematic analysis on the qualitative data. Allow time for this and use the qualitative analysis guidance ([tool 3.4](#)) to help you.

The survey explicitly advises respondents that their qualitative responses will be shared in full and you will need to make sure to treat all answers sensitively.

You are encouraged to scan all qualitative data for information that directly or indirectly identifies individuals. To ensure the data is not identifiable, you must anonymise the data by replacing personal data with randomly generated codes or labels.
### Analysing the results

#### Heat map of behaviours by demographics

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Behaviour</th>
<th>Positive</th>
<th>Neutral</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Department</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Department</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

#### Spider graph – staff and external partner views

#### Column graphs of behaviours by demographics

#### Quantitative data

<table>
<thead>
<tr>
<th>Behaviour Title</th>
<th>Demographic Split</th>
<th>Number of Respondents (%)</th>
<th>Very Weak (%)</th>
<th>Very Strong (%)</th>
<th>Strong (%)</th>
<th>Moderate (%)</th>
<th>Weak (%)</th>
<th>Relatively Weak (%)</th>
<th>Relatively Strong (%)</th>
<th>Very Strong (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership q71</td>
<td>Children</td>
<td>50</td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>40</td>
<td>50</td>
<td>60</td>
<td>70</td>
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<tr>
<td>Leadership q72</td>
<td>Children</td>
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<tr>
<td>Leadership q73</td>
<td>Children</td>
<td>50</td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>40</td>
<td>50</td>
<td>60</td>
<td>70</td>
<td>80</td>
</tr>
</tbody>
</table>

#### Qualitative data

What do you feel are the one or two particular strengths of our trust’s leadership?

- n/a
- n/a
- Working with the front line
- Senior leaders visits to clinical areas
- Ambitious but difficult for front line staff
- Open to opinions
Presenting the results

Present the survey results as a report containing both quantitative and qualitative data and share it with the change team and your board. See tool 3.5 for an example report template.

Make sure you exclude any comments or parts of comments that could identify individual staff or partners.

Improving the process

Reflect on and note what went well and what could go better for future surveys, considering your response rate outcomes against how you approached sample selection, communication and interpretation of the data.

We will review feedback on the survey provided by your staff within the survey questions and use this to improve the survey for you and other trusts. You can also contact us with your views on the survey at NHSI.culture@nhs.net.
Tool 3.1: Information governance and data processing agreement
Tool 3.2: Key messages

These are examples of messages you can use, they are not intended as a ‘script’. You should modify them to meet your needs.

The culture and leadership programme

We are running a programme on culture and leadership.

The purpose of the leadership behaviours surveys

The surveys aim to provide a snapshot of the leadership culture and identify areas for improvement.

Definitions

Culture: An organisation’s culture can be defined as the values lived by its employees every day – these may not be the same as the stated values. The lived values can be seen by ‘the way we do things around here’.

Collective leadership: Means a type of culture where staff at all levels are empowered as individuals and in teams to act to improve care within and across trusts – ‘leadership of all, by all and for all’. This is in contrast to command and control cultures which are not conducive to achieving high quality care.

Purpose of the leadership behaviours surveys

The surveys aim to provide a snapshot of the leadership culture and identify areas for improvement.
Tool 3.3: Email templates

Tool 3.4: Analysing qualitative data
Tool 3.5: Report template
Culture and leadership programme

Phase 1: Discover

Culture focus groups

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Introduction

The culture focus groups look at culture and levels of collective leadership in detail. They do not depend on any of the other diagnostics and can be used at any time in the process. Running them in parallel with the leadership behaviours survey can maximise staff engagement.

Marczak and Sewell\(^1\) define focus groups as: “A group of interacting individuals having some common interest or characteristics, brought together by a moderator, who uses the group and its interaction as a way to gain information about a specific or personal issue.”

Their benefits include:

- identifying where people agree and disagree through discussion
- helping people explore and clarify their views, for example they make it easier to capture not only knowledge and experience, but also how and why people feel the way they do
- encouraging participation from those who are reluctant to be interviewed on their own or do not feel confident in expressing their views
- supporting people who struggle with reading and writing.

---


Once this diagnostic is completed, you should have robust information on ten topics: the five cultural elements and the five levels of collective leadership.
What did other trusts do? Impact on staff

What’s been interesting is that simply participating in focus groups has already led to a noticeable positive change in some of our staff.

In one focus group there were two of our domestic staff who said they did not consider their role to be crucial in delivering patient care. The other participants and facilitation team helped explain just how crucial their role was and you could literally see the lightbulb switch on in their minds. Weeks later their line manager told me how much more productive, engaged and happy these two individuals had become.

Allowing them the opportunity to express their views and hear those of others in a safe space was a powerful intervention in its own right.

*Ann Ines-Smith, Organisational Development Programme Director, Northumbria Healthcare NHS Foundation Trust*

“It’s straightforward, user-friendly and allows you to run a focus group successfully.”

*Lola Makinde, Human Resources Manager, East London NHS Foundation Trust*
Using the diagnostic

Here we explain how to run the culture focus groups to give you robust information to inform your leadership strategy. Adapt it for your organisation, based on what has worked well in the past in planning and delivering focus groups.

Designing your approach

Start planning and arranging your focus groups well in advance. The more people who attend a focus group who represent the breadth and depth of your organisation, the greater the reliability of the findings will be. Clinicians and other staff groups may require several weeks' notice. Rooms will need to be booked in advance. Depending on resources and the number of sessions organised, allocate a minimum of 6-8 weeks for the whole process: run sessions, undertake the analysis and create a summary report.

You could use two types of focus groups, or even consider a different approach if you think this will be more effective:

**Full focus groups**
A structured focus group session where participants are carefully selected and invited to participate.

**Mini focus groups**
Where culture and collective leadership questions may be discussed in existing meetings, workshops or other gatherings (e.g. a nurses’ forum or a departmental meeting). Mini focus groups are not sufficient on their own, but can enhance the richness of data if used alongside full focus groups.

**Alternative approaches**
Our guidance uses focus groups for collecting information on the cultural elements and collective leadership because they provide a safe space for participants to talk freely, which will increase the quality of data. However, this should not put you off trying other ways in which to engage with staff, as long as you engage with them from across the organisation at all levels.
**Full focus groups**

These are structured sessions with participants carefully selected to ensure reliable data, reflect the organisation's make-up and avoid bias.

To obtain reliable information, test each of the 10 topics in at least two different full focus groups. A typical focus group lasts 1.5 to 2 hours and could cover two topics in it.

Set selection criteria and prioritise them according to your local circumstances. The criteria should broadly reflect the organisation's staff for example: location, professional group, demographics, etc. Once you have pools of eligible participants, select participants randomly.

To ensure participants feel able to be open we recommend that where possible they are at a similar level of seniority (ie similar banding or stage of training).

The ideal number of participants is 6 to 12, although an experienced facilitation team may want to invite as many as 15 at a time.

Use larger groups with caution as they:

- can be more challenging to facilitate
- do not allow facilitators to create an intimate environment for disclosure
- can limit each person's opportunity to share their insights
- alter the group dynamic and therefore affect the quality of data captured.

Over-recruit by 20-50% to allow for last-minute withdrawals.

You can hold extra focus groups to get insights into particular issues or understand variation across your organisation across:

- different sites or departments
- different staff groups
- different demographics (ie protected characteristics).

To preserve reliability of data captured, consider running focus groups on a given topic until no new insights emerge. A pragmatic approach would involve balancing the quality of the results with your resources and available time.
Mini focus groups

Mini focus groups may take any form: for example if there was not enough nurse participation in the full-length sessions you could organise mini groups to engage nurses more fully.

Mini focus groups are not sufficient on their own, but can enhance the richness of data if used alongside full focus groups. As mini focus groups often take place in existing meetings, workshops or other sessions there is often a bias in participants. This bias may be helpful in understanding variation across an organisation (eg if meetings were arranged in a departmental meeting, or a meeting of pharmacists).

Testing at least one topic in a mini group typically takes 45 minutes to 1 hour.

Thinking about the patient

Getting the patient perspective can uncover new information as well as give you a new perspective. The prompt questions in tool 4.1 can easily be adapted to patients.
ELFT patient focus group case study

One of the things we quickly learned when running focus groups with our staff is that whilst one group may feel as though they’re doing something in a certain way it’s not always seen like that by other groups.

We began to wonder whether our patients – the people who this entire piece of work ultimately aims to help – might have something to say and so we decided to ask them for their views too.

We also had to give some thought as to the questions we put to them as we were aware that our patients may not be able to comment on some of the cultural elements or levels of collective leadership (eg ‘vision and values’ or the ‘cross-organisational’ level of collective leadership). That said, we were able to use the prompt questions as a starting point and be creative with how they were used. In particular, we found that questions about support and compassion were very easy to adapt for patients.

Ultimately the hard work paid off and we learned a great deal of useful information from our patients. It was fascinating to hear what they had to say and then compare that with what our staff said. Thankfully our patients were very positive about our staff and echoed what they had to say in many instances. It was also clear that they appreciated being given the opportunity to have their say, and so I would strongly encourage other trusts doing similar work to include patients in their thinking at every stage if possible.

Lola Makinde, Human Resources Manager, East London NHS Foundation Trust
CMFT ‘market place’ case study

CMFT is a trust with large numbers of staff spread across multiple sites. Even though we were confident we could get the breadth and depth of information we required from focus groups, we wanted to ensure we engaged with as many staff as possible. We were also very aware of how busy our staff were with delivering care to patients and how hard it could be for them to find time to attend a full length focus group.

This made us begin to think of other ways we could reach out to staff without compromising on the quality of the information we gathered. From this we developed the ‘market place’. These were held at various times and locations (such as the staff canteen or corporate off site days) and were made up of a set of posters, each one focusing on a specific cultural element or level of collective leadership. Staff were engaged by a facilitator (aided by the offer of a biscuit or two!) and encouraged to leave anonymous comments and opinions using colour-coded post-it notes to indicate which staff group they belonged to. This feedback was then analysed together with the information gathered from the ‘regular’ focus groups.

Our efforts led to an additional 516 members of staff giving us their views on culture and collective leadership who may not have otherwise been able to contribute. Even better was that we managed to achieve this level of engagement within a relatively short period of time. Their views have been invaluable to us as we look to better understand our organisation’s culture.

Marilyn Brandwood, OD Practitioner
Central Manchester University Hospitals
NHS Foundation Trust

**LEADING TOGETHER**

We need **your help** to ensure that the **culture of our trust** (the way we do things) **supports high quality care**.

Come along to one of our focus groups!

<table>
<thead>
<tr>
<th>Date</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday 6th June</td>
<td>Radiotherapy Treatment Centre Seminar Room</td>
</tr>
<tr>
<td></td>
<td>from 1:30pm</td>
</tr>
<tr>
<td>Wednesday 8th June</td>
<td>Rheumatology Education Room</td>
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<tr>
<td></td>
<td>from 1:00pm</td>
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<tr>
<td>Thursday 9th June</td>
<td>Mini Seminar Room, Merital</td>
</tr>
<tr>
<td></td>
<td>from 9am</td>
</tr>
<tr>
<td>Wednesday 15th June</td>
<td>Paediatric Seminar Room</td>
</tr>
<tr>
<td></td>
<td>from 1:30pm</td>
</tr>
</tbody>
</table>

**All staff welcome!**

**No need to book** – just turn up and contribute!

Figure 4.2
Preparing a focus group

Focus groups are more effective when run by experienced facilitation teams. Identify individuals with this experience or arrange training if necessary. You might also consider using external facilitators.

Select facilitators who will make the participants comfortable contributing honestly. For example, the director of a department may not be appropriate as a facilitator for a mini focus group in that department.

Focus groups work best when they are run by two facilitators: a moderator and a note-taker. This also helps reduce the risk of bias.

**Moderators** lead the discussion, posing questions and encouraging contributions. They also ensure the discussion is balanced, relevant and helps deepen the organisation’s understanding of its culture and leadership.

**Note-takers** capture the information from the discussion and typically manage general ‘on the day’ logistics (administrative and technical matters). Participants could also be invited to document their own discussions (on flipcharts). Facilitators should ensure they collect this as well.

You will need to communicate with participants before the focus group and while you’re recruiting them, and align this with your wider communications on the culture and leadership programme. However, avoid providing detail on content to ensure that you do not influence participants’ contributions (see also key messages in **tool 4.3**).

You will need to get informed consent from each participant to their information being used and to encourage confidentiality. (See the model consent form, **tool 4.2**).

You also need to inform the facilitators of their duties in relation to confidentiality they should sign an agreement.

Conduct the focus groups somewhere private if possible.
Items that may be useful (depending on how you plan on running the session), include:

- Chairs
- Notepads
- Pens and pencils
- Post-it notes
- Flip charts and marker pens
- Audio-visual equipment (for any presentations)
- Recording equipment (if being used)
- Refreshments
- List of participants (for the facilitator’s use)
- Prompt questions
- Session briefs, eg key messages, break timings, etc

During the focus group

Use the prompt questions ([tool 4.1](#)) to initiate discussions with participants and ensure that by the end you have enough data for a robust assessment of culture.

Be prepared to alter the language and explain specific terms (eg strategy, collective leadership) to help participants better understand the question. You may need to ask follow-up questions depending on the discussion.

Encourage participants to give you examples where possible to assist you with the analysis and final report. You may need to remind participants to avoid giving details that could potentially identify a patient or other members of staff.

Avoid using:

- leading questions (which prompt the respondent to answer in a particular way)
- loaded questions (that contain controversial or unjustified assumptions)
- multiple questions (two or more questions within a statement).

Analysing the results

You will need to interpret the responses and conduct your own thematic analysis on the qualitative data. You can use the qualitative analysis guidance ([tool 4.6](#)) to help you with this.
Presenting the results

We recommend you write up the individual focus groups and then synthesise the findings into a summary report. See tool 4.4 for a template.

The report will outline:

- a brief summary of the diagnostic, purpose and methodology
- general findings
  - what did you notice overall?
  - what themes seemed to emerge across all cultural elements or all levels of collective leadership?
- findings for each cultural element
  - what are the key themes that emerge for each element?
  - is this talked about in a predominantly positive or negative way?
- findings for each theme
  - where possible illustrate with quotes from participants
  - with more time given to the most common themes
  - highlight themes discussed both positively and negatively
- findings for each of the five levels
  - what key themes emerge for each level?
- discuss any additional insight the focus groups have provided
- suggested next steps for the board.

Improving the process

You may wish to reflect on the process and note your thoughts on what went well and what could go better in future. You can review the data from the feedback forms in tool 4.5.
Tool 4.1: Prompt questions

These are designed to help facilitators initiate discussions with participants, and ensure that they get enough data. Amend this wording to suit your participants and trust.

FIVE CULTURAL ELEMENTS

Introductory questions (optional)

a. What words would you use to describe our trust?
b. What are you most proud of at our trust?

Vision and values

a. Does our trust as a whole have a clear idea of what its overall strategy is?

b. How closely linked is our strategy to our vision (our overall purpose and aim), values and culture (how we do things in our trust)?

c. Does everyone in our trust model our vision and values?

d. If we were to start again, what principles should guide how we work? Can you explain why?

e. Do you think the leaders and managers of our trust put quality of patient care at the centre of everything the trust does?

Goals and performance

a. Do staff, teams, directorates and the board have clear, challenging and measureable objectives which are easy to link to the organisation’s vision?

b. How often do all staff, teams, directorates and the board get timely, helpful, relevant and developmental feedback on their performance?

c. How often do you see staff, teams, directorates and the board make sure we are all:

- involved in decision-making?
- given autonomy and discretion in our work?

d. Do you believe managers and leaders in our organisation help to remove the obstacles to staff being able to do their jobs efficiently and effectively?

- Do you have any examples you could share?

e. If you or someone else you know in our organisation has needed more support from a manager, what was the experience like? Was it helpful, or did it make things more difficult?
FIVE CULTURAL ELEMENTS

Learning and innovation

a. If someone in our trust came up with a way to do something better, how supportive would this trust be of them?

b. What would you say if a friend who doesn’t work here asked whether quality and quality improvement were a core part of our trust’s culture?

c. To what extent is everyone encouraged to lead changes in order to improve the quality of work?

d. To what extent does the organisation encourage and reward members for improving their skills take over and performance?

Support and compassion

a. To what extent is our trust committed to compassionate and supportive leadership, at every level of the organisation?

For example, a compassionate leader engages with people, puts people first, is meaningful and sincere while remaining frank, courageous and affirming.

b. To what extent are staff genuinely compassionately towards patients and each other?

c. How does the organisation ensure that staff and patients are included in conversations, discussions and decision-making, and not discriminated against in any way, shape or form?

d. Would you describe this trust as a warm, supportive and caring place to work?

e. How can we act more compassionately?

Teamwork

a. How well do you think teams in this trust work together (both within a team and between teams)? What are the strengths and weaknesses?

b. To what extent does the leadership style in the organisation have characteristics which indicate a collective rather than command and control approach to leadership?

Collective leadership means everyone taking responsibility for the success of the organisation as a whole – not just for their own jobs. It requires organisations to distribute leadership power to wherever the expertise, capability and motivation sit within that organisation at that time.

c. To what extent do our leaders ensure accessibility, supportiveness, empowerment, fairness, transparency, and openness to learning and feedback?

d. When we talk to one another, how do we sound? (Eg friendly, happy, angry, irritated, loud, quiet, etc)

e. What do you think our partners in the local area would say about how we work with them? Do you have any examples?
FIVE LEVELS OF COLLECTIVE LEADERSHIP

### At the individual level
Do you think individual members of staff in our trust:

a. model the trust’s vision and values on a daily basis?

b. have clear objectives and receive helpful feedback on whether they’ve achieved them?

c. always look to do their job better?

d. are compassionate and supportive towards others (patients and staff)?

e. are team players?

### At the team level
Do the different teams (clinical and non-clinical) in our trust:

a1. ensure its work is in line with the trust’s vision?

a2. ensure the way it works is in line with the trust’s values?

b. have clear objectives and receive helpful feedback on whether they’ve achieved them?

c. support quality improvement and innovation?

d. work together in a positive and compassionate way?

e. share leadership among them and support one another?

### At the ‘inter-team’ level
When different teams are working together:

a. do they work around a shared vision and set of values that align with the trust’s?

b. do they agree on objectives?

c. do they frequently learn from one another to be innovative?

d. do they foster a supportive, respectful and compassionate environment for them to work in?

e. do they work well with one another?

These are designed to help facilitators initiate discussions with participants, and ensure that they get enough data. Amend this wording to suit your participants and trust.
FIVE LEVELS OF COLLECTIVE LEADERSHIP

At the ‘organisation’ level

When thinking about our trust/organisation as a whole, how consistent are we when it comes to:

a. knowing, understanding and living our vision and values?

b. setting ourselves goals, and holding ourselves to account?

c. focusing on continuous improvement and thinking of new ways to improve what we do?

d. being supportive and compassionate towards one another (ie towards other staff as well as patients)?

e. working together as a team?

At the ‘cross-organisation’ level

By ‘cross-organisation’ we refer to the interactions between our trust and any other organisations locally, regionally and nationally (such as other providers, commissioners and voluntary organisations).

When thinking about how our trust works with other organisations:

a. do we try to ensure our vision and values are in line with those of our partners?

b. do we have a clear and shared set of objectives?

c. do we work together to ensure we learn from one another and push ourselves to develop ideas that benefit everyone (not just ourselves)?

d. do we respect our partners in the same way that we respect ourselves?

e. would our partners think of us as good team players?

Tool 4.2: Consent form template
Tool 4.3: Key messages

These are examples of messages for facilitators to use with participants. Thinking about the culture and leadership programme, what do you think and feel? You should modify these according to your needs.

The culture and leadership programme
Our trust is running a programme on culture and leadership.

This programme aims to develop and implement strategies for collective leadership which result in cultures that deliver high quality, continuously improving, compassionate care.

This work should help improve the health and wellbeing of staff and lead to better health outcomes for patients.

We are currently in phase one of this programme – diagnosing our culture.

We are using resources developed by NHS Improvement, The King’s Fund and the Centre for Creative Leadership.

Definitions

Culture: An organisation’s culture can be defined as the values lived by its employees every day – these may not be the same as the stated values. The lived values can be seen by ‘the way we do things around here’.

Collective leadership: Means a type of culture where staff at all levels are empowered as individuals and in teams to act to improve care within and across trusts – ‘leadership of all, by all and for all’. This is in contrast to command and control cultures which are not conducive to achieving high quality care.

Purpose of the culture focus groups

Culture focus groups aim to increase our understanding of the different elements that make up our culture from how we work personally to how we work with other organisations.

Culture focus groups will also give us a better idea of the strength of leadership that exists throughout our organisation at all levels.

Culture and leadership programme - improvement.nhs.uk
What is meant by analysis?

Analysis of the focus group data aims to describe, summarise and begin drawing conclusions from responses. Broadly, this entails looking for patterns or themes across the focus groups, while considering their frequency and how intensely they are expressed. In doing this, it may be possible to identify relationships between themes and relate ideas or behaviours to elements of the organisational culture. The themes appearing in the focus groups can also be cross-referenced with results from other tools, highlighting consistencies and discrepancies across the organisation.

Having completed the analysis, you will have a set of key themes which form the basis of the final report.

Tips for analysing the data

There are a number of methods for the analysis of qualitative data and there is no prescribed method for doing this. It may be that members of your change team have previous experience of particular approaches, and would prefer to apply these.

There are, however, a number of general tips which may help you analyse your data and ensure accuracy and consistency:

- Try to ensure the facilitator is involved in the analysis – they will be able to give a sense of the ‘tone’ of the answers, and offer a unique insight into the intended meaning.
- Have at least two people look at each answer – this should help with consistency, and avoid the potential bias of one person conducting all the analysis.
- If a number of people are conducting the analysis, allocate each person the same few questions across all the focus groups, rather than a few whole focus group sessions. This allows one person to start to see the common themes occurring across the focus groups.

Note

When analysing staff and patient information please ensure you are adhering to your organisation’s information governance policy and treating information in line with the Data Protection Act and the Caldicott principles. If in doubt, seek the advice of your Data Protection Officer, information governance team, or Caldicott guardian as necessary.
Leadership workforce analysis

Phase 1: Discover

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- Analysing and presenting the results 111
- Improving the process 111

Tools:
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- Tool 5.2: Questions on the future state of key leadership roles 112
- Tool 5.3: Identifying the gaps in key leadership roles 112
- Tool 5.4: Questions on organisational design and workforce 112
- Tool 5.5: Questions on current policies and procedures 112
Introduction

The leadership workforce analysis helps you collect different types of information to develop the collective leadership strategy and resulting talent management and development priorities in Phase 2: Design.

As highlighted in the overview to Phase 1: Discover, your organisation will need leaders with the right skills and behaviours in key leadership roles across the next five to ten years to support continuously improving, safe, high quality compassionate care and deliver your business strategy.

As those in key leadership roles are particularly important in influencing the culture of the organisation, this diagnostic helps you undertake a talent review and gap analysis1 to support collective leadership by ensuring you have:

- leaders in post substantively rather than vacancies or interim position holders
- enough individuals in the leadership pipeline – people with the skills, motivation and appropriate styles – to act as replacements when vacancies occur or to step into key new leadership roles.

Read more about the workforce capacity areas in the concepts and evidence base.

Table of Leadership Behaviours and Cultural Elements:

<table>
<thead>
<tr>
<th>Levels</th>
<th>Individual</th>
<th>Team</th>
<th>Inter team</th>
<th>Organisation</th>
<th>Cross organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership behaviours</td>
<td>Facilitating shared agreement about direction, priorities and objectives</td>
<td>Ensuring effective performance</td>
<td>Modelling support &amp; compassion</td>
<td>Enabling learning and innovation</td>
<td>Building cohesive and effective team working</td>
</tr>
<tr>
<td>Cultural elements</td>
<td>Vision and values</td>
<td>Constant commitment to quality of care</td>
<td>Goals and performance</td>
<td>Effective, efficient, high quality performance</td>
<td>Support and compassion</td>
</tr>
<tr>
<td></td>
<td>Support and compassion</td>
<td>Support, compassion &amp; inclusion for all patients and staff</td>
<td>Learning and innovation</td>
<td>Continuous learning, quality improvement and innovation</td>
<td>Team Work</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Quality and value (Clinical effectiveness, positive experience, safe &amp; financial efficiency)</td>
<td>Continuous improvement</td>
<td>Healthy, flourishing and engaged staff</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Workforce capacity
- Numbers
- Diversity and demographics
- Knowledge, skills and abilities
This diagnostic:

- focuses on the **current and future state of ‘key leadership roles’** – roles that are essential to support high quality care cultures and make sure your organisation’s business strategy is delivered over the next 5 to 10 years. It helps you to work out the gaps in relation to key leadership roles to support the design of your collective leadership strategy

- covers the current state of **your workforce as a whole** because collective leadership is essential for high quality care. It does not look at these areas in detail as these would form part of your organisation’s broader workforce plan and workforce development plan

- gathers information on your **organisational design** because this will influence how people work together and where leaders are located. Future organisational design may form part of the wider collective leadership strategy or as a result of it

- looks at your organisation’s **policies and procedures** to support Phase 2: Design. Future changes to policies, procedures and systems may be recommended to better support high quality care.
This diagnostic focuses primarily on the key leadership roles that are necessary for the organisation both now and in the future, but tool 5.4 asks you to consider the workforce as a whole. The figure above summarises the main components of the diagnostic.

The work with pilot trusts has shown that some were able to respond to the future state questions about numbers whilst others found this challenging because of a rapidly changing local environment.

We recommend that where possible, some planning assumptions should be used to address these questions.
Using the diagnostic

There are four sets of questions to answer as part of this diagnostic. You can answer the questions by collecting data and consulting people across your organisation.

You should set up a team of three to five people, at least one of whom is a member of the change team, who know the organisation well. They should be familiar with the processes for acquiring, retaining and developing leadership talent to help you conduct the interviews and answer the questions. You will also want to liaise with your workforce information team to answer some of the questions relating to leadership workforce numbers.

In the interests of ensuring equality, you should pay particular attention to diversity (age, gender, ethnicity and other protected characteristics) when conducting this type of work. For additional guidance, you should pay particular attention to the requirements of the workforce race equality standard (2016).²

Please note:

- The questions are designed to inform your approach and guide the reporting of your findings. They are not for use directly in interviews.
- You will need to consult people with care and sensitivity because identifying certain positions as ‘key leadership roles’ may suggest that other positions are less important and staff could have concerns or feel disempowered.
What did other Trusts do? Using conversations

We used the tools with a number of senior leaders in the organisation: divisional directors, clinical heads of division and heads of nursing and some specialists particularly in the field of HR. The HR meeting was part of a regular meeting, the others were arranged specially. They lasted an hour.

We carried out some conversations where we followed the questions in the tools line by line and we did find this took a while and seemed repetitive at times. We also split some conversations and covered ‘current’ state in one conversation and ‘future’ state in another which made the conversation feel less repetitive, but we did find combining the current and future states into one conversation was more productive and actually the conversations seemed to move from current to future quite organically.

As we anticipated, we found that some of our senior leaders did not articulate some of the more focused areas such as recruitment and selection and on-boarding in detail, so it was important to get the involvement of and data from HR specialists to gain a fuller picture in these areas.

*Stacey Bullock, Assistant Head of Organisation Development and Training, Central Manchester University Hospitals NHS Foundation Trust*

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**Step 1: Re-familiarise with your strategic drivers**

In *getting started*, you will have considered the strategic drivers from your business strategy and their impact for the direction of the leadership strategy as a whole, and discussed this with your board.

Use this information to support the work of the steps below. (for example, in step 2 to help assess the demand for key future roles aligned to the strategic intent which may involve focus on particular skills to lead transformational change).
Step 2: Identify the current state of key leadership roles

See tool 5.1 questions on current state of key leadership roles.

Quantities

The first step is to identify the ‘key leadership roles’ for your organisation currently.

For this step, you may want to concentrate on the board and two or three levels below the board to ensure the scope is manageable. You can identify additional levels of

Key leadership roles

One way of identifying key leadership roles is to review your organisational structure chart and use a set of criteria before you have any discussions. This may help reduce any natural bias. Suggested criteria include:

- **Strategic impact**: the loss of a qualified post holder for even a modest amount of time would affect the future success of the organisation in terms of the quality of care, patient confidence, business continuity or achievement of the business strategy.

- **Immediacy**: the short-term loss of the post holder would seriously affect service delivery; affect patients or service users, the quality of care, the financial efficiency, operations, work processes, staff morale or the reputation of your organisation.

- **Demand**: the job market for post holders in this position is tight now or will be in the future because of internal or external factors.

- **Regulatory**: there is a regulatory requirement for the post.

- **Uniqueness**: the position requires a set of competencies that is, or will be, unique to the organisation or the market your organisation operates in, for example, if you are a specialist healthcare provider.

You can then use conversations and/or HR data to provide you more information on current quantities.
key leadership roles below this depending on your capacity.

**Diversity and demographics**

As discussed previously, diversity and clinical leadership support high quality care. Human resource information system (HRIS) data and job descriptions may help you gather information on the professional background, managerial, medical and clinical leadership experience required in current key leadership roles. Again, this should link to the workforce race equality standard.

Many NHS trusts have a stated aim of seeking to be representative of the communities they serve, yet this has not yet proved sufficient to ensure that NHS trusts are truly representative. Trusts should seek to be representative in all roles and at all levels of their organisation.

**Knowledge, skills, and abilities**

Possible data or information sources to inform discussions on knowledge, skills, abilities and behaviours include:

- outputs of assessment centres
- leadership style assessment / personality profiles
- HRIS data, outputs of talent management forums / review sessions
- career profiles
- ability testing
- staff surveys
- observations
- culture surveys
- interviews.

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**Note**

When considering clinical, managerial and technical skills and knowledge, it is important to also think about communication skills. Communication skills are crucial for successful collective leadership because they support information flow and relationship building³, and help people shape culture.

In terms of behaviours, you may also want to consider how open leaders are towards collective leadership. Senior leaders’ experience usually derives from largely hierarchical and often ‘siloed’ organisations. This creates barriers that must be overcome before all leaders in your organisation can guide their organisation’s journey towards collective leadership.
Step 3: Identify the future state of key leadership roles

See tool 5.2 questions on future state of key leadership roles.

This helps you to assess the demand for talent in order to align talent delivery with the organisation’s objectives.4 You can identify the information you need to answer these questions by:

- reviewing the business strategy to understand what the organisation is trying to achieve – also see step 1 and Identifying your purpose.
- reviewing any workforce strategies or plans which may give you information on skills and behaviours as well as quantities, qualities and location5,6
- consulting people who know the organisation and its culture and strategy well, to identify what leaders must do to create the desired future.
- using data to help you forecast numbers and trends when thinking about numbers or demographics.

Step 4: Work out the gaps in and priorities for key leadership roles

Having conducted steps 1, 2 and 3, you can compare the information to identify the gaps. Using tool 5.3 Identifying the gaps on key leadership roles may help you to make sure that priority areas are identified in the leadership strategy so that effort and attention are focused on the
right areas.

Step 5: Determine the current organisational design and workforce make-up

Understanding the overall make-up of your workforce and the existing organisational structure and processes can help you understand the current culture and behaviours.

In addition to conversations, you can draw this information in summary from:

- any existing workforce strategies and plans
- your workforce systems and documentation.

Step 6: Determine policies and procedures

Conversations with colleagues can help you to identify high level strengths and weaknesses in workforce policies and procedures influencing the workforce.

See tool 5.5 policies and procedures.

Note

This is meant to be a brief information-gathering exercise, not a detailed process review.
Analysing and presenting the results

Once you have the results we recommend that you synthesise the key findings into a summary report of five to ten pages consolidating your results across the four sets of questions.

You may also wish to incorporate a nine block talent management engagement scale in respect of key leadership roles in your report, based on the evidence you have gathered.

The document will outline:

- a brief summary of the diagnostic, its purpose and the methodology used to implement it.
- general findings
- findings for each of the questions
  - what are the key themes that emerge from each question?
  - findings for each theme
- discuss any additional insights the discussions have provided
- recommendations for the Board.

Improving the process

You may wish to hold a lessons learnt session and identify what worked and how you can improve the results and process of undertaking this diagnostic. Here, you may wish to review the data you have gathered and see if there are any areas you want to explore further.

REFERENCES
3 Communication is the currency of collective leadership (Yammarino, Salas, Serban, Shirreffs and Shuffler, 2012; p.394).
6 Monitor (2014) Strategic Workforce Planning Tool
7 NHS Leadership Academy (2015) Developing a Talent Strategy - Step 1
Tool 5.1: Questions on the current state of key leadership roles

Tool 5.2: Questions on the future state of key leadership roles

Tool 5.3: Identifying the gaps in key leadership roles

Tool 5.4: Questions on organisational design and workforce

Tool 5.5: Questions on current policies and procedures
Phase 1: Discover

Patient experience

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Tool 6.2: Analysing the qualitative data 123
Tool 6.3: Report template 123

Culture and leadership programme
Introduction

Patients' views can help you understand the existing strengths of your organisation culture and where you can improve. While patient experience indicators are used in the culture and outcomes dashboard at a high level, this diagnostic helps you undertake a systematic analysis of patient experience feedback and use it to inform your understanding of culture.

This tool suggests ways to use quantitative and qualitative patient experience to inform your understanding of the cultural elements.
Using the diagnostic

Quantitative information

You can review your trust’s scores from any quantitative patient experience surveys your trust collects – such as the national patient surveys – against the cultural elements.

A template with national inpatient questions from 2015 is available. The scores for your national patient surveys are available on the CQC’s website on the webpage for your trust and on NHS Surveys webpage (nhssurveys.org/surveys).

If you would like to use other patient surveys conducted by your trust, you can use a similar approach but will need to map the questions to the cultural elements yourself. Figure 6.1 may help you to do this.

Once you have gathered the data, you can use different methods for highlighting your strengths and development areas from your patients’ perspective. The purpose is to find areas to focus improvement – the ‘red’ areas. For example, you could:

- benchmark the data with other trusts, if using national survey data
- look at the trends across the years
- calculate an average score across the indicators for each of the five cultural elements, and rank each of these averages to find the top and bottom scoring cultural elements.

See methods 1, 2 and 3 in figure 6.2.
Qualitative information

You can put existing qualitative information gathered from patients into themes to tell you about your culture (see analysing the results).

As this may result in a lot of data, you may wish to select a sample of comments from a representative group across your organisation.

If you need to capture more views you can run patient culture focus groups or conduct interviews.

What do other trusts do?
Northumbria’s comprehensive approach to listening to patients

At Northumbria, we have developed a nationally recognised approach to measuring and improving patient experience. We listen to the views of more than 50,000 people every year. Real time information is captured whilst patients are still in hospital and fed back immediately to teams. Patients and families are also followed up at home, after care, to really understand what could be done better and celebrate what’s working well.

This means we have access to large amounts of quantitative data which allows experience to be understood at a ward, site, specialty and individual consultant level.

But we’ve learnt it is equally important to pay attention to the qualitative data: all patients’ free text comments are themed and classified to support improvement in order to close the gap on the best and the worst of care.

      Annie Laverty, Director of Patient Experience and Quality,
      Northumbria Healthcare Foundation Trust
Figure 6.1: Patient experience themes mapped to cultural elements

<table>
<thead>
<tr>
<th>Patient experience theme</th>
<th>Cultural element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence and trust in staff (including quality of staff, feeling safe)</td>
<td>Vision and values</td>
</tr>
<tr>
<td>Staff helping patients feel positive</td>
<td>Vision and values</td>
</tr>
<tr>
<td>For feeling that overall they had a good experience</td>
<td>Vision and values</td>
</tr>
<tr>
<td>Agreements on care (including care planning)</td>
<td>Vision and values</td>
</tr>
<tr>
<td>Environment and efficiency of processes (including cleanliness and quality of food)</td>
<td>Goals and performance</td>
</tr>
<tr>
<td>Sufficient staff and equipment</td>
<td>Goals and performance</td>
</tr>
<tr>
<td>Advice or information on managing their condition or life (helping people manage their own care)</td>
<td>Learning and Innovation</td>
</tr>
<tr>
<td>Kind, empathetic, caring staff (including respect, dignity, emotional support and privacy)</td>
<td>Support and compassion</td>
</tr>
<tr>
<td>Involvement in decision making and personalised care (excludes information on managing condition)</td>
<td>Teamwork - patient</td>
</tr>
<tr>
<td>Roles and contact (information on the roles and how to contact people involved in their care)</td>
<td>Teamwork - patient</td>
</tr>
</tbody>
</table>
Figure 6.2: Methods for highlighting strengths and development areas

<table>
<thead>
<tr>
<th>Cultural element</th>
<th>National inpatient survey</th>
<th>2018 score</th>
<th>Method 1</th>
<th>2014 score</th>
<th>Method 2</th>
<th>Method 3</th>
<th>Ranking between cultural elements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Vision and values</strong></td>
<td>for feeling that they were well looked after by hospital staff</td>
<td>9.1</td>
<td>Better</td>
<td>9.0</td>
<td>About the same</td>
<td>Down</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>for having confidence and trust in the doctors treating them</td>
<td>9.1</td>
<td>Better</td>
<td>9.1</td>
<td>About the same</td>
<td>Down</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>for having confidence and trust in the nurses treating them</td>
<td>5.9</td>
<td>Better</td>
<td>5.8</td>
<td>About the same</td>
<td>Down</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>for having confidence in decisions made about their condition or treatment</td>
<td>9.2</td>
<td>About the same</td>
<td>9.2</td>
<td>About the same</td>
<td>Down</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>for having excellent care and service when they had a good experience</td>
<td>9.2</td>
<td>About the same</td>
<td>9.3</td>
<td>About the same</td>
<td>Down</td>
<td>8.9</td>
</tr>
<tr>
<td><strong>2. Goals and performance</strong></td>
<td>for hand-wash gel being available for patients and visitors to use</td>
<td>8.6</td>
<td>About the same</td>
<td>7.6</td>
<td>Up</td>
<td>7.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>for maintaining their admission date change by the hospital</td>
<td>8.5</td>
<td>About the same</td>
<td>8.5</td>
<td>About the same</td>
<td>Down</td>
<td>7.2</td>
</tr>
<tr>
<td></td>
<td>for describing the hospital to or wards as clean</td>
<td>7.1</td>
<td>Worse</td>
<td>6.6</td>
<td>Up</td>
<td>6.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>for describing the toilets and bathrooms as clean</td>
<td>7.2</td>
<td>Better</td>
<td>5.8</td>
<td>Down</td>
<td>5.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>for describing the hospital food as good</td>
<td>5.0</td>
<td>About the same</td>
<td>3.0</td>
<td>Up</td>
<td>3.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>for not having to share a sleeping area, such as a room or bed, with patients of the opposite sex</td>
<td>9.5</td>
<td>Better</td>
<td>9.4</td>
<td>About the same</td>
<td>Down</td>
<td>7.2</td>
</tr>
<tr>
<td></td>
<td>for not having to share a bedroom or shower area with patients of the opposite sex</td>
<td>9.6</td>
<td>Better</td>
<td>9.7</td>
<td>Better</td>
<td>Down</td>
<td>7.2</td>
</tr>
<tr>
<td></td>
<td>for feeling that there were enough nurses on duty to care for them</td>
<td>7.1</td>
<td>About the same</td>
<td>7.3</td>
<td>About the same</td>
<td>Down</td>
<td>7.2</td>
</tr>
<tr>
<td></td>
<td>for having staff available if any equipment or home accessories were needed when leaving hospital, if this was necessary</td>
<td>7.1</td>
<td>About the same</td>
<td>1.0</td>
<td>Up</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>for the call button being reasonably fast when used</td>
<td>6.0</td>
<td>About the same</td>
<td>6.0</td>
<td>About the same</td>
<td>Down</td>
<td>7.2</td>
</tr>
<tr>
<td></td>
<td>for not being delayed for a long time (on exchange)</td>
<td>6.4</td>
<td>About the same</td>
<td>6.6</td>
<td>About the same</td>
<td>Down</td>
<td>7.2</td>
</tr>
<tr>
<td></td>
<td>for feeling that they waited the right amount of time on the waiting list to be admitted</td>
<td>6.8</td>
<td>About the same</td>
<td>5.8</td>
<td>About the same</td>
<td>Down</td>
<td>7.2</td>
</tr>
<tr>
<td></td>
<td>for feeling that they were able to see a nurse at any time</td>
<td>7.0</td>
<td>About the same</td>
<td>5.9</td>
<td>About the same</td>
<td>Down</td>
<td>7.2</td>
</tr>
<tr>
<td><strong>3. Support and compassion</strong></td>
<td>for doctors not talking in front of them, as if they weren't there</td>
<td>9.2</td>
<td>Better</td>
<td>8.1</td>
<td>About the same</td>
<td>Down</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>for nurses not talking in front of them, as if they weren't there</td>
<td>9.2</td>
<td>Better</td>
<td>8.1</td>
<td>About the same</td>
<td>Down</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>for receiving enough emotional support, from hospital staff, if needed</td>
<td>8.8</td>
<td>Better</td>
<td>7.9</td>
<td>About the same</td>
<td>Down</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>for being given enough rest, time to rest, to either watch TV or read</td>
<td>7.7</td>
<td>About the same</td>
<td>7.3</td>
<td>About the same</td>
<td>Down</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>for being listened to by nurses at night from hospital staff</td>
<td>8.6</td>
<td>Better</td>
<td>8.1</td>
<td>About the same</td>
<td>Down</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>for those who were injured, had their hospital staff told them how to manage their pain</td>
<td>8.3</td>
<td>Better</td>
<td>9.1</td>
<td>About the same</td>
<td>Down</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>for being given enough privacy on their condition or treatment in A&amp;E</td>
<td>9.0</td>
<td>About the same</td>
<td>9.2</td>
<td>About the same</td>
<td>Down</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>for being given enough privacy when discussing their condition or treatment</td>
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<td>About the same</td>
<td>8.3</td>
<td>About the same</td>
<td>Down</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>for being given enough privacy when being examined or treated</td>
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<td>9.0</td>
<td>About the same</td>
<td>Down</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>for being treated with respect and dignity</td>
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<td>About the same</td>
<td>7.2</td>
<td>About the same</td>
<td>Down</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>for those who were treated, receiving enough support from health and social care professionals, if needed</td>
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<td>About the same</td>
<td>Down</td>
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</tr>
<tr>
<td></td>
<td>for feeling someone on the hospital staff to talk about worries and fears, if needed</td>
<td>7.6</td>
<td>About the same</td>
<td>7.2</td>
<td>About the same</td>
<td>Down</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>for feeling someone on the hospital staff to talk about worries and fears, if needed</td>
<td>7.6</td>
<td>About the same</td>
<td>7.2</td>
<td>About the same</td>
<td>Down</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>for not being threatened by other patients or visitors during their hospital stay</td>
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<td>About the same</td>
<td>8.6</td>
<td>About the same</td>
<td>Down</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>for feeling that their family and friends were able to see them easily when they wanted</td>
<td>8.5</td>
<td>About the same</td>
<td>8.6</td>
<td>About the same</td>
<td>Down</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>for having access to a source or support</td>
<td>8.6</td>
<td>About the same</td>
<td>8.7</td>
<td>About the same</td>
<td>Down</td>
<td>8.1</td>
</tr>
<tr>
<td><strong>4. Learning and Innovation</strong></td>
<td>during their hospital stay, being asked to give their views about the quality of their care</td>
<td>1.8</td>
<td>About the same</td>
<td>1.4</td>
<td>About the same</td>
<td>Down</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>for being given enough information on their condition or treatment</td>
<td>1.2</td>
<td>About the same</td>
<td>1.0</td>
<td>About the same</td>
<td>Down</td>
<td>7.0</td>
</tr>
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<td>for being given enough information on their condition or treatment</td>
<td>1.2</td>
<td>About the same</td>
<td>1.0</td>
<td>About the same</td>
<td>Down</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>for being given enough information on their condition or treatment</td>
<td>1.2</td>
<td>About the same</td>
<td>1.0</td>
<td>About the same</td>
<td>Down</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>for being given written or printed information about what they should or should not do after leaving hospital</td>
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<td>About the same</td>
<td>1.0</td>
<td>About the same</td>
<td>Down</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>for feeling that the operation or procedure was gone, just how they wanted</td>
<td>8.5</td>
<td>About the same</td>
<td>8.5</td>
<td>About the same</td>
<td>Down</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>for feeling that they understood the situation with a nurse or another professional doctor</td>
<td>8.6</td>
<td>About the same</td>
<td>8.5</td>
<td>About the same</td>
<td>Down</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>for feeling that they understood the situation with a nurse or another professional doctor</td>
<td>8.6</td>
<td>About the same</td>
<td>8.5</td>
<td>About the same</td>
<td>Down</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>for having surgery on the operation or procedure that they wanted</td>
<td>7.2</td>
<td>About the same</td>
<td>7.2</td>
<td>About the same</td>
<td>Down</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>for having surgery on the operation or procedure that they wanted</td>
<td>7.2</td>
<td>About the same</td>
<td>7.2</td>
<td>About the same</td>
<td>Down</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>for having surgery on the operation or procedure that they wanted</td>
<td>7.2</td>
<td>About the same</td>
<td>7.2</td>
<td>About the same</td>
<td>Down</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>for feeling that they had enough time to talk to a nurse or another professional doctor</td>
<td>8.0</td>
<td>About the same</td>
<td>7.7</td>
<td>About the same</td>
<td>Down</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>for feeling that they had enough time to talk to a nurse or another professional doctor</td>
<td>8.0</td>
<td>About the same</td>
<td>7.7</td>
<td>About the same</td>
<td>Down</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>for feeling that they had enough time to talk to a nurse or another professional doctor</td>
<td>8.0</td>
<td>About the same</td>
<td>7.7</td>
<td>About the same</td>
<td>Down</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>for feeling that they had enough time to talk to a nurse or another professional doctor</td>
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<td>About the same</td>
<td>7.7</td>
<td>About the same</td>
<td>Down</td>
<td>7.0</td>
</tr>
<tr>
<td><strong>5a. Teamwork - patient</strong></td>
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<td>0.1</td>
<td>About the same</td>
<td>Down</td>
<td>7.9</td>
</tr>
<tr>
<td></td>
<td>for feeling that, who is involved in service, communication and involvement in their treatment</td>
<td>0.1</td>
<td>About the same</td>
<td>0.1</td>
<td>About the same</td>
<td>Down</td>
<td>7.9</td>
</tr>
<tr>
<td></td>
<td>for feeling that, who is involved in service, communication and involvement in their treatment</td>
<td>0.1</td>
<td>About the same</td>
<td>0.1</td>
<td>About the same</td>
<td>Down</td>
<td>7.9</td>
</tr>
<tr>
<td></td>
<td>for feeling that, who is involved in service, communication and involvement in their treatment</td>
<td>0.1</td>
<td>About the same</td>
<td>0.1</td>
<td>About the same</td>
<td>Down</td>
<td>7.9</td>
</tr>
<tr>
<td></td>
<td>for feeling that, who is involved in service, communication and involvement in their treatment</td>
<td>0.1</td>
<td>About the same</td>
<td>0.1</td>
<td>About the same</td>
<td>Down</td>
<td>7.9</td>
</tr>
<tr>
<td><strong>5b. Teamwork - staff</strong></td>
<td>for feeling that, who is involved in service, communication and involvement in their treatment</td>
<td>8.6</td>
<td>About the same</td>
<td>8.6</td>
<td>About the same</td>
<td>Down</td>
<td>8.7</td>
</tr>
<tr>
<td></td>
<td>for feeling that, who is involved in service, communication and involvement in their treatment</td>
<td>8.6</td>
<td>About the same</td>
<td>8.6</td>
<td>About the same</td>
<td>Down</td>
<td>8.7</td>
</tr>
<tr>
<td></td>
<td>for feeling that, who is involved in service, communication and involvement in their treatment</td>
<td>8.6</td>
<td>About the same</td>
<td>8.6</td>
<td>About the same</td>
<td>Down</td>
<td>8.7</td>
</tr>
<tr>
<td></td>
<td>for feeling that, who is involved in service, communication and involvement in their treatment</td>
<td>8.6</td>
<td>About the same</td>
<td>8.6</td>
<td>About the same</td>
<td>Down</td>
<td>8.7</td>
</tr>
</tbody>
</table>
Analysing the results

When analysing data please ensure you are adhering to your organisation’s information governance policy. Use of patient identifiable data may require approval from your Caldicott guardian. This will depend on the purpose for which the data was originally collected.

For quantitative data you can use the templates to help you analyse your data against the cultural elements.

For qualitative data you can use a similar methodology to that used in the board interviews and culture focus groups (see tool 6.2).

The three steps of the qualitative analysis are:

1. Theme the comment
2. Identify whether the theme is positive or negative
3. Consider what this tells you about your culture (see also figure 6.1).

What did other trusts do? Qualitative analysis for culture

In addition to classifying all comments as positive, negative or neutral - we like to give some thought as to why our patients may be delighted or frustrated with care.

Figure 6.3 below illustrates how we made sense of the 602 responses that we received in the 2015 national inpatient survey. Within these responses were 991 individual statements that could then be aligned to specific themes that mattered most to patients.

We also theme the data in a simpler way. We look at:

- does it have something to do with our transactions – what we do to people, or
- is it more about the relationships we have with people - the kindness of our staff for example or the way the doctor may not have listened to what mattered most to the individual concerned.
This simple method has really helped us understand variation within our wards, teams, hospitals and departments. We can see if this transactional vs relational split is consistent year on year and equally understand the profiles for our ward teams and if we can identify variation between our wards that should concern us. This simple classification helps us to use patient feedback to target improvement effort in the right areas which is so important.

Finally, through this work we’ve explored how themes could be linked to cultural elements such as ‘support and compassion’ or ‘teamwork’ (see also figure 6.1).

Annie Laverty, Director of Patient Experience and Quality, Northumbria Healthcare Foundation Trust

Figure 6.3

Variation by year
Statistically significant improvement from 2014-2015

Patient experience theme (2015)
The top positive themes. Quality of care, quality of staff and kindness and compassion
The top negative themes were waiting/access to care, integration of care, information and quality of staff

Relational-transactional themes (2015)
When patients were happy with care, the transactional and relational elements were usually balanced.
When patients were unhappy with care it was more likely to be about the transactions of care – the systems and processes and the things that happened to them rather than the quality of relationships with staff.
Presenting the results

Once you have gathered the data, you can present it in any format suitable for your organisation. You may wish to use the report template in tool 6.3.

Only anonymised information should be shared with the wider change team and organisation. Check that any information you report and present carefully to make sure that all identifiable information is removed. Seek advice from your Caldicott guardian as necessary.

Improving the process

You may wish to reflect on what worked well and what you might do differently next time. For example:

- what method did you use to identify strengths and development areas?
- which themes did you use for your patient experience data?

Share your learning on patient experience with other trusts

Join our culture community by contacting NHSI.culture@nhs.net
### Tool 6.1: Patient experience template

#### National patient surveys mapped to the cultural elements and leadership behaviours

<table>
<thead>
<tr>
<th>Question</th>
<th>Leadership attitudes</th>
<th>Average</th>
<th>Cultural elements</th>
<th>Average</th>
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<tr>
<td>Q2</td>
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<td>Q3</td>
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<td>Q4</td>
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<td>Q7</td>
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<td>Q36</td>
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</table>

Download resource
Tool 6.2: Analysing the qualitative data

Tool 6.3: Report template
Culture and leadership programme

Phase 1
Discover

Synthesis
The synthesis stage is the bridge between Phase 1: Discover and Phase 2: Design of your culture and leadership programme. It enables you to bring together the results of ‘Getting started’ and the six diagnostics to form a current state analysis on culture and leadership. This will mean you can target approaches and interventions in designing your strategy for collective leadership.

Synthesis takes between three to six weeks. It will involve the change team but you can include others as well.
What should I include in synthesis and why?

During ‘Getting started’ you will have determined the **purpose** of your collective leadership strategy. You will have identified how the strategy can help deliver your organisation’s business plan and how it fits with your existing work. This is essential information in designing your collective leadership strategy in Phase 2: Develop.

From the six diagnostics you will have captured the current state information on the **concepts** shown in the diagram below. You will need to look at strengths and development areas across the concepts for each diagnostic to identify:

- the points of agreement
- the points of difference.

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<th>Diagnostic</th>
<th>Outcomes</th>
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<th>Leadership behaviours</th>
<th>Levels</th>
<th>Workforce capacity</th>
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<td>High level understanding</td>
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<td>Board interviews</td>
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</tbody>
</table>
Reviewing this information will help you identify your strengths and development areas across the concepts to identify areas of focus in Phase 2.

The leadership workforce analysis will also have helped you:

- capture initial views on the future state for the leadership workforce. It is important to include this as the basis for forecasting workforce capacity needs in ‘key leadership roles’ in Phase 2
- identify the strengths and development areas in your existing policies and processes. This knowledge will help you identify initiatives you can build on in Phase 2.

Which diagnostic is more important?

The different diagnostics give you a rich source of data on culture. They offer different perspectives - they do not ‘outrank’ each other. Through your work on culture you will have collected views from:

- staff
- patients
- the board
- partners in external organisations.

The diagnostics ask different questions to each group. This may lead to different interventions for different groups when you develop your collective leadership strategy.

When you synthesise the findings from the diagnostics, you will need to compare and contrast the results paying attention the subtleties of the questions and any bias in the methodology.

What do other trusts do? Time for analysis and synthesis

Don’t underestimate the amount of data produced particularly from the diagnostics where the method for obtaining information is mostly face to face. This data is extremely rich but requires dedicated time and the ability to analyse it.

Previously we focused on the quantitative methods – primarily the national Staff Survey – to understand our culture. This means we only gained a superficial understanding.

The approach taken in the Phase 1: Discover now means that we have some real concrete information that will ensure our interventions are more accurately designed and targeted. This is increasing our chances of really making a difference to the environments within which we work and receive care. Although it has been time consuming it has been worthwhile!

*Stacy Bullock, Assistant Head of Organisational Development and Training, Central Manchester University Hospitals NHS Foundation Trust*
Tips for synthesis

When synthesising the cultural elements:

• draw out information on how these cultural elements are applied across the five levels for collective leadership (see concepts and evidence base for how the five levels and cultural elements relate)

• be careful that information from the board interviews on the culture of the board is distinct from information on the culture of the organisation

• note differences between the staff perception of culture from the focus groups and patients’ perspective from the patient experience diagnostic.

When synthesising the leadership behaviours:

• note that the leadership behaviours are related to the cultural elements (see concepts and evidence base) and use this to compare the results from the external partner perspective to patients, staff and the board

• use information from the culture focus groups as well as the text questions in the surveys to help you understand the quantitative results on the surveys. Checking the number of responses to and nature of demographics the surveys and culture focus groups will help you understand the angle of respondents

• be careful that if you have used the optional questions on leadership behaviour in the leadership workforce analysis they is likely to be more biased than the survey as it will have involved smaller number of people from specific demographics than the surveys.
Hold a synthesis workshop for the change team to discuss and bring together the results of the diagnostics. This will help everyone in the team engage with the findings and the key messages.

This exercise will involve a lot of data and involve a good knowledge of the concepts so we recommend you keep attendees in the synthesis workshop to the members of the change team. You can invite wider involvement and scrutiny later (See Engaging and communicating the results).

The workshop should be designed and led by an experienced facilitator within your organisation based on what has worked well previously. There is no prescribed format for this workshop. You will need a minimum of one day for a synthesis workshop but you can run your synthesis workshop over a number of sessions.

During the workshop:

- leads from each diagnostic will need to present their reports and findings
- the change team should collectively bring together the results of the diagnosis in line with concepts
- if you wish, you can discuss quick wins and priorities for the collective leadership strategy.

What do other trusts say? Thoughts on synthesis workshops

We focused the first half of our workshop on reviewing the findings from each of the diagnostics and the second half on comparing the findings between the different diagnostics on the leadership behaviours and cultural dimensions. While this gave us helpful information, in hindsight I would’ve held our workshop a couple of weeks later so that the leads on each diagnostic had more time to consider and write-up their individual findings. I might also run two half-day sessions with the change team with the first session just to go through the findings of the diagnostics. Leaving a gap would mean everyone would have time to reflect on the wealth of data generated.

Kristina Henry, Head of Learning & Organisational Development, Northumbria Healthcare NHS Foundation Trust
Circulate the diagnostic reports at least a week before the workshop to allow team members time to read them.

If any raw data is circulated or presented it will need to be checked very carefully first to ensure that no individual can be identified. Patient data must be treated in line with the Caldicott principles and advice from your Caldicott guardian. You may wish to remind people of any agreements on the handling of data you made with the team when you were ‘Getting started’.

Synthesis workshops can be intensive, particularly in parts where findings from each diagnostic are being reported. Add interactive elements where possible to make it more engaging and effective result.

You may wish to see an example agenda (tool S1) and examples for capturing information and ideas from synthesis workshops (tool S2).
You will need to consolidate the findings to produce a short report or presentation for the board.

It will be important to both produce an easily digestible and engaging report while keeping the richness of the data generated in the diagnostics - perhaps through a longer version or appendix.

Purpose

It is an assessment of the current culture and leadership which is used to inform the design stage. It should contain the results of the diagnostics.

Content

- Summarise the purpose for your collective leadership strategy from your ‘getting started’ discussions
- Explain your methodology – how you ran the diagnostics and broadly how many people participated from which groups
- Identify key areas of work for the collective leadership strategy. In particular:
  - describe the themes, strengths and development areas across each of the five cultural elements, ten leadership behaviours and five levels
  - describe the current state across the three workforce capacity areas for both key leadership roles (as defined in your leadership workforce analysis) and the workforce as a whole
  - for key leadership roles only, identify issues for the future and where possible, provide a high level forecast in terms of the three workforce areas.
- Describe strengths and development areas in your policies and processes from your leadership workforce analysis.
- Describe timeframes for the next steps or what will happen in Phase 2: Design. Propose priorities and a few quick wins as necessary but remember that developing and planning solutions will be part of Phase 2: Design.
What do other trusts do?
Different approaches to sharing the findings

The final report to the board was huge, a lot of information and some important messages. It had a short executive summary to help make it digestible. The board dedicated a four hour development session to receiving the feedback which was presented by the ‘change champions’ (change team members). The findings were themed into key messages and although some of these were hard for the board to hear there were no real surprises.

The change champions then worked with the board to determine priorities and develop next steps. Further presentations were made and feedback sought from the clinical directors and the council of governors. This work was then translated into an action plan which was agreed at the board meeting in July. The action plan set out our quick wins ‘just do it’ actions and things we need to take to the next phase:

Phase 2: Design.

Nicola Hartley, Director of Organisational Development and Leadership,
Royal Bournemouth and Christchurch NHS Foundation Trust
Engaging and communicating the results

Your staff will already be aware of the culture and leadership programme as part of your communications plan and because of the leadership behaviours surveys and culture focus groups.

It is important to acknowledge their contribution to the programme by sharing findings at the end of Phase 1: Discover and explaining the next steps. A common concern for staff is that no action will be taken and their efforts will be in vain.

You can also choose to involve staff before the synthesis workshop to help inform you findings.

Before the synthesis workshop

As an optional part of your synthesis step, you can involve staff beyond your change team in reviewing the findings of the different diagnostics to help provide a fresh perspective. The individuals would act as ‘critical friends’, supporting the lead by providing feedback and additional points.

Invite a handful of people outside the change team to reviewing the data and report on each diagnostic. The review can take place in facilitated meetings or by circulation.

You will also need to:

- ensure only anonymised data is used during the session. Patient information must be treated in line with Caldicott principles
- select people carefully to ensure that they can work competently with the data
- brief the reviewers on the project and the concepts being tested in the diagnostic
- be clear what you are asking from the reviewers
- explain the methodology, data and analysis.
After the synthesis workshop

You can test the findings of synthesis through meetings and workshops with staff, if you wish. This will involve interested stakeholders not all staff. We recommend you share analysed information rather than raw data at this stage.

After the board report

The purpose of communications at this stage is to maintain engagement while demonstrating openness and transparency on findings and next steps.

You can disseminate the findings through a variety of communications channels. Refer to your communications plan and lead for the best channels to use.

In addition to communicating the findings, you can also run engagement sessions. This may help keep staff interested and give you ideas for developing your collective leadership strategy in Phase 2.

You can involve any groups you choose outside your core team, including staff representatives and governors. There is no set format and the session should be designed and led by an experienced facilitator within your organisation. Getting the format right is important. Staff will not have detailed knowledge of the culture and leadership programme so short sessions are better.

If you are running an engagement session:

- familiarise participants with the culture and leadership programme and any concepts they will need during the session
- make sure they are clear on the objectives for the day and their role
- present the analysed reports and findings not the full raw data - this must first be anonymised and raw data will be difficult for the majority of participants to engage with in the time.

What did other trusts do? Sharing the findings of Phase 1

We formed a ‘reference group’ of almost 50 people which became an extension of the change team. We invited them to be part of the synthesis phase of the work. As many of them were members of established leadership schemes, this gave us a slice through the organisation with whom we could test our findings.

Sandra Drewett, Director of HR and OD, East London NHS Foundation Trust
We managed expectations that those who contributed to the leadership behaviours surveys and focus groups would not receive bespoke feedback about their contributions, although the fact that these diagnostics had taken place were acknowledged in our monthly briefing cascaded to teams. We are planning to disseminate the findings further after the board report.

Kristina Henry, Head of Learning and Organisational Development, Northumbria Healthcare NHS Foundation Trust

Roadshows from our diagnostic phase – the ‘cultural audit’ – is now underway with a series of open meetings and attendance at existing team meetings being held. In these sessions, the findings of the cultural audit are being shared, staff are being invited to feed back on the findings and recommendations and shape the new culture. These sessions are being delivered by the change champions who are working in pairs and supported by a member of the Executive team at each session.

We are now developing the design phase and looking to recruit more change champions to augment the current team.

Nicola Hartley, Director of OD and Leadership, Royal Bournemouth and Christchurch NHS Foundation Trust
You will have already created an evaluation plan during the ‘getting started’ stage.

The end of Phase 1: Discover will be too early to review programme outcomes using the culture and outcomes dashboard, but you can evaluate the process and impact on the change team. Gathering feedback from one another should be done in the spirit of support and reflection and with openness to improvement.

The most important output of this exercise is the learning and process of reflection for the change team. However, you should write up your lessons learnt or evaluation drawing out the themes to capture learning for the future. Any notable impact – for example changes in behaviours, increase in knowledge and self-reflections – should be documented and shared with the board at the end of the phase.

Objectives

Review the objectives you set for Phase 1 of your culture and leadership programme in ‘getting started’ and review to what extent these objectives were met. You can also get feedback from your executive sponsor and the change team on this through the evaluation interviews or evaluation focus group mentioned below.

Feedback from the diagnostics

Review the diagnostic reports or talk to the leads on each diagnostic to identify specifically for that diagnostic:

- What went well?
- What was challenging?
- What could go better?

In each of the six guides on the diagnostics we have included a short section on improving the process which may help.

Collect and analyse the feedback forms from board interview and culture focus groups to inform your evaluation. This will give you valuable information to improve the process and inform your engagement processes in Phase 2: Design.
Change team development

You can also evaluate the effect of the programme on your change team and include the results of the following in your evaluation report:

- your team working assessments – if you have run more than one assessment
- completion of any agreed group actions from your leadership behaviours reflection questionnaire
- if you have run any development programme or training for your change team you can collect and analyse the results of any feedback sheets from that training.

Evaluation interviews

You can interview your change team. Interview all members if possible. If it is not possible, make sure you interview a representative sample across your demographics – a mix of gender, age, occupational roles, seniority, ethnicity and so on.

Interviews can be done in-person or by telephone. You can nominate one or several members of the change team to conduct the interviews. Ensure whoever conducting the interviews is clear about the need to protect personal identifiable information.

We recommend that you ask the same questions to each interviewee – this is called semi-structured interviewing. The way these questions are asked, the order of questioning and timings can vary from person to person. This allows for greater flexibility in getting information. See tool S3 for a list of Phase 1 evaluation questions.

Tips for conducting these interviews:

- Before you begin, try to establish some rapport with the person and find a quiet space where you know you will not be disturbed
- Ask the interviewee if you can record the interview or take notes. Always ask for permission before recording interviews and assure the interviewee that their audio will be transcribed, anonymised and later destroyed. This is in the interests of protecting their anonymity and ensuring there is no personally identifiable information
- Encourage the interviewee to adopt a solutions-focused approach to responding. It can be easy to fall into casual conversation or thinking about issues and inter-personal challenges where no solution is given
- If things go off topic or become uncomfortable, remind the interviewee that you will only be able to discuss topics that they are happy to have shared with the wider team.
Evaluation focus group

As an alternative to evaluation interviews, you may find it easier to hold a single workshop with your change team. You can use the same questions as for interviews (see tool S3).

Here are some tips for conducting the session:

- Use a combination of group discussion and private reflection to make sure everyone can share their perspective on all the questions.
- Have a trained facilitator conduct the session to make sure all the knowledge is shared and allocate someone to take minutes so that discussions are captured.
- Allow everyone to contribute to each question. This may require a ‘world café’ style approach or splitting off into separate groups. Find a method that works best for you. But ensure all feedback is captured in some way.
- Ensure there is enough time scheduled in for reflection and discussion. People need different amounts of time to process and reflect.
- You may wish to suggest ground rules or allow the change team to decide these themselves. This will help everyone stay focused on the purpose of the session, make sure everyone feels comfortable and privacy is respected.

- Here are some examples:
  » All feedback is encouraged. You are able to express your thoughts, feelings or opinions without consequence.
  » Respectful disagreement is helpful – it will enable us to improve things for the next phase.
  » We will all engage in the process of feeding back. If you feel unable to say a point aloud, note it down on paper and feed it back in this way.
Preparing for Phase 2: Design

Phase 2: Design will help you develop your collective leadership strategy. The strategy should fit in with your trust’s approach to organisational and workforce development.

During Phase 2 you will develop your collective leadership strategy by:

- revisiting the purpose
- reviewing findings from Phase 1 in relation to diagnosing culture and leadership needs
- forecasting leadership needs, building on the future state information you obtained in Phase 1
- generating options - coming up with a range of ideas to address the issues described in the Phase 1: Discover board report
- prioritising ideas to pursue and building them into a coherent strategy combining quality care for patients with financial viability, resulting in sustainable clinical services.

The diagram below (taken from NHS Improvement’s strategy development toolkit) shows the seven stages for strategy development alongside the three sets of resources being released as part of the culture and leadership programme.

Figure s.2: Seven-stage framework for strategy development
Phase 2: Design and Phase 3: Deliver will require more engagement than Phase 1: Discover, so you may need to expand governance and stakeholder involvement arrangements. Keep the change team you created for Phase 1 for consistency.

The governance is likely to require:

- a change board involving members of the executive management team
- a change team of approximately 10 people to write the strategy and drive Phase 2: Design. It is better if this includes the majority of members of the Phase 1: Discover change team
- a design team of up to 50 people including specialist areas and interests across the organisation such as: organisational development, equality and diversity, chief finance officer, director of nursing, programme management office, clinical directors, public and staff governors, non-executives, communications, staff health and wellbeing, human resources, learning and development, professional leadership, quality improvement and innovation, planning.

We expect the design phase to take three to six months and several workshops with the change and design teams to:

- brief change team members on the Phase 1: Discover phase, exploring and agreeing the scope for Phase 2: Design
- discuss options for objectives and actions in the collective leadership strategy
- prioritise options and develop the draft strategy
- the resources for Phase 2: Design are expected to be released in mid-2017.
# LEADING TOGETHER

Creating Supportive Leadership Cultures

## Synthesis Workshop

Example with facilitator notes

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.15</td>
<td>Arrival and refreshments</td>
</tr>
<tr>
<td>9.30</td>
<td>Facilitator/sponsor</td>
</tr>
<tr>
<td>9.30</td>
<td><strong>Introduction</strong></td>
</tr>
<tr>
<td></td>
<td>• Context, background and expectations - including setting up capturing comments, main messages for afternoon session</td>
</tr>
<tr>
<td></td>
<td>• Diagram with all summary of concepts printed – briefly explains diagram</td>
</tr>
<tr>
<td></td>
<td><strong>Video</strong></td>
</tr>
<tr>
<td></td>
<td>• Play video – managers in the trust talking about the leadership challenges</td>
</tr>
<tr>
<td>09.50</td>
<td>Change team member</td>
</tr>
<tr>
<td></td>
<td><strong>Icebreaker</strong></td>
</tr>
<tr>
<td></td>
<td>• Sushi or pie line and conversation about self – intro, role, NHS experience and interesting fact, then speak to someone opposite.</td>
</tr>
<tr>
<td>10.15</td>
<td>Lead on each diagnostic</td>
</tr>
<tr>
<td></td>
<td><strong>Presentations: leadership behaviours survey (staff and partner) and board interviews</strong></td>
</tr>
<tr>
<td></td>
<td>• Presentations – 10 mins each diagnostic</td>
</tr>
<tr>
<td></td>
<td>• While listening attendees to write on post-its (including the name of the diagnostic on the post-it):</td>
</tr>
<tr>
<td></td>
<td>• What story are we telling?</td>
</tr>
<tr>
<td></td>
<td>• What is attracting your attention?</td>
</tr>
<tr>
<td></td>
<td>• What conclusions are you coming to?</td>
</tr>
<tr>
<td></td>
<td>• Questions and feedback - 5 minutes each diagnostic led by facilitator</td>
</tr>
<tr>
<td>10.45</td>
<td>Coffee</td>
</tr>
<tr>
<td>11.00</td>
<td>Facilitator</td>
</tr>
<tr>
<td></td>
<td><strong>Video of change team insights</strong></td>
</tr>
<tr>
<td></td>
<td>• Play video - change team talking about the programme</td>
</tr>
<tr>
<td>11.05</td>
<td>Lead on each diagnostic</td>
</tr>
<tr>
<td></td>
<td><strong>Presentations: culture focus groups, leadership workforce analysis, culture and outcomes dashboard</strong></td>
</tr>
<tr>
<td></td>
<td>• Presentations – 10 mins each diagnostic</td>
</tr>
</tbody>
</table>
### Tool S1: Example agenda for your synthesis workshop

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:50</td>
<td>Facilitator: Collecting reflections by cultural element</td>
</tr>
<tr>
<td></td>
<td>- All staff to put their post-its on flip charts against each of the five cultural elements</td>
</tr>
<tr>
<td></td>
<td>- Discussion of the content on the flip charts</td>
</tr>
<tr>
<td>12:15</td>
<td>Lunch</td>
</tr>
<tr>
<td>13:00</td>
<td>Facilitator: Analysis by cultural element</td>
</tr>
<tr>
<td></td>
<td>- Groups assigned to a new flipchart with each of the five cultural elements</td>
</tr>
<tr>
<td></td>
<td>- In groups answer - 15 mins:</td>
</tr>
<tr>
<td></td>
<td>- If the ambition for this cultural element was being realised:</td>
</tr>
<tr>
<td></td>
<td>1. What would we be noticing?</td>
</tr>
<tr>
<td></td>
<td>2. What would it be like for patients, partners, staff? How would it feel?</td>
</tr>
<tr>
<td></td>
<td>3. What would people be talking about?</td>
</tr>
<tr>
<td></td>
<td>- In groups answer - 15 mins:</td>
</tr>
<tr>
<td></td>
<td>- What data from the diagnostics tells you:</td>
</tr>
<tr>
<td></td>
<td>1. We are already there?</td>
</tr>
<tr>
<td></td>
<td>2. What requires attention?</td>
</tr>
<tr>
<td></td>
<td>3. What needs to happen? Consider:</td>
</tr>
<tr>
<td></td>
<td>- Formal Leadership</td>
</tr>
<tr>
<td></td>
<td>- Leadership skills and behaviours</td>
</tr>
<tr>
<td></td>
<td>- Collective leadership culture</td>
</tr>
<tr>
<td>13:45</td>
<td>Facilitator: Review and feedback by cultural elements</td>
</tr>
<tr>
<td></td>
<td>- Walk around the flip charts and make any additions (by group)</td>
</tr>
<tr>
<td></td>
<td>- Feedback on each flip charts (one nominee from each group)</td>
</tr>
<tr>
<td>14:10</td>
<td>Coffee</td>
</tr>
<tr>
<td>14:45</td>
<td>Facilitator: Summary of findings</td>
</tr>
<tr>
<td></td>
<td>- Summary of key points so far</td>
</tr>
<tr>
<td></td>
<td>- Reflections from change team members</td>
</tr>
<tr>
<td>14:55</td>
<td>Next phase: Summarise of Phase 2: Design</td>
</tr>
</tbody>
</table>

See concepts and evidence for information on the five cultural elements.
<table>
<thead>
<tr>
<th>Time</th>
<th>Role</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>15:55</td>
<td>Facilitator</td>
<td>Reflections from the day and close</td>
</tr>
</tbody>
</table>

**Resources:**
- Copies of the presentations and videos
- Flip chart and pens
- Highlighter pens
- Post-its
- Coloured dots

**Note:**
Capture on flip chart – review each of the three post-its and apply 1 coloured dot to 3 of your top ideas/recommendations.

See collective leadership strategy to understand why questions 1, 2 and 3 have been chosen.

*Figure x: Example agenda with facilitator notes*

– Central Manchester University Hospitals NHS Foundation Trust
Tool S2: Examples of capturing ideas and information

Analysis by cultural element – Northumbria Healthcare NHS Foundation Trust
<table>
<thead>
<tr>
<th>Constraints</th>
<th>Enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Converting forces not being programmed in CRIS</td>
<td>Enabling clear goals</td>
</tr>
<tr>
<td>Fear and blame</td>
<td>Committed staff, internal tolerance</td>
</tr>
<tr>
<td>Lack of compelling vision</td>
<td>Open to learning, senior team</td>
</tr>
<tr>
<td>Lack of direction, mixed messages</td>
<td>Leadership, modelling behaviour</td>
</tr>
<tr>
<td>Innovation, fatigue, sense (cause Risk Aversion, Inertia)</td>
<td>Connections, Support for workforce</td>
</tr>
<tr>
<td>Too communication, external forces</td>
<td>QI Refreshed Development</td>
</tr>
<tr>
<td>Lack of senior support, political</td>
<td>Leadership, seeing, Sheer force of will</td>
</tr>
<tr>
<td>Geography</td>
<td>Staff participation</td>
</tr>
<tr>
<td>Time, staff change, heart of argument</td>
<td>Skilled workforce, Accountability</td>
</tr>
<tr>
<td>Local health care services, local</td>
<td>Creating space for Scarcity + innovation</td>
</tr>
</tbody>
</table>

Enablers and constraints for culture change - East London NHS Foundation Trust

**Tool S3:** End of phase questions

Download resource
Culture and leadership programme

Phase 1
Discover

Concepts and evidence
Introduction

This document summarises the national and international research identifying the concepts associated with high quality care cultures. The resources to support you in developing and running your culture and leadership programme have been designed based on these concepts and we will refer to them throughout the resources so it is worth keeping them to hand.

These resources rest on the principles that:

- **Cultures** – ‘the way we do things around here’ – drives **outcomes**.

- This happens at all levels of the **NHS** – within teams, departments, organisations and in cross-organisational collaborations. Cultures that support high quality care display ‘collective leadership’. Collective leadership means a type of culture where staff at all levels are empowered as individuals and in teams to act to improve care within and across trusts – ‘leadership of all, by all and for all’. This is in contrast to command and control cultures which are not conducive to achieving high quality care.
• Everything we do in organisations as well as the, systems, processes and structures, influences our organisational culture. This means that individuals in local, regional and national organisations need to consider how their systems and processes affect the values and behaviours of those who work in the NHS.

• However, leadership is the most powerful influence on the culture of an organisation whether it is formal or informal leadership. Therefore leadership behaviours are particularly important in shaping culture and organisations need the workforce capacity, particularly in key leadership roles, to achieve the organisation’s business strategy and deliver high quality care.

The resources aim to support the NHS to achieve the ambitions on culture and leadership set out in recent national reports.

Figure c.1: Link between leadership behaviour and outcomes

This diagram shows the elements of a simplified leadership model created especially for these resources. There are more complex models such as McKinsey 7 S² or Burke-Litwin³ which also demonstrate that an organisation’s leadership is also affected by its culture.
Three outcomes

**Quality and value**

The aim of any healthcare system is to deliver high quality care and value.

In this programme, in line with the Health and Social Care Act 2012, we define quality as:

- clinical effectiveness
- positive experience
- safety.

Delivering value for money is essential to maintain quality, ensure safety and good patient experience and to ensure long-term sustainability. Value is defined by the outcomes delivered for resource used. For simplicity, we use financial efficiency, productivity and sustainability measures in the diagnostics even though these are not true calculations of value.

Evidence from the private sector shows that income and productivity can be increased and customer experience improved through the effective engagement of staff.

Improving financial performance needs to be seen as a mission to deliver better value if staff are to be engaged effectively. Staff commitment and engagement will not be realised if the focus is overwhelmingly on cost reduction.
Healthy flourishing and engaged staff

Healthy, flourishing and engaged staff are essential to drive continuous improvement and deliver quality and value. There is strong evidence this impacts positively on outcomes for patients. Engaged employees are proactive, enthusiastic and motivated to contribute to the success of their organisation while their positive engagement with work should enhance their own sense of wellbeing.

Continuous improvement

For high quality care and value to be sustainable the healthcare system must continuously improve and evolve. According to the Berwick report:

“The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.”

There is increasing evidence that investment in improvement is good business, through delivering measurable return on investment and showing how the consistent application of continuous improvement techniques can reduce waste.
Five cultural elements

Culture is defined by the values we live by every day – these may not be the same as the stated values. The lived values can be in seen by ‘the way we do things around here’.

Evidence shows there are five key elements in high quality care cultures and these are closely aligned with the values in the NHS Constitution. If everyone in an organisation consistently works to implement create and support the values, they lead to a collective leadership culture. Command and control cultures weaken attempts to sustain these cultural elements.

<table>
<thead>
<tr>
<th>Cultural Elements</th>
<th>Values</th>
<th>The way we do things</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision and values</td>
<td>Constant commitment to quality of care</td>
<td>Everyone taking responsibility in their work for living a shared vision and embodying shared values</td>
</tr>
<tr>
<td>Goals and performance</td>
<td>Effective, efficient, high quality performance</td>
<td>Everyone ensuring that there are clear priorities and objectives at every level and intelligent data constantly informing all about performance</td>
</tr>
<tr>
<td>Support and compassion</td>
<td>Support, compassion and inclusion for all patients and staff</td>
<td>Everyone making sure all interactions involve careful attention, empathy and intent to take intelligent helping action</td>
</tr>
<tr>
<td>Learning and innovation</td>
<td>Continuous learning, quality improvement and innovation</td>
<td>Everyone taking responsibility for improving quality, learning and developing better ways of doing things</td>
</tr>
<tr>
<td>Teamwork</td>
<td>Enthusiastic cooperation, team working and support within and across organisations</td>
<td>Everyone taking responsibility for effective team-based working, interconnectedness within and across organisations, systems thinking and acting</td>
</tr>
</tbody>
</table>
Vision and values

With collective leadership, everyone in an organisation takes responsibility for their work and through their actions shows dedication to shared vision and values focused on constant commitment to high quality care.

The evidence for strong, shared vision and values as underpinning high quality care is clear. In a large study of cultures of quality and safety in the English, NHS, Dixon-Woods and colleagues\textsuperscript{12} demonstrated that in the best performing healthcare organisations, leaders at all levels made it clear that high quality and compassionate care was a priority. These organisations had a clearly articulated vision about delivering high quality care, explicit goals and a strategy to achieve them.

McKee and colleagues\textsuperscript{13} also showed a link between good patient safety performance and chief executives with a clearly communicated strategic vision, long-term goals and organisational plans for patient safety and staff wellbeing. Trusts with good patient safety performance tended to mention national patient safety alert actions more frequently than poorer performing organisations. Their leaders prioritised safety over other organisational goals, and demonstrated this to all staff through their behaviours. This is also true in other industries where chief executive values and associated organisational culture are correlated with outcomes including financial performance.\textsuperscript{14}

Demonstrating and living the values through behaviour is fundamental. In poorly performing NHS organisations, senior leaders ignored staff concerns, avoided discussing workload pressures and paid little attention to addressing systemic problems such as inter-departmental conflict.\textsuperscript{8} This created a negative unspoken message about what was valued and how staff should behave, and thus undermined organisational performance.
Goals and performance

High quality care cultures are characterised by commitment to effective, efficient and high quality performance. In day-to-day working, this means everyone in the organisation ensuring there are clear priorities and objectives, while using relevant data to understand their level of performance. Clarity of goals and objectives correlates closely with outcomes and agreeing rather than imposing difficult goals leads to better performance than no goals. Moreover, specific, difficult goals are more effective than general objectives such as ‘do your best’. Studies comparing goal ‘type’ and performance show that those with the most challenging goals perform 250% better than those with easier goals. People with clear and challenging objectives at work are also more motivated to innovate.

Unsurprisingly, this pattern is also present in healthcare. Drawing on data from the NHS Staff Survey, Dawson and colleagues showed that patient satisfaction was highest where staff had clear purpose and there were clear goals at every level of the organisation. Where this happens, communication between patients and staff members is good and patients feel engaged in decisions about their care.

This study also showed a relationship between the percentage of staff receiving appraisals and improved levels of patient mortality. Moreover, good appraisal and good financial performance were closely correlated. As well as being an indicator of outcomes, appraisals are associated with higher levels of staff engagement which drives performance at individual, team and organisational levels. A poor appraisal is associated with a decline in engagement.

Clear objectives begin with the top management team having a clear purpose and five or six clear objectives. In collective leadership cultures, this clarity of objectives is then replicated at every level: each directorate, department, team and individual has clear objectives aligned with the purposes, vision and values of the organisation.
Support and compassion

In healthcare, West et al\(^8\) found that for staff to treat “patients with respect, care and compassion, all staff, especially leaders must treat their colleagues with care, respect, and compassion. The higher the levels of satisfaction and commitment that staff report, the higher the levels of satisfaction that patients report”.

Support and compassion are fundamental components of a culture that encompasses inclusion for patients and staff.

Compassion in an organisational context can be understood as having four components: attending, understanding, empathising and helping.\(^21\) In the context of an interaction between a health care professional and a patient, compassion involves:

1. paying attention to the other and noticing his or her suffering – attending and being present
2. understanding what is causing the other’s distress, by making an appraisal of the cause - understanding
3. having an empathic response, a felt relation with the other’s distress - empathising
4. taking intelligent (thoughtful and appropriate) action to help relieve the other’s suffering – helping.

Compassionate leadership has these same four components and these four domains of compassionate leadership are particularly powerful in health care, where the workforce is largely composed of highly skilled and motivated professionals. Motivated as they are, they require support rather than direction and enabling rather than controlling interventions from leaders.

In a study conducted across a range of organisations, Saks\(^22\) found that one of the factors contributing to higher levels of staff engagement was the level of support from the organisation and supervisors. Employees who perceived that they have higher levels of organisational support, are more engaged in their job and organisation.\(^23\)

Maslach and Leiter\(^24\) found that employees whose supervisor was supportive and fair were less likely to experience burnout and more likely to engage with organisational change.

An earlier study by Goodrich and Levenson\(^25\) which examined Schwartz rounds (multidisciplinary forums where staff discuss the emotional and social aspects of providing patient care) found that the rounds had several potential benefits, particularly improved teamwork, increased empathy and an enhanced feeling of working in a supportive environment.

West and Dawson\(^26\) also found that high engagement was associated with lower staff absenteeism and lower levels of staff turnover.

Several public and private sector studies have found that level of staff engagement affects staff drive, innovation and willingness to overcome obstacles. Managers who engage their staff effectively provide them with direction while giving them latitude and ensuring that they have a voice.\(^27,28\)
Learning and innovation

The National Advisory Group on the Safety of Patients in England recommended that the NHS should become a ‘learning organisation’, with its leadership creating and supporting learning capability and through this introduce change at scale.

As identified in the previous section, “happier and more content employees are more likely to foster an innovative environment”.27

West et al⁸ report that in collective leadership cultures in healthcare, all staff focus on continual learning and through this, on the improvement of patient care.

As an example of this, The King’s Fund⁶ cites Salford Royal, a trust with a well-developed quality improvement (QI) strategy, where staff initiates and sustain improvements, supported by internal QI specialists and championed by the board. The QI approach, along with good staff engagement and firmly embedded leadership values and behaviours, has led to this trust becoming one of the best performing in the country.

Hakanen et al²⁹ support the finding that higher levels of engagement are correlated with innovation at work.

A Chartered Institute of Personnel and Development (CIPD) study suggested that engaged employees are more likely to seek out new ways of working and turn their ideas into useful applications.30

An international study explored the role of leaders in creating the right conditions for high performing healthcare systems.31 The organisations all enjoyed:

• consistent leadership
• quality and system improvement as a central strategy
• cultures that supported teamwork, continuous improvement and patient engagement
• learning strategies that were effective and enabled testing of improvement and scaling up.
Teamwork

Where there is genuine teamworking “staff demonstrate enthusiastic co-operation, work across professional boundaries, and work interdependently to provide high quality care for patients”. ⁸

Leadership is crucial in creating an environment where real teamwork can flourish. ³¹

The distinction between real teams and groups is that teamwork requires members to work closely and interdependently. A team has shared objectives and works “dynamically, interdependently and adaptively toward a common goal”. ³² This is distinct from groups where individuals may think they are working as a team, when actually they share a supervisor or work in close proximity and are co-acting. ³³ Co-acting groups typically do not share a common purpose or objectives.

Real teams have clarity of direction, an enabling team structure and a supportive organisational context. These have a powerful impact on team self-management and team performance. ³⁴

Effective teamwork across several industries, including the aeronautical industry, is associated with a reduction in team errors. ³⁵ In healthcare this means improved patient safety. ³⁶

Teams that reinforce safe practice through shared objectives are less likely to expose individual members to hazardous processes that affect their health and wellbeing. ¹³ Members collectively spend time reviewing their past performance, assessing the potential risks of doing things differently and adapting their shared objectives and task activities. They work as self-correcting performance units. ³⁷

Team working benefits not just individual members of staff and organisations but also patients. ⁸ Effective teams are more likely to innovate to provide better quality healthcare and to be more productive. ³⁸
Ten leadership behaviours

Leadership, particularly collective leadership, is the most powerful factor influencing culture in healthcare organisations because it determines staff engagement and commitment to high quality care. It is the key to creating cultures that will give NHS staff the freedom and confidence to act in the interests of patients, and will lead to sustainable clinical, operational and financial performance.

The King’s Fund has identified 10 leadership behaviours linked to the five cultural elements that support collective leadership. These leadership behaviours are based on a review of both general leadership literature and research on leadership in healthcare. For the purpose of the culture programme they specifically support the approach of collective leadership and the five cultural elements.

There are a range of other leadership models available, for example the NHS Leadership Academy’s health care leadership model is in part based on the idea of distributed leadership, and as such does have some connection to the approach described here. Both are fundamentally concerned with improving patient care through staff engagement, with leaders playing a pivotal role.

<table>
<thead>
<tr>
<th>Leadership behaviours</th>
<th>Cultural elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitating shared agreement about direction, priorities and objectives</td>
<td>Vision and values</td>
</tr>
<tr>
<td>Ensuring effective performance</td>
<td>Constant commitment to quality of care</td>
</tr>
<tr>
<td>Modelling support and compassion</td>
<td>Goals and performance</td>
</tr>
<tr>
<td>Enabling learning and innovation</td>
<td>Effective, efficient, high quality performance</td>
</tr>
<tr>
<td>Building cohesive and effective team working</td>
<td>Support and compassion</td>
</tr>
<tr>
<td></td>
<td>Support, compassion and inclusion for all patients and staff</td>
</tr>
<tr>
<td></td>
<td>Learning and innovation</td>
</tr>
<tr>
<td></td>
<td>Continuous learning, quality improvement and innovation</td>
</tr>
<tr>
<td></td>
<td>Team Work</td>
</tr>
<tr>
<td></td>
<td>Enthusiastic cooperation, team working and support within and across orgs.</td>
</tr>
</tbody>
</table>
The ten leadership behaviours for collective leadership are described in more detail below:

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Ensuring direction and alignment** | Includes:  
- seeking shared agreement on direction (the overall purpose and aims of the work) within teams/organisations and across teams  
- encouraging everyone to work together to ensure all are clear on the direction and strategy of their teams and of the organisation  
- and helping people to make sense of events in the organisation.  

**The evidence suggests:**  
Clarifying direction, strategy and the priorities for people’s efforts is important to ensure that staff are clear about their roles and to avoid overload – particularly in the highly demanding environment of health care.  
- defining a few key priorities and making clear what the team is not going to do, rather than overwhelming people with inspirational priorities.  
Leadership in this domain results in clear, agreed, challenging and, measureable objectives for all individuals and teams. |
| **Developing positivity, pride and identity** | Includes:  
- celebrating the successes of the team and organisation  
- emphasising how the work makes a difference to patients and the community  
- encouraging others to be positive  
- expressing optimism, confidence, gratitude and humour  
- building a sense of positivity about the future.  

**The evidence suggests:**  
- Effective leaders support those they lead by creating an environment where people can freely express and discuss the way they feel, which in turn helps them make sense of their circumstances, seek or provide comfort, and imagine a more hopeful future.  
- help those they lead make sense of change, catastrophes, successes and the future by attending, understanding, empathising and responding to their reactions.  
- providing a helpful narrative which makes sense to people inspires them to give of their best.  
- encourage and model positive attitudes, experiences and compassion rather than cynicism, depersonalisation or defeatism and do so with humour, empathy, kindness, belief and a sense of purpose.  
- leaders nurture this sense of commitment by being actively and compassionately committed to meeting the needs of their employees to support them in their work.  
- create collective identity through a positive vision of the team’s work, a sense of pride in team performance and nurture team identity through rituals, celebrations, humour and narrative so that people feel proud of who they work for and with. |
<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensuring effective performance</td>
<td>Includes:</td>
</tr>
<tr>
<td></td>
<td>• ensuring everyone is clear about each other’s roles and responsibilities</td>
</tr>
<tr>
<td></td>
<td>• seeking agreement and shared understanding about of key priorities and objectives</td>
</tr>
<tr>
<td></td>
<td>• organising and co-ordinating work efforts towards agreed goals</td>
</tr>
<tr>
<td></td>
<td>• dealing with obstacles to the delivery of high quality work such as systems difficulties, challenges and co-ordination problems</td>
</tr>
<tr>
<td></td>
<td>• giving timely and balanced feedback about progress towards objectives.</td>
</tr>
<tr>
<td></td>
<td><strong>The evidence suggests:</strong></td>
</tr>
<tr>
<td></td>
<td>• help people work together in a co-ordinated way that enhances their wellbeing, thereby building alignment, connection and compassion.</td>
</tr>
<tr>
<td></td>
<td>As with other domains, this reflects a leadership style that supports staff: enabling them rather than directing.</td>
</tr>
<tr>
<td>Ensuring the necessary resources are available and used well</td>
<td>Includes:</td>
</tr>
<tr>
<td></td>
<td>• ensuring staff have the resources and support needed to get the job done, such as money, staff, IT or other specialist support, time;</td>
</tr>
<tr>
<td></td>
<td>• reducing demands on staff when they are overwhelmed;</td>
</tr>
<tr>
<td></td>
<td>• ensuring resources are used efficiently and effectively.</td>
</tr>
<tr>
<td></td>
<td><strong>The evidence suggests:</strong></td>
</tr>
<tr>
<td></td>
<td>This involves political acumen and risk taking in dealing with the wider organisations, patients and other stakeholders.</td>
</tr>
<tr>
<td></td>
<td>It requires leadership that wins the necessary resources so that teams do not work in chronically under-resourced environments</td>
</tr>
<tr>
<td>Enabling learning and innovation</td>
<td>Includes:</td>
</tr>
<tr>
<td></td>
<td>• sharing learning about errors, near misses, and improved ways of working</td>
</tr>
<tr>
<td></td>
<td>• improving the quality of their work, including regular reviews of working methods</td>
</tr>
<tr>
<td></td>
<td>• developing and implementing ideas to improve quality</td>
</tr>
<tr>
<td></td>
<td>• supporting others in implementing ideas for new and improved ways of working</td>
</tr>
<tr>
<td></td>
<td>•  avoid blaming unnecessarily by creating a psychologically safe environment.</td>
</tr>
<tr>
<td></td>
<td><strong>The evidence suggests:</strong></td>
</tr>
<tr>
<td></td>
<td>This facilitation of learning focuses on both emotional and cognitive elements as they help the team process negative emotions – pain and grief – where necessary.</td>
</tr>
<tr>
<td></td>
<td>It ensures the team regularly takes time out to review objectives, strategies and processes so they collectively learn and improve and ensure their own wellbeing.</td>
</tr>
<tr>
<td>Behaviour</td>
<td>Description</td>
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<tr>
<td>---------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Helping people to grow and lead | Includes: • promoting continued learning and development for all • ensuring everyone has the freedom to work autonomously where appropriate rather than being restricted • ensuring everyone has the chance to take part in challenging projects and other development opportunities; and to lead in their work.  

**The evidence suggests:** • develop and empowering staff by ensuring their continued growth and development (fundamental to human health and well-being) • encourage followers to respond successfully to challenges. |
| Modelling support and compassion| Includes: • being supportive and compassionate to staff and patients who are distressed or under pressure; • understanding the pressures and difficulties staff face • taking practical action to help those under pressure; • encouraging everyone to support each other.  

**The evidence suggests:** • underpin trust and co-operation between staff members because compassion results in a stronger connection between co-workers. Supportive and compassionate leadership emphasises collegial support, kindness and valuing others’ contributions which increases trust, compassion and cohesion. It involves helping to resolve conflicts quickly and fairly and building a strong sense of community |
| Valuing diversity and fairness  | Includes: • ensuring equality and valuing diversity (of race, disability, religion or belief, age, gender, gender reassignment, sexual orientation, professional background, work experience, marital status, pregnancy and maternity) • encouraging listening carefully to other’s contributions (‘listening with fascination’) • ensuring everyone’s opinions are valued (staff and patients) and that people feel comfortable to be honest and open • challenging aggressive or intimidating behaviours, and dealing effectively with bullying, harassment or discrimination. promoting social justice and morality and emphasising fairness and honesty in all dealings • setting an example of ethical/moral behaviour, especially when it requires the sacrifice of personal interests.  

**The evidence suggests:** • a diverse workforce in which all staffs contributions are valued is linked to good patient care. |
<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building effective teams</td>
<td>Includes:</td>
</tr>
<tr>
<td></td>
<td>• ensuring the team has clear objectives and team members have helpful data on team performance</td>
</tr>
<tr>
<td></td>
<td>• co-operative working</td>
</tr>
<tr>
<td></td>
<td>• shared leadership so everyone contributes their expertise and ideas</td>
</tr>
<tr>
<td></td>
<td>• regular time for collective reviews of team functioning and performance.</td>
</tr>
<tr>
<td><strong>The evidence suggests:</strong></td>
<td>Leadership in this domain enables the team to see how their work makes a positive difference to patients and society.</td>
</tr>
<tr>
<td>Building partnerships between teams departments and organisations</td>
<td>Includes:</td>
</tr>
<tr>
<td></td>
<td>• encouraging everyone to build trust, respect and cooperation- across teams, departments and organisations</td>
</tr>
<tr>
<td></td>
<td>• describing and emphasising shared visions</td>
</tr>
<tr>
<td></td>
<td>• building long-term continuity and stability in cross-boundary relationships and ensuring frequent contact with these others</td>
</tr>
<tr>
<td></td>
<td>• surfacing and resolving cross-boundary conflicts swiftly and creatively.</td>
</tr>
<tr>
<td></td>
<td>promoting a ‘how can we help you?’ orientation of team members towards those in other teams or organisations.</td>
</tr>
<tr>
<td><strong>The evidence suggests:</strong></td>
<td>It also involves leaders prioritising care overall, not just their area of responsibility.</td>
</tr>
</tbody>
</table>
Collective leadership means the distribution and allocation of leadership power to wherever the expertise, capability and motivation sit within organisations.

This purposeful, visible distribution of leadership responsibility onto the shoulders of every person in the organisation is vital for nurturing high quality care cultures. This implies reducing reliance on traditional command and control styles of leadership which research shows are not effective in delivering high quality healthcare cultures. However, it is not only individual leaders that determine organisational performance, but the extent to which everyone acts collectively to implement the five key elements of culture within the organisation and across local communities.

The King’s Fund has identified five levels of focus for collective leadership.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Cultural Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Does every individual take responsibility whenever appropriate for …</td>
<td>Vision and values: Modelling organisational values and focusing on vision?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Goals and performance: Ensuring they have clear objectives and receive helpful performance feedback?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Learning and innovation: Continuously improving performance?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support and compassion: Modelling support and compassion to all others?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Teamwork: Leading good team and inter-team working?</td>
</tr>
<tr>
<td>Team</td>
<td>Do all team members take responsibility for ….</td>
<td>Vision and values: Ensuring the team is aligned with its vision and models values?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Goals and performance: Ensuring there are clear team objectives and frequent performance feedback?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Learning and innovation: Supporting quality improvement and innovation?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support and compassion: Working cohesively, compassionately and efficiently as a team?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Teamwork: Shared team leadership, team effectiveness and inter-team support and cooperation?</td>
</tr>
<tr>
<td>Inter-team</td>
<td>Do teams take responsibility for working collaboratively and supportively together across teams and departments by ….</td>
<td>Vision and values: Ensuring there is aligned working around shared vision and modelling values?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Goals and performance: Agreeing shared objectives for inter-team work?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Learning and innovation: Learning from each other and working together to develop and implement innovations?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support and compassion: Building inter-team relationships of support, compassion and respect?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Teamwork: Ensuring a long term focus, frequent contact, quick and fair conflict resolution, sustained mutual support?</td>
</tr>
<tr>
<td>Organisational</td>
<td>To what extent is there consistency across the organisations in ….</td>
<td>Vision and values: individual, team, inter-team, and inter organisational working in relation to vision and values</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Goals and performance: individual, team, inter-team, and inter organisational working in relation to goals and performance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Learning and innovation: individual, team, inter-team, and inter organisational working in relation to learning and innovation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support and compassion: individual, team, inter-team, and inter organisational working in relation to support and compassion</td>
</tr>
<tr>
<td>Cross Org</td>
<td>Does the organisation ensure there is collaborative, supportive and collective leadership in …</td>
<td>Vision and values: Shared vision and values across organisations?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Goals and performance: Clear shared objectives across organisations?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Learning and innovation: Working together across organisations to develop and implement system-wide innovation?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support and compassion: Support, respect and compassion in all interactions across organisations?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Teamwork: Long term focus, frequent contact, conflict resolution and mutual support across organisations?</td>
</tr>
</tbody>
</table>
Workforce capacity

Sufficient workforce capacity is essential in delivering high quality care.

As leadership is the strongest influence on culture, those in formal leadership roles will be particularly important in influencing the culture of the organisation. We therefore include resources focused on assessing and developing leadership workforce capacity in three areas as outlined below:

Wider workforce strategy and workforce development plans will address these areas for all staff. See the separate guide on strategic workforce planning and the NHS leadership academy’s talent strategy guidance for details.

Numbers

One of the fundamental issues facing NHS organisations relates to supply of leadership talent. A survey conducted within NHS and foundation trusts by NHS Improvement in January 2015 found:

113 board level vacancies were not filled substantively or were filled with an interim. At the time of the survey it was anticipated that a further 140 posts would become vacant within six months.

Key reasons given for the failure to appoint to hard-to-fill vacancies included:

- insufficient skills available in the area / nationally
- inability to offer a competitive package / attract external candidates
- insufficient talent pool internally.

Diversity and demographics

The lack of diversity in NHS leadership and the wider workforce is a major concern in developing cultures of high quality and compassionate care. For example, there is a clear relationship between black and minority ethnic (BME) staff representation and staff and patient outcomes.

You should also consider the growing evidence that the more clinicians are involved in healthcare leadership, the better patient outcomes tend to be.

Knowledge, skills and abilities

In addition to recruiting and developing leaders with the right leadership behaviours, consideration needs to be given to the technical skills that may be required. This may vary depending on the level or function of the role, the context of each organisation but could include, for example, specific clinical skills, marketing or entrepreneurial skills.
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NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

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