Evidence:

What's leadership got to do with it?

Exploring links between quality improvement and leadership in the NHS

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The Health Foundation
Inspiring Improvement

Identify Innovate Demonstrate Encourage

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Foreword

The Health Foundation is an independent charity working to continuously improve the quality of healthcare in the UK.

We want the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable.

We believe that in order to achieve this, health services need to continually improve the way they work. We are here to inspire and create the space for people to make lasting improvements to health services.

Working at every level of the system, we aim to develop the technical skills, leadership, capacity and knowledge, and build the will for change, to secure lasting improvements to healthcare.

Leading quality improvement is complex and demanding. It requires leaders to manage uncertainty, foster cultural and behavioural change, and manage implementation. We aim to develop leaders who are capable and confident of responding appropriately to the wide range of complexities and opportunities that they might face.

Over the years we have supported a range of programmes to help develop and foster leadership talent and ability in the NHS. These have been set up for people working in different roles in the NHS - clinicians, managers, research scientists. Our programmes have used a number of different approaches to test out ways of supporting leaders, support development in different contexts, and more specifically, to develop leadership for quality improvement.

After several years of running these programmes, we felt it was time to review what how well they had worked for the individuals participating and what they had learned about leadership. But we also saw an opportunity to review what participants in the different programmes had found out about leadership to help identify what key leadership behaviours and skills are specifically needed for improving the quality of healthcare.

We commissioned ORCNi Ltd to review our programmes, and bring together learning from them all to inform our thinking about the leadership behaviours that are needed to implement quality improvement at different levels of complexity. Despite the difference in programmes, there were common themes and findings. Most significantly these showed the importance of good relationships and of working well and collaboratively with individuals and groups as key strengths in leading the delivery of service improvements.

As we move forward into yet more challenging times, with fewer resources and ever higher expectations of health services, it becomes increasingly important to understand how we can invest in staff and leadership to improve services. Despite a wide range of evaluations of the impact of leadership, there has not been conclusive evidence of what difference leadership development makes, and how it can have impact on services. This research succeeds in finding some answers to these difficult questions.

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Executive summary

In December 2007, the Health Foundation commissioned ORCNi Ltd to undertake an in-depth evaluation of the Health Foundation's leadership programmes, including an exploration of the links between leadership and quality improvement (QI).

The three core enquiry questions for the study were:
1. What are the links between QI and leadership behaviour?
2. Do different types of QI require different leadership behaviours?
3. What are the lessons for leadership development generally and for the Health Foundation specifically?

In exploring these questions, the intended outcomes were identified as:
1. Developing an approach to measure and classify different types of improvement work.
2. Identifying leadership behaviours associated with QI.
3. Providing the Health Foundation with specific data about perceptions of effectiveness of their existing leadership programmes.
4. Furthering understanding about the extent that leading QI can be attributed to leadership development.
5. Distilling lessons for the design and delivery of leadership development focused on improvement.

This report

This report presents a detailed account of the two-year study and the conclusions that emerged. It contains insights into how leadership development can support QI in the NHS. In addition, our findings contribute to what is known about the links between leadership and improvement in the NHS, and provide new ways of understanding the nature of this improvement work.

The results of the study provide the Health Foundation with evidence to further develop its suite of leadership development work. The practical application of our findings lies in the future

design and development of leadership programmes, both within the Health Foundation and more broadly. The findings also provide lessons about approaches to evaluating the impact of leadership development which are of relevance to commissioners, providers and sponsoring organisations.

Key findings

At the beginning of this study, our understanding of the links between leadership and improvement in the NHS was very limited. Our starting point encompassed some of the following factors:

- Non-specific messages from the literature about the relationship between leadership and improvement, and little that could usefully be applied in the NHS.
- A lack of clarity about how to differentiate the broad concept of improvement into categories to define the type or nature of different improvement work.
- A gap in our understanding about whether different types of improvement work were associated with different types of leadership behaviours.
- An appreciation of the drawbacks of conventional methods for evaluating leadership development, but little evidence of tried and tested attempts to overcome these obstacles.
- Limited evidence of how leadership development could be designed to optimise its impact on the improvement of services.

At the conclusion of the study, the following findings were evident:

- Engagement and relationship skills are fundamentally important in leading improvement. These skills feature more prominently in reported patterns of leadership behaviour than task-related or conceptual skills.
- The study provides a small but convincing case that enabling and facilitating others to make their contribution is central to leading improvement in the NHS.
- The QI type measure developed by the study team allows different types of QI work to be identified and differentiated.
- At the outset of this study, it was unknown whether the complexity of an improvement initiative had any relevance to the type of leadership used to enact it. The results of the study indicate that complexity is indeed a relevant factor, with greater complexity reportedly leading to greater use of certain aspects of leadership.

- Whether an improvement is led at a local or strategic level does not appear to make a significant difference to the behaviours used to lead the improvement.
- As QI work becomes more complex, NHS leaders increasingly rely on their interpersonal and relational skills to bring about the changes involved. These skills characterise the leader as playing a key role in enabling others in the system to contribute their views, expertise and ideas. The effectiveness of the dialogue and the quality of relationships between people in the system become the foundation for making good ideas into tangible improvements.
- More innovative improvement work, involving more complex influencing, is associated with combining operational management with longer term relationship-building, while keeping an opportunistic eye on the possibilities for the future.
- Responsive and nimble leadership which anticipates change, is ready to adapt to altering, unpredictable circumstances, and is particularly associated with sustainable improvement and tangible impact.
- Participants found the most helpful leadership programme content to be the academic input, informal networking, action learning and coaching.
- Participants' perceptions about the personal benefits they obtained from their programme tended to be greater than those about organisational or service benefit.
- The study team's model for developing leadership for QI enables the design of bespoke leadership development interventions to enhance the effectiveness of improvement leaders.
- In evaluating the process and impact of leadership development, a reliance on retrospective, self-reported data has evident weaknesses that can be overcome with more sophisticated evaluation methods.
- Attributing improvement to leadership behaviours is fraught with difficulties, but the lessons learned about how to do this pave the way for linking leadership input with service outcome.

Implications

- Given the clear pattern emerging from the study about the importance of engagement and relationship behaviours in leading improvement, it will be important for the Health Foundation and other providers to decide how these can effectively be embedded into leadership development activities in a way that complements more technical QI skills.

- The model for developing leadership for QI can be used as an evidence-based approach to prioritising and designing leadership development interventions focused specifically on NHS improvement. Beyond this, the model has potential use for assessment and selection of leadership development participants, evaluating progress in skills development, and organisational, team-based skills development.
- The QI type measure has potential application in diagnosing and mapping improvement work being undertaken, particularly as part of leadership development activities. Used together with the model for developing leadership for QI, it could support participants in identifying the nature of their improvement work and anticipating the skills development that may be most useful to optimise impact and sustainability.
- It has become increasingly clear throughout this study that the effectiveness of leadership development activities is more validly measured in real-time, prospectively, rather than merely in retrospect. We suggest that it is both desirable and achievable to build in prospective evaluation methods into the design of leadership development from the outset.
- For the future, we propose an approach to evaluating leadership development based on a four-way partnership comprising of the:
  - commissioning organisation overseeing the aims and objectives of the programme
  - programme provider delivering the programme to specification
  - impact evaluators working alongside participants at organisational level to assess service impact and attribution.
- A number of small adjustments would make the concept of a blind counterfactual method exploring the issues of attribution between behaviours and outcome more realistic.

Introduction

In December 2007, the Health Foundation commissioned ORCNi Ltd to undertake an in-depth evaluation of its leadership programmes:

- Leaders for Change
- Leadership Fellows
- Leading Practice through Research
- Quality Improvement Fellowships
- Clinician Scientist Fellowship
- Harkness Fellowships in Health Care Policy and Practice.

The Health Foundation wanted to build on previous work undertaken, in particular, its detailed internal evaluation (completed in May 2007) of these programmes. One of the conclusions from that internal evaluation was:

> *'The programme would benefit from a clearer articulation of the relationship between leadership development and quality improvement within which to frame the growing body of evidence being generated.'*
>
> (The Health Foundation 2007a, p 8)

We worked closely with the Health Foundation to clarify how the evaluation could add to what was already known about the leadership programmes, and grow the Health Foundation's understanding of the links between leadership development and quality improvement (QI).

It was agreed that the study would include a conventional evaluation of the leadership programmes and explore the nature of leadership for QI. We would use the experience of the leadership programme participants as the basis for this investigation.

This report presents a description of the process followed and the conclusions that emerged. The results of the study provide the Health Foundation with evidence to develop its leadership development work. It contains insights into how leadership development can support QI in the NHS.

Our findings contribute to what is known about the links between leadership and improvement in the NHS, and provide new ways of understanding the nature of this improvement work.

The practicality of our findings lies in future design and development of leadership programmes. The findings can provide lessons about approaches to evaluating the impact of leadership development relevant to commissioners, providers and sponsoring organisations.

Chapter 1

Background and context

1.1 Beyond conventional evaluation

Developing leaders to improve healthcare is a key focus for the Health Foundation. Its current and past leadership programmes have been experimental in nature and have emerged over the life of the organisation. Six of the programmes are aimed at individuals but there is another set aimed at teams, known as shared leadership programmes.

The programmes supported at the beginning of this study were the:

1. Leadership Fellows
2. Leaders for Change
3. Quality Improvement Fellowships
4. Clinician Scientist Fellowship
5. Harkness Fellowships in Health Care Policy and Practice
6. Leading Practice through Research
7. Shared Leadership for Change (BME)
8. Shared Leadership for Change (diabetes).

This report is concerned with the first six programmes above. The other two programmes were subject to separate external evaluation.

The invitation to tender for the Health Foundation leadership programme evaluation had posed the following evaluation hypothesis:

> *'Investing in leadership development of mid-career health professionals with significant leadership potential leads to a sustainable impact on the quality of health care quality; the impact achieved represents a good return on the investment made.'*
>
> (The Health Foundation 2007a, p 9)

Historically, the three main challenges faced in the evaluation of leadership programmes have been:

1. Too much emphasis on the concept of self-efficacy. This means that personal benefits derived (such as, growth in confidence, influencing skills) are given more attention than any objective assessment of impact or performance. A basic assumption often made is that if you increase the confidence and skills of individuals you get better performance. However, this is not necessarily defined or measured in terms of the impact of leadership on quality, efficiency or effectiveness of the service.
2. Retrospective sense-making of the value of leadership development. This typically involves those involved in programmes finding ways of justifying the investment of time and resources, often without having considered these issues in an outcomes-focused way during the development experience itself.
3. The cause and effect between inputs (such as the development programme) and outputs (for example, service improvement). This relationship becomes more difficult to measure with the passage of time and with other intervening variables such as changes to the system and policy context.

The Health Foundation wanted to use this evaluation study as an opportunity to overcome some of these inherent difficulties. In particular, there was a desire to use the Health Foundation's experience of supporting several cohorts of leaders through leadership development programmes as a basis for deepening understanding of how development affects leadership behaviour and impacts on improving health services.

This was of particular interest, given the conclusion of the internal evaluation report (Health Foundation 2007), quoted in the invitation to tender for this study:

> *'The Leadership Programme would benefit from a clearer articulation of the relationship between leadership development and quality improvement within which to frame the growing body of evidence being generated.'*
>
> (The Health Foundation 2007a, p 8)

1.2 Pre-study phase

There was a formal inception period at the outset of the work, when we worked with Health Foundation colleagues to clearly define and refine the parameters of the study.

This involved clarifying how the evaluation could achieve the Health Foundation's three main objectives:
- avoiding the conventional limitations described in section 1.1
- providing insights into value for money of the programmes
- adding to the Health Foundation's understanding of how developing leaders can improve health services.

During the pre-study phase, we undertook a literature review, initial background reading to familiarise ourselves with the Health Foundation leadership programmes, and participated in several seminar sessions involving the Health Foundation's external experienced advisers (Professor John Øvretveit and the late Professor Bob Sang).

This initial work resulted in the shift of emphasis in the study. While the effectiveness of the leadership programmes remained a key line of enquiry, there was an agreement to address three core questions.

These broadened the study to encompass wider considerations of the links between leadership development, leadership in action and its impact on QI of health services. The three questions were:

1. What are the links between QI and leadership behaviour?
2. Do different types of QI require different leadership behaviours?
3. What are the lessons for leadership development generally and for the Health Foundation specifically?

1.3 Scope of the study

The scope of the study's enquiry questions is potentially broad, so it is important to clearly define the parameters of the study.

Study sample

In terms of the sample of leaders for the study, we initially considered all past and current participants of the following six leadership progammes:

1. Leadership Fellows
2. Leaders for Change
3. Quality Improvement Fellowships
4. Clinician Scientist Fellowship
5. Harkness Fellowships
6. Leading Practice through Research.

Patricipants of these programmes were NHS leaders. We aimed to study how, while partaking in these progammes, participants led their own improvement work. We were also interested to explore the leadership behaviours they had used to enact the improvements.

However, on learning about the development programmes, we realised that the latter three programmes (Clinician Scientist Fellowship, Harkness Fellowships, and Leading Practice through Research) lay outside the scope of our study due to their content and focus. The focus for participants of the these programmes was more on researching policy or practice (or both) rather than in leading improvement work. These three programmes did not provide the data we needed to analyse links between leadership and improvement. These progammes also had fewer participants in each cohort, and some were abroad, meaning that access to a reasonable participant sample was more difficult.

For these reasons, it was then agreed that the study would only concentrate on the Leadership Fellows, Leaders for Change and Quality Improvement Fellowships programmes.

Evaluating improvement success

The range of improvement work undertaken by participants was wide and varied. We explored in detail the nature of the improvements undertaken, together with the intended outcomes of these. We also collected qualitative data that enabled us to compare the impact of the improvement work with the intended outcomes. Together with the Health Foundation, we made a deliberate decision at the outset that we would not make judgements about which improvement work was more or less successful.

There are many factors affecting the outcome of improvement work (for example, organisational context, changes in roles and responsibilities, policy shifts). Such an attempt to rate success would be extremely complex and lengthy. Success can be measured in both objective or subjective terms, from a wide range of perspectives, and it was beyond the scope of this work to venture into defining measures of success.

Our interest was in understanding the different types of intended outcome. We aimed to understand the variety of improvement work underway and consider the leadership approaches being used to bring these about. Our study concentrated on how improvement work was led rather than on whether or not the improvement worked.

What counts as QI?

For each leadership programme, content and focus on QI varied. For example, the Quality Improvement Fellowships programme was strongly influenced by Institute for Healthcare Improvement (IHI) thinking. It emphasised improvement tools and techniques. The

Leaders for Change participants all had an identified improvement project, whereas the Leadership Fellows' improvement work tended to be part of their day-to-day work.

This broad range of interpretations illustrates that QI is a wide, non-specific term, potentially encompassing different work. For the purposes of this study, we needed to define QI. We decided to retain a broad interpretation. For this study, each participant chose an example of their improvement work at the time on the programme. And rather than be constrained by a tight definition, we defined QI as work which aimed to improve the quality of care and services.

Chapter 2

Literature review

2.1 What's already known about links between leadership and QI?

Leadership purpose, in a QI context, is the core of this study. At every stage, we have refocused from examining leadership as a generic concept to exploring it as a process specifically for bringing about QI.

At the outset of the study, there was lack of empirical and research evidence about leadership specifically for QI. As Øvretveit's recent review of the literature states:

> *'There are many publications stressing the importance of leadership, but only a few studies provide observational evidence to support this view, and no studies have rigorously tested this proposition in health care.'*
>
> (Øvretveit 2009, p 31)

The current evidence base does not provide any consistent findings to determine whether or how effective leadership with a QI purpose is different from any other kind of leadership (for example, leadership in a crisis, leadership for financial balance). Furthermore, the nature of leadership required for effective QI is unclear; the critical factors which explain how leadership for QI might be contingent on its context are ambiguous; and how leadership for effective QI might be developed is practically uncharted territory.

The indirect impact of leadership on QI

> *'It is a long causal link from a leader's actions to outcomes.'*
>
> (Øvretveit 2008, p 25)

While direct causal links between leadership and QI remain largely unsubstantiated, it is important to take into account evidence which suggests an indirect relationship. There is a growing body of such evidence, pointing towards the effect of leadership on the culture or climate of an organisation or team. This has been shown to have an important impact on outcomes, and in some cases, on quality.

In a detailed investigation into this area, Ogbonna and Harris (2000) studied organisations in the private sector. They found that leadership style was not directly associated with organisational performance, but that it did affect organisational culture, which in turn had a significant impact on organisational performance.

Several other studies indicate a link between a leader's approach and the safety of care. Firth-Cozens and Mowbray reviewed the evidence and concluded that:

> *'One important way in which leaders affect patient care and satisfaction is through their management of teams.'*
>
> (Firth-Cozens and Mowbray 2001, p ii5)

Meta-analytical studies (Hogan, Raskin and Fazzini 1990) have indicated that the prime cause of stress in the workplace is the 'boss', inferring that good leadership produces good teams with lower stress and higher quality patient care. Corrigan (2000) found that team leadership ratings independently accounted for 40% of the total variance in client satisfaction amongst mental health patients.

According to a report into public sector leadership by the government's Performance and Innovation Unit (2000), the climate within a team can account for 30% of a team's performance. The leader has a critical influence on this team climate, with up to 70% of the climate being influenced by the leadership style adopted in the team.

Leggat and Dwyer (2003) completed a review of the literature on factors associated with high performance in healthcare organisations and other industries. Unsurprisingly, leadership consistently emerged as a necessary factor for high performance. More pertinent was that the difference made by leaders was specifically in the influence they could have on setting the tone for the rest of the team or organisation:

> *'The contribution that organisational leaders make to organisational climate, culture and team working suggested that effective leadership is an important prerequisite.'*
>
> (Leggat and Dwyer 2003, p 11)

In his examination of total quality management as a potential source of competitive advantage, Powell (1995) showed the importance of leadership and culture in relation to performance outcomes. He concluded that the key to QI performance appeared to lie more with factors like leadership and organisational culture than in tools or techniques such as process improvement, quality training and benchmarking.

This reaffirms findings from research into high-performing teams (Larson and LaFasto 1989), which proposed a causal chain between improvement and leadership:

- To achieve an elevated goal or vision, change must occur.
- For change to occur, a risk must be taken.
- To encourage risk taking, a supportive climate must exist.
- A supportive climate is demonstrated by day-to-day leadership behaviour.

Firth-Cozens and Mowbray cite studies from the airline industry (Chidester et al 1991) which show a correlation between airline captain behaviour and the number of crew errors. They conclude:

> *'It therefore seems that leaders are able directly to affect the safety of their teams' actions and outcomes—an extremely important finding for patient care.'*
>
> (Firth-Cozens and Mowbray 2001, pp ii3–ii7)

Dickinson and Ham (2008) cite an established evidence base from high-reliability industries (for example: Weick 1987; Reason 2000; Ojha 2005) which point to the role that leadership plays in shaping organisational culture, and the consequences of this for safety. In a healthcare context, Edmonson's much-cited work (1996) demonstrated a correlation between nursing team leadership, the quality of teamwork and staff willingness to record errors.

In a study of community health centres, Xirasagar et al (2005) discovered a significant association between transformational leadership and success in achieving organisation-wide changes in clinician behaviour.

As these examples from the literature demonstrate, there is sufficient evidence from a range of perspectives to support the assertion that leadership and culture are both associated with effective and sustainable QI. When the literature is further scrutinised, some commonalities begin to emerge, defining and describing the type of leadership and cultures which foster enhanced quality or performance. It is worth rehearsing these here, as the evidence suggests an important relationship between the two factors and QI. In Schein's words:

> *'Leadership and culture are so central to understanding organisations and making them effective that we cannot afford to be complacent about either one.'*
>
> (Schein 1985, p 327)

Types of leadership

An investigation of leadership effectiveness necessarily veers into the often debated realm of leadership style. Much has been written about leadership style over the past several decades, since the emergence of contingency theories of leadership in the 1950s. The fundamental belief that leadership styles can all play their part under the appropriate circumstances is still prevalent within the literature. However, this does not necessarily take us much nearer to a workable model of leadership specifically for QI, as highlighted by Leggat and Dwyer (2003), commenting on high performance in healthcare organisations:

> *'There is limited agreement on the leadership style that is most effective, perhaps reinforcing a contingency viewpoint.'*
>
> (Leggat and Dwyer 2003, p 10)

Leggat and Dwyer goes on to cite several different studies (for example: Lowe et al 1996; Waldman et al 2001; Yousef 2000) in which transformational, charismatic and consultative leadership are respectively found to have positive associations with improved performance. The lack of consistency in this regard does indeed suggest that contingent leadership, involving aspects of all these styles at different times, may be a more fruitful line of enquiry. Where better consistency does emerge is in relation to transactional leadership, which fails to be associated with improvement across several studies (Lowe et al 1996; Waldman et al 2001) and in some cases, appears to be negatively correlated with enhanced performance (Ogbonna & Harris 2000).

Edmonson's (1996) study into error reporting demonstrated that in nursing teams led in a dictatorial and hierarchical manner, fewer medication errors were recorded. Her conclusion from this was that 'repressive and dictatorial regimes are almost bound to produce data which are less than accurate', because staff are less inclined to admit mistakes. In short, this kind of team leadership results in higher levels of unsafe or poor quality practice and is contrary to leadership for QI.

This is echoed by Firth Cozens and Mowbray (2001), who reviewed the evidence on importance of leadership in healthcare. They drew on Chidester et al's (1991) study, indicating that error levels among airline crew were lowest when the captains were 'warm, friendly, self-confident and able to stand up to pressure'. Higher error levels were associated with airline captains who typically behaved with 'arrogance, hostility, boastfulness or being dictatorial' (Chidster et al 1991, p ii4). This study, more than recent ones, focuses on

the importance of leader personality type and how this impacts upon culture, and therefore performance. From this perspective, leadership can become defined as a very individual and personal matter.

While a case for the importance of individual characteristics in leadership effectiveness can be made, there are considerable drawbacks to considering leadership for QI as being vested primarily in an individual. Some of these are borne out in the literature. For example, in Holmboe's (2003) taxonomy of the characteristics of the physician quality leader, he notes:

> *'One key insight was substantial heterogeneity in the roles and characteristics of physician leaders involved in quality improvement efforts.'*
>
> (Holmboe 2003, p 294)

In a similar vein, Locock (2001) concluded that previous definitions of physician leaders had been oversimplified; they tended to over-emphasise the individual characteristics of opinion leaders and overlook the importance of that leader's linkage with others within the system, especially with non-physicians. Holmboe (2003) supported this finding, asserting that a team approach was the bedrock of successful patient care, and implying that the team concept was crucial to the process of leading QI.

At the heart of this evaluation study is an investigation into the enactment of leadership by individual leadership programme participants. This remains centrally important to the research questions, in order to understand what leaders can do to optimise the improvement of quality. However, this perspective needs to be tempered with an appreciation that the leader as individual concept is likely to provide only a partial answer to the question of leadership's role in improving the quality of services. Issues relating to organisational culture and team climate will also need to be taken into account, as illustrated in the next section.

Type of culture

From Ogbonna and Harris's work (2000), innovative and competitive cultures seem to be associated with superior organisational performance. These are typically outward-looking cultures where striving for excellence is the norm, a strong focus on outcomes is the main driver, and risks in pursuit of improvement are encouraged.

Within a healthcare context, in a study of the role of leadership and culture in hospital-based QI, findings by Parker, Wubbenhorst et al suggest that:

> *'A culture emphasising innovation and teamwork provides an important foundation for implementing a QI initiative.'*
>
> (Parker, Wubbenhorst et al 1999, p 1278)

The themes of innovation and teamwork from these studies resonate with the notion of developing a culture where trying new things is the norm. Experimentation is encouraged; risk taking is viewed positively; mistakes provide learning; improvement is a core team activity; individuals are supported to excel by those around them.

Work by Choi and Behling (1997) classified the various orientations that top managers take toward QI initiatives. Defensive and tactical orientations were shown to be largely short-term orientated, lacking long-term planning and vision. With the converse approach (a developmental orientation), management used the improvement work as a vehicle to develop the organisation's culture, and to focus on current performance and to position the organisation for the future. Choi and Behling proposed that long-term success could only be realised when top managers operate from the developmental orientation.

Leggat and Dwyer's (2003) summary of her literature review sums up the array of evidence on the role of culture on performance:

> *'A non-punitive organisational climate, with a participative team-based culture, in which members have developed sufficient trust and psychological safety to constructively question behaviours and discuss mistakes openly, supported by a decentralised, participative structure is identified as an enabler of high performance.'*
>
> (Leggat and Dwyer 2003, p 15)

The evidence trail leading to this conclusion is circuitous, but the implication is clear. If these are the cultural factors which pre-dispose a system to achieve and sustain improvement, it would seem that the core role of leadership is to nurture and foster such a culture. An increasingly common term in the leadership literature is one which appears synonymous with the leadership required to create a non-punitive, participative and team-based culture. Termed engaging leadership, it is discussed briefly in the next section to highlight its potential relevance to the research questions guiding this evaluation.

Inclusivity in leadership

Although not new, there is a theme of inclusive leadership, also referred to as engaging leadership.

Bradley and Alimo-Metcalfe (2008) investigated whether and how leadership contributed to the effectiveness of 24 hour mental health crisis resolution teams. Data reported by team members showed that the only significant factor that was positively associated with improved team performance was the level of engaging leadership perceived by the team members. An output from this study was a common set of features associated with the leadership of teams achieving improvements to services (such as, providing effective alternatives to hospital admission).

At first glance, Bradley and Alimo-Metcalfe's list appears to resemble several transformational leadership frameworks. However, with deeper consideration, an important common thread distinguishes it from other such lists. All aspects emerging as key features to improving performance relate to how the leader does things rather than what the leader does. It is less about the transformational leader as individual hero or heroine and more about the degree to which their style and approach is inclusive of other stakeholders in the process of developing vision and direction, sharing problems and co-developing solutions.

For example, most lists of leadership competencies mention 'creating a vision' as a core part of the leadership role. But in this instance, the key to improved quality outcomes for the crisis resolution teams is not the creation of the vision as a task in itself (which would be considered a leadership capability in Bradley and Alimo-Metcalfe's terminology), but the fact that this vision is shaped, shared and agreed by team members, who consequently have a strong sense of ownership in it.

Similarly, in addressing organisational top-down changes, the teams showing most improvement in productivity were led in a way which developed a collective team response to these changes, and a jointly agreed way of dealing with them. Mentioned by almost all leadership frameworks, leading change is a core aspect of any leadership role. However, the emphasis on how others will play a part in shaping (not just implementing) change is distinct in the concept of inclusive leadership when compared with the spotlight more commonly being placed on what the leader will do to bring about change him or herself.

The concept of inclusiveness in leadership resonates clearly with earlier transformational models of leadership (for example: Bennis 2000; Kouzes and Posner 1998), but seems to emphasise the importance of others as at least equal to, and arguably greater than, that of the individual leader. This signifies a tacit but potentially crucial shift in where leadership for improvement is deemed to lie (that is to say, spread across a diverse range of people rather than in a few elite individuals).

The differences between leadership approaches defined in the literature can appear subtle, but could be critical in terms of improving the quality of patient services. Analysis of Bradley et al's categories suggests a move away from a leader who is clearly in charge, in control and who knows all the answers, to one who sees his or her role as facilitating others to contribute. This entails a mindset shift in the leader from 'I am centrally important to this work' to 'I have a unique part to play in this work, and so does everyone else.' The leader's role then moves from being centred on the importance of his or her own individual actions to facilitating everyone to make their personal contribution. Necessarily, this must be accompanied by a willingness to delegate and pass power, authority and autonomy to others.

As a final note on the subject of inclusivity in leadership, it is important to highlight that our evaluation study is not limiting the concept to those stakeholders within organisations. We are mindful of the currently under-published area of engagement with patients and the public, as core to the leadership of improvement, and consider this to be integral to our study. Sang highlights this in his paper:

> *'Thus, 'Engagement' and its necessary corollary 'Empowerment', can no longer remain as easily misunderstood rhetoric, or marginalised as a PPI function: it is core to leadership practice throughout health and social care.'*
>
> (Sang 2008, p 6)

Beyond leadership behaviour and skills

A more recent contribution to the literature about leadership for improvement in healthcare raises a challenge to the conventional thinking about leadership skills and behaviours:

> *'We think that we can say with growing confidence that effective improvement leadership is more about habits of mind than about qualities or competencies.'*
>
> (Lucas and Buckley 2009, p 45)

Lucas and Buckley's conclusion arises from action research undertaken at Alder Hey Hospital to identify what improvement leaders actually do to bring about QI. What is particularly interesting about their reflections on the research is their struggle with how any of the leadership frameworks available, including the NHS Leadership Quality Framework (LQF), helped in identifying the characteristics which best equipped leaders whose 'explicit passion' is improvement:

> *'No amount of qualities on their own will make an effective improvement leader. It is not enough to have certain skills.'*
>
> (Lucas and Buckley 2009, p 45)

As well as skills, they make a case for the attitudes, or the 'habits of mind', held by improvement leaders to be given more attention in developing capacity and capability in the system for sustainable improvement. These habits of mind are distilled from their observations of the how leaders think and act, into four core aspects: improvement-focused; questioning; facilitating; and empowering.

Summary

As John Øvretveit (2008) highlighted in his review of the literature, it is indeed a long journey to explore the causal links between an individual leader's actions and the eventual and ultimate impact on quality outcomes. The route through this literature initially appears to involve many dead-ends and partly-trodden paths, with no clear navigation channel connecting the roads together.

There is very limited evidence about the nature and extent of links between leadership and QI, particularly in an NHS context. Certainties in this field therefore remain a distant prospect, and perhaps an unrealistic aspiration, given the subject matter. However, there is a growing body of evidence which points in a similar general direction. It suggests that leadership for improvement is:

- Culturally sensitive. Culture plays an important role in QI, and leadership and culture are inter-dependent.
- Inclusive. It is linked less with striving to know all the answers and more with engaging others to make their personal contribution.
- Team-based. It has a direct impact on teams and their ability to improve the quality of what they do.
- Personal. The significance of personal style and preference has an undeniable impact.
- Collective. To become embedded in the culture, the focus is on groups of individuals creating collective effort.

While lessons and messages from the literature are becoming increasingly congruent, they remain non-specific and therefore difficult to usefully apply in a context such as the NHS. This study aimed to make a modest but important contribution to understanding how leadership is associated with QI to health services. In doing so, the intention was to gain insights which could be of both theoretical interest and practical use.

2.2 What's already known about different types of QI?

The literature has numerous QI case studies examples, and description and analysis of the relative merits of different improvement tools and techniques (for example, Boaden et al 2008).

However, the literature appears less fruitful in addressing the problem that QI work varies enormously: from very local and small-scale changes, to whole-system redesign, with a wide range in between. This raises a question about how pieces of improvement work are similar or different. Some improvement research uses disease groups as the primary organising principle (for example, Shojania et al 2005). Others adopt the type of intervention as the basis for differentiating improvement work. An example of this is Leatherman and Sutherland's work (2007), which develops a taxonomy of quality enhancing interventions. This typology encompasses the categories of:

- patient-focused interventions
- regulatory interventions
- incentives
- data-driven and information technology based interventions
- organisational interventions
- healthcare delivery models.

The purpose of this typology was to systematically categorise evidence about QI interventions, with a view to guiding the design and implementation of QI by policy makers and managers. When developing a typology of QI for the purposes of this study, the most pertinent recent contribution to the literature appears to be Walshe's (2007) discussion of the need for theory-driven evaluation of QI. His analysis defines the four main variables of QI as being:

- Content: the situation, setting or organisation in which the QI intervention is deployed.
- Context: the nature or characteristics of the intervention itself.
- Application: the process through which the intervention is delivered.
- Outcomes: the results of the intervention.

This analysis moves away from high-level classification categories, into the detail of the nature and context of a QI, for the purposes of evaluating it. Further development of these ideas is not currently evident in the literature.

In summary, it can be seen that few attempts have been made to develop a taxonomy of QI, and the varying purposes of those in existence means that their application is not easily transferable. The emphasis on analysing QI type in this study is to investigate the leadership process associated with its implementation. Existing taxonomies from the literature provided a starting point for this analysis, but it was clear that the development of a new typology, specifically for investigating improvement leadership, would be a necessary and intrinsic part of the study.

Chapter 3

Study design

The study had three core enquiry questions:

1. What are the links between QI and leadership behaviour?
2. Do different types of QI require different leadership behaviours?
3. What are the lessons for leadership development generally and for the Health Foundation specifically?

The conceptual framework for the study was based on these guiding questions, and is summarised in figure 1.

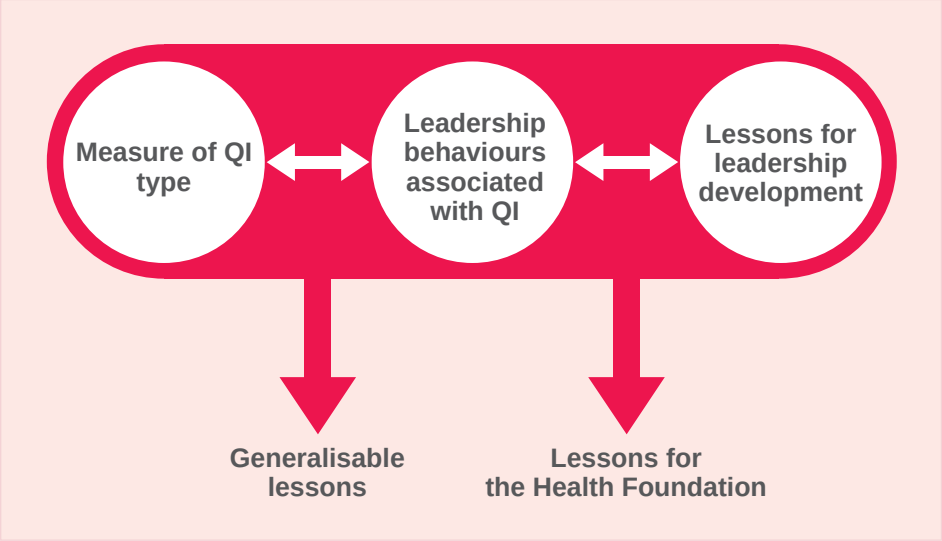


Figure 1: Conceptual framework for the study

This framework guided the study, with one circle clearly linked to each of the three enquiry questions. The enquiry question relating to lessons for leadership development however incorporated three slightly different aspects. This resulted in five identified aims that the study was designed around:

1. Developing an approach to measure and classify different types of improvement work.
2. Identifying leadership behaviours associated with QI.
3. Providing the Health Foundation with specific data about perceptions of the effectiveness of their existing leadership programme.

4. Furthering understanding about the extent to which leading QI can be attributed to leadership development.
5. Distilling lessons for the design and delivery of leadership development focused on improvement.

To identify and understand links between leadership and QI, we first needed to clarify what was included within the concept of QI. We then began developing a measure for classifying different QI work. This would allow leadership behaviours to be analysed (in the context of the specific type of improvement work undertaken) to consider to what extent different improvement work requires different leadership approaches. The development of this measure is detailed in section 5.1.

Next we needed to identify a set of leadership behaviours associated with QI work. For this purpose, the team used the Indicators of Quality Leadership© (IQL©) framework as a robust, literature-based model for categorising leadership competencies. This is described in further detail in section 5.2.

We also gathered the perceptions of leadership programme participants of the effectiveness and value for money of the programmes. This aspect of the study represented a more conventional approach to evaluating leadership development activities, and its outputs were intended to be for the Health Foundation's specific purposes. The approaches used are detailed in sections 5.2 (ii) and 5.2 (iii).

We also aimed to explore the attribution process between leadership development and improving health services. We were interested in whether improvement work was directly attributable to the participant and their development as a leader, or would have happened anyway. The approach to investigating this question is detailed in section 5.3.

And finally we aimed to reveal lessons relevant to the design and delivery of leadership development for the Health Foundation, commissioners and providers of similar programmes in the health and social care sectors.

Chapter 4

Methodology overview

A multi-method approach was used for this study. This included:
- development of the QI type measure
- semi-structured interviews (SSIs)
- paper-based survey
- Q sort methodology
- organisational based blind counterfactual interviews.

The detail of how each of these research stages was carried out, is provided in section 5. The overall methodology of the study is illustrated below in figure 2. This figure demonstrates how each research method contributed to the overall study design.

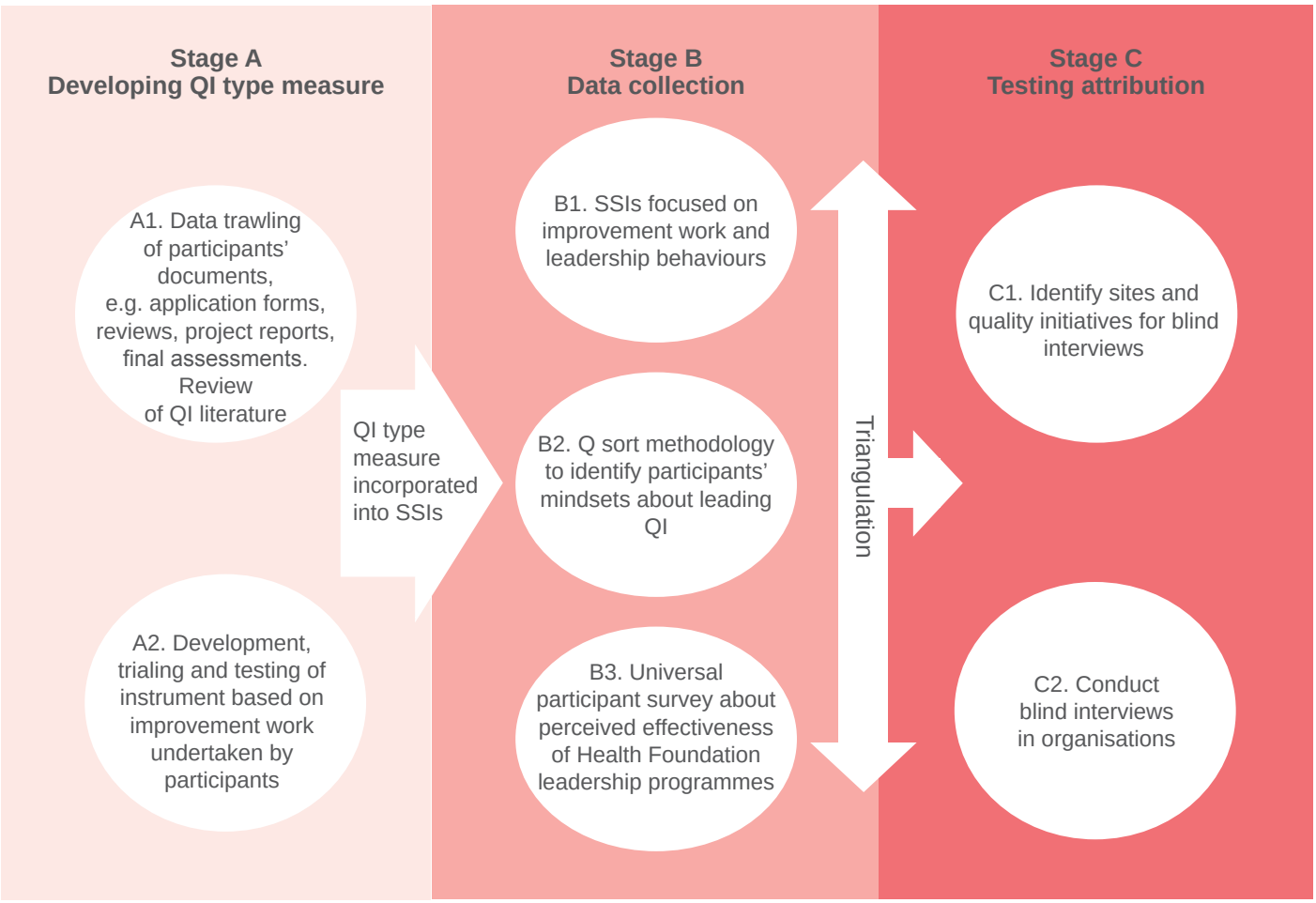


Figure 2: Overview of the study methodology

Stage A: developing the QI type measure

The focus of early work was to devise and develop a measure which could be used to classify different types of QI work. The process was literature-based and empirically-grounded. We included the documentary and anecdotal evidence of improvement work undertaken by programme participants. This stage of the study involved several iterations of trialling, re-testing and refining the measure, before using it to inform stage B.

For further detail about stage A, see section 5.1.

Stage B: data collection

There were three main methods of data collection within the study:

- **SSIs** were designed to gather data from participants about improvement work they had led, and the leadership behaviours they used.
- **The Q sort methodology** was used to gather data about participants' mindsets regarding leadership for improvement (for triangulation with behavioural data).
- **The paper-based survey** was used for conventional evaluative purposes: to gather perceptions from participants about their experience on leadership programmes.

For further information about stage B, see section 5.2.

Stage C: testing attribution

This stage involved an experimental approach. We aimed to retrospectively track whether it was possible to attribute QI work to specific leadership behaviours, and whether these leadership behaviours had been enacted by individuals who had participated in Health Foundation leadership programmes.

This approach involved members of the research team, who had no knowledge of the individual participants or the improvement work being investigated (blind), interviewing stakeholders involved in the improvements about how the improvements were led.

For further information about stage C, see section 5.3.

Chapter 5

How the research was conducted

5.1 Stage A: developing QI type measure

> *'The only generalisation which can be made about leadership actions which are, or are not, effective for improvement is that it depends on the type of improvement and situation.'*
>
> (Øvretveit 2009, p 74)

One of the enquiry questions in this study was: do different types of QI require different leadership behaviours? The participants in the study were involved with improvements spanning a wide spectrum. For example, from a departmental change in the way operating theatre lists are conducted, to setting up a pan-London service involving dozens of agencies. What were the similarities and differences in the leadership behaviours needed to enact such changes, which were so different in nature? Did different types of improvements require different behaviour sets, or were there commonalities which applied regardless of the nature of the intended change?

To explore these questions, we wanted to find a way of identifying and classifying different types of improvement work. This would allow us to investigate whether or not different types of QI were associated with different leadership. A significant part of our early work focused on developing this method, which we refer to as the QI type measure.

Developing the QI type measure involved testing out many versions and iterations, starting with an attempt to use single categories for classifying improvement work. (See appendix 1 for further detail about this process.) This proved counterproductive, as the improvement work was multi-faceted and did not lend itself to being placed in a single category.

Our work led us to the realisation that, at its most fundamental level, improvement work could be differentiated on the basis of how complex it was. Some examples of improvement work were much more complex than others for varying reasons. Consequently,

we developed a matrix approach, whereby the complexity of improvement work could be rated on four factors to categorise its type:

- **Focus**: the size of the group of people affected and the scope of their clinical needs.
- **Level**: whether the improvement is local, intra-organisational, across organisations, regional, national or international.
- **Process**: whether the improvement is adaptive or innovative; the range of stakeholders to be influenced, and the perceived difficulty of the influencing process.
- **Intended Impact**: the extent to which the improvement had the intended impact on the health, wellbeing and experience of service users, and its apparent sustainability.

The final QI type measure we developed is shown in figure 3.

Degree of compexity	**1**	**4**	**7**
Focus	The improvement is aimed at a defined group of people and is limited to a single clinical condition or one aspect of a clinical pathway.	The improvement is aimed at a wide group of people with a range of clinical needs.	The improvement covers several national and/or international agencies or organisations.
Level	The improvement is focused within a single ward, department or general practice.	The scope of the improvement covers several departments or care pathways within a single health economy.	The improvement covers several national and/or international agencies or organisations.
Process	The change involves small improvements to existing practice. It only involves influencing one or two specific, identifiable individuals, and the task involved in this is extremely easy.	Some aspects of the change involve different ways of doing or thinking about things. Influencing is both direct and indirect, involving identifiable individuals and identifiable groups of people. Some of this influencing is problematic.	The change is entirely innovative, with completely new ways of doing or thinking about things. It involves influencing a range of people so diverse that it is virtually impossible to define them all; a task as complex and difficult as it could possibly be.
Intended impact	The change does not appear to be making any direct difference to the health, wellbeing or overall experience of service users. It appears to have no sustainability beyond its initial 'input' phase	It appears that the improvement has had a direct impact on improving the health, wellbeing or overall experience of service users. Some aspects of the improvement appear sustainable beyond its initial 'input' phase.	It appears that the improvement has had a direct impact on improving the health, wellbeing or overall experience of service users, and is sustainable indefinitely.

Figure 3: QI type measure

During the SSIs with participants, we collected descriptive data about the QL work they had led. We used these descriptions to classify the improvement work according to the QI type measure. Each participant's QI work was rated with a four-integer rating (for example, F2L4P3I5, abbreviated to 2435), according to how the data matched with the four defined categories in the QI type measure.

These ratings provided a quantitative expression of the descriptive accounts of improvement work given during interviews. The QI type ratings provided us with a basis for analysing whether and how the different types of improvement work were associated with the leadership behaviours reported by participants. This helped us to understand whether different types of leadership are needed for different types of improvement work.

5.2 Stage B: data collection

SSIs

The aims of the SSIs were to:
- Identify the type of QI projects and the work undertaken to allow rating against the QI type measure.
- Gather data about reported leadership behaviours.
- Gather data about perceived benefits of the individual programmes.
- Spot potential organisations for the blind organisational based interviews.
- Inform and triangulate with subsequent data (the survey, Q sort and blind interviews).

Sampling

When the SSIs commenced in October 2008, there were just over 180 individual programme participants on the updated database.

The sampling guidelines agreed for past cohorts were:
1. Random sampling as to gender, ethnicity and profession.
2. Circa 50% of the participants on small programmes. These programmes were the Harkness Fellowships, Clinician Scientist Fellowship and Quality Improvement Fellowships.
3. Circa 25% of participants on large programmes. These programmes were Leaders for Change, Leadership Fellows, Leading Practice through Research.

The sampling guidelines agreed for current cohorts were:
1. Random sampling as to gender, ethnicity, profession.
2. Circa 20% of current participants from Leaders for Change and Leadership Fellows.

In practice, the sample of participants interviewed was largely influenced by factors outside our control, such as response rates, date availability, logistics and geography.

A total of 44 SSIs provided fully analysable data, as shown in figure 4. These were in addition to two early fact-finding interviews, seven pilot interviews and six interviews with participants who were half-way through a programme. The invalid interviews included one participant who had left the programme halfway through, and two where the transcription was not possible due to technical difficulties such as poor sound.

	No	% of sample
LeadershipFellows	14	31.8
Leaders for Change	18	40.9
Quality Improvement Fellowships	4	9.1
Harkness Fellowships	3	6.8
Leading Practice through Research	2	4.5
Invalid interviews	3	6.8
Total	**44**	**100**

Figure 4: Sample for SSIs

Questionnaire design

The SSI schedule was developed around four areas:
- biographical details including career aspirations
- type of improvement work
- leadership behaviours used to lead the improvement work
- programme-specific evaluation, including a section on value for money.

Pilot stage

The purpose of the pilot interviews was to test the interview schedule and to review the extent to which this methodology would achieve the intended aims.

The SSI schedule was piloted with seven programme participants during November and December 2008:
- three Leaders for Change
- one Leadership Fellows
- one Harkness Fellowships
- one Leading Practice through Research
- one Clinician Scientist Fellowship.

The pilot interview schedule is shown in appendix 9. Pilot interviews were undertaken by interviewers in pairs to cross-check findings and approach. Where possible, the interviews were also recorded on audio equipment for transcription and additional analysis. Interviews were carried out either at the participant's workplace or in a neutral workplace location.

Pilot findings

From the pilot interviews, the following points were noted:
- Little useful data about leadership behaviours were gathered from Harkness Fellowships, Clinician Scientist Fellowship or Leading Practice through Research programme participants. This was largely due to their emphasis on research or policy rather than on the enactment of improvement. It was therefore proposed and agreed with the Health Foundation to remove these from the substantive SSI stage, and to focus analysis on data from the Leadership Fellows, Leaders for Change and Quality Improvement Fellowships.
- The structure of the SSIs proved effective in eliciting the necessary data about improvement type and associated leadership behaviours. In practice, some of the questions could be merged. However, no significant changes to the schedule were deemed necessary.
- It was decided that an additional question asking respondents to typify the essence of their leadership approach would be added. This was so that the two or three most important aspects of leadership for QI, in their view, could be highlighted.

The SSI schedule was slightly amended in the light of the feedback from the pilot. The final schedule is shown in appendix 10.

IQL© framework

Discussion had taken place within the study team about the relative benefits of approaches to gathering data about leadership behaviours. One possible approach, implicit within the pilot SSI schedule, enabled interviewees to discuss leadership behaviours without any particular frame of reference. An alternative to this was to build into the interview schedule a preordained frame of reference. This approach would probe interviewees specifically for data relating to the aspects of the framework.

Extract from *IQL© Theoretical roots and practical rationale*, Applied Research Ltd (2008)

This framework provides a practical way in which indicators of leadership can be recognised and categorised. The competencies and behaviour indicators which have been included in the instrument have been derived from reviewing the leadership literature and integrating this with our own research into effective leadership and performance in healthcare. The resulting framework has been specifically designed to incorporate the following benefits:

1. Only includes those competencies crucial to healthcare leadership.
2. Clearly aligned to modern thinking about the process of leadership.
3. Uses simple language and is clear and easy to understand.
4. Practical, focused and relates directly to leadership roles and behaviours.

Figure 5: Description of IQL© framework

Several frameworks were considered, including the LQF, which is in widespread use across the NHS. After consideration, it was decided that an alternative framework, the IQL©, would be used as leadership the frame of reference. More detail about this framework is provided in figure 5 below. The main reason for this choice was that the IQL© contains detailed behavioural descriptors for each leadership competency, which the LQF does not. Such behavioural descriptors lend themselves readily to behavioural-based research, because they allow objective coding of behavioural data, and thus reduce the risk of researcher bias.

A full version of the IQL© framework is shown in appendix 11. The framework is structured into three competency areas, namely:

- interacts authentically
- acts effectively
- conceptualises issues.

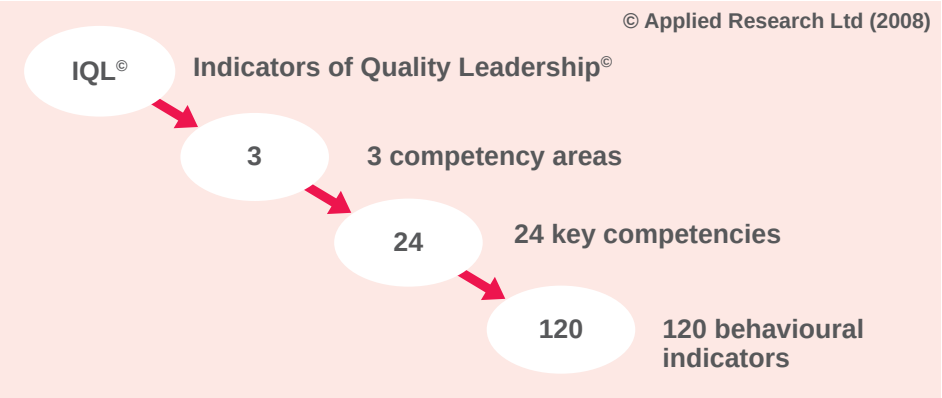


Figure 6: Structure of the IQL© **framework**

Within each of these competency areas, there are 24 key competencies, which are defined through 120 behavioural indicators. The structure of the IQL© is shown in figure 6.

It was decided that it would not be helpful to embed the IQL© dimensions into the SSI schedule. This was partly to do with the large number of dimensions in the instrument. If some were included (for exmaple, interacts authentically), then all would need to be. Instead, the research team decided to stick with the grounded approach, letting data emerge from an open-ended questioning approach. The researchers decided to hold the aspects of IQL© at the forefront of their minds when undertaking the interviews, so data on these could be probed, if relevant.

The Q methodology

Q methodology is a research method used in a number of qualitative approaches to study people's subjectivity, that is their personal viewpoint on a particular topic. It was developed by psychologist William Stephenson (1953) and is used both in clinical settings for assessing patients, as well as in research settings to examine how people think about a topic.[1]

The methodology is unusual for a qualitative research approach in that it has some inherent quantitative features. Developed to enquire into the subjectivity of the human mind (such as personal preference or experience of events), the method facilitates conversion of qualitative data into quantitative form and so straddles the interface between qualitative and quantitative research, combining the respective strengths of both (Dennis and Goldberg 1996).

[1] The name 'Q' comes from the form of factor analysis that is used to analyse the data. Normal factor analysis, called 'R method', involves finding correlations between variables (for example, height and age) across a sample of subjects. Q, on the other hand, looks for correlations between subjects across a sample of variables.

From the outset of the study, we were keen to combine the experiential aspects of qualitative methodology (the methods traditionally used in evaluations of this kind) with the rigour of a more numerate, quantitative approach. Q methodology allowed us to reduce the viewpoints on various topics of individuals within a studied group down to a few factors that represented their commonly held ways of thinking, an approach that has been used widely in healthcare in such areas as doctor-patient relationships (Morecroft et al 2006) and quality of life (Stenner et al 2003). We felt that it offered us a way of systematically eliciting the viewpoints of programme participants, making it a useful part of our approach.

The methodology works by compelling participants to prioritise a set of statements in relation to each other, so that a rank order emerges for them. The set of statements (the Q set) is drawn from a concourse; that is, the sum of what people say or think about the issue being investigated, and participants begin by reading the respective Q set statements and sorting them into three piles: 'those that least reflects my experience', 'those on which I have no strong views', and 'those that most reflect my experience'. They then proceed to a more refined sorting using a scale of –4 (least agree) to +4 (most agree).

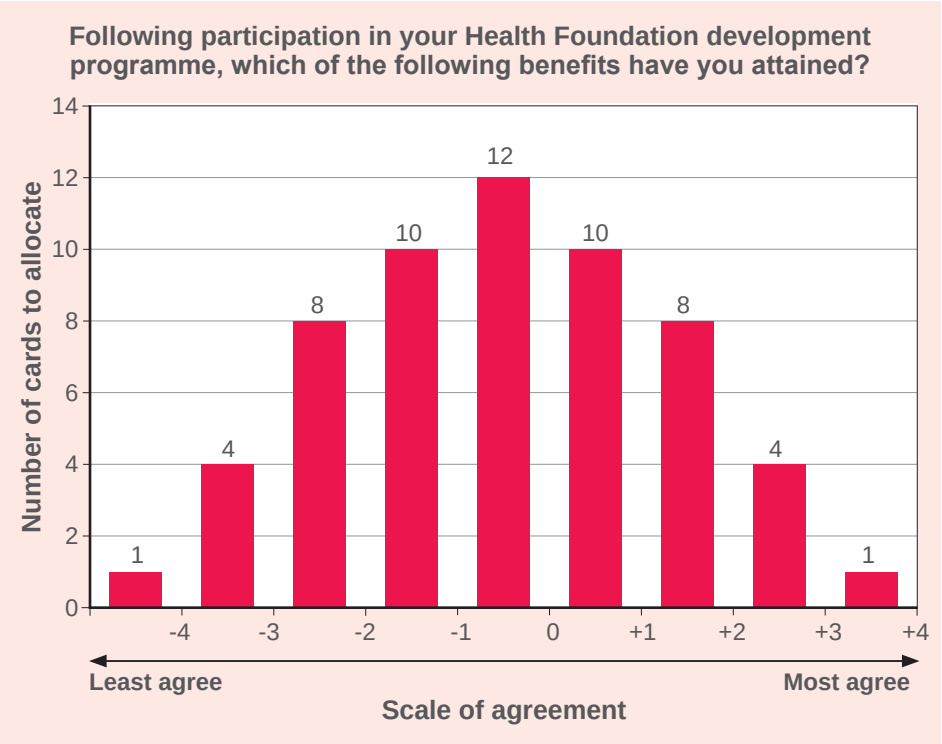


Figure 7: Q sort pre-set scale

The completed sort is then arrayed as a quasi-normal distribution: participants are asked to allocate their choices into a preset scale, with a predetermined number of items allocated to each scale point (as illustrated in figure 7). The use of ranking, rather than asking subjects to rate their agreement with statements individually, is based on the notion that people tend to think about ideas in relation to other ideas, rather than in isolation.

The process is completed by those participating then writing down their reasons for ordering their cards (but only at the extreme ends of the distribution) on the comments sheet provided.

As the study progressed, we identified two areas where Q sort seemed to offer the potential to be useful.

Q sort one: to assess the benefits of each of the pogrammes

The first Q sort was designed to determine how commonly (or differently) the benefits of each of the programmes were subjectively perceived by their participants, and whether these opinions could be grouped in any meaningful way. The Q set contained 58 statements (shown in appendix 19), that focused on the benefits that participants felt that they had acquired from attendance on their respective Health Foundation leadership programme.

The research question overarching all 58 statements was: following participation in your Health Foundation development programme, which of the following benefits have you attained that have helped you to enact your 'leadership for quality' role more effectively?

Q sort two: determining the leadership behaviours felt to be important for QI

The second Q sort was aimed at defining which leadership activities the Health Foundation programme participants deemed important in making QI happen. The Q set items were gleaned from the 120 behavioural statements in the IQL© (see appendix 20), and addressed the following overarching question: which of these leadership behaviours do you feel are most important for the enactment of QI?

Both Q sort exercises were run at a meeting for participants of the various Health Foundation leadership programmes. The meeting was held in London in the Spring of 2009 and 50 participants from a range of programmes attended. Although relatively small, the sample was still consistent with the general guideline that Q sorts require between 40 and 80 participants. However, 'this is only a rule-of-thumb…for effective Q studies can be carried out with far fewer participants' (Watts and Stenner 2005, p 79).

Participants completed the exercises in their own time, after which their papers were systematically bundled, and removed for analysis using a range of methods including factor analysis. This brings the data together into categories, grouping those participants who have responded in similar ways. The technical term for each set is a 'factor', but for the purposes of clarity, we will use the term 'grouping'. Where individuals sorted the Q sort items in similar ways, they were assigned to the same grouping. As these groupings all sorted statements in a similar way, they can be viewed as representing similar ways of thinking (or mindsets) about the issue in question.

Survey

In the original inception of the study, we wanted to explore more accurate, formative models of evaluation that could be used to link input and output in a more defined and reliable manner than usual. For this purpose, a number of new approaches were developed, some of which have previously been described.

As an additional arm to the study, it was felt important to incorporate the views of the various programmes' participants, in what we termed the traditional arm of the evaluation. The manner chosen was through the use of a paper-based universal survey that would be sent to all programme participants for whom the Health Foundation held viable contact details. Email invitations were sent to 180 programme participants, with instructions to print, complete and return (by post) the questionnaire. In the event, 82 responses were were suitable for analysis.

Our purpose in doing this was not to gain specific comments about each of the programmes (although some such comments were sought as part of the SSIs), but to gain an impression in a common currency of the perceived strengths and weaknesses of the programme. Thus, the content of the survey was not framed in terms of specific inputs on each programme but on a generic set of items aimed at broad and common areas of potential interest. These items were derived from a combination of outputs: the SSIs and the Q sort process presented a number of possible questions, and the evaluators' extensive prior experience of a range of different leadership development programmes also had an influence. A total of 26 items made up section A of the survey and these were sub-divided into four key themes:

1. leadership
2. personal growth
3. teamwork
4. service improvement.

Each item was rated on a visual analogue scale rated from 1 (strongly disagree) to 10 (strongly agree) on which respondents were asked to place a mark that best represented their own position. The line was then calibrated and a score allocated.

In addition, the survey contained two further sections that contained more qualitative, less easily categorised data. Section B asked respondents to identify up to three components of their particular programme that had had a positive impact on them, and up to three aspects that could have been improved. Section C contained four individual items relating to career impact, recommendation of programme to others, value for money and the relationship between leadership and the undertaking of QI work. A copy of the survey is shown in appendix 12.

5.3 Stage C: testing attribution

Traditionally, evaluations of leadership and similar development programmes have depended largely on the impressions formed by participants, often after the event. Such an approach makes it difficult to form an accurate impression of the impact that a programme may have had on its participants, their behaviours, and their work. This is partly because of the retrospective nature of such evaluation, and also partly due to the inevitable glow that surrounds the recollection of events at which participants have been fêted, and had their leadership prowess emphasised and enhanced.

From the outset of this study, it was decided that our methodology would include an attempt to examine the effectiveness of leadership and its development in a more objective way than is normal practice. In this section we describe the methodology developed to investigate the links between QI, leadership behaviours, and the impact of leadership development.

Why a new approach was needed

In the formal medical research community, research is traditionally carried out in a prospective, randomised manner; the apogee of this approach is the randomised controlled trial, in which the experimental intervention is matched by a recognised control. Such controls may either comprise doing nothing, or intervening with an agent whose effects are known and ideally are carried out in a blind manner.

The blind approach means that the choice of intervention is not known to the subject of the experiment, nor (in the ideal

experiment) to the investigator (the double blind trial), therefore there is no risk of knowledge of the intervention (by either the subject or the investigator) influencing the outcome of the experiment.

However, it is one thing to carry out a simple intervention with only one element (for example, the use of a new drug) in a relatively linear way, but a completely different matter to measure the impact of a complex, multi-factorial, qualitative intervention such as leadership development. In fact, leadership development may be taken as an excellent example of the opposite extreme of interventions when it comes to their measurement and evaluation; not only can the intervention not be blind to either the subject or the facilitator, but it is so nebulous and complex that the isolation of any one particular aspect to allow the attribution of cause and effect is by definition almost impossible. At the specific level, there may be a wide variety of didactic presentations, networking opportunities, action learning sets, site visits, and a legion of other activities, all of which may well take place in unusual and often luxurious locations far removed from the normal work environment.

More generally, and even more difficult to measure, are the expectations and attitudes of the participants on a programme. In many cases, the participants will have gone through a competitive process to obtain a place on the programme. This in itself is likely to colour their attitude in a highly positive way: they will have received the affirmation of being a high-flyer working in a rarefied atmosphere among other high-flyers; and the nature of both the environment and the interventions will all do their part to influence their perception of the programme, and its impact on all aspects of their lives.

It is this complexity that has led to the objective evaluation of leadership programmes being so difficult. In attempts to demonstrate a casual link between leadership development and changes in perceived behaviour, some programmes ask for participant feedback throughout the course or at its completion; other progammes attempt to map participants' career progression once the programme has been completed. Alternatively, the use of progress markers, perhaps on a repeated basis, may be applied as the programme progresses (such as the 360° assessment). In all cases, those taking part in the evaluation process are aware both of the inputs that have taken place and of the fact that some sort of special treatment has been applied. Thus, a truly objective and disinterested assessment of the impact of a leadership programme can by definition never be carried out in this way.

In theoretical terms, the only way in which such an evaluation could be attempted is by taking a counterfactual approach, examining the changes to the status quo had the intervention under examination not taken place; or the obverse, linking defined and acknowledged change to specified interventions.

Developing a new evaluation methodology

Our original approach proposed a counterfactual analysis, and as the study progressed, this was embodied in the blind study in an attempt to carry out counterfactual analysis in an experimental way. The basic concept was that researchers who were not aware of other parts of the study would be used to investigate certain chosen organisations in a carefully choreographed blind way to ascertain:

1. Whether and what kind of QIs had taken place.
2. Whether and what kind of leadership behaviours had been exhibited in delivering these.
3. Whether these leadership behaviours could be linked to specific developmental inputs (individual or group).

For full impact, the study was intended to be carried out in a double blind way so that neither the researchers carrying out the work nor those working in the visited sites were aware (initially at least) of the specific nature of the improvement work being investigated.

The experimental nature of this work was always emphasised, and the methodology and results described below are intended to offer some constructive lessons for any future work in this area.

The experimental sites for the blind study were identified by the core study team, who examined the transcripts of the SSIs and selected a number of the QIs cited by interviewees for further examination. The criteria used for selection were informal, but included factors such as the specificity of the work (for example, how well-defined it was), how tangible its objectives were, and the potential ease or difficulty of linking the studied improvement to a particular person's input. Given that the purpose of the study was to examine the linkage between leadership behaviour and QI, it was not intended to make value judgements as to the perceived behaviours of any identified individuals.

Initially, it was hoped that up to 10 sites would be identified. However, it transpired duing the event that only eight sites met the criteria established by the study team.

Two pilot blind studies were conducted, following which a report on the pilot was prepared by the blind study team (appendix 24). This included several recommendations for amendments to the

methodology. The process described below is the one that was applied following the pilot phase, on which any further work in this area would need to be based.

Participant consent

Extensive discussion took place between the study team and the Health Foundation to ensure that the blind study was ethical in terms of issues of consent. Programme participants had all given their consent to the Health Foundation to take part in evaluations of the leadership programmes, and to be directly involved in these as necessary.

At the beginning of this study, a written briefing outlining the evaluation was emailed by the Health Foundation to all programme participants. In addition, members of the study team and Health Foundation staff briefed many participants in person when they were attending Health Foundation events. However, this was not systematic enough to ensure that all participants had been informed specifically about the counterfactual study. In the specific sites where the counterfactual study was carried out, full awareness by the participant of their site being selected would have jeopardised the blind nature of the study

The role of the case controller and the access person

For each of the studied projects, the appropriate interviewer for the SSI was identified as the case controller, whose role it was to liaise between the blind study team and the study site. The blind study team comprised a number of experienced consultants used to working with members of the ORCNi team, who had a knowledge of the areas of leadership and QI, and with the interpersonal skills to be able to cold call individuals within the studied organisations. The controller was responsible for identifying and contacting an access person in each of the sites. This person was a senior staff member within the organisation, who would be able suggest further members of staff appropriate for interview, give permission for them to be contacted, and provide access.

The role of the controller was to carry out the following:

- summarising the QI work in a way that identified the area of exploration without being too specific about either the improvement itself, or the individuals involved (to ensure that the study remained double blind)

- identifying (from the SSI transcript and from conversations with the access person) appropriate participants for interview; as well as identifying contacting the access person and providing them with sufficient information (within the constraints of the blind study) to gain both their permission and cooperation to carry out the study
- providing the blind study team with the outline of the area of QI being studied, the organisation involved and the appropriate contact details for potential interviewees once they had been received from the access person.

Overall blind approach

To aid understanding of the blind approach and its purpose, the overall sequence of the blind study is outlined in figure 8 below.

Figure 8: Counterfactual enquiry process

The initial blind screening interviews

Using the organisational and contact details supplied by the case controller, the blind research team next made contact with potential interviewees and set up a series of short screening interviews. Where possible, these were conducted on a face-to-face basis; where this was impractical, the interviews were carried out on the telephone.

The purpose of these screening interviews was for the researchers to identify any QI work that had been, or was being, undertaken, and where possible, to begin to gain an overall sense of its type (as measured by the QI type measure).

Only enough information to enable identification of the potential QI work was sought. Sufficient emphasis had to be put on the notion of QI to ensure that that other managerial, clinical or operational processes were not included. As the screening interviews progressed, the blind researchers intended to gain a sense of the QI projects and to identify the specific project under study.

After these early interviews, the researchers contacted the case controller to check whether or not they had identified the piece of improvement work under study. The controller would either confirm the project being studied, or (if there was no obvious single choice), list the possible contenders that interviewees had mentioned.

In so doing, they should have carried out the first piece of counterfactual analysis: the clear identification of a project by the blind researchers would suggest that a well-defined piece of work had taken place, whereas the lack of clear identification would suggest a weakness in the counterfactual argument.

At this stage, the blindness of the study would be partially lifted, and the research team would be told the overall nature of the studied improvement project. A definite identification at this stage was required to allow the interview team to conduct a number of follow-up interviews with their contacts to explore the nature of the improvement work further, and understand what leadership behaviours (if any) could be identified within its enactment.

The follow-up interviews

In the third phase, the blind research team arranged a series of follow-up interviews with their earlier contacts. These interviews sought to ascertain details about the specified improvement work (the typology of the QI project), and the perceptions of each interviewee of the various behaviours demonstrated in carrying out the initiative.

The particular areas to be explored could be summarised by the following list of prompts:

- What happened? (Details of the specified improvement, how it fits into the QI type measure.)
- How did it happen? (The origins and story of the improvement.)
- Who was involved? (Both the kinds of staff, and, where possible, the individuals.)
- What behaviours were exhibited? (These were linked to the IQL© leadership tool.)
- Observations about these. (The softer comments about style and leadership behaviours.)
- What changes were achieved? (Any difference made by the project.)
- Are these sustainable, and if so, what makes them sustainable?

In essence, as with the first screening interviews, the researchers would be asking for information from people whom they didn't know, to talk about projects they may not have been able to identify, and that had no demonstrable impact at all on their own work.

From this second tranche of discussions with the study sites, the blind research team then produced a report that summarised findings for each study site.

Chapter 6

Data analysis

6.1 Data about types of improvement

Each piece of improvement work was described by participants during the SSIs, which provided detailed qualitative data. For each participant, these data were then used to assign a quantitative rating to the improvement work, against the QI type measure (for example, 1,111 to 7,777). The higher the rating, the more complex its nature, based on the dimensions of focus, level, process and intended impact. We treated this rating as an index of complexity for the improvement work undertaken.

A worked example of how ratings were assigned to improvement work is shown in appendix 13.

Data range

The range of improvement work reported by the participants was from 1,121 – 5,366/5,554. At the low end of this range, the improvement might, for instance, involve attempts to reduce mortality rates for elderly people undergoing a specific major surgical procedure in one department of a hospital. At the high end of this range, improvement work might, for example, involve: setting up from scratch a city-wide, community-based multi-agency service for previously unidentified patients; systematically improving nutrition to all patients across several trusts in a health community; or integrating children's services across all related agencies within a health community.

The full data range of QI types identified during the evaluation are shown in appendix 14. It is clear that the QI work undertaken by the sample of programme participants studied did not encompass the whole spectrum covered by the QI type measure (which extends up to rating seven on each dimension).

On the **level** dimension, the sample covers the range from one to five. This illustrates that improvement work done by programme participants tends to take place within a single organisation, a single

health economy, or across a region, but does not tend to stretch to a national level or beyond. In this respect, the early decision taken to remove the Harkness Fellowships programmne from the sample may be pertinent, as participants of this programme are involved with improvements which are often wider than regional in their level.

In relation to the **focus** dimension, the QI work analysed ranged from one to six. Just one example of the ratings one and six were obtained, with the majority of the sample falling in the range two and five. This is to be expected, as the focus of the improvement work would correspond in broad terms to the level at which the improvement was taking place. Hence, as the level of improvements was limited to rating five, it is unlikely that the focus of the changes would fall into the realms of unlimited numbers of people. Such indefinable numbers, with focus ratings of six or seven, would relate more obviously to national and international levels of work, which are not represented within our sample.

The highest focus rating of six related to a project to develop a self management strategy for all people with long term conditions across a whole London borough, where the numbers of people involved and the range of conditions involved are inordinate but not unlimited. The lowest focus rating of one related to a project to reduce the mortality rates of elderly patients admitted for emergency laparectomy. In this case, the focus is clearly on a very specific condition, for a very specific, defined group of people.

When considering the **process** dimension, the range covered by the sample is two and six. The extremes at each end of the spectrum are not relevant to the programme participants studied; no participants were involved with improvement work affecting only one or two people, nor was any participant involved with changes which were inordinately complex with indefinable numbers of people to influence. Fo process, only six pieces of improvement work were rated two, and only six were rated six, with the rest falling in the narrower range of three to five. An example of a two rating for process would be a project which aimed to reduce post-operative deep vein thrombosis (DVT), in which a small number of individuals were the main people to be influenced in changing their practice, to model the change to others. A six rating for process was attributed to a project where stakeholders from a very wide range of agencies were being engaged in establishing a completely innovative mobile service for detecting and treating tuberculosis among the homeless and prison populations across London.

In relation to the **intended impact** dimension, the range of ratings for the sample of Health Foundation programme participants was between one and six. There were no examples of improvement work where the impact appeared to be sustainable indefinitely. This was partly due to the lack of time passing since the improvement work was completed, meaning that this kind of assessment was not yet appropriate.

However, in those improvement projects with a six rating for intended impact, there were typically changes which had become largely embedded as a new way of doing things, with direct impact on patient experience and clinical outcomes. A new way of managing the transition of teenagers with diabetes into adult services would be such an example. The lowest rating of one for intended impact tended to be associated with attempted improvements where the scope changed mid-project, meaning that the work was never completed or where the programme participant moved jobs or responsibilities changed. Follow through on the project was therefore rendered unrealistic or impossible.

6.2 Data about leadership behaviours for improvement

The 36 SSIs were transcribed from the audio recordings. Each transcription contained data relating to:

- The nature and aims of improvement work undertaken by the interviewee.
- The leadership behaviours used in effecting the improvement work.
- Qualitative experiences of being a participant on a particular programme.
- Quantitative ratings of value for money relating to the award.

Identifying patterns of leadership behaviour

As part of the SSIs, detailed descriptive accounts were obtained from all participants about the leadership behaviours they had used to lead the improvements. These accounts consisted of verbal explanations from each participant about how he or she acted and behaved to lead the work. These data were then coded and analysed to identify the leadership behaviours identified, and the frequency with which different behaviours were mentioned. As outlined in section 5.2, the framework used for analysing reported leadership behaviours was the IQL©.

For each interviewee, the behavioural data were coded according to the 120 behavioural indicators (see appendix 15 for an example). A summary document (appendix 16) was then created for each interviewee, which brought together all the coded data relating to their reported leadership behaviours and mapped against the IQL©. From this, a record was made of the frequency each IQL© key competency was reported (figure 9). This was represented graphically to show the individual leadership profile of that interviewee (figure 10).

A summary of frequency data relating to reported leadership behaviours for all interviewees of the SSIs is shown in appendix 17. This is represented graphically in figure 11, where the pattern of reported leadership behaviours start to become apparent.

Interacts authentically										Acts effectively								Conceptualises issues					
a	b	c	d	e	f	g	h	i	j	a	b	c	d	e	f	g	h	a	b	c	d	e	f
0	0	4	2	0	2	0	1	1	1	0	0	0	0	0	0	0	1	0	1	1	0	0	0

Figure 9: Chart showing frequency of reported key competencies for one interviewee

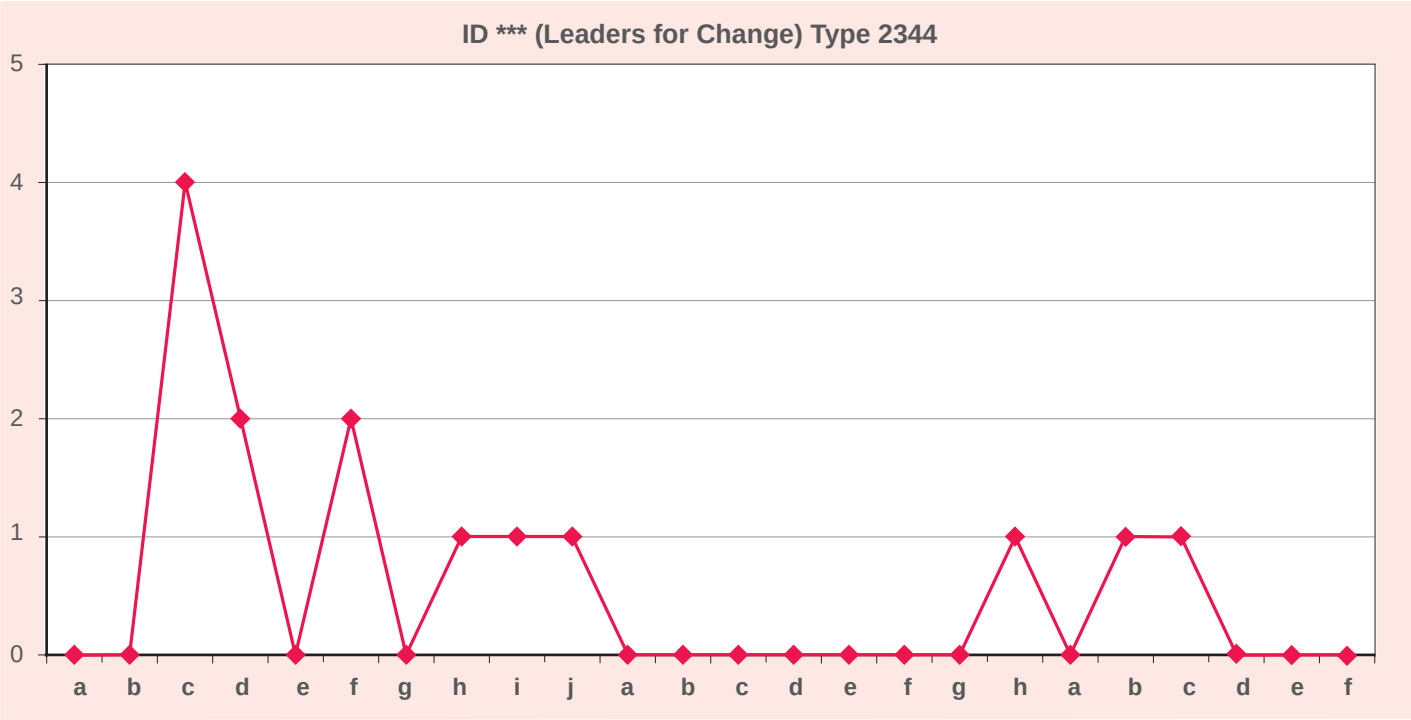


Figure 10: Graphically represented profile of IQL© reported behaviours for one interviewee

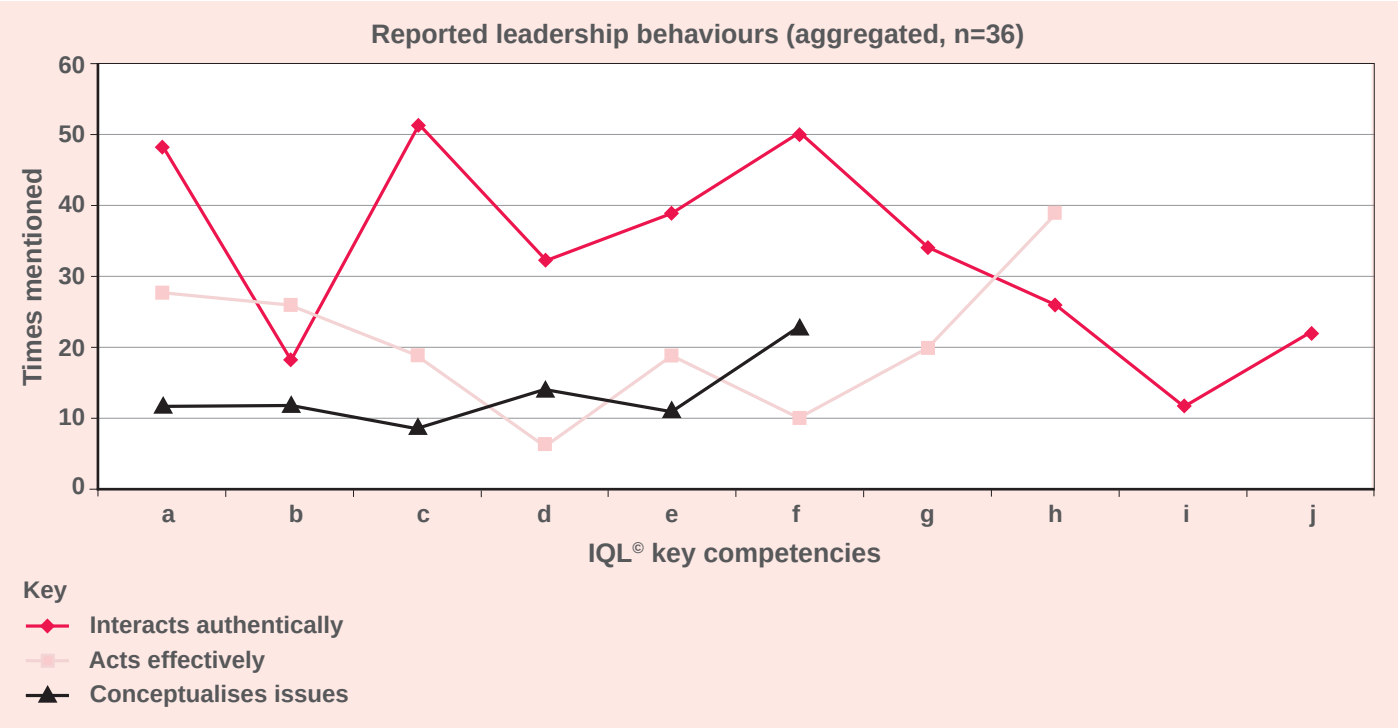


Figure 11: Self-reported leadership behaviour data from all SSIs

A correlation analysis was undertaken between two datasets. The first dataset was the frequency data from the SSIs, indicating how many times each of the IQL© key competencies had been reported by each interviewee. The second dataset was the type ratings attributed to each participant's QI work, rated against the QI type measure. The full dataset used for this correlation analysis is provided in appendix 18.

The aim of this analysis was to ascertain whether any links were evident between the complexity of the QI work undertaken (categorised against the QI type measure) and the leadership behaviours reported to effect this improvement. The IQL© leadership behaviour data used were at the key competency level (see figure 6), encompassing 24 competencies.

The QI type was analysed from two main perspectives. The first was to take the whole QI type rating (for example, 2344) and to treat it as an overall index of complexity for the improvement work. This involved addition of the four integers within the type, in this example, giving a complexity rating of 2+3+4+4 = 13. This combined complexity rating was then the basis for correlation with the leadership behaviour frequency data.

A second correlation analysis was undertaken, which separated out the four components of the QI type rating (level, focus, process

and intended impact), rather than dealing with them as an overall combined rating. Hence, correlation indices were obtained, which indicated the extent of any relationship between each of these four dimensions within the QI type measure and the associated reported leadership behaviours.

Q sort mindsets

In the Q sort exercise exploring leadership behaviours, rich data were obtained, indicating which behaviours participants believe to be important for leading improvement work. The Q sort required participants to sort 120 statements about leadership behaviours into an order which reflected their relative importance to leading improvement. The analysis of the Q sort data indicated 3 groupings (or mindsets) among participants. Of the 50 participants, 35 were significantly linked to one of the three mindsets.

The detail of how these groupings were derived is provided in appendix 21. A summary of the groupings is provided below. It should be noted that the labels given to these groupings are for differentiation purposes only, and should not be over-interpreted.

Mindset one: engagement

Participants in this grouping prioritise the 'feeling' components of one-to-one relations with staff in order to engage, encourage, communicate and motivate. Key to this grouping is a belief in the importance of explaining the need for change and inspiring commitment in the process; soliciting all points of view; using broad perspectives to build consensus; and showing trust and confidence in staff by acknowledging their efforts. Communications are integral to this grouping, and valued attributes include: listening carefully to others to gain a real insight into their issues and concerns; creating meaning for one's audience by using events and stories, anecdotes and analogies; and illustrating key points, and ideas to bring their messages to life.

Mindset two: enhanced performance

Participants in this mindset prioritise behaviours that relate to planning and performance, and are keen to nurture skills as a means of building capacity and capability.

Participants in this mindset believe important leadership behaviours are: uniting staff around an inspiring vision; aligning staff capacities with planned activities, and taking a 'helicopter view' to ensure that they consider both short and longer-term issues.

To ensure performance, people in this grouping prefer to:
- Establish structures that delineate authority with clear lines of accountability.
- Directly address issues of under-performance.
- Have clear and explicit accountability for the effective delivery of results.
- Offer constructive support and feedback.
- Focus on identifying and nurturing talent to build both capacity and capability within the organisation.

Mindset three: innovation

Participants in this group emphasise the behaviours that are conducive to creating a broad improvement and innovation culture; persuasion and networking are emphasised as key leadership behaviours.

Participants value a role model of creativity and learning, seeking out opportunities to try out new ideas and to innovate; they value flexible and creative thinking and under rapidly evolving or unexpected circumstances. They like to adopt influencing skills to involve, engage and gain others' support, constructing persuasive arguments to facilitate the acceptance and adoption of change. Key to this grouping is the identification of the appropriate decision makers for a particular topic, consulting with them, and developing and sustaining a diverse range of internal and external relationships to help promote and facilitate change.

Ranking leadership behaviours

The Q Sort data show that several progammes are associated with each of the three groupings, and no one progamme is particularly lined to any of the groupings. However, some patterns do emerge:
- Leadership Fellows (six of nine participants) appear to believe that engagement behaviours are most important.
- Harkness Fellowships (three of three participants) correlate with the enhanced performance grouping.
- Leaders for Change (six of 12 participants) also have a strong belief in the enhanced performance behaviours, with some also represented in the innovation grouping (four of 12 participants).
- Quality Improvement Fellowships and Leading Practice through Research show more spread of views, with no clear grouping preferences.

In addition to these three groupings, the Q sort data were also analysed across the programmes to provide an overall ranking of which leadership behaviours are perceived as most important to

improvement. The top 27 ranked behaviours, rated highly by all participants (taking the mean average), are shown in table 1. The explanations given by participants as to why the top 10 behaviours are most important to them are provided in appendix 25. The full ranking of all 120 statements is provided in appendix 26.

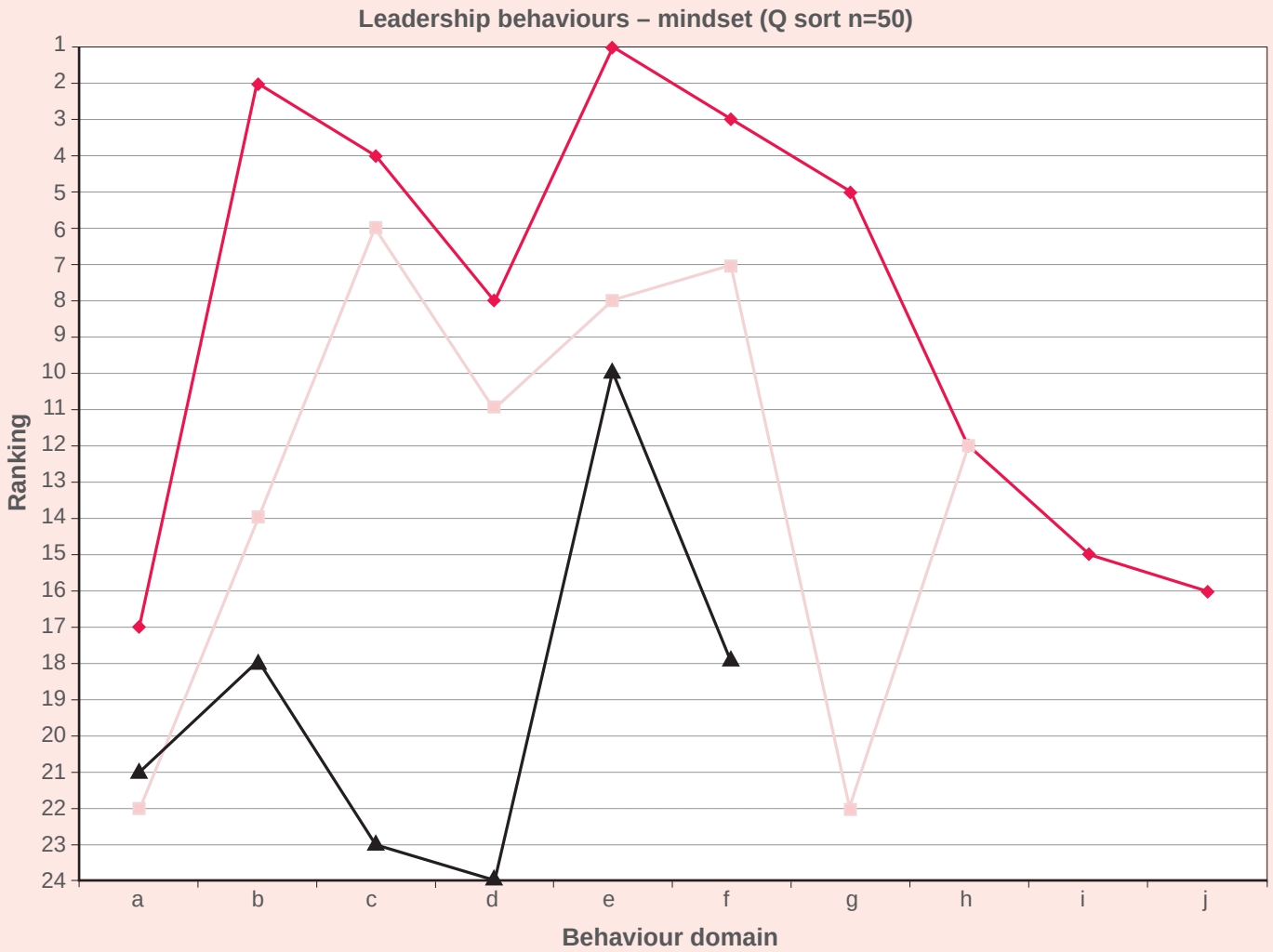
Table 1: Top 27 out of 120 ranked behavioural indicators

Statement	Rank
12. Identifies and nurtures talent to build capacity and capability	1
11. Capitalises on the range of skills and talents present in the organisation	2
34. Demonstrates honesty in interactions by matching deeds to words	3
36. Explains the need for change and inspires commitment to the process	4
38. Demonstrates commitment to innovation and to continuous improvement	5
63. Unites staff around an inspiring vision and aligns staff capacities with planned activities	6
116. Takes a 'helicopter view' of the system to oversee both short and longer-term issues	7
29. Helps others create their own solutions to facilitate ownership and commitment	8
13. Offers support, rewards achievements and celebrates success	9
14. Gives clear constructive feedback, timely praise and focused recognition	10
16. Identifies and consults with key stakeholders to obtain buy-in for ideas	11
28. Uses influence and persuasive skills to involve, engage and gain others' support	12
37. Communicates a common compelling vision for the future organisation	13
81. Encourages others to produce novel suggestions and solutions to organisational problems	14
90. Challenges accepted behaviour and pushes forward even under difficult circumstances	15
101. Thinks flexibly and creatively under rapidly evolving or unexpected circumstances	16
3. Harnesses different opinions and capitalises on the benefits of diversity	17
33. Shows trust and confidence in staff by acknowledging their effort and contribution	18
60. Holds both self and others accountable for effective delivery of results	19
76. Identifies and consults with the appropriate key decision makers on emerging issues	20
1. Solicits all points of view and uses these perspectives to build consensus	21
2. Regularly initiates discussion and facilitates open sharing of opinions	22
17. Build and enthuses a wide base of support for innovation and change	23
25. Develops cooperation and teamwork by encouraging key stakeholders to work together	24
35. Listens carefully to others to gain a real insight into their issues and concerns	25
39. Presents as a role model of creativity, innovation, and learning	26
72. Plans ahead and recognises that services can and should change for the better	27

In order to compare the patterns emerging from the Q sort data with the SSI data, it was necessary to analyse the data at the level of 24 key competencies rather than at the level of 120 behavioural indicators. The Q sort data were therefore aggregated into the 24 key competencies, and the resulting ranking is shown in table 2 and illustrated in figure 12.

Table 2: 24 key competencies in rank order

Rank	Statement
1	Values the skills and expertise of others
2	Empowers others to inspire and create commitment
3	Builds confidence and trust in other
4	Seeks, understands and values the viewpoint of others
5	Creates strategies to influence others through persuasive reasoning
6	Identifies risks and opportunities
7	Explores new suggestions and solutions
8	Tolerates ambiguity to promote creative solutions
9	Creates networks for the creation and sharing of ideas
10	Identifies links between the wider system and its components
11	Specifies roles, tasks and performance standards
12	Responsive to changing or emerging internal and external context
13	Builds structures that facilitate cooperation and collaboration
14	Aligns people, tasks and resources
15	Adapts style of communications to audience
16	Communicates in a clear and compelling way
17	Understands personal impact and influence on others
18	Manipulates complex facts and opinions
19	Articulates and formulates key issues clearly
20	Makes important decisions in a timely manner
21	Evaluates options to create powerful decisions
22	Identifies project implications
23	Creates clarity from diverse perspectives
24	Structures, analyses and integrates hard and soft data



Key

- Interacts authentically Q sort
- Acts effectively Q sort
- Conceptualises issues Q sort

Interacts authentically

a. Understands personal impact and influence on others
b. Empowers others to inspire and create commitment
c. Seeks, understands and values the viewpoint of others
d. Creates networks for the creation and sharing of ideas
e. Values the skills and expertise of others
f. Builds confidence and trust in other
g. Creates strategies to influence others through persuasive reasoning
h. Builds structures that facilitate cooperation and collaboration
i. Adapts style of communications to audience
j. Communicatess in a clear and compelling way

Acts effectively

a. Makes important decisions in a timely manner
b. Aligns people, tasks and resources
c. Identifies risks and opportunities
d. Specifies roles, tasks and performance standards
e. Tolerates ambiguity to promote creative solutions
f. Explores new suggestions and solutions
g. Identifies project implications
h. Responsive to changing or emerging internal and external context

Conceptualises issues

a. Evaluates options to create powerful decisions
b. Articulates and formulates key issues clearly
c. Creates clarity from diverse perspectives
d. Structures, analyses and integrates hard and soft data
e. Identifies links between the wider system and its components
f. Manipulates complex facts and opinions

Figure 12: 24 ranked key competencies

Is leading improvement different from generic leadership?

In the survey, one question explored a broader issue about leadership development in the domain of QI: did participants believe that leadership skills for QI are distinct from or the same as the leadership skills required in any context? The figures in table 3 cannot represent a definitive answer, as they are merely the views of participants, but the responses are interesting nevertheless.

There are some marked differences amongst the programmes. The overall majority view is that leadership is the same in any context; however, there is a group within most programmes ranging from 16% to 41% who think it is distinct.

Table 3: Leadership for improvement: same or different?

Item	Clinician Scientist Fellowship	Leaders for Change	Leadership Fellows	Leading Practice through Research	Quality Improvement Fellowships
Specific and distinct to service improvement	0%	28%	16%	23%	50%
Same as leadership in any context	83%	60%	64%	30%	17%
Not sure	16%	12%	19%	46%	33%

6.3 Data about programme benefits and content

Data about programme benefits and content were derived from multiple sources: the SSIs (n=41), the survey (n=82) and the Q sort (n=50). The breakdown of respondents by programme is given in table 4.

The survey returns could be used for programme-specific analysis, with the exception of the Harkness Fellowships, where only one form was returned. This form was therefore excluded from the analysis.

For the SSIs, data were only obtained from three of the six programmes: Leaders for Change, Leadership Fellows, and Quality Improvement Fellowships.

Table 4: Breakdown of SSI, survey and Q sort respondents

	Survey	SSIs	Q sort
Clinician Scientist Fellowship	6	0	0
Harkness Fellowships	1	0	6
Leaders for Change	25	18	14
Leadership Fellows	31	14	13
Leading Practice through Research	13	0	11
Quality Improvement Fellowships	6	4	6
Shared Leadership	0	0	2
Total	**82**	**36**	**50**

Table 5: Programme-specific ratings from survey questions

Programme	Behaviour change (1–6)		Recommend (1–6)	
Overall	Average Range	4.00 2 to 6	Average Range	5.40 3 to 6
Leadership Fellows	Average Range	4.14 2 to 5	Average Range	5.60 3 to 6
Leaders for Change	Average Range	4.08 2 to 6	Average Range	5.67 4 to 6
Quality Improvement Fellowships	Average Range	3.00 2 to 4	Average Range	5.33 4 to 6

Quantitative data were obtained in response to the following two questions:

- On a scale of one to six, to what extent would you say that your behaviour has changed as a result of the Health Foundation progamme? For example, in your approach to leadership or QI (or both.
- On a scale of one to six, how likely are you to recommend this programme to others?

The answers to these questions were collated by programme, and are shown in table 5. These results are based on five respondents from the Quality Improvement Fellowships, 13 from Leadership Fellows, and 18 from Leaders for Change.

Qualitative data were also obtained in response to a number of SSI questions:

- Which, if any, programme-related activities – at or away from work – were of particular value to you?

- What have the key factors been in helping or hindering you in transferring your learning from the programme to work?
- Was there any particular incident or situation which stands out in your mind when you look back over your time on the programme? A particularly difficult or breakthrough situation? A light-bulb moment?

Responses to these were categorised by programme and placed into themes. Themed comments are shown in figures 13 to 15.

In the survey, participants were asked to suggest three components of their programme which had had a particularly positive impact on their own development. They were also asked to suggest three aspects of the programme that could have been improved. Not all respondents replied to this question, and among those who did, not all provided three suggestions for each part.

The interventions that were deemed most important varied by programme (Harkness Fellowships interventions were excluded because of their low numbers). Table 6 shows the top eight responses by programme, accompanied by the numbers of participants who identified that component in their top three.

Across all programmes, the aspects of programme content and delivery identified as the most positive were:
- coaching
- action learning sets
- academic content
- time for reflection
- multidisciplinary approach
- strategies to influence change
- awareness of approaches to leadership
- networking
- one-to-one sessions
- opportunities to meet other colleagues, tutors and speakers.

Aspects which could be improved included the following as frequently occurring issues:
- more project support
- closer organisational involvement
- possibility of accreditation
- stronger alumni framework
- strengthen QI focus
- clearer, more practical links between leadership and implementation
- better ethnic representation
- support with work-based influence

Personal development and insight

Leadership Fellows

- Actually getting on a programme like this and giving a person confidence.
- It really has helped me to become much more rounded and confident.
- I think I'm a lot more confident; I'm much more likely to put myself 'out there'.
- An increased confidence gained from the scheme.
- I have a broader awareness of what's happening elsewhere.
- Part of it is confidence and part of it is understanding that your thoughts do have validity.
- What I got from the Leadership scheme was not lots and lots of new leadership skills, but a much better understanding of what I have got and how to use it.
- I have become a much better strategic thinker and operator.
- I think it is true that there's something about, you know, seeing the chess game as opposed to being one of the pawns.
- I have more of an awareness of my impact on other people and how to approach other people.
- It's about being creative and not expecting there to be a one dimensional solution, which I probably am better at now than I was before the programme.
- I now have a lot more of the vocabulary I suppose that I can use to talk to people about these things.

Leaders for Change

- It is just getting an opportunity to have some space to think.
- Quite a lot of us found the first module really quite difficult and emotionally quite difficult because we hadn't quite banked on it being as emotional.
- Being challenged …was brilliant.
- I'm more considered.
- I felt far more confident and less worried.
- I went expecting them … to teach you tools and leadership strategy, etc, and some management stuff. I expected all that. What I didn't expect was the impact that it has on you as an individual at a very personal level. And it rips you apart and puts you back together. And … quite a few people on the course felt the same. That's the bit that you weren't ready for, you know. It's not described in any of the literature I have a much better idea of my optimum influencing style.
- It has encouraged me to understand much more about the evidence based around improvement.
- I find myself observing other ways of doing things much more than before.
- I now view myself as somebody who is a leader and who is comfortable in that role, which is probably something that I wouldn't have said before the Leaders for Change.
- Understanding how change effects an organisation. Understanding the effects of change on individuals.
- Having that time out to actually reflect on things really helped to make me be able to see the wood for the trees.

Quality Improvement Fellowships

- The tools that I learnt were very important and, in terms of functioning, I now have a theoretical framework and practical tools.
- You asked me what people might say is different about me, a level of confidence and a directiveness.
- (I) have taken the lid off the possible and made me believe that I've got something to contribute.
- I live and breathe the dimensions of quality, and putting the patient at the centre of things.

Figure 13: Qualitative survey data: personal development and insight

One-to-one support, action learning and networking

Leadership Fellows

- Above and beyond anything, to be honest, has been the networking.
- Coaching invaluable, very useful and helpful.
- The action learning has been incredible.
- The coaching and the learning sets have been really useful as sort of labs.
- I think the coaching was good in terms of moving all sorts of things forward, but I still don't think I was fully engaged in the coaching.
- The coaching has been very helpful on particular tangible issues.
- It's been very useful for me having a coach that's not working within the NHS.
- The interaction with other professions and people working in different areas of the country.
- I quite like the collegial kind of structure to it and that's what I got probably the most out of is the learning sets with my cohort and the kind of, actually, quite professional relationships we developed.
- There's a lot of preparation and organisation that goes along with the coaching. Some of which is entirely reasonable but some of which just seems that, you know, it's almost like the evaluation of the coaching is sometimes slightly more important than the coaching itself.
- I think the action learning sets and the coaching were the most powerful.
- The Leadership programme was a place where I could take those things and figure them out in a safe environment.
- Having a number of peers across the whole health-economy has really helped me to understand.

Leaders for Change

- The biggest learning came from the conversations and the interaction more than anything.
- I gave more than I got in terms of the interactions with the peer group.
- One of the big benefits of the programme is this bringing together of people from different parts of the health service.
- My action learning sets with the course were incredibly useful.
- The learning from other people was phenomenal. They said to us at the beginning was that you will learn almost as much in the bar as you do on the course.
- I was very fortunate that we were put in an action learning set, which was a very functional set … still carries on today.
- The highlights were the networking, think tanks with the Leadership Fellows and with the other cohorts, meeting loads of people.
- One of the biggest, major advantages was the sessions that we did with other NHS colleagues and academics. It was a fantastic period to reflect, not only on the broader leadership principles but on your specific projects.
- The peer networking amongst colleagues and with academics, when we were interacting with them that was absolute key.
- It was a very safe environment, you were out of your organisational structure so you didn't have to pretend to be anything to anybody and it was just a really good learning environment and it was a really stimulating environment.

Quality Improvement Fellowships

- I'm wondering whether it's also the American attitude or whether its IHI opens so many doors, but the fact that you can ring people up and they're very willing to speak to you and open.
- Presence in a class of 30 incredibly bright, educated people having to make your point, having to discourse and argue in public and all these things are just very helpful building skills.
- One of the reasons I had that low moment was that the mentorship that has been put in place for me was not working at all.

Figure 14: Qualitative survey data: one-to-one support, action learning and networking

Most valued programme content

Leadership Fellows

- Patient and public involvement content. Now I'm a champion for patient and public involvement.
- A big realisation which came out of the programme was quality.
- The weighting that the course adds to patient experience is too high.
- I enjoyed the reading and book reviews – they have been very helpful.

Leaders for Change

- I really liked the academic framework.
- I liked the idea that it was linked to the university.
- A whole new world for me really in terms of research.
- The university was very theory based, everything was very educational based and sometimes they couldn't relate what we were doing in the health service to some of the things that they were teaching.
- Thoroughly enjoyed the Lancaster University Business School bit.
- I'm not sure that (the Lancaster bit) was value for money.
- I liked the fact that I could learn something academically about change.
- Leadership within a peer situation wasn't really covered well.
- The other thing I really, really, really found very interesting was the visits.
- The skills workshop was very interesting.
- We had some really key speakers as well coming to talk to us, and we did the cultural portraits which were fabulous.
- The module that we did on culture stands out the most for me.
- Site visit was amazing.
- The politics module particularly look, taught me to understand that it's not always personal.
- The stuff that I really liked was when we went off to do an organisational analysis ... of a different organisation. That was fantastic.
- Learning about the actor network theory was genius.

Quality Improvement Fellowships

- Everything about it was absolutely top class.
- IHI are trying to change the world.
- The exposure to experts was fantastic.

Figure 15: Most valued programme content

Table 6: Content preferences by programme (top 8)

Rank	Leaders for Change	Leadership Fellows	Quality Improvement Fellowships	Leading Practice through Research	Clinician Scientist Fellows
1	Academic leadership inputs including influencing (6); change (4), leadership (3) and power (2). (22/25)	Coaching (23/31)	Academic inputs: access to experts (IHI) (5/6)	Academic leadership inputs (8/13)	Networking and peer contact time (4/6)
2	Site visits (10/25)	Action learning sets (20/31)	Netwoking and peer contact time (4/6)	Networking and peer contact time (8/13)	Academic leadership inputs (3/6)
3	Networking and peer contact time (9/25)	Networking and peer contact time (18/31)	Practical components: placements and projects (4/6)	Time (6/13)	Feedback/360 (3/6)
4	Feedabck/360 (6/25)	Academic leadership inputs (8/13)	Team working skills (1/6)	Research money (3/13)	One-to-ones with consultants (2/6)
5	Action learning sets (5/25)	Practical components: projects (4/31)	Mentoring (1/6)	Mentoring (2/13)	Research money (2/6)
6	Coaching (4/25)	Site vists (3/31)	Flexibility of learning (1/6)	Flexibility of learning (2/13)	Practical components: research focus (2/6)
7	Venue (3/25)	Feedback/360 (3/31)	Will to improve (1/6)	Practical components research focus (1/13)	Site vists (1/6)
8	Practical components: projects (2/25)	Woking patients (2/31)	Problem solving (1/6)	Working with patients (1/13)	-

- more involvement and profile from Health Foundation staff
- clearer objectives at outset
- focus on outcomes as part of evaluation
- more academic input to seminar days.

In the survey, participants were asked to rate different aspects of their programme on a scale of one to 10 (one being the lowest and 10 the highest). The scores for all programmes are extremely positive, ranging from 6.6 to 9.7. On a 10 point scale, this is an outstanding set of scores. A full set of average scores for each programme is presented in figure 16. The four levels of shading in the table represent the degree of endorsement for each item for each programme, in the following manner:

Darker red shading	9.0 +
Lighter red shading	8.0 – 8.9
White	7.0 – 7.9
Grey shading	Below 7.0

The items in the survey were grouped into particular themes and the scores for these sub-themes for the five programmes are presented in table 7.

In the Q sort exercise exploring benefits of the Health Foundation programmes, extensive rich data were obtained about perceived programme benefits. The Q sort required participants to sort 58 statements about programme benefits into order of relevance to them. The four statements ranked as most positive by each participant were collated into a list, which contains 30 statements in total. For each of these highly ranked statements, participants were asked to explain why they rated these most highly. These rich data are shown in appendix 22.

The analysis of the Q sort data indicated five groupings, or mindsets, among participants in terms of how they perceived the benefits of their respective programmes. Of the 50 participants, 32 significantly fitted into one of the five groupings. The detail of how these groupings were derived is provided in appendix 23. A summary is provided below. It should be noted that the labels given to these groupings are for differentiation purposes only, and should not be over interpreted.

Q sort grouping one: influencers

These participants believe that their programme has increased their influencing effectiveness, making them feel more empowered and determined to lead others. These benefits typically extend beyond organisational boundaries, with participants gaining an

Survey item	Clinician Scientist Fellowship (n=6)	Harkness Fellowships (n=1)	Leaders for Change (n=25)	Leadership Fellows (n=31)	Leading Practice through Research (n=13)	Quality Improvement Fellowships (n=6)
Met my expectations in terms of delivering on the stated aims and objectives	8.6	8.9	9.2	8.2	7.8	9.2
Stimulated me to think differently about my work	8.8	9.5	9.1	8.8	8.3	9.6
Provided an opportunity for personal growth and development	9.3	9.6	9.5	9.0	9.0	9.7
Enhanced my understanding of the concept of leadership	7.7	8.4	8.2	8.3	8.3	8.2
Helped me recognise my own strengths and weaknesses	7.7	8.3	8.3	8.5	8.3	7.8
Improved my understanding of the contribution of others	7.2	8.7	7.8	8.4	7.5	7.2
Enabled me to implement concepts from the scheme into practice	8.0	7.3	8.2	7.8	7.1	8.7
Helped me to undertake real service improvement	8.2	7.2	8.3	7.8	7.5	9.0
Was a well organised, well run scheme	8.6	7.9	8.8	8.7	7.3	8.9
Enhanced my knowledge of a number of key policy issues	7.7	8.7	7.6	7.1	7.1	8.3
Allowed me to develop my leadership potential	8.5	8.6	8.8	8.7	8.0	9.2
Made me a better team worker	8.0	6.9	8.1	8.0	7.1	7.8
Felt more self-confident and assured at work	8.4	9.2	8.7	8.4	8.0	8.8
Became aware of different approaches to leadership	8.7	8.9	8.7	8.2	7.4	7.9
Felt more able to influence others	7.8	8.8	8.3	8.4	7.9	8.4
Enabled me to undertake sustainable change in my organisation	7.4	7.4	7.8	7.8	6.8	8.3
Improved my motivation and sense of "can do" attitude	7.8	8.6	8.2	8.2	8.1	8.8
More ambitious about the impact I can make to improve services	8.2	8.6	8.5	8.5	7.9	8.9
Emphasised the need for effective teamwork in achieving my goals	7.8	7.1	8.2	8.6	7.4	8.2
Made me believe I could have more influence on others	7.8	8.5	8.2	8.4	7.4	8.6
Made me feel more committed to innovation and service improvement	8.0	8.3	8.2	8.1	7.6	9.3
Felt more able to critically evaluate and challenge service standards	6.6	8.4	7.5	8.1	8.0	9.0
Gave me an understanding of the methods and approaches to quality improvement	6.9	8.4	7.5	7.2	7.4	9.7
Enabled me to feel I could unite my team around a future goal	8.4	8.1	8.3	7.8	6.8	8.1
I am better able to understand the workings of my organisation	7.6	8.8	7.8	7.5	6.6	6.9
Pulled together ideas and opinions into coherent explanations	7.4	8.4	7.8	7.6	7.2	8.1

Rating 1–10 (strongly disagree to strongly agree)

Figure 16: Summary of quantitative survey data

Table 7: Survey results on programme benefits

	Leadership	Service improvement	Teamwork	Personal growth
Clinician Scientist Fellowship	8.1	7.8	7.8	8.5
Leaders for Change	8.5	8.0	8.1	8.8
Leadership Fellows	8.8	7.9	8.2	8.5
Leading Practice through Research	7.9	7.6	7.2	8.3
Quality Improvement Fellowships	8.4	9.1	7.8	8.7
Average scores	8.2	8.0	7.8	8.7

increased awareness of the importance of partnership and inter-agency working. Participants feel that their newfound influence enables them to challenge outdated organisational norms. As part of exerting their influence they now value high quality, qualitative and quantitative data to inform their decision making process.

Grouping two: effective managers

These participants typically believe that they have obtained skills for more effective management. Time management has been a specific growth area, with participants able to prioritise their time more effectively and achieve a healthier work-life balance. Participants have realised the importance of paying attention to the emotional state of staff (for example, by showing openness, genuine sensitivity and giving due praise). As a result, they have developed a more effective multidisciplinary team working, are more able to handle difficult situations, and chair meetings more effectively.

Grouping three: change agents

This group of participants feels able to lead change through others, and better equipped to identify and overcome barriers that have historically prevented service improvement. Participants feel more able to scrutinise and redesign care pathways, using appropriate tools and techniques, combined with an enhanced knowledge of, and approach to, organisational development. They feel that these benefits have been realised by increased flexibility (allowing them to adapt their leadership approach to the tasks in hand), and the ability to both build organisational leadership capacity and better inter-team dynamics.

Grouping four: service leaders

Participants in this grouping feel more confident in their leadership capability at service level, having increased their corporate awareness and tolerance of organisational ambiguity. They feel more ambitious about the degree of impact they can make individually, and feel that they better know how to facilitate corporate decision making more effectively. They also feel that they have acquired the ability to tackle behavioural and performance dysfunctions proactively.

Grouping five: networkers

These participants feel more ambitious to progress their careers, and seek more senior roles. They feel that their colleagues are more responsive towards them since they participated in the Health Foundation programme, with increased access to, support from, and dialogue with senior staff. These participants feel that they have built stronger networks in their areas of interest and that this has enabled them be more effective.

The Q sort data show that several programmes are associated with each of the five groupings, and no one programme is particularly linked to any of the groupings. However, some patterns do emerge:

- Leadership Fellows appear to develop primarily as service leaders (six of 12 participants) with a secondary grouping around effective managers (four of 12 participants).
- Leaders for Change participants primarily develop as change agents (five of 12 participants) with a secondary grouping around effective managers (four of 12 participants).
- Harkness Fellowships are split between networkers (three of five participants) and influencers (two of five participants).
- The Leading Practice through Research participants fell into three groupings: influencers (three of nine participants), effective managers (three of nine participants) and networkers (two of nine participants).

In addition to these five groupings, the Q sort data were also analysed across the programmes to provide an overall ranking of perceived programme benefits. The top 15 ranked benefits (taking the mean average) are shown in table 8. The explanations given by participants as to why the top 10 benefits were most relevant to them are provided in appendix 27. The full ranking of all 58 statements is provided in appendix 28.

Table 8: Top 15 ranked programme benefits

Statement	Rank
12. Identifies and nurtures talent to build capacity and capability	1
2. I feel more confident in my own leadership capabilities	1
3. I gained powerful insights into my own strengths and weaknesses	2
7. I have built stronger networks in my areas of interest which have enabled me to be more effective	3
13. I feel more ambitious concerning the degree of impact I can individually make to improve services	4
24. I am better able to motivate and instil a 'can do' attitude in others	5
25. My leadership style is more collaborative, involving key stakeholders in service development activities	6
26. I feel more empowered to lead others	7
43. I feel better motivated to drive for service improvement	8
50. I have benefited from the multidisciplinary nature of the scheme	9
1. I understand more clearly my leadership role and its impact on my organisation	10
17. I am increasingly able to work outside my comfort zone, taking calculated risks	11
18. I am better at leading change through others	12
22. I feel more confident and assertive in the workplace, doing things I previously shied away from	13
31. I feel more determined to challenge outdated organisational norms	14
36. I feel more influential at a strategic level both locally and regionally	15

6.4 Data about career impact

The survey contained two questions relating to the impact of the Health Foundation programmes on participants' jobs and careers:

- Has your participation in the programme changed your personal career ambition?
- Has your participation in the programme resulted in career enhancement through career change or promotion?

Replies were expressed as 'yes' or 'no', and are summarised in table 9.

The survey also provided qualitative data about participants' views of the impact of their Health Foundation programme on their current role and career development. Comments are shown in figure 17.

Table 9: Career impact (expressed as % saying 'yes')

Programme	Increase in personal ambition?	Career enhancement?
Clinician Scientist Fellowship	66%	66%
Leaders for Change	92%	72%
Leadership Fellows	80%	77%
Leading Practice through Research	93%	61%
Quality Improvement Fellowships	83%	66%

Impact on current job and career development

Leadership Fellows

- I'm not sure I would have even got into the job that I'm doing now without it the Fellowship.
- I don't think I'd have progressed at all without it.
- I tend to chair those meetings now, whereas I never would have done before.
- I think it got me through some very, very difficult things.
- I am behaving as a leader in the field of QI and I wasn't before.
- It's been very helpful in allowing me to think about leadership in lots of different ways, but in terms of career advancement within my own organisation, I don't think it's been any help at all.
- It has made me better at doing what I do, but I'm not sure that it helps me make a next step.

Leaders for Change

- The relationships that I've created since then have been professionally more productive.
- Had I not had that grounding (from Leaders for Change) and knowing and that belief in myself, then I probably would have crumbled.
- There's no way I could pull that strategy together if I hadn't been taught how to do all the other basic stuff.
- I think the fact that I left the course on a totally different path, where I'm really nothing to do with therapies now, I think was an amazing achievement.
- The people who knew me operationally see me now working at a strategic level.
- When I went for this job, one of the essential criteria for the post was to have a degree; I didn't have a degree, but what I had was Leaders for Change.

Quality Improvement Fellowships

- The other thing that I would say about the fellowship that what it does do, without any shadow of a doubt, is opens doors.
- If I hadn't become an IHI fellow I don't think I'd have looked at the registry job. I don't think I'd ever have thought of myself as an improver.
- It's changed the way I think, and work, and work with other people.

Figure 17: Impact on current job and career development

6.5 Data about value for money

Questions about this issue were included in both the SSIs and the survey.

In the SSIs, participants were asked to rate on a scale of one to 10 to which they thought their Health Foundation programme represented good value for money in terms of several factors:

- personal development
- better clinical outcomes
- more effective leadership
- better patient experience
- organisational benefits
- overall value for money.

The results are shown in figure 18.

In the survey, questions about value for money firstly asked participants to estimate the cost of their programme based on a selection of cost ranges. Then, based on their cost estimate, they were asked whether they thought the programme offered value for money for themselves as individuals, and also to their organisations One or two individuals did not answer the question, which explains why the percentages do not add up to 100%. We were not checking the accuracy of their estimates, but rather we were recording their perceptions. As might be expected, this varied according to the particular programme. The participants' cost estimates are presented in table 10.

For two of the programmes (Clinician Scientist Fellowship and Quality Improvement Fellowships) there is a strong view that the programmes are relatively expensive: 83% of Quality Improvement Fellowships interviewees thought the programme cost more than £100,000 per person. However, there is more of a spread of perception in the other programmes, with the majority estimating the medium cost range.

In terms of value for money however, there is more agreement and at a very positive level. If the categories of outstanding value and good value are combined, then for perceptions of personal value for money the results are:

Clinician Scientist Fellowship	100%
Leaders for Change	100%
Leadership Fellows	86%
Leading Practice through Resarch	84%
Quality Improvement Fellowships	100%

Perception of value for money for the organisation shows a similar pattern:

Clinician Scientist Fellowship	99%
Leaders for Change	100%
Leadership Fellows	89%
Leading Practice through Research	92%
Quality Improvement Fellowships	83%

Although there is some uncertainty about the actual cost of each programme, virtually all participants (irrespective of programme) believe that their programme represents good value for them and their organisation.

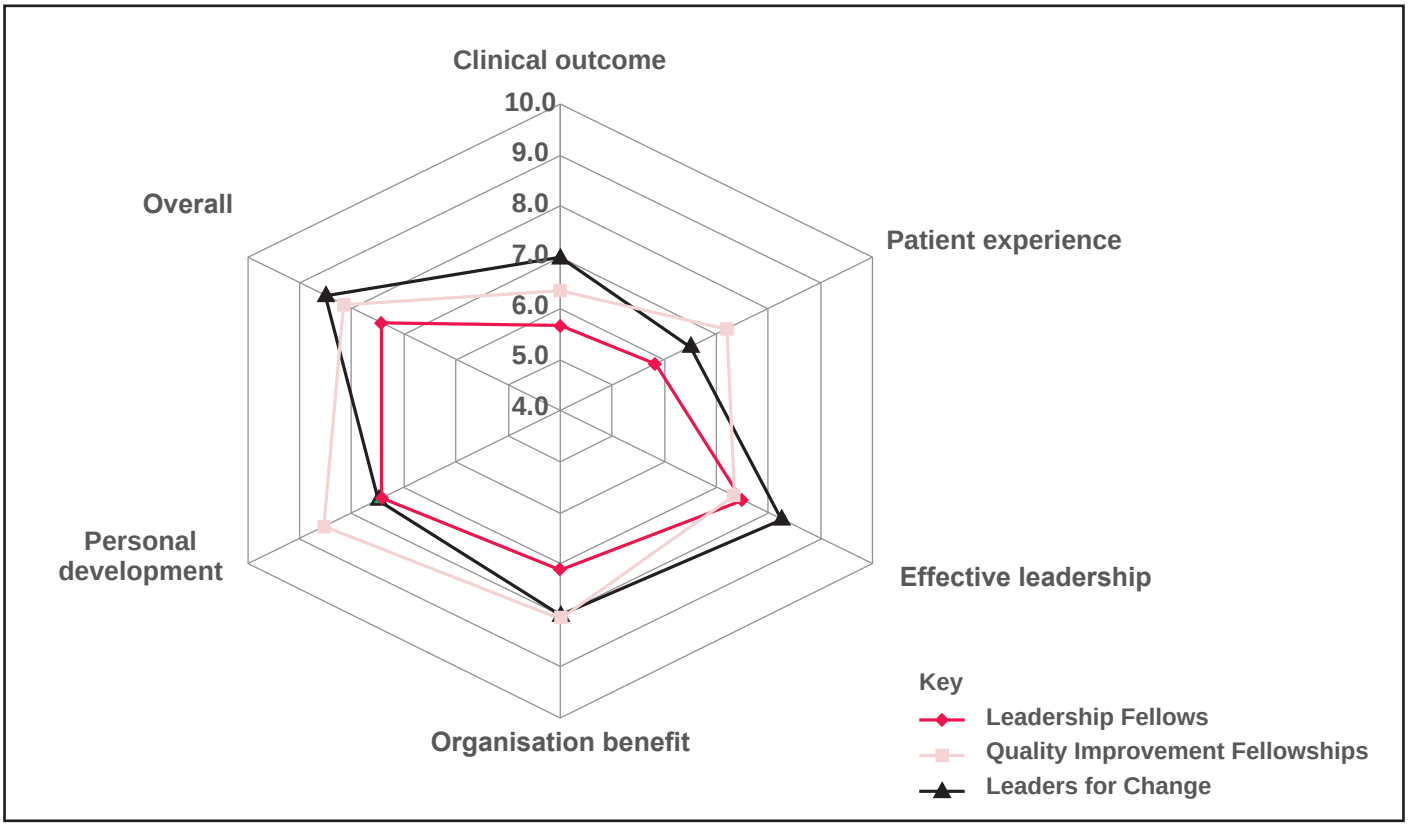


Figure 18: Participants' ratings of the value for money of their Health Foundation programme

Table 10: Cost of programmes – participants' estimates

Cost range	Clinician Scientist Fellowship	Leaders for Change	Leadership Fellows	Leading Practice through Research	Quality Improvement Fellowships
£0–10k		8%		23%	
£10–20k		32%	6.8%	7%	
£20–50k	16%	32%	54%	7%	
£50k+		20%	29%	15%	
£100k+	83%	4%	9%	46%	83%

6.6 The blind study – what we discovered

At the most basic level of identifying the chain of attribution between the Health Foundation leadership participant and improvement work, the following results emerged. In addition to this basic quantification of the results of the approach, extensive qualitative data were gathered during the course of the site interviews. A summary of the results from the blind study is available in figure 19. Each site interview was written up as a summary report, and an example of this is provided in appendix 29.

During the first phase interviews, low rates of identifying the project in question were partly due to the relative small size and specifity of the type of project we were investigating, and the open nature of the question: What improvement work has been going on in this service area? Another factor was the passage of time since some of the improvement projects had been delivered in the past and therefore faded from consciousness for some interviewees.

Once the project had been identified, the rate of second interviewees attributing particular leadership behaviours to the improvement work and then to the Health Foundation participant was higher, with two of the sites having 100% positive identification of the Health Foundation participant. In those sites where the participant was not identified, there was not a clear pattern of the reasons why this occurred .

The results show that the blind methodology adopted did not reliably or consistently establish a causal link between particular leadership behaviours and improvements made in organisations. Nevertheless, given that the approach was always acknowledged as experimental by nature, important learning was derived in terms of how such an approach could be further developed to explore this issue of attribution.

	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6
Number of first interviews	5	5	6	3	5	2
QI project positively identified	1	3	0	0	1	1
Number of second interviews	5	5	5	2	3	n/a
Progamme participant positively identified	5	5	4	0	1	n/a

Figure 19: Results from the blind study

Originally, we had hoped to identify and conduct 10 blind projects, but this aspiration was modified for two main reasons.

Firstly, it proved more difficult than originally anticipated to find improvement work which was suitable for the blind approach. The counterfactual study needed to be based on improvement work described to us in the SSIs, as it was this interview data that gave us indications as to the feasibility of a blind study in the sites. To some extent, the range of SSIs we had undertaken had been determined by those participants volunteering to be interviewed (a minority of all participants).

The possible blind sites therefore numbered 36, and within these, the majority did not lend themselves to the counterfactual study. One of the main problems was the passage of time since the participant had been on a programme, meaning that the stakeholders involved in a piece of improvement work had often moved on. Many of the participants had also moved jobs and organisations, so the organisation's link with the Health Foundation was no longer active in the way it had been when a member of their staff had been a programme participant. Several of the improvement projects for more recent programme participants had also not materialised and therefore were not suitable for a counterfactual study.

Secondly, the logistics of arranging the blind studies on site proved much more convoluted than first anticipated, with the original approaches to organisations commencing in Spring 2009 and work continuing up until Christmas 2009.

In the event, eight pieces of improvement work were selected as being suitable, and approaches were made to the access person at each of them. Six responded positively, but the remaining two had to be abandoned at this stage: one because of lack of response, and the other because the access person at the organisation concerned was not prepared to take part in a blind study of which the Health Foundation programme participant was not directly aware.

Thus, the final choice for the blind study was restricted to six pieces of improvement work.

Ethical considerations

The blind study was predicated on the fact that the leadership programme participants were aware of the ORCNi evaluation study, and that the Health Foundation had gained implicit consent from them to allow some exploration of the programmes at a site specific level. The form of consent was vague enough to cause some concerns about exploring individual actions and behaviours too deeply, even on a confidential and anonymised basis.

In the event, one of the sites approached for assistance in setting up blind studies refused to cooperate since the programme participant who had been interviewed for the SSIs process was not made explicitly aware of the blind study intended at their workplace. This was despite the reassurances that the blind study was intended to explore the links between leadership and QI initiatives generally, and the types of behaviours exhibited, with less emphasis on the role of individual programme participants (although establishing their role and identities were both part of the process).

Practical problems

One of the obstacles we discovered was in retrospectively identifying suitable stakeholders who had been involved in, and could comment on, a participant's improvement work. In some cases, names of stakeholders were offered by participants during the SSIs and it was possible to trace these for the blind interviews. However, where names of stakeholders were not given, it was not part of the SSI schedule to specifically request this information. This omission was partly because it was inherent, and partly a result of the iterative nature of the project which meant that not all the possible variables for study could be predicted at the outset. Once the question of 'Who else could we approach if we wanted to find out more about the way the project is progressing?' is raised, then the blind nature of the study risks being compromised as participants' awareness of the possibility of further exploration is raised. The practical answer to this conundrum is to build into the interview schedules some more oblique questions about others involved in the piece of improvement work, so that these people may then be contacted at a later date if necessary.

From the outset, the counterfactual aspects of the blind study were kept prominent. This meant that any form of forewarning to participants that their site might be subject to the blind study was seen as a possible contaminant. In retrospect, this may have been unduly purist, but it did mean that when the access person was approached, they would not be aware of the study and the blind study could remain intact.

Of course, the corollary was that the study controller had their work cut out to gain a figurative 'foot in the door' without giving away too much about the nature of the project, or the name of the individual involved in the Health Foundation programme. This made the logistics of the project convoluted and complex, with the possibility of study failure at every step.

The controllers were in effect cold calling the access person, which was especially difficult as the access people were busy, senior staff within the NHS. The controller needed to persuade the access person to act as an introduction agency to the potential interviewees, and write emails to these people on their behalf. The controller was also reliant on the access person's ability to identify further potential interviewees (and to provide their contact details) without knowing the details of the project being evaluated. This was quite a lot to expect from the access person, given that they were being asked to do all this for an unknown agent (the controller working for an unknown agency (ORCNi Ltd), on a vague connection to the Health Foundation in London.

Seen in the light of these substantial obstacles, the recruitment of six sites into the blind study seems more positive than it might at first appear.

Chapter 7

Findings

7.1 What are the links between leadership and improvement?

The results of the study indicate that a consistent pattern of leadership behaviour is reported by leaders in the NHS when working to improve services. This typical behaviour pattern appears to be associated with improving the quality of services in an NHS context.

Out of 24 key competencies, seven are most frequently reported for leading improvement. Listed here below and illustrated in figure 20, the first six competencies are relational and interpersonal skills and the final one is a task-related behaviour:

- seeks, understands and values the viewpoint of others
- values the skills and expertise of others
- creating networks for the creation and sharing of ideas
- builds structures that facilitate cooperation and collaboration
- creates strategies to influence others through persuasive reasoning
- builds confidence and trust in others
- tolerates ambiguity to promote creative solutions.

The reported behaviour pattern indicates that interpersonal behaviours, focusing on the quality of relationships between people in the system, are the most prominent feature in how NHS leaders bring about improvement (interacting authentically).

These are supported by underlying task-related behaviours (acts effectively), which are less frequently reported in descriptions of improving services. Leadership competencies related to thinking and making sense of events (conceptualising issues) are not insignificant in the typical reported leadership pattern, but they appear to provide a backbone underpinning the action and the interactions which bring about improvement, and are much less frequently reported as being central to leading improvement.

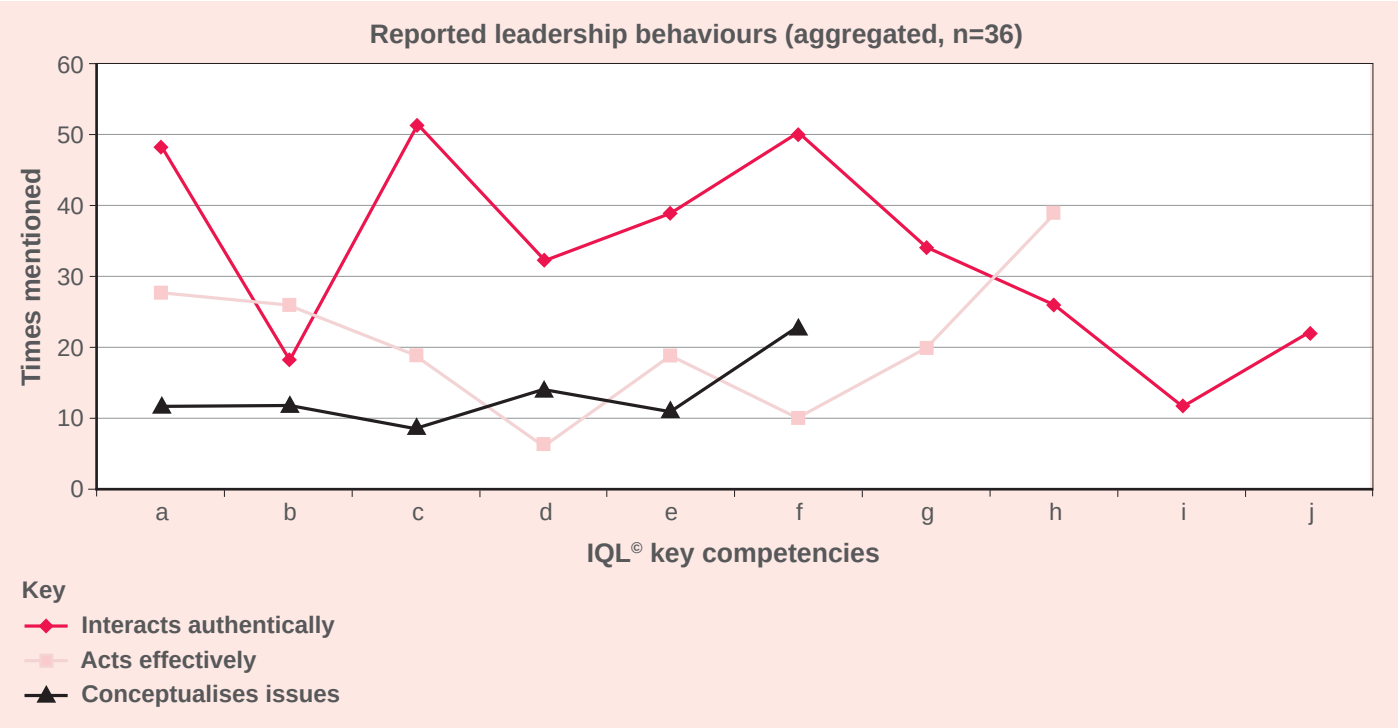


Figure 20: Self-reported leadership behaviours from all SSIs

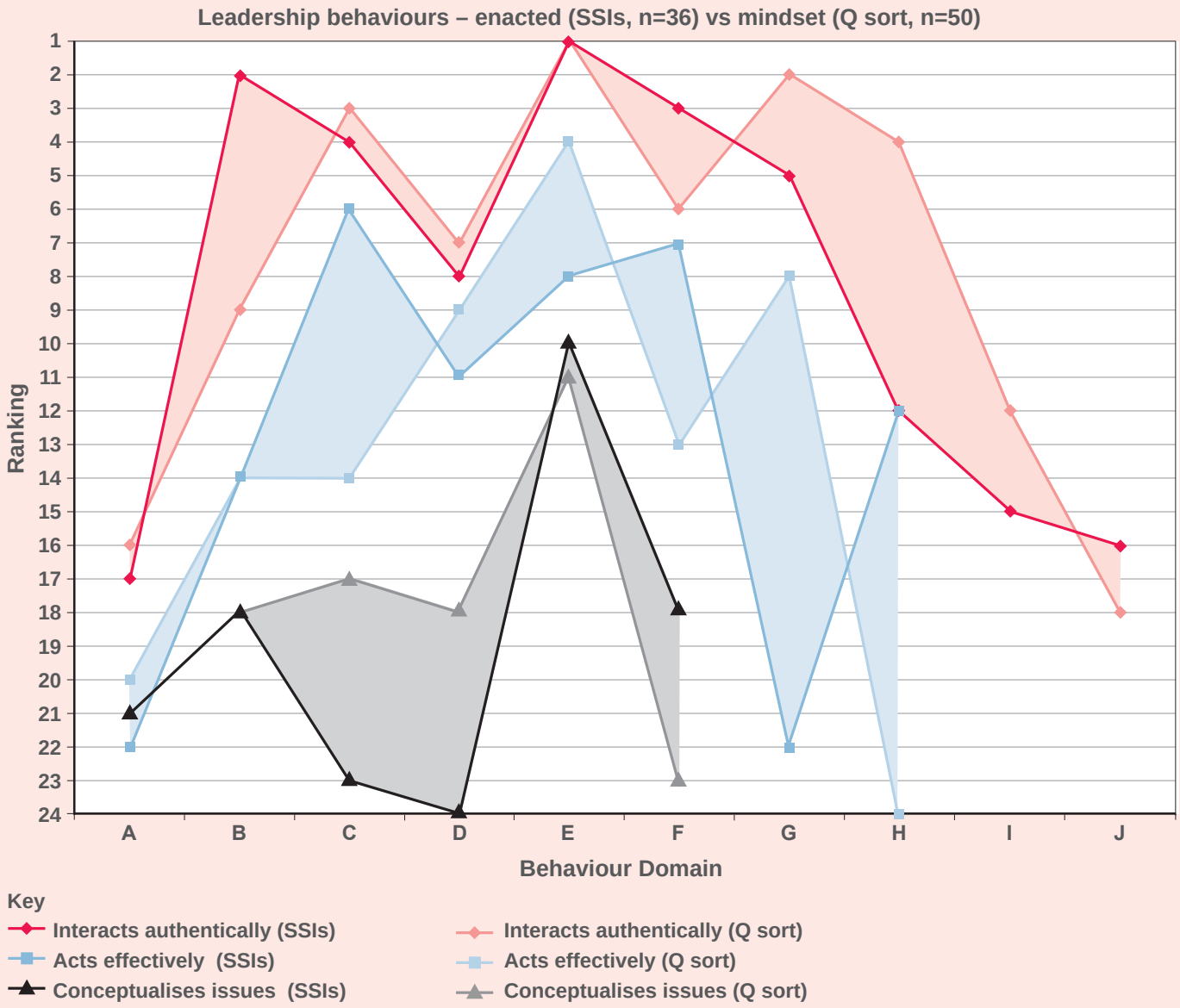
When participants were asked to prioritise the leadership behaviours they believed to be most critical to leading QI (as part of the Q sort methodology), a similar pattern emerged.

What participants think is important for leading improvement and how they report that they behave when leading improvements show a consistent pattern, emphasising the importance of the interacting authentically behaviours.

This is illustrated in figure 21, which shows the ranking of different leadership behaviours related to how participants say they enact improvement leadership and their mindset (what they think is important) in leading improvement.

Key finding

This study indicates that engagement and relationship skills are of fundamental importance in leading improvement. These skills feature more prominently in reported patterns of leadership behaviour than task-related or conceptual skills. What participants **think** is important for leading improvement and how they report that they **behave** when leading improvement shows a consistent pattern, both emphasising the importance of interacting authentically behaviours.



Interacts authentically

a. Understands personal impact and influence on others
b. Empowers others to inspire and create commitment
c. Seeks, understands and values the viewpoint of others
d. Creates networks for the creation and sharing of ideas
e. Values the skills and expertise of others
f. Builds confidence and trust in others
g. Creates strategies to influence others through persuasive reasoning
h. Builds structures that facilitate cooperation and collaboration
i. Adapts style of communications to audience
j. Communicates in a clear and compelling way

Acts effectively

a. Makes important decisions in a timely manner
b. Aligns people, tasks and resources
c. Identifies risks and opportunities
d. Specifies roles, tasks and performance standards
e. Tolerates ambiguity to promote creative solutions
f. Explores new suggestions and solutions
g. Identifies project implications
h. Responsive to changing or emerging internal and external context

Conceptualises issues

a. Evaluates options to create powerful decisions
b. Articulates and formulates key issues clearly
c. Creates clarity from diverse perspectives
d. Structures, analyses and integrates hard and soft data
e. Identifies links between the wider system and its components
f. Manipulates complex facts and opinions

Figure 21: Comparison of enacted leadership behaviours and those perceived as important to QI

The importance of interacting authentically

Certain aspects of the typical behaviour pattern are worthy of particular note. Firstly within interacting authentically, the relational skills, which appear to typify leading improvement, are:

- seeks, understands and values the viewpoint of others (1a)
- values the skills and expertise of others (1c)
- creates networks for the creation and sharing of ideas (1d)
- builds structures that facilitate cooperation and collaboration (1e)
- creates strategies to influence others through persuasive reasoning (1f)
- builds confidence and trust in others (1g).

When considered together, these skills characterise a leadership approach where the leader as an individual plays a key role in enabling others in the system to contribute their views, expertise and ideas. This is done on a one-to-one basis, and by fostering networks and processes whereby people in the system can connect freely and openly, both formally and informally, on issues relating to improvement.

The effectiveness of the dialogue and the quality of relationships between people in the system become the foundation for making good ideas into tangible improvements. The individual leader enables the energy of others to be channelled into improvement work, but is not necessarily involved directly in the work itself.

Such a characterisation resonates clearly with the trends in the literature away from 'leader as individual' towards creating a 'system of leadership for improvement' (Ovretveit 2005). This is an approach whereby 'senior leaders stimulate a variety of other leaders in an organisation' (Ovretveit 2005) to lead the type of improvement necessary for that organisation. The aim of the approach is to institutionalise improvement into the culture of the organisation so that it is not dependent on individual (often transitory) leaders.

Key finding

This study provides a small but convincing case that enabling and facilitating others to make their contribution is central to leading improvement in the NHS.

The **interacting authentically** behaviours which do not form part of the typical behaviour pattern reported in the study are:

- understands personal impact and influence on others (1b)
- empowers others to inspire and create commitment (1h)
- communicates in a clear and compelling way (1i)
- adapts style of communication to audience (1j).

Three of these (1b, 1i and 1j) are linked to the way that individual leaders communicate. It is important here to restate that the basis for this analysis were self-reported data. This means that it was not sufficient for the interviewee to directly demonstrate the clarity of their communication with the interviewer, for example, through articulate responses to the interview questions. Rather, during the course of the interview they needed to provide examples of how this behaviour was evident in the way they brought about their improvement work. Given that interviewees were not prompted specifically about aspects of leadership, but asked to talk about their approach in general terms, these areas of introspection about communication style did not feature very frequently during the SSIs.

It could be argued that it is perhaps unlikely for an interviewee to report their own communication strategies, saying, for instance, 'I pitched my messages in a way that meant they were understood.' Communication skills could arguably fall into the area of unconscious competency, whereby a skill is so automatic that a person is hardly aware that they are doing it.

Nevertheless, it would be feasible to think that an interviewee might report, for example: 'I found it to be really important to talk in language people understand and to avoid management jargon'. This sort of statement during a SSI would provide data to be coded under: communicates in a clear and compelling way (1j). Indeed, there are instances in the data where interviewees have made these kinds of comments about their own communication styles. However, the frequency of these was lower than that for the other behaviours in the interacting authentically category, and this suggests that the interviewees typically viewed these as less significant in effecting improvements.

Another consideration in interpreting the results relates to the key competencies of: communicates in a clear and compelling way (1i) and understands personal impact and influence on others (1b). These interacting authentically behaviours do not feature prominently in the reported leadership for improvement behaviour pattern. Does this mean that these behaviours are relatively unimportant when leading improvement work?

Common to both of these key competencies is that they depend to a large extent on the perceptions of other people. It could be argued that the leader him or herself is not in a position to judge their impact on other people or how well people understand them, as these perceptions would primarily be held by those around them. While some data might be gathered to show an individual's level of self awareness in these respects, this would only provide indirect evidence of the behaviour itself.

The other key competency under interacting authentically that does not emerge prominently in the reported behaviour pattern is: empowering others to inspire and create commitment (1h). This key competency focuses on behaviours which build commitment to change. It combines communicating vision, impacting on culture and explaining why change is needed, as well as role modelling continuous improvement.

To interpret the relative lack of data reported by participants in this leadership behaviour category, it is useful to break the key competency down into its behavioural indicators:

- Explains the need for change and inspires commitment to the process.
- Communicates a common compelling vision for the future organisation.
- Demonstrates commitment to innovation and to continuous improvement.
- Presents as a role model of creativity, innovation and learning.
- Ensures the organisation has a culture of promoting commitment and engagement.

What is striking about the five behavioural indicators within this key competency is that they are largely centred on the leader as an individual and their ability to behave as a figurehead. The behaviours defined suggest that the leader can provide clarity, explanations and a vision of the future, and that he or she has the capacity to determine what the culture of the organisation will be. This model of leadership is in subtle contrast to the prominent behaviour pattern emerging from the rest of the study, which focuses on facilitative, engaging and enabling leadership.

It therefore seems that Health Foundation leadership programme participants typically tend to enact their leadership as enablers and facilitators rather than as figureheads. This finding may, of course, be related to the fact that most participants are working at middle levels of organisations. A small minority of participants in this study were at executive level, but most reported in to executive level

or the next level down in the organisational structure. It is possible that leader-centric, figurehead behaviours may be more prominent among more senior leaders. Nevertheless, the data indicate a clear pattern among middle-level improvement leaders as one where their key role is to enable and support those around them to pursue and effect improvement.

Is leading improvement linked to attitude?

Overall, it appears that leadership behaviours focusing on managing tasks and project implementation (acts effectively) feature less frequently among NHS staff leading improvement than relational, interpersonal behaviours. The exception to this is the key competency: tolerates ambiguity to promote effective solutions. This is reported as a much more commonly-used behaviour than any of the other key competencies in the acts effectively competency area.

The behavioural definition of this key competency includes continually striving to find better ways of doing things, considering new possibilities, striving for improvements and keeping expectations high, even when things are difficult or when the situation is not completely clear. Why might this aspect of acts effectively stand out more prominently among NHS improvement leaders than other task-related behaviours?

Most of the key competencies under the heading of acts effectively relate to breaking down what needs to be done into tasks and stages, which all contribute in an incremental way to realising improvement work. Examples of this would include project planning, resource allocation, clarifying objectives, coordinating activities, and making decisions. None of these key competencies are reported as being of particular significance.

Where 'tolerates ambiguity to promote creative solutions' differs from the task-focused behaviours listed above is that it has more to do with attitude than action. This key competency is about having a mindset that is focused on continuous improvement, continual striving for excellence and an ongoing quest to overcome obstacles to better services. It is not the only attitudinal aspect of the acts effectively competency area, but it certainly seems to be the one that leaders most often cite as being central to their improvement work.

This finding has interesting links to debates in the leadership literature about the importance of attitude to improvement. Lucas and Buckley (2009) concluded from a recent study at Alder Hey Hospital that:

> *'We believe that improvement is fundamentally an attitude of mind and one that formal and ordinary leaders will increasingly need to adopt if improvements in health care are to be sustainable.'*
>
> (Lucas and Buckley 2009, p 45)

Our study provides further support for Lucas and Buckley's assertion. An attitude which tolerates the uncertainty of improvement, and strives for it nevertheless, was reported as one of the key aspects of improvement leadership among the participants.

Conceptualising issues: a backbone for leading improvement

The data show that conceptual, thinking-based behaviours are typically used at a low frequency level as part of improving services, and are much less prominent in the reported pattern than the task-related or interpersonal behaviours. They could be viewed as providing a backbone underpinning the action and the interaction which bring about improvement.

There are methodological issues which may shed some light on this finding. For instance, many of the key competencies outlined within this aspect of the IQL© are cognitive processes which inform behaviour, rather than external manifestations of the behaviour itself. Somebody sitting at a desk, thinking, or working at the computer are possible outward manifestations of conceptualising issues, making sense of improvement work and the context for it. However, because the impact of these types of behaviours are less immediate and obvious than when somebody is directly acting or interacting, perhaps these behaviours are less valued organisationally and therefore less reported by participants.

In addition, it could be argued that these types of behaviours are possibly performed on a more individual basis, rather than in conjunction with or in relation to other people.

Notwithstanding these possible interpretations, it is important to remember that the SSI data represent the participants' own descriptions of what they did to make improvement happen. Each participant voluntarily chose what to say to describe how they led QI. The data show that across the whole sample, it was the outwardly-manifested behaviours which were reported much more frequently than the inward-focused thinking behaviours.

At face value, this is a clear indication that leadership actions and interactions are perceived by participants as being more significant to their improvement activities than thinking and cognitive processes. If the SSI had lasted three hours instead of one and a

half hours, it is possible that participants would have moved on to describe the more conceptual behaviours in their account of enacting improvement. However, even if this were the case, it would not alter the fact that it is typically the relational aspects of leadership which are the first ones to be mentioned by improvement leaders as key. The conceptual aspects of leading improvement appear to be secondary among the Health Foundation programme participant sample.

In summary, the prominent pattern of leadership behaviour associated with leading improvement in this study consists of:

- seeking, understanding and valuing the viewpoint of others
- valuing the skills and expertise of others
- creating networks for the creation and sharing of ideas
- building structures that facilitate cooperation and collaboration
- creating strategies to influence others through persuasive reasoning
- building trust and confidence in others
- tolerates ambiguity to promote creative solutions.

The findings from the Q sort which explored beliefs about leadership behaviours offers a different, but complementary perspective on which behaviours are most important to leading improvement. The Health Foundation programme participants fell into three mindsets about this, that emphasised the importance of engagement, enhancing performance and innovation.

7.2 Do different types of QI require different leadership?

The key aspect of the study for answering this question was the development of the QI type measure. Applying this measure to each participant's improvement work provided, at a glance, an indication of the complexity of each piece of work, across the four dimensions of focus, level, process and intended impact. In addition, it allowed comparison across the various pieces of improvement work, by indicating where they were similar to or different from each other.

The underlying concept used to differentiate the improvement work was that of relative complexity, and each factor in the QI type measure (focus, level, process, intended impact) was rated on this basis. Consequently, our analysis focused essentially on how leadership differs according to the relative complexity of the improvement work.

Key finding

The QI type measure developed by the study team allows different types of QI work to be identified and differentiated.

We found that as the overall complexity of QI work increases, certain aspects of leadership are more frequently reported, as shown in figure 22. The more complex the QI work (as defined by the QI type measure), the more these eight key leadership competencies are reported by those leading the improvement work in the NHS.

An important finding emerging from these results is that each of the three competency areas from the IQL© (interacts authentically, acts effectively and conceptualises issues) has a significant, positive relationship with the QI type measure. In other words, the greater the complexity of a piece of improvement work, the more frequently the behaviours within these competency areas are reported by leaders in the NHS.

This is of particular note given the relatively small dataset. With a dataset of this size, the extent of significant relationships shown by the correlation analysis indicates that the links between the complexity of QI work and their associated leadership behaviour patterns are noteworthy. In analysing the correlation matrix of relationships between leadership behaviours and the QI type measure ratings, we have reported p value significance levels from 0.01, 0.05 to 0.10. We have chosen to include all these levels because the data is in a consistent direction and there are very small absolute differences in the actual correlations observed. These levels of significance are in themselves remarkably impressive given the relatively small sample size.

There is indeed a widespread view that significance testing for correlational data is always potentially misleading since, as Hicks (2009) states, the size of the sample is a major influence upon the significant data obtained. For example, very large samples will often report significant results at correlations of 0.20 but the same result will almost certainly not be significant with a smaller sample. Rather, it is proposed that the pattern and absolute size of correlations should be examined without the use of significance testing at all. This is sometimes referred to as 'effect size' and Cohen (1988) suggests exactly this approach. He suggests a simple rule of thumb as follows:

Competency area 1	**Interacts authentically**	*
Key competency 1a	Seeks, understands and values the viewpoint of others	10%
Key competency 1b	Understands personal impact and influence on others	*
Key competency 1c	Values the skills and expertise of others	10%
Key competency 1e	Builds structures that facilitate cooperation and collaboration	10%
Competency area 2	**Acts effectively**	*
Key competency 2a	Identifies project implications	*
Key competency 2c	Aligns people, tasks and resources	*
Key competency 2e	Identifies risks and opportunities	*
Competency area 3	**Conceptualises issues**	*
Key competency 3d	Creates clarity from diverse perspectives	*

* = significance $p<0.05$
10% = significance $p<0.10$

Figure 22: Key competencies used more frequently as overall complexity of improvement increases.

0.1 – 0.29	small correlation
0.3 – 0.49	medium correlation
0.5 – 1.0	large correlation

In our data, we have worked with both approaches, so for example: a correlation of 0.28 is significant at the $p<0.05$ level, yet a correlation of 0.27 is significant at the $p<0.10$ level. Our view is that the consistent direction and very marginal difference between such correlation figures for a small sample justify reporting an extended significance level.

Key finding

At the outset of this study, it was unknown whether the complexity of an improvement initiative had any relevance to the type of leadership used to enact it. The results of the study indicate that complexity is indeed a relevant factor, with greater complexity reportedly leading to greater use of certain aspects of leadership.

Given the limited size and source of the dataset, it would be inappropriate to make generalised statements about the links between QI type and leadership behaviour. However, taking into account the fact that these data emerge from a sample of programme participants, the following pertinent points seem clear at this stage:

- As QI work becomes more complex, NHS leaders increasingly report a reliance on their interpersonal and relational skills to bring about the changes involved. This skill set includes: self-knowledge and empathy; appreciating others' perspectives; placing central importance on the skills and contributions of others; and encouraging processes which encourage and enable others to cooperate and collaborate in the improvement work.
- These skills of engagement are supported by a core set of behaviours to 'get things done', which may be described as more task-focused skills. As improvement work becomes more complex, NHS leaders more frequently report that they are: considering the detail of executing the changes; working out the likely implications of the improvements; calculating what is required to introduce the improvements and how this will be done. In addition to this here and now focus, as improvement work becomes more complex, there is a reported increase in forward-thinking behaviours which maintain an alertness to changing circumstances and opportunities for further improvement.
- With increasingly complex improvement initiatives, certain sense-making leadership behaviours are reported as being more frequently used. Typically, these are behaviours which seek meaning from diverse and complex information, views and perspectives.

How does the level and focus of an improvement link to the leadership used?

The next level of enquiry sought to analyse the factors contributing to the overall complexity of the improvement, and to see if this was related to the leadership behaviours used. A reminder of these factors is provided here:

- **Focus**: the size of the group of people affected and the scope of their clinical needs.
- **Level**: whether the improvement is local, intra-organisational, across organisations, regional, national or international.
- **Process**: whether the improvement is adaptive or innovative; the range of stakeholders to be influenced, and the perceived difficulty of the influencing process.

– **Intended impact**: the extent to which the improvement had the intended impact on the health, wellbeing and experience of service users, and its apparent sustainability.

Firstly, we consider the focus and level dimensions. A working common sense hypothesis might have been that as QI work becomes more complex, encompassing a wider focus and being led from a higher organisational level, the behaviours used for leading the improvements would be different from those used at a more local level and with a narrower focus.

On the contrary, the data from our work suggest that most leadership behaviours used by programme participants were unrelated to the level or focus of the improvement work being undertaken. In other words, the focus and level of improvement work do not appear to significantly affect the typical pattern of leadership behaviour used. The data analysis supporting this finding is shown in figures 23 and 24 below. They show the extent to which there was any significant relationship between the relative level or focus of an improvement and the leadership used to effect it.

There is no statistical relationship between the IQL© competency areas of interacting authentically, acts effectively or conceptualises issues for either the level or the focus dimension of the QI type measure. This indicates that differences in the level and focus of an improvement are not associated with the use of particular leadership behaviour patterns. When considering the key competencies, a small number of relationships are evident from the data, but they do not present a consistent or meaningful pattern. The four leadership behaviours identified in figure 23 are more frequently used with higher level improvement work. However, these four are also associated with more complex improvement work overall (figure 22), suggesting that there are no uniquely defined behaviours associated with improvement being effected at a local level, lower down in a hierarchy, or more strategic improvements higher up. This reinforces the important message from the data that the organisational level at which an improvement takes place is not associated with particular patterns of leadership behaviour.

Key finding

Whether an improvement is led at a local or strategic level does not appear to make a significant difference to the behaviours used to lead the improvement.

Competency area 1	**Interacts authentically**	
Key competency 1a	Seeks, understands and values the viewpoint of others	*
Key competency 1e	Builds structures that facilitate cooperation and collaboration	10%
Competency area 2	**Acts effectively**	
Key competency 2a	Identifies project implications	10%
Key competency 2e	Identifies risks and opportunities	10%

* = significance $p<0.05$
10% = significance $p<0.10$
= no significance

Figure 23: Key competencies which correlate with different organisational level

The focus dimension is the only factor in the QI type measure that correlates negatively with certain leadership behaviours, as shown in figure 24. These negatively significant relationships are intriguing in both their origin and meaning. It is possible that the data is revealing certain associations, for example: the broader the focus of a QI becomes, the less a leader is likely to persuade others (1f), clarify key issues (3a), and weigh up critical factors affecting decision making (3c). Such an interpretation of the data might suggest that the detailed work involved in persuading, problem solving and evaluating options is largely operational, and therefore less prominent among people leading wide-ranging improvements.

This explanation seems rather implausible in the context of the Health Foundation's leadership programmes. The lack of coherent meaning emerging from the data on the focus dimension further serves to throw the usefulness of the dimension into question. As the significant correlations for this dimension are of a very small number, it would seem that it would need to be tested on a larger and wider sample in order to ascertain its significance.

How are innovation and stakeholder influencing linked to improvement leadership?

The third dimension of the QI type measure is called process, and comprises the adaptive or innovative nature of the improvement and the range and attitudes of stakeholders involved. When we consider how this dimension is associated with leading improvement, some interesting and significant findings emerge, as illustrated in figure 25.

Competency area 1	**Interacts authentically**	
Key competency 1f	Creates strategies to influence others through persuasive reasoning	negative 10%
Competency area 3	**Conceptualises issues**	
Key competency 3a	Articulates and formulates key issues clearly	negative *
Key competency 3c	Evaluates options to create powerful decisions	negative 10%

* = significance $p<0.05$
10% = significance $p<0.10$
= no significance

Figure 24: Key competencies which correlate with different breadth of project focus

As improvements become increasingly innovative, involving more complex influencing, it appears that:

- NHS leaders increasingly combine interpersonal and task focused skills in their leadership approach.
- Leaders typically report more frequent use of persuasive reasoning, building relationships of trust and confidence and adapting their communication styles to suit different audiences.
- Leaders increasingly depend on management skills such as resource allocation and decision making, while remaining open-minded to new ways of solving problems.
- Conceptual skills do not feature significantly reported leadership patterns.

Key finding

The study suggests that more innovative improvement work, involving more complex influencing, is associated with combining operational management with longer term relationship-building, while keeping an opportunistic eye on the possibilities for the future.

Competency area 1	**Interacts authentically**	
Key competency 1b	Understands personal impact and influence on others	10%
Key competency 1c	Values the skills and expertise of others	*
Key competency 1e	Builds structures that facilitate cooperation and collaboration	10%
Key competency 1f	Creates strategies to influence others through presuasive reasoning	10%
Key competency 1g	Builds confidence and trust in other	*
Key competency 1j	Adapts style of communications to audience	
Competency area 2	**Acts effectively**	
Key competency 2a	Identifies project implications	10%
Key competency 2c	Aligns people, tasks and resources	*
Key competency 2e	Identifies risks and opportunities	
Key competency 2f	Makes important decisions in a timely manner	*
Key competency 2g	Explores new suggestions and solutions	10%

* = significance $p<0.05$
10% = significance $p<0.10$
= no significance

Figure 25: Behaviours associated with more innovative QI and complex stakeholder issues

How is improvement leadership linked to impact and sustainability?

The final dimension of the QI type measure is called intended impact, and measures the extent to which intended impact was achieved in terms of patient experience, clinical outcomes and sustainability. Leadership behaviours associated with achieving greater impact in these areas are shown in figure 26.

Two leadership behaviours, in particular, are uniquely associated with intended impact (that is, they do not show associations with the other three dimensions of the QI type measure). Firstly, it appears that responsive, nimble leadership which anticipates change and is ready to adapt to altering circumstances is positively associated with sustainable improvement and tangible impact (key competency 2d: responsive to changing or emerging internal and external context). Secondly, improvement work which achieves its intended impact is related to a leader's skills in moving initiatives forward in a rapidly evolving and unpredictable context (key competency 3d: creates clarity from diverse perspectives).

Competency area 1	**Interacts authentically**	*
Key competency 1a	Seeks, understands and values the viewpoint of others	10%
Key competency 1b	Understands personal impact and influence on others	*
Key competency 1c	Values the skills and expertise of others	10%
Key competency 1e	Builds structures that facilitate cooperation and collaboration	10%
Competency area 2	**Acts effectively**	
Key competency 2a	Identifies project implications	10%
Key competency 2c	Aligns people, tasks and resources	*
Key competency 2d	Responsive to changing or emerging internal and external context	*
Key competency 2e	Identifies risks and opportunities	10%
Competency area 3	**Conceptualises issues**	*
Key competency 3c	Manipulates complex facts and opinions	*
Key competency 3d	Creates clarity from diverse perspectives	

* = significance $p<0.05$
10% = significance $p<0.10$
= no significance

Figure 26: Key competencies associated with achieving greater impact

The study has demonstrated that some leadership behaviours appear differentially important depending on the complexity of improvement work being undertaken. These findings provide a basis for identifying those leadership behaviours which may be most useful and appropriate for various types of improvement work.

Key finding

It appears that responsive, nimble leadership which anticipates change and is ready to adapt to altering, unpredictable circumstances, is particularly associated with sustainable improvement and tangible impact.

7.3 What are particpants' perceptions of the Health Foundation leadership progammes?

All the data gathered in the course of this study suggest that the programmes are highly valued by their participants. All the different tools of traditional evaluation have scored the programmes well in terms of their content, their delivery, and the impact that they are perceived to have on the participants' work and career trajectories. A number of very practical messages also emerge, whose implementation would strengthen an already strong programme and future-proof it for years to come.

At the level of programme content and design, there was evidence that participants of all the programmes valued the academic inputs they received and the informal networking they were able to achieve. Appreciation of the coaching and the action learning was also expressed. It would be useful to bear these in mind as key aspects of design that could be built into future leadership programmes.

Key finding

The programme content that participants found most helpful were the academic input, informal networking, coaching and action learning.

The Q sort exploring programme benefits produced a list of statements sufficiently strong and consistent to suggest that they symbolised a Health Foundation identity, identifying the nature of personal development benefits attained by participation in a leadership pogramme. These statements, which might form a basis for marketing future programmes, are shown in figure 27.

In almost all cases, participants' perceptions about the personal benefits they obtained from their programme tended to be greater than those about organisational or patient benefit. While this is not uncommon for leadership development programmes, given that the programme is focused on the individual, it may be helpful for the Health Foundation to consider putting more emphasis on the service impact of the development process, as well as on the skills and career-enhancing aspects. Not only would this make the programmes more effective in terms of their stated objectives

- I feel more confident in my own leadership capabilities.
- I gained powerful insights into my own strengths and weaknesses.
- I have built stronger networks in my areas of interest which have enabled me to be more effective.
- I feel more ambitious concerning the impact I can make to improve services.
- I am better able to motivate and instil a 'can do' attitude in others.
- My leadership style is more collaborative, involving key stakeholders in service development activities.
- I feel more empowered to lead others.
- I feel better motivated to drive for service improvement.
- I have benefited from the multidisciplinary nature of the scheme.
- I understand more clearly my leadership role and its impact on my organisation.
- I am increasingly able to work outside my comfort zone, taking calculated risks.
- I am better at leading change through others.
- I feel more confident and assertive at work, doing things I previously avoided.
- I feel more determined to challenge outdated organisational norms.
- I feel more influential at a strategic level both locally and regionally.

Figure 27: Key personal development benefits identified by programme participants

(which are more to do with organisational and patient benefit than anything else), but it might give the Health Foundation an extra edge in raising awareness and profile for the programme nationally.

Raising an awareness of impact, both personal and service-based, and how to measure it in the consciousness of participants, would help to retain a sense of leadership purpose at the core of future programmes.

Given the clear pattern emerging from the study about the importance of engagement and relationship behaviours in leading improvement, it will be important for the Health Foundation to decide how these can effectively be embedded into leadership development activities, in a way which complements more technical QI skills.

Key finding

Participants' perceptions about the personal benefits they obtained from their programme tended to be greater than those about organisational or service benefit.

7.4 What are the lessons for leadership development generally?

This study has made important progress in understanding more about the links between leadership and improvement. It provides evidence of the critical nature of leadership in bringing about improvement, and begins to illuminate the question of which aspects of leadership are particularly related to improvement work. The findings from the study make a strong case for a leadership skill set as a complementary set of skills alongside, and possibly underpinning, any QI tools and techniques in use.

At a pragmatic level, the challenge is to translate these findings into a form that can be of practical use to those engaged in leadership development work.

This section of the report starts to address this challenge. We present a model for developing leadership for QI, which maps the leadership competencies that appear to be of particular significance to QI. This model illustrates how these competencies can be used as building blocks for developing improvement leaders, with the scope to differentiate the development experience according to the prime outcomes desired.

A model for developing leadership for QI

The developing leadership for QI model, shown in figure 28, is intended to enable the design of bespoke leadership development interventions to enhance the effectiveness of improvement leaders. The premise for this model is the assertion that it is unlikely that any one person can excel across the whole range of leadership skills, such as those outlined in a comprehensive leadership framework. It is therefore both desirable and necessary to prioritise and tailor leadership development activities to optimise their effect.

This model provides a guiding framework to support these prioritising and tailoring decisions. It is crucial that use of this model take full account of the needs of individuals being given access to leadership development, their organisational context and their intended outcomes.

Of the 24 leadership competencies in the IQL© framework, the study shows that seven of them feature as a prominent pattern of leadership behaviour among the NHS participants involved. These are shown on the model in **red** and are the leadership competencies that, according to this study, can be viewed as the essential foundation stones for building effective improvement leadership. As a core set of leadership for QI competencies, a case

can be made for these being at the heart of development activities which aim to develop improvement leaders.

Over and above these essential improvement leadership competencies, decisions about prioritising the development of other skills and behaviours become discretionary, depending on the emphasis and purpose of the development experience.

The **pink** competencies are those which have been shown to be increasingly important as improvement work becomes more complex. There are seven of these in total; four of which are in addition to the essential competencies, and which may prove to be of particular significance for leaders struggling with the overall complexity of their QI challenges.

The **grey** competencies indicate leadership skills which are particularly associated with more innovative change, where difficult stakeholder issues are involved. Of these 11 competencies, three are uniquely associated with this type of change. For leaders engaged in improvement work of this nature, it may be that enhancing these three competencies warrants priority attention.

The 10 competencies shown in **blue** are those associated with higher levels of sustainability and patient or clinical impact. From the findings of this study alone, it would be misleading to conclude that the red behaviours result in sustainable improvement with clear impact on services. However, these behaviours have been shown to be prominent among clinicians and managers leading improvements where sustainability and direct quality impact are evident. In particular, three of these are uniquely associated with this type of improvement.

The remaining competencies, highlighted in **black**, are not indicated by this study as playing a significant role in the repertoire of improvement leaders. Nevertheless, this does not mean that they lack importance. It may be that these behaviours are in deficit skill areas, and as such, their use is under-reported by improvement leaders. While this study indicates that these competencies are of lesser priority, an assessment of their significance would need to be undertaken in the context of an overall leadership development programme.

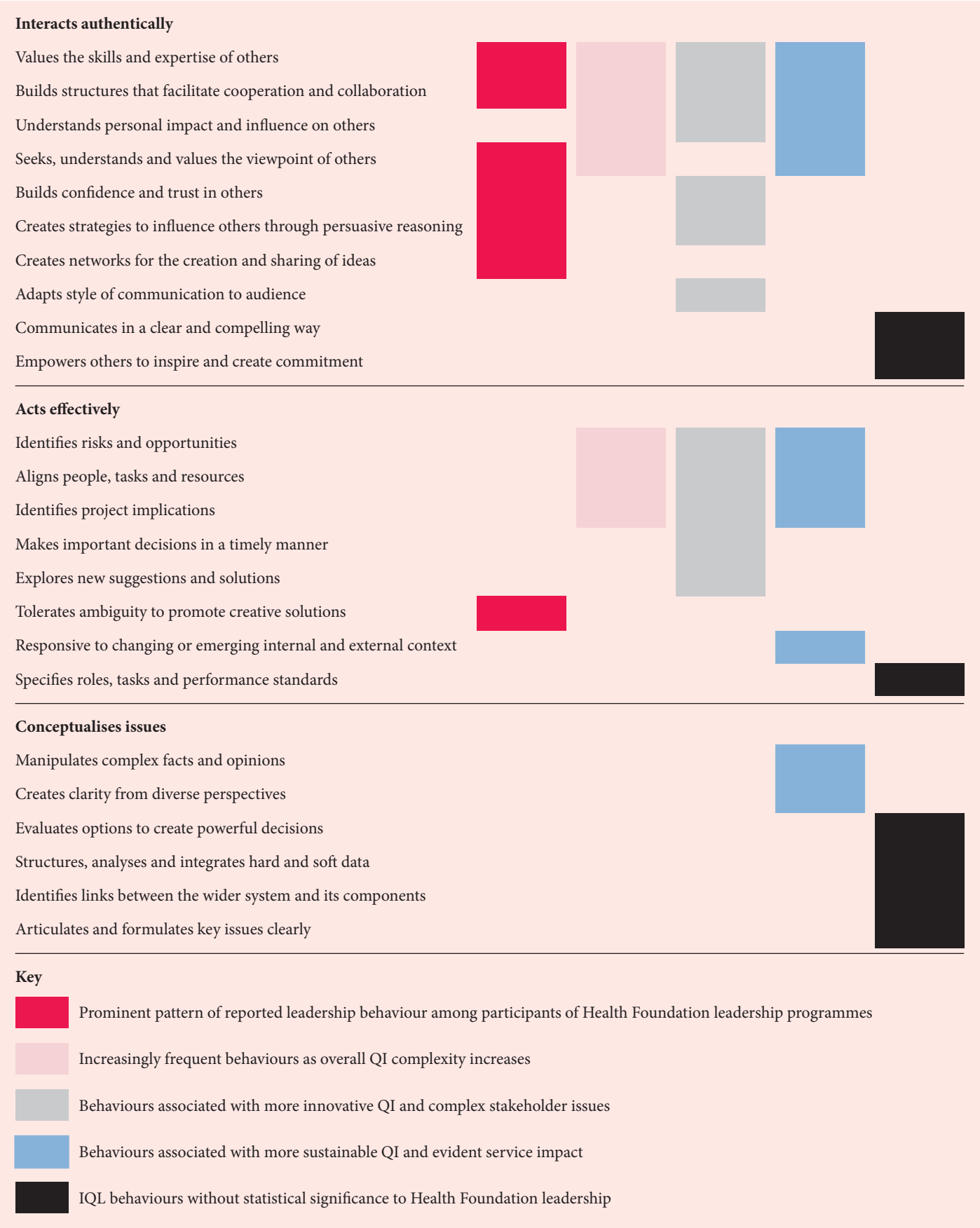


Figure 28: Building blocks for developing leadership for QI

Applying the findings to the design and delivery of leadership development

A list of 17 key leadership competencies emerged from this study, all of which have a link to leading improvement. Some prioritisation of these may be useful to tailor leadership development; this is outlined in figure 29. It is important to remember that each of these leadership competencies has five behavioural descriptors within it, which detail the leadership behaviours (these are shown in the IQL© framework in appendix 11).

To apply the findings of the study, figure 29 could be used as a basis for designing the leadership component of a leadership for QI development programme. All 17 of the identified competencies could be incorporated within such a programme, and tailored to suit participants and their particular improvement work. Participants could be supported to prioritise which leadership competencies to develop, and for what purpose. With the detailed behavioural descriptors within each key competency, a tailored set of development activities could be created to provide the development most likely to meet the needs of individual improvement leaders. Unlike other leadership skills curricula or frameworks, this approach differs in that it has been derived from empirical evidence of the skills which are in use by contemporary NHS improvement leaders.

Key finding

The developing leadership for QI model developed by the study team enables the design of bespoke leadership development interventions to enhance the effectiveness of improvement leaders.

7.5 What are the lessons for evaluating leadership development?

The triangulation of the data from different sources in the study sheds light on how ongoing evaluation of the effectiveness of leadership development could be enhanced. There were a small number of participants for whom data were available from two self-reported sources (SSIs and Q sort) and one third party source (blind study). It was apparent from these data that self-reported

Figure 29: A model for applying the findings to leadership development

behaviours and those reported by others, though consistent in some cases, differed significantly in other cases. There are a range of reasons why the self-report may be inconsistent with reports from third parties, but what this underlines is that a reliance on self-reported data on impact and effectiveness has evident weaknesses.

Key finding

In evaluating the process and impact of leadership development, a reliance on self-reported data has evident weaknesses. This can be overcome with more sophisticated evaluation methods.

Figure 30 illustrates the differences between self-reported behaviour or outcomes, and third party assessments. The survey was a straightforward self-assessment exercise, and produced a pure self

report of what respondents thought and felt about themselves, their programmes, and their projects (if any). In the SSIs, the self report was slightly modified by the fact that the interviewers were involved: seeking evidence from the interviewee to probe and explore leadership behaviours mentioned and implicitly interpreting that evidence. We have called this dual reported data. The blind interview process sought independent, third party evidence of leadership behaviours, and so was more objective; we have called this externally reported data.

The analysis in figure 30 brings together the data from these three sources for the same individual participant. For each data source, the study team made an assessment as to whether the data provided high (red), medium (pink) or low (grey) levels of evidence of leadership enactment. The analysis shows that higher levels of evidence tended to be associated with the self-reported methods, while third party reports yielded lower levels of evidence. There is no entry in the blind column for personal growth, as that is not tested in the methodology.

This is the most telling example of how self-reported evidence is not in itself enough to make assessments of either development, or of programmes intended to encourage development. Here we see no real corroboration between what the participant reported in their response to the survey, the results of the SSIs (which are basically self reported, but filtered through the interpretation of the trained interviewer), and the externally-reported actual behaviours reported in the blind study.

While the passage of time may be a contributing factor (the blind study was carried out some time after the actual project was enacted), there was a singular lack of evidence of positive leadership behaviours or impact recalled by several people interviewed as being attributed to the participant. (perhaps the reverse, in fact). Without the third party data, a less balanced evaluation of impact and effectiveness would be almost inevitable.

Leaders for change participant		SSI	Survey	Blind study
Benefit area	Personal growth	Dual report	Self report	
	Working with others	Dual report	Self report	External report
	Leadership behaviour	Dual report	Self report	External report
	Improvement behaviour	Dual report	Self report	External report

Figure 30: Evidence of leadership enactment from different data sources

Chapter 8

Discussion and implications

At the beginning of this study, our understanding about the links between leadership and improvement in the NHS was very limited. Our starting point encompassed some of the following factors:

- Non-specific messages from the literature about the relationship between leadership and improvement, and little that could usefully be applied in an NHS context.
- A lack of clarity about how to differentiate the wide-ranging concept of improvement into categories to define the type or nature of different improvement work.
- A gap in our understanding about whether different types of improvement work were associated with different types of leadership behaviours.
- An appreciation of the drawbacks of conventional methods for evaluating leadership development, but little evidence of tried and tested attempts to overcome these obstacles.
- Limited evidence of how leadership development could be designed to optimise its impact on the improvement of services.

At the conclusion of the study, insights have been provided to the three enquiry questions and each of the five study aims (outlined in chapter 3) have been achieved.

Having been immersed in this work for two years, we discuss here some of our reflections, which highlight some aspects of the modest but important learning which has resulted from the study.

8.1 Contribution to the evidence base

The literature review which informed this study led us to understand leadership for improvement as typically culturally sensitive, inclusive, team-based, personal and collective (outlined in chapter 2). This characterisation was drawn from literature relating to general organisational settings, and so was not specific to health and social care or the NHS specifically.

To some extent, the findings of this study reinforce the importance of these characteristics, and endorse their relevance to the NHS. Particularly resonant are the findings which show that NHS leaders involved in the study rely heavily on fostering a collective and inclusive approach to improvement rather than an egocentric, individualistic style of leading improvement. This is consistent with messages emerging from other settings and other empirical findings.

Interpersonal and engagement skills, which involve and encourage others in achieving excellence, are undisputed by this study as crucial to NHS improvement. Underpinning this finding are other important leadership competencies that are of increasing significance as improvement becomes more complex.

The exploration of different types of improvement resulted in the clear message that the more complex the improvement work becomes, the more leaders need to draw on their management skills as well as their relational skills. Leading improvement involving multiple stakeholder interests, moving from adaptive to innovative change, combines relationship-building with operational management and opportunistic forward-thinking. NHS managers and clinicians report blending together people-related and task-related leadership skills when leading complex improvement work. It seems that the skills of interacts authentically provide a backdrop for improvement, to which certain task-related and conceptual skills need to be added, depending on the nature of the improvement.

8.2 Practical application of the findings

Where this study provides particular value is in pinpointing the exact leadership competencies and behaviours which appear to be associated with improvement. This level of analysis opens up the scope for the findings to be of practical help in the field of leadership development as well as of theoretical interest.

The developing leadership for QI model is an evidence-based approach to prioritising and designing leadership development interventions focused specifically on NHS improvement. Beyond this, the model has potential use for assessment and selection of leadership development participants, for evaluating progress in skills development and indeed for organisational, team-based skills development.

As far as we are aware, the QI type measure is the only existing instrument which attempts to differentiate improvement work on the basis of complexity across a range of factors. Needless to say,

the measure requires further testing and validation for any broader application. However, it has potential application in diagnosing and mapping improvement work being undertaken, particularly as part of leadership development activities. Used together with the developing leadership for QI model, the QI type measure could support participants in identifying the nature of their improvement work and anticipating the skills development which may be most useful to optimise impact and sustainability.

8.3 Impact-driven evaluation

It has become increasingly clear throughout this study that the effectiveness of leadership development activities is more validly measured in real time prospectively, rather than merely in retrospect. We suggest that it is both desirable and achievable to build in prospective evaluation methods into the design of leadership development from the outset.

While it is important that participants of leadership courses become more competent and confident, it is only by evaluating changes to the participants enactment of leadership that real and tangible performance improvement outcomes can be demonstrated. Measuring this enactment involves observing changes in behaviour, attitude and approach that lead to enhanced personal and organisational performance.

The best time to start facilitating the capture of this attribution is during the design phase of leadership programmes. Prospective methods of evaluation would be effective, focusing from the beginning on the intended impact on services. Using others' perceptions from the workplace helps redress the clear limitations of subjective self-reported accounts.

Each of the methods of evaluation used in this study (survey, SSIs, Q sorts, blind studies) tend to give slightly different messages, but their cumulative effect is synergistic rather than antagonistic. This provides support for a multidimensional method of evaluation.

For the future we propose an approach based on a triumvirate (figure 31) that comprises of:

- the commissioning organisation overseeing the aims and objectives of the programme
- the programme provider delivering the programme to specification
- impact evaluators working alongside participants at organisational level to assess impact and attribution.

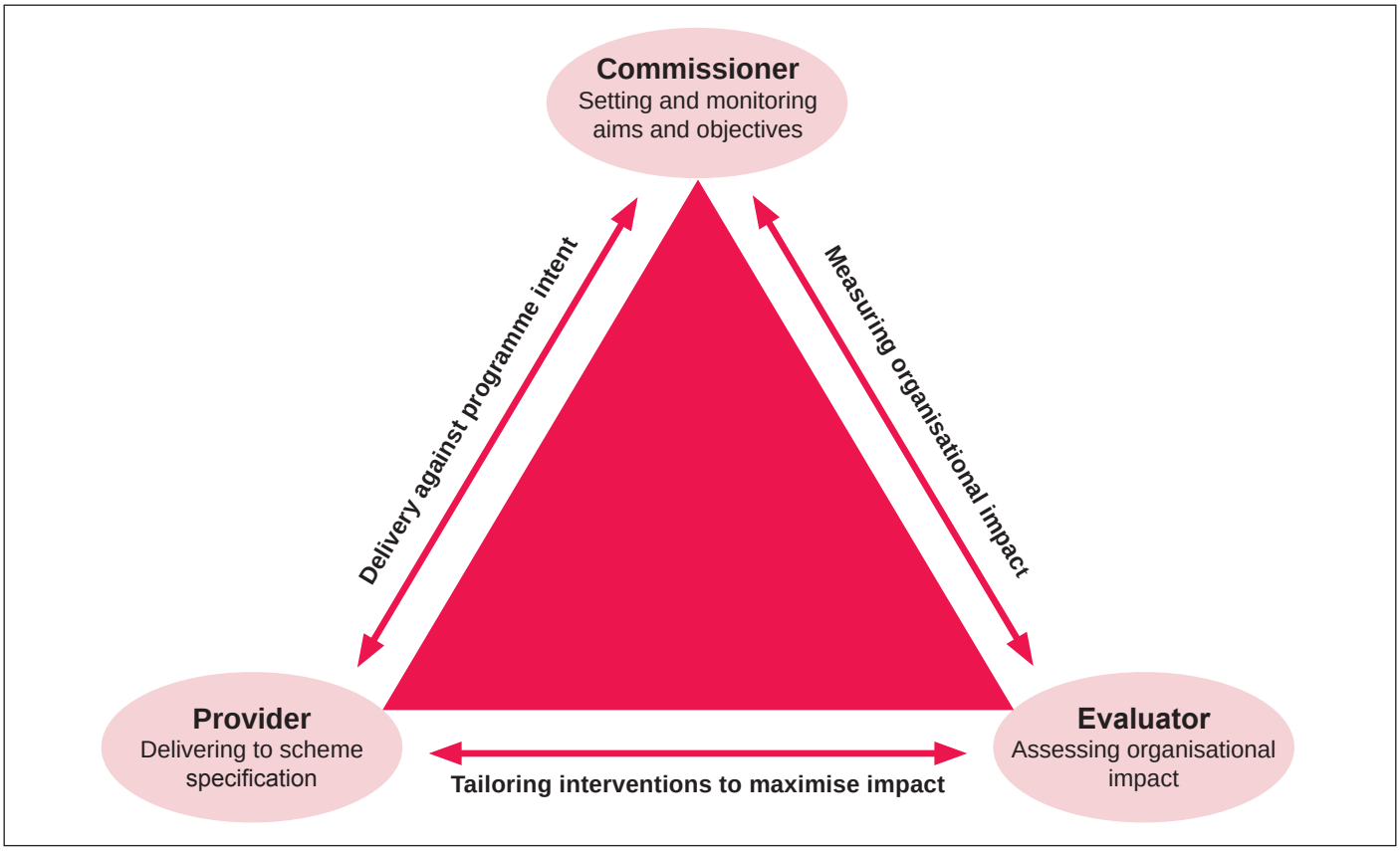


Figure 31: Prospective, formative triumvirate approach to leadership development evaluation

Ground rules and constructive challenge between the three parties as programmes progress would enable real time changes and tailoring of programme design, as well as providing behavioural data to address in action learning sets, coaching sessions etc. The programme participants would be at the centre of this triumvirate, themselves learning skills and methods for self-evaluation of personal, service and organisational impact. This approach in no way implies that the evaluative aspects of a programme become more important than the developmental aspects, as this would be counterproductive. Rather, identifying leadership purpose and measuring its impact becomes embedded into the development experience itself.

8.4 Overcoming obstacles in attributing improvement to leadership behaviours

From the outset of the study, the Health Foundation and the study team acknowledged the challenge of testing objectively whether there was a link between actual behaviours and certain

improvement outcomes (seeing if a chain of attribution could be determined between what was put into leadership, and what came out of it).

This has proved just as difficult as first anticipated, but we are satisfied that a start has been made and that with the implementation of a few relatively simple modifications, it should be possible to establish such links.

Given the logistical complexities of the counterfactual method as conducted in this study, it is difficult to draw any definitive conclusions. There is not enough data to prove or disprove that the impact of improvement work may be linked to the leadership behaviours enacted, or to the leadership development experienced by Health Foundation participants.

There are, however, enough hints even from the results of this small study to suggest that the approach may well have a utility and applicability in other Health Foundation programmes and beyond.

In more pragmatic terms, what has been useful about the experimental method is to show the potential strengths and current pitfalls of the process. As carried out in this evaluation, the logistics were cumbersome, with too many practical and ethical issues to make it a workable approach. There is an inherent paradox in carrying out a blind study with full consent, but as long as both the study and the consent were broad enough, this should not be an insurmountable problem.

A number of small adjustments would make the concept of a blind counterfactual method exploring the issues of attribution between behaviours and outcome more realistic:

- At the start of any new leadership development programme, the consent obtained from new participants and key members of their employing organisations should be more overt. It should also include reference (albeit non-specific) to the notion of exploring leadership behaviours among programme participants. In this way, the conundrums of having too much knowledge to make a study blind on the one hand, or too little knowledge thereby making a study unethical, may be averted.
- Knowing from the outset of a programme that some form of counterfactual assessment is likely to be carried out would enable the programme designers to take that fact into account in both the planning and delivery of a programme. Carrying out any form of evaluation prospectively is always more straightforward (as well as being more accurate and reliable) than retrofitting summative assessments into existing programmes.

- From the standpoint of QI, it would be helpful to know that participants had genuinely done some work in developing a project under the aegis of the programme that would be amenable to some form of evaluation. Too often in the existing programme, there was ambiguity about the reported QI projects: whether they had existed at all, and had been a genuine prerequisite for success; whether they were merely a vehicle to gain admission into a programme; or whether they had evolved and changed out of all recognition as the programme had developed.
- The other key stakeholders involved in any specific initiatives (QI or otherwise) should be identified early on in the life of the project, so that if some form of attribution study were to be carried out again, it would be more straightforward to identify the appropriate people to include in any triangulation exercise. Moreover, identifying these people early on in the project reduces the Hawthorne effect caused when those being researched change their behaviour when they realise that they are being researched.

Enacting these changes would allow the development of a counterfactual methodology that is both feasible and practicable, a tool to deliver results in a coherent manner, standardised for any particular programme, and allowing the attribution of leadership input and outcome. Having done that, the next challenge would be to challenge the linkage between leadership development and its enactment; whether this can also be done in a counterfactual manner remains to be seen.

8.5 Dissemination

We would propose a multi-level process of dissemination and wider sharing of the ideas and development of dialogue with a wide range of stakeholders and other influential bodies and individuals. These stakeholders include for example:

- The inner team of key stakeholders, such as the internal Health Foundation evaluation team members concerned with this study and the current leadership development programme commissioners. In order to establish a strong foundation for disseminating the learning from the study, it will be critical that those key stakeholders inside the Health Foundation are comfortable with the concepts and the detail of the findings if they are to communicate the findings effectively.

- The wider Health Foundation organisational stakeholders, both internal (for example, the Board, leadership development programme commissioners and evaluation staff) and the external key organisations and individuals who have a close association with the Health Foundation on leadership development (such as all past and current participants (the alumni), leadership development consultants and other providers, plus others where there is already a special or partnership relationship).
- The wider NHS and health community, specifically trust chief executives and human resources directors (communicated to, for example, through publications and conferences). Specifically leadership leads at Strategic Health Authorities (SHAs) and trust level should be approached as should relevant groups at SHA's.

Consideration should also be given to:

- Appropriate academic publications to embed the Health Foundation model in the literature on leadership for QI.
- The potential transferability of the learning from this study into other areas of Health Foundation work such as patient safety. For example, are the lessons about what type of leadership drives QI similar to those which can help to drive safety?

Chapter 9

Limitations of the study

The sample for this study was drawn from current and previous participants of Health Foundation leadership programmes (these programmes are selective by nature). Consequently, while the sample comprised a range of clinical and managerial leaders from different professional backgrounds, it arguably does not represent a typical range of improvement leaders within the NHS. It is also a relatively small sample, compared with the number of clinicians and managers affecting improvement in the NHS as a whole, and this effects the extent to which the findings can be generalised. In addition, the retrospective nature of the study, whereby most participants undertook the leadership programmes several years ago, leads to potential memory bias in their reporting of their intentions, behaviours and attitudes.

A recurrent theme from the literature is the important role played by the context and culture of organisations in supporting or hindering leadership for improvement. This factor has been beyond the remit of this study, and therefore consideration needs to be given to how cultural factors may affect the results of the study. The culture of the whole NHS system, the organisations within it, and the local culture in specific departments and teams, could all impact on the leadership enacted in those environments.

Finally, the findings of the study are based almost entirely on self-reported data, through participants describing or calculating their actions or thoughts relating to leadership. The range of methods used enables some degree of triangulation at an aggregated level, but not at an individual level. The blind study was designed to counter this to some extent, by gathering accounts from those around participants, which could serve to compare with self-reported accounts. However, while this was a potential by-product of the blind interviews, their main purpose was to ascertain the extent to which the improvements made to services would have happened anyway, without the leadership development inputs. The possible bias created by self-reported data therefore needs to be acknowledged as a limitation the study design.

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Appendix 1

Development of the QI type measure

In the early stages of the project, our intention was to base our classification of types of various Health Foundation leadership programmes. We therefore reviewed all the documentation for each separate programme, in their various iterations. Although this gave us a much better understanding for the various programmes, it became apparent that the level of detail with which different quality initiatives were described varied enormously amongst the different programmes: some awards (for example, Leaders for Change) were explicitly linked to QI projects identified by participants in their application, while others (for example, Leadership Fellows) often stated an intention or aspiration, identified in a relatively vague way, that was difficult to quantify.

Nevertheless, some useful participant information about intended improvements was recorded, albeit not in a comprehensive way. We analysed these data using definitions and classifications of QI from the literature, including the QQUIP/Health Foundation research initiative. However, reducing the data down into predetermined categories before we had considered it in its raw form seemed prematurely reductive, and the analysis proved inconclusive.

Instead, we listed examples of intended QIs, and tried to group them into categories of type (for examples, see appendix 2). While this exercise differentiated the QI examples more effectively, it also highlighted the methodological drawbacks of attributing sometimes multifaceted QIs to one single type. In several cases, one QI example would fall into several type categories.

It proved difficult (and potentially counterproductive) to be attributing such items to a single type category, given their complexity. Other examples clearly fitted into a single type. So it seemed important to be able to differentiate between the complexities of each QI. In developing our approach to the QI type measure at this stage, we were guided by the hypothesis that the relative complexity of different types of QI work might affect the leadership required for realising the QI. Hence, it seemed important that the QI type measure captured and reflected the differences in nature, complexity and aims of QI work undertaken by participants.

A matrix approach

We therefore explored the concept of a matrix typology, whereby different levels of complexity could be represented through a QI taxonomy incorporating a range of dimensions. An initial set of dimensions, based on the team's understanding of QI was considered:

- **Focus** (aim, objective, outcome) of the initiative: for example, improving direct patient experience/enabling system/organisation context.
- **Level** at which QI initiative takes place: for example, front-line, middle/operational, top/strategic, intra-/inter-organisational, national, international.
- **Processes or methods** used by QI leader: for example, project management, QI techniques and tools, change management approaches.

A three-dimensional taxonomy model of QI was emerging, based on focus, level and process, with progression along each axis implying an increasing complexity, as shown in figure A1.

The focus dimension was originally intended to encompass the number and type of patients involved in the QI, and the nature of the intervention. The level dimension covered the level of the organisation at which the initiative was taking place, from

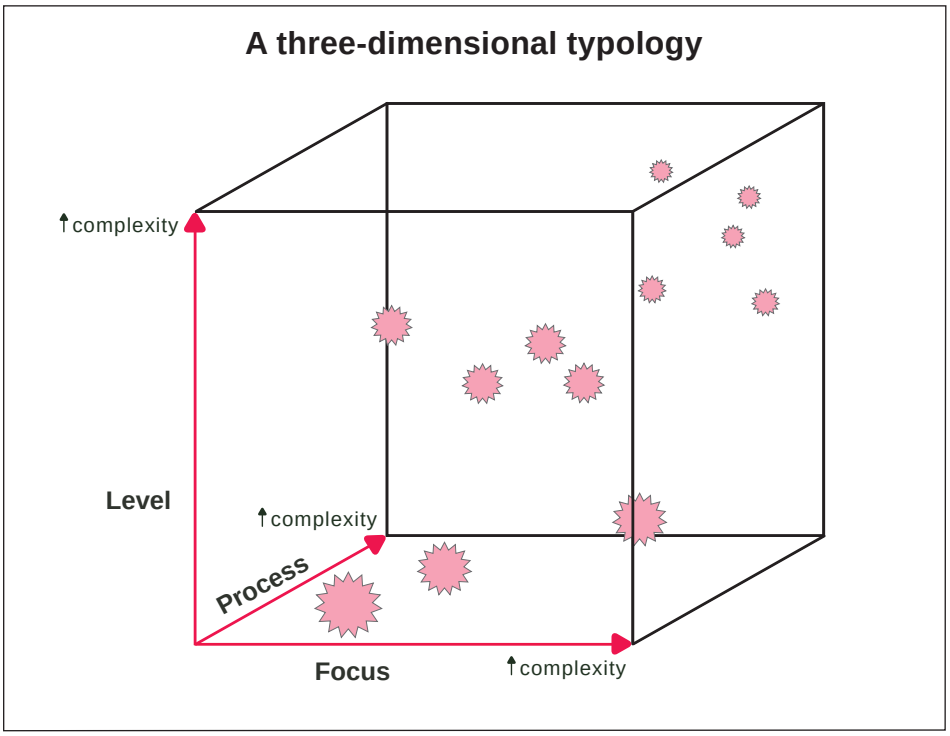

Figure A1: First draft of a QI matrix typology

single departments or intra-organisational linkages, through inter-organisational relationships, right through to national or international working. The process dimension encompassed aspects such as the number of stakeholders involved, degrees of resistance, and complexity of the change management process itself. The three-dimensional model (figure A1) was informally tested in various parts of the Health Foundation, including with the leadership development consultants and staff from within the leadership programme. There was an intuitive agreement with the basic model, and a high level of interest in the multifaceted way of capturing diverse types of improvement work.

When referring to the QI literature to inform the QI type measure development, the most pertinent recent contribution to the literature was Walshe's (2007) discussion of the need for theory-driven evaluation of QI. His analysis defined the four main variables of QI as being:

- Content: the situation, setting or organisation in which the QI intervention is deployed.
- Context:the nature or characteristics of the intervention itself.
- Application: the process through which the intervention is delivered.
- Outcomes: the results of the intervention.

Walshe's categories resonated with the focus, level and process dimensions from our internal analysis, with the content, context and outcomes variables conflated into the focus' category At this stage, it appeared relevant to retain a separate dimension to capture data about level, as there was such a range of data presenting about this from the early documentary trawl. The team decided to retain this as a dimension until it could be tested out further. The third dimension of process was similar in meaning to Walshe's application variable.

The next stage of QI type measure development was to create a methodology for categorising different QI types. Using the idea of a QI matrix as a basis, numeric values were added to each dimension to allow them to be compared and, to some extent, measured. The relative complexity of each dimension was thus intended to be rated along the lines: '1: defined and simple', '2: defined and complex' or '3: ambiguous' as shown in figure A2. Each QI example could therefore be categorised as for example, F1L2P2; F3L3P3 etc.

We decided to use the matrix in figure A2 as a basis for developing a visual analogue scale (an unnumbered measurement scale) to measure the QI work undertaken. To inform this, a further examination of the QI literature was undertaken. In addition to

	1	2	3
Focus	Single patient group Single intervention/outcome	Multiple patient groups Multiple determinable interventions/outcomes	Indeterminate patient groups Indeterminate interventions/outcomes
Level	Within single organisation (intra-)	Across several organisations (inter-)	Beyond inter-organisational, e.g. regional, national, international
Process	Defined and simple	Defined and complex	Ambiguous

Fig A2: Trial matrix QI rating model

the constructs already identified as important, several additional constructs of QI emerged from the literature. These are discussed briefly below.

Construct validity

Crump's (2008) exploration of key factors driving improvement in the NHS stresses the significance of the source of motivation for the improvement. Crump maps 11 typical examples of NHS improvement drivers onto a simple matrix showing whether they are internal, external, voluntary or compelled.

Crump's analysis resonated with the evaluation team's experience of working with NHS staff, whereby the response and attitude towards improvements could sometimes be linked to whether the change was imposed or voluntary. An item was therefore developed to reflect the voluntary-compelled dimension of QI within the QI type measure:

- At one end of the spectrum: the improvement is only being made due to an imposed imperative.
- At the other end of the spectrum: the improvement is being made proactively, without any external requirements to do so, entirely because the people involved believe it to be important.

This item has been the subject of continuous debate among the evaluation team, in an attempt to extricate the motivational aspects of this factor (how is motivation for QI affected by compulsion or voluntarism?) from the contextual factors (how important are the political imperatives in affecting QI implementation?). Parker, de Pillis et al (2007) draw a distinction between local participatory and central expert QI:

> *'Local participatory QI is a bottom-up approach in which frontline staff members identify a problem … and develop and implement local solutions to those problems. Central expert QI, on the other hand, is a top-down approach whereby experts and expert-informed managers implement QI programs based on research evidence and expert experience regarding best practices'.*
>
> (Parker, de Pillis et al 2007, p 1268)

This key difference is characterised by Greenhalgh et al (2004) as naturally emergent innovation as compared with managerial innovation. Kirton's (2006) descriptors of adaptive and innovative change are a simple alternative differentiation. While there remains a debate about the extent to which these terms refer to the nature of the change or the style of its implementation, there is agreement among researchers that this aspect of the improvement can be important to consider in understanding its impact.

An item was therefore developed to capture data about the adaptive and innovative nature of QI:

- At one end of the spectrum: the change involves small improvements to existing practices.
- At the other end: the change is entirely innovative, involving completely novel ways of doing or thinking about things.

These literature-derived constructs were added to those empirically-derived by the evaluation team, to create a trial version of a visual analogue QI type measure, as shown in appendix 3.

Trialing the QI type measure

To trial the QI type measure, some descriptions of QI projects were required, against which ratings could be made. Examples of QI work undertaken by Health Foundation programme participants were extracted from paper records and were formed into brief descriptive paragraphs, as shown in appendix 4.

Some initial internal trialing of the QI type measure was undertaken within the evaluation team, using the written scenarios as a basis. The first trial of the QI type measure took place at the end of a workshop for Leadership Fellows in York in June 2008. Seventeen people took part, including a Health Foundation staff member and two leadership development consultants. The group was asked to read through each QI description and to use the QI type measure instrument (appendix 5) to rate each one. Voluntary verbal feedback about the process was given by some participants at the end. The data collected from this trial was analysed. The main findings and feedback were as follows:

- The most common comment received was that there was not sufficient information in the scenarios to accurately rate each item.
- There was very little consistency in ratings obtained from 15 completed questionnaires (2 questionnaires incomplete).
- Some of the polarities are too complicated, conflating more than one element (for example, items 5 and 7).
- Is there a left-right bias on the dimensions?
- Scenarios 2, 5 and 7 are not QIs – they are studies, therefore the QI type measure is difficult to apply.
- Regarding item 6, even if a QI is an imposed imperative, the implementation can still be creative.
- Limited knowledge of clinical areas among some participants limited their ability and confidence to answer questions.

The lack of sufficient information to make a rating was clearly an underlying factor in the inconsistency of ratings in the trial at York, and was therefore a prime area of focus in refining the methodology. The evaluation team refined the QI descriptions, replacing the seven brief summary paragraphs with three more detailed descriptions (appendix 6).

In addition, some changes were made to the items on the QI type measure in response to feedback from the first trial. The wording at each end of the visual analogue scale was simplified, and the dimension measuring the scale and complexity of influencing stakeholders was divided into two separate items. In response to specific feedback from trial participants, the dimension measuring patient impact was divided into two separate items to allow for health outcome and patient experience to be rated separately. This created a QI type measure with nine dimensions; a longer, more complicated assessment tool (appendix 7). The QI type measure trial was then run a second time, at a lunchtime session with Health Foundation staff. Twenty-two completed questionnaires were returned.

Reliability, validity and utility

Despite the more detailed scenarios, specifically written to contain information relating to each item on the QI type measure, analysis of data from the second trial showed only slightly better reliability. The most concrete scenario (Cleft Lip and Palate Network) had the most reliable consistency, and the most ephemeral scenario (high impact changes) had the least consistentency. However in both cases, the spread of ratings showed that the QI type measure in its current form was far from being a reliable measure.

The two trials provided positive feedback about the face validity of the dimensions, and no gaps were identified by trial participants in this respect. However, there was a sense that while the face validity was good, the utility of the instrument as a self-assessment tool was potentially becoming reduced by its intricacies.

The evaluation team spent many hours debating the tension between developing a holistic but qualitative tool on the one hand and a highly precise, quantitative but reductionist model on the other. The evaluation team sought to design a typological instrument whereby reliability, validity and utility could be optimised.

Given the difficulties encountered by trial participants from a lack of sufficient information in a written scenario, a paper-based approach to classifying QI was looking increasingly impractical. At this stage, it became apparent that the essence and detail of QI work required for useful classification could only be captured through conversation and verbal explanation. Consequently, it was decided that the QI type measure would be amended into a SSI format, that could be used with individual programme participants (appendix 8).

This work was shared with the participants at the Health Foundation seminar on the 25 July 2008, held in London. During the seminar, we described the development journey outlined in this section and discussed the various issues arising. The discussion endorsed our findings and views on the nature of the QI type measure and its use in practice. As a result, a further development was to change the QI type measure from a self-assessment instrument into one that had to be administered by trained experts. Clearly such a move made the wider dissemination of the instrument harder to envisage, but it did allow the notion of a more sophisticated, detailed instrument to be developed. The instrument's utilisation could have benefits beyond the simple assessment of the complexity of a quality initiative, and into the realms of a mature developmental tool.

Once this decision had been made, the focus of the evaluation team was to improve the reliability of the interview-based QI instrument. Trials of this instrument took the form of recorded and transcribed interviews with two previous Leaders for Change programme participants. The transcripts were then independently rated by each of the core evaluation team against the QI type measure. The team then met to discuss the results; on the basis of these discussions, it became apparent that a core method of interpreting each QI was developing among the evaluation team, leading to a good level of internal consistency in rating QI types.

Refining the QI type measure

To reflect the methodological move towards verbal explanation rather than paper-based description of QI work, the data-gathering process for the QI type measure was incorporated into the SSI phase of the project. Some final refinements were made to the QI type measure prior to commencing the SSIs and these are outlined below.

Firstly, the measure about the reasons or drivers for change was removed, as the trials had not provided sufficient data to suggest that this was a discriminating factor in the way QI was implemented. Some feedback from the trials had highlighted this item as being misleading; the evaluation team also had reservations about its value.

Secondly, a factor that emerged as warranting more attention was the sustainability of the changes made to services. An item was therefore added to capture data about the extent to which the QI was a one-off or embedded into the way the organisation now work: is it dependent on the individual leader or champion, or is it part of 'the way we do things around here'?

Thirdly, early discussions about the QI type measure dimensions had included debates about the extent to which the focus and level of the QI work could be differentiated or conflated, and this issue needed to be resolved. An assumption existed amongst some team members that an improvement occurring at a local level led by someone in the lower hierarchical levels of an organisation, would require simpler, and possibly fewer, leadership skills than a change being led by someone senior in the hierarchy attempting to change things more strategically. Other members of the team remained unconvinced about this issue.

It was decided that data gathered from the study would help to illuminate this issue and to indicate how significant level and focus were in terms of their links to leadership for QI. Accordingly, the two separate dimensions were retained within the QI type measure, to be tested against the data gathered.

Fourthly, a decision was made to extend the scale for each dimension from a three–point scale (as outlined in figure A2) to a seven-point scale. The team's increasing familiarity with the nature of the QIs made by Health Foundation programme participants led to a concern that there would be a large degree of clustering of ratings towards the centre of a one to three , resulting in many ratings of two. This could potentially obscure differences

in the types of QI work, and make it more difficult to uncover relationships and links between datasets. The move to a seven-point scale was therefore designed to allow a greater degree of differentiation between the various QI initiatives being carried out.

From the various iterations of the QI type measure described above, the matrix approach to categorising different types of improvement was becoming clearer. The QI dimensions were arranged to form broad headings of focus, level, process and intended impact, summarised into a QI type measure fFigure 3). This QI type measure reflects the changes to the dimensions made in response to the trialing of the QI type measure, and the internal reliability testing within the evaluation team. Each QI encountered during the study was classified according to the QI type measure, with a four-integer rating (for example, F2L4P3I5, abbreviated to 2435). This provided the working QI taxonomy for the study, and formed the basis of analysis and correlation to leadership behaviours.

Appendix 2

Example groupings of intended QI work

* Indicates that this example falls into more than one type/category.

Achieve externally-driven standards

104	Meet access and key performance indicator targets
105	Implement National Service Frameworks
113	Improving organisational performance at four challenged Trusts (by SHA)
208	Improved ambulance 8 minute response times by 14%
211	Improvement in clinical division performance
* 407	Reduction of waiting times

Introduce new clinical processes

102, 218	Service redesign
107	Develop new models of care (for new build)
* 217	Developing new low secure intensive care mental health unit (based on different/new care principles)
* 206	Introduce West Yorkshire-wide direct referral by paramedics to angioplasty service for heart attack patients
* 403	Engaging doctors in care planning
* 407	Reduction of waiting times
* 411	Shift from inpatient to day case/community

The role of the service user

103	Patient involvement in service change
402	Copying GP letters to patients
* 404	Improving the clinic experience
* 405	Plan-do-study-act (PDSA) cycles to enable patients to be more involved in their consultations
* 407	Reduction of waiting times (gathering patient views)
412	Developing culture of collaboration with mental health service users
420	Engaging young people in developing services
421	Baseline and measure patient satisfaction
422	Supporting people to become 'expert patients'

Inter and intra-organisational working arrangements

106	Improve partnership working
111	Successful integration between NHS Direct and 999 service
114	Developing a neonatal network
210	Clinical engagement in PbC
* 212	Development of a Cleft Lip and Palate Network in England's North West, Isle of Man and North Wales (bringing four previously separate units together)
214	Improve multidisciplinary working
423	Engaging learning disability services more with primary care

Enhance current clinical practice (for example, make safer, more effective)

108	Improve clinical governance
101	Improve patient care

110	Evidence of a safer, patient-centred service
115	Reducing methicillin-resistant staphylococcus aureus (MRSA) rates
121	Improved clinical risk management
207	Clinical standardisation across three formerly separate ambulance services
216	Reduce clostridium difficile (CDiff) rates
401	Improving patient safety and outcomes
* 403	Engaging doctors in care planning
* 404	Improving the clinic experience
* 405	PDSA cycles to enable patients to be more involved in their consultations
* 407	Reduction of waiting times
414	Improving nutritional care for patients

Improve access to services

109	Modernise emergency access
112	Provision of out of hours single access routes
117	Developing Choose and Book
119	Developing unscheduled care services in partnership with primary care
203	Improve access for mental health service users in primary care
* 206	Introduce West Yorkshire-wide direct referral by paramedics to angioplasty service for heart attack patients
* 219	All parents of affected newborns seen within 24 hours by specialist team
215	Develop an Emergency Assessment Unit
413	Online health promotion regarding drugs and alcohol
417	Redesigning referral pathways to secondary and tertiary care

Building infrastructure

116	Developing the country's first Independent Sector Diagnostics Centre
* 217	Developing new low secure intensive care mental health unit
416	De-commissioning and re-providing 16 bed independent community mental health hospital

National improvement initiatives

118	Leading 'Improvement Partnership for Hospitals'

Working practices

120	Different ways of working in A&E
202	Preparing nurses for nurse consultant roles
209	Emergency care practitioners delivering better care to patients in own home
301	Enhanced understanding among professionals of health promotion and public health
* 411	Shift from inpatient to day case/community

Auditing, reviewing, assessing current quality

201	Reviewing city-wide talking treatments
418	Developing contract data to enable whole system comparisons

Other

408	Improved management of outpatients
415	Attract equitable resources for mental health services
424	Keeping children's services agenda mainstream

Appendix 3

Trial version of QI type measure as a visual analogue scale

ORCNi / The Health Foundation Evaluating the impact of leadership development on quality improvement

Stage A: developing a typology for quality improvement

Introduction

In evaluating the leadership development programme provided by the Health Foundation, one of the first stages is to classify different 'types' of quality improvement undertaken by programme participants. The scale below is currently being trialed, to assess its reliability in measuring the nature, depth and complexity of different quality improvement work. Your help with this trial will help us to refine the instrument, so that it can be used as a basis for a typology of quality improvement.

Please place a VERTICAL line through each of the scales below to indicate where you think the scenario best fits, as shown in the example:

Example

The improvement is aimed at a defined group of people, less than 20 in number, limited to a single clinical area.

The improvement is intended to benefit unlimited numbers of diverse people.

Thank you for your help with this trial.

1. Target group affected by the improvement

The improvement is aimed at a defined group of people, less than 20 in number, limited to a single clinical area.

The improvement is intended to benefit unlimited numbers of diverse people.

2. Level in the organisation

The improvement is focused within a single ward, department or practice.

The improvement involves a range of national and international organisations.

3. Type of change

The change involves small improvements to existing practices.

The change is entirely innovative, involving completely novel ways of doing or thinking about things.

4. Scale of change

The improvement involves one or two straightforward changes

The improvement involves so much change that it is impossible to quantify.

5. Stakeholders

The improvement involves influencing one or two specific people who support the change.

The improvement involves influencing such a diverse range of resistant people, that it is impossible to define them all.

6. Reason for the improvement

The improvement is only being made due to an imposed imperative.

The improvement is being made proactively, without any external requirements to do so, entirely because the people involved believe it to be important.

7. Intended impact

The impact of the improvement will be indirect, and therefore will not be evident in the patient experience in any tangible way.

The improvement will significantly enhance the direct experience of people using services and improve their health and wellbeing.

Appendix 4

Descriptions of QI for typology testing

1. To address the increasing demand on Child and Adolescent Mental Health Services (CAMHS) and improve timely access to the service. To be achieved though the introduction of a triage or brief assessment system for the CAMHS team and to evaluate its impact on referral rates, waiting times for first appointment and the nature of cases first referred to a specialist CAMHS service. The project includes the evaluation of how the team accepts and operates the system of change.
2. To explore how children (aged 5–12) experience community children's nursing (CCN) services and the factors that shape the experience, including gender, ethnicity and social position. To seek to understand the implications for the CCN services of a child-centred view, by asking children what they want and expect from being nursed at home.
3. Reducing Clostridium Difficile rates within an acute trust. This included developing antibiotic procedures across the organisation, a training programme for all staff within the division and a Ward Managers' Environmental Checklist to strengthen their accountability for the care environment. This also required establishing, and overseeing the formation of, an isolation facility.
4. Leading the development of a new county-wide Cleft Lip and Palate Network. This provided rapid and continued local support on the birth of a baby with a cleft via a network-wide, nurse-led on-call service, covering all new referrals to the service. This ensured that all newborns and their parents were assessed and counselled by a specialist nurse within 24 hours of diagnosis.
5. To assess how hospital payment systems are evolving in the US to improve integration across the health system, and to learn lessons for UK policy.
6. To deal with increasing demand for cataract surgery in a district general hospital. To facilitate the change, cataract services were redesigned to increase throughput and reduce waiting times,

while assessing and preserving the quality of patient care. A secondary end point was to maintain surgical caseload mix, thus allowing trainees to continue to fulfil the number and type of operations required to acquire higher surgical training standards, as per the Royal College of Ophthalmologists' guidelines.

7. To develop a core set of High Impact Safety Changes based on US best practice, which could be implemented through a national target system and enable the UK's NHS to engage clinicians in the patient safety agenda.

Appendix 5

Trial version of the QI type measure visual analogue scale, York, 17 June 2008

Evaluating the impact of leadership development on quality improvement

Stage A: developing a typology for quality improvement

Introduction

In evaluating the leadership development programme provided by the Health Foundation, one of the first stages is to classify different 'types' of quality improvement undertaken by programme participants. The scale below is currently being tested, to assess its reliability in measuring the nature, depth and complexity of different quality improvement work. Your help with this trial will help us to refine the instrument, so that it can be used as a basis for a typology of quality improvement. Your contribution will be entirely anonymous, so if you have any additional comments or queries about any aspect of the questions, please do enter them in the boxes provided.

Please read the seven scenarios of improvement provided. For each example, please place a line through each of the scales below where you think the scenario best fits, as shown in the example below. Please then give us a brief explanation of why you have rated it in this way. Please don't spend too much time on each; the assessment should take no more than a few minutes for each of the scenarios.

Example

The improvement is aimed at a defined group of people, less than 20 in number, limited to a single clinical area.

The improvement is intended to benefit unlimited numbers of diverse people.

Scenario 1 – Child and adolescent mental health triage system

1. Target group affected by the improvement

The improvement is aimed at a defined group of people, less than 20 in number, limited to a single clinical area.

The improvement is intended to benefit unlimited numbers of people in a number of clinical areas.

Rationale for this rating:

2. Organisational level of the improvement

The improvement is focused within a single ward, department or general practice.

The improvement covers several national and/or international bodies or organisations.

Rationale for this rating:

3. Type of change

The change involves small improvements to existing practices.

The change is entirely innovative, involving completely novel ways of doing or thinking about things.

Rationale for this rating:

4. Scale of change

The improvement involves one or two straightforward changes

The improvement involves so much change it is impossible to quantify.

Rationale for this rating:

5. Stakeholders

The improvement involves influencing one or two specific people who support the change.

The improvement involves such a diverse range of resistant people, it is impossible to define them all.

Rationale for this rating:

6. Reason for the improvement

The improvement is only being made because of an imposed imperative.

The improvement is proactive, without any external requirements to do it, entirely because those involved believe it to be important.

Rationale for this rating:

7. Intended impact

The improvement will significantly affect the direct experience of those people using services and improve their health and wellbeing.

The impact of the improvement will be indirect, and hence not be evident in the patient experience in a tangible way.

Rationale for this rating:

Any other comments about how easy / hard it was to rate this scenario:

Please continue to Scenario 2 below.

(Questions repeated for 6 more scenarios)

Thank you for your help with trialing this methodology. If you have any queries or comments about any aspect of our work, please contact the ORCNi team on Jeanne.Hardacre@orcni.com

Appendix 6

Three scenarios for the second typology trial

Scenario 1: Cleft Lip and Palate Network

The aim of this improvement was to develop an improved, equitable, sustainable, high quality Cleft Lip and Palate Network throughout England's North West region, Isle of Man and North Wales. Patient feedback and clinical outcome data had provided evidence of a need for the service to be improved. The development of the Network has improved access to multidisciplinary services (addressing waiting time targets) and enhanced the quality of the service by ensuring that all patients are now operated on by high volume surgeons.

A £1.05m annual recurrent new resource has been provided for the Network. This has been used principally to increase staffing and to create new roles, including a new key surgical post. These new staffing arrangements improve initial contact for patients and families, and provide local support and services for families through outreach. This increases the time available to clinicians for patient consultation and treatment and improves the coordination of services.

A Network-wide, nurse-led on-call service has been introduced, covering all new referrals to the service throughout the large geographic area covered. This significant development ensures that all newborns and their parents are assessed and counselled by a specialist nurse within 24 hours of diagnosis; this was not previously possible. The service also provides antenatal, postnatal support and treatment wherever a cleft lip or palate (or both) is diagnosed. The service includes visits to the patient's local hospital and home.

Following surgery to repair the cleft lip or palate (or both), ongoing care for children, young people and adults with cleft lip and palate is provided by a multidisciplinary team which may include the following and other specialists: specialist nurses; speech and language therapists; clinical psychologists; consultant orthodontists; consultants in restorative dentistry and deneticists.

A service specification and surgical model for the new service, focused on patients with cleft lip/palate, were negotiated and agreed with colleagues and specialised commissioners. It has been important that the new surgical model is viewed as fair to ensure that the Network has sustained support from all those involved. The process of agreeing a fair surgical model was difficult, however now that the model has been agreed, there is much more unity about the direction for the Network and trust is being rebuilt. Successful whole Network workshops (five held to date) and social events are also contributing to the reality of a single network team. Considerable efforts by the Network Clinical Director and the Network Manager in spending time in all the surgical and outreach centres is also helping to develop working relationships, as is the rotation throughout the region of the Network management meetings (approximately 30 held to date).

The views of patients and families have been sought using a questionnaire regarding their involvement with the management of the service. This has been followed by an initial meeting (attended by approximately 70 patients and carers) to explore this and other issues further. The Network is in the process of seeking views about the service provided by means of a service evaluation questionnaire.

Mechanisms are in place to measure some early indicators of improvement, although it will take many years before the more significant treatment outcomes will be able to be assessed meaningfully.

Scenario 2: high impact safety changes

This scenario was a proposal put forward by a Harkness Fellowships programme participant (the researcher) as the basis of their year long research project; the details have been filled in for the purposes of this exercise, and do not necessarily reflect the original project aspirations.

> *'To develop a core set of High Impact Safety Changes (HISC) based on US best practice, which could be implemented through a national target system and enable the UK's NHS to engage clinicians in the patient safety agenda.'*

The researcher's approach was triphasic. The first part was to carry out a literature review of published articles about improving patient safety, with a particular emphasis on hospitals that had published work about their projects and the results obtained from implementing them. The researcher was looking for results that could be quantified in a number of different ways: absolute

outcomes (such as physical issues such as infection, readmission, and even mortality); a measure of how patients perceived their experience; and any discussion regarding the cost benefits of introducing the changes made to enhance patient safety.

Using the list generated, the researcher then expected to move into the second phase of their work: the researcher intended to visit a selection of US hospitals that had delivered successful projects, to explore in more detail the initiatives that had been carried out. The researcher expected to investigate projects in three areas, and choose one in each as exemplars: acute urgent care (the treatment of deep vein thrombosis), elective procedures (knee replacement), and acute non-urgent process (post stroke rehabilitation). This was undertaken to develop the researcher's own list of high impact changes.

The researcher then intended to synthesise the conclusions of these successful projects into a framework of high impact safety changes that could be used in any UK hospital, and into which any clinical condition could be fitted. This was an ambitious idea, and upon return to the UK, the researcher planned to restrict the third phase of her project to working with the hospitals in one SHA area, looking at the three identified conditions as pilots for future work.

The researcher aimed to recruit sufficient interested volunteers amongst the clinical staff of each trust in the local SHA area to make the introduction of the high impact safety changes practical. The researcher was aware, however, that there may be some resistance by certain groups of clinicians who may feel threatened by various changes to improve patient safety.

Scenario 3: the clostridium difficile problem

The Trust's clostridium difficile rates were significantly above average and were causing concern within the SHA. An urgent meeting of the Infection Control Committee was set up and extended to include representatives from all services within the Trust. A review of the existing Trust policy and procedures suggested that although sound in principle, they were manifestly not achieving the desired goals and there was an obvious failure of implementation.

An action plan devised by the team included strict Trust-wide guidelines on the use of antibiotics and a mandatory (no exceptions) training programme for all staff. A Ward Managers'

Environmental Checklist was established to strengthen their direct accountability for the care environment. Milestone measures to monitor implementation were introduced with immediate feedback protocols if targets were not met. Month on month targets for reducing clostridium difficle rates were agreed and patient representatives were consulted about how education and more better information could allow patients and visitors to support the action.

Perhaps the most challenging proposal was the creation of isolation facilities requiring both senior clinicians and services to agree to procedures that might jeopardise their own targets.

Members of the committee were allocated specific roles and asked to report back to a sub-committee on a weekly basis.

Appendix 7

Second trial version QI type measure visual analogue scale, July 2008

Evaluating the impact of leadership development on quality improvement

Stage A: developing a typology for quality improvement

Introduction

In evaluating the Leadership Programme provided by the Health Foundation, one of the first stages is to classify different 'types' of quality improvement undertaken by programme participants. The scale below is currently being tested, to assess its reliability in measuring the nature, depth and complexity of different quality improvement work. Your help with this trial will help us to refine the instrument, so that it can be used as a basis for a typology of quality improvement. Your contribution will be entirely anonymous, so if you have any additional comments or queries about any aspect of the questions, please do enter them in the areas provided.

Please read the three improvement scenarios provided. For each example, please place a vertical line through each of the scales below where you think the scenario best fits, as shown in the example below. Please then give us a brief explanation of why you have rated it in this way. Please don't spend too much time on each; the assessment should take no more than a few minutes for each of the scenarios.

Thank you for your help with this trial.

Example

The improvement is aimed at a defined group of people, limited to a single clinical area.

The improvement is intended to benefit unlimited numbers of people in unlimited clinical areas.

Scenario 1 – Cleft Lip and Palate Network

1. Target group affected by the improvement

The improvement is aimed at a defined group of people, limited to a single clinical area.

The improvement is intended to benefit unlimited numbers of people in unlimited clinical areas.

Rationale for this rating:

2. Health outcome

The improvement will directly improve the health and wellbeing of service users.

The improvement will make little or no direct difference to the health and wellbeing of service users.

Rationale for this rating:

3. Patient impact

The improvement will positively transform the direct experience of those people using services.

The improvement will have little or no direct impact on the patient experience.

Rationale for this rating:

4. Organisational level of the improvement

The improvement is focused within a single ward, department or general practice.

The improvement covers several national and/or international bodies or organisations.

Rationale for this rating:

5. Type of change

The change involves small improvements to existing practices.

The change is entirely innovative, involving completely novel ways of doing or thinking about things.

Rationale for this rating:

6. Scale of change

The improvement involves one or two straightforward changes.

The improvement involves so much change, it is virtually impossible to specify.

Rationale for this rating:

7. Range of stakeholders

The improvement involves influencing one or two specific people.

The improvement involves influencing such a diverse range of people, it is virtually impossible to define them all.

Rationale for this rating:

8. Influencing

The influencing involved in the improvement is extremely easy.

The influencing involved in the improvement is as complex and difficult as it could possibly be.

Rationale for this rating:

9. Reason for the improvement

The improvement is entirely in response to an imposed imperative.

The improvement is entirely because those involved believe it to be important.

Rationale for this rating:

Any comments about how easy/hard it was to rate this scenario:

Any comments about any part of any of the scenarios or of the process itself:

Thank you for your help with this trial.

Appendix 8

Trial version of SSI incorporating QI type measure

The Health Foundation / ORCNi leadership evaluation

Pilot of QI typology-based SSI schedule

Name: _____

Job title: _____

Organisation: _____

Interviewed by: _____

Date: _____

Opening comments
Introduce researchers, background to study, reason for trial, permission to record, confidentiality and use of data.

1. Biographical details:
   a) Main job responsibilities.
   b) Award/scheme name.
   c) Changes to job during scheme.
   d) Career aspirations.

2. Please tell me about any improvements to services you have been involved with during the past year.
   - Why did it come about?
   - What was the aim? (intended change, desired impact)
   - Who was involved?
   - Timescale?

3. Please tell me the story of how the improvement happened.

4. What was your direct involvement in the work?
   - What did you do?
   - How did you do it?

5. What aspects of the work were relatively easy?

6. What aspects of the work were difficult?

7. What have the outcomes been?

8. How have outcomes been measured or evaluated?

9. Would a service user's experience be different after the change? If yes, then how?

10. How do you envisage the future of this improvement work?

Thank you for your cooperation

Appendix 9

Pilot version of SSI schedule

The Health Foundation / ORCNi leadership evaluation

Pilot of SSI schedule

Name: _____

Job title: _____

Organisation: _____

Interviewed by: _____

Date: _____

Opening comments
Introduce researchers
Purpose of study
Reason for the pilot
Stages of the interview:
i) biographical
ii) type of work
iii) leadership enactment
iv) experience of the Health Foundation scheme
Confidentiality and use of data
Permission to record and transcribe
Timings – c. 90 minutes?

NB: with Leadership Fellows, avoid using the word 'project', as they do not have one!

Summary

Typology	Brief 'improvement' description
Key leadership behaviours	Scheme feedback

A. Biographical details

Ai) Main job responsibilities.

Aii) Changes to job during scheme.

Aiii) Career aspirations? Other relevant info.

B. Typology

Please tell us about any improvements to services you have been involved with during the past year.

Why did it come about?

What was the aim? (intended change, desired impact)

Timescale?

Focus

- Target Group – this is likely to emerge from the interviewee's description
- Level – as 1.
- May need to summarise – for example, 'So, do I understand correctly that this piece of work focused on the whole Women and Children's directorate, but also involved community services?'

Process

- Type of change – Can you please describe the sorts of changes involved?
- Scale of change – likely to be evident from 3.
- Range of stakeholders – Who were the key people involved in the work? How were they involved?
- Influencing – How did you work with others to achieve your aims?

Impact

- Health outcome – What would you say the main outcomes to the work have been? (Probe: Have any of these been health outcomes?
- Patient experience – To what extent would you say the work has had an impact on the patient experience? (Probe: What sort of impact? How do you know? How would a service user's experience be different after the change?)
- Sustainability – How do you envisage the future of this improvement work? (Probe: how much is the change dependent on you or other individuals?)

C. Leadership enactment

We are seeking to understand the activities with which you were personally involved in undertaking these changes.

We would like to talk this through sequentially and trace each step, occasionally asking for more detail or clarifying how your role may have linked to others. There is no sense of testing you or an expected right way – we just want to understand as far as possible what was involved.

To start, what was the first step in your involvement in the improvement work?

D. Scheme specific evaluation

Di) What was your motivation for joining this scheme?
(Probe: Was there any particular QI objective?)

Dii) To what extent did the scheme enable you to realise your aims?

Diii) Taking an overall view of yourself, at this point in time, to what extent would you say that your behaviour has changed as a result of the Health Foundation scheme? (For example, in your approach to leadership and/or QI.)
A little 1 2 3 4 5 6 A lot
Comments on this rating:

Div) What changes have become evident to you in the way you behave as a leader?
In your approach to QI?
Examples?

Dv) What, if any, changes have been noticed by others around you? (For example, your staff, manager, colleagues, who may have responded differently to you or commented about any changes.)
Examples?

Dvi) Was any scheme-related activity – at or away from work – of particular value to you ?
Which one(s)?
How?
Why?
What difference did it make to your behaviour/mindset/approach?

Dvi) What have the key factors been in helping or hindering you in transferring your learning from the scheme to work?

Dvii) Can you give any examples to specify or quantify the impact of your leadership/QI approach at work?

Dix) Value for money
Do you know what it costs Health Foundation to put you through this programme? If not, what would your estimate be?

Dx) Overall, to what extent do you think your participation on the Health Foundation scheme represented good value for money?
In terms of:

Personal development?	Low	1 2 3 4 5 6 7 8 9 10	High
Better clinical outcomes?	Low	1 2 3 4 5 6 7 8 9 10	High
More effective leadership?	Low	1 2 3 4 5 6 7 8 9 10	High
Better patient experience?	Low	1 2 3 4 5 6 7 8 9 10	High
Organisational benefits?	Low	1 2 3 4 5 6 7 8 9 10	High
Overall?	Low	1 2 3 4 5 6 7 8 9 10	High

Dxi) Was there any particular incident or situation which stands out in your mind when you look back over your time on the programme? A particularly difficult or breakthrough situation? A light-bulb moment?

Dxii) How strongly would you recommend this programme to a colleague at the same level as you in your organisation?
A little 1 2 3 4 5 6 A lot

Any additional info/final comments

Appendix 10

Final version of the SSI schedule

Final Version 23/02/09

The Health Foundation / ORCNi

Leadership programme evaluation: SSIs

Name: _____

Job title: _____

Organisation: _____

Health Foundation scheme: _____

Interviewed by: _____

Date: _____

Opening comments
Introduce researchers
Purpose of study
Reason for the pilot
Stages of the interview:
i) biographical
ii) type of work
iii) leadership enactment
iv) experience of the Health Foundation scheme
Confidentiality and use of data
Permission to record and transcribe
Timings – c. 90 minutes?

NB: with Leadership Fellows, avoid using the word 'project', as they do not have one!

Summary

Typology	Brief 'improvement' description
F ___	
P ___	
O ___	

Key Leadership behaviours	Scheme feedback

A. Biographical details

Ai) Main job responsibilities.

Aii) Changes to job during scheme/since the scheme/ into the future.

B. Typology

Please tell us about any improvements to services you have been involved with during the past year.

Why did it come about?

What was the aim? (intended change, desired impact)

Timescale?

Focus

- Target Group – this is likely to emerge from the interviewee's description
- Level – as 1.
- May need to summarise – for example, 'So, do I understand correctly that this piece of work focused on the whole Women and Children's directorate, but also involved community services?'

Process

- Type of change – Can you please describe the sorts of changes involved?
- Scale of change – likely to be evident from 3.
- Range of stakeholders – Who were the key people involved in the work? How were they involved?
- Influencing – How did you work with others to achieve your aims?

Impact

- Health outcome – What would you say the main outcomes to the work have been? (Probe: Have any of these been health outcomes?)
- Patient experience – To what extent would you say the work has had an impact on the patient experience? (Probe: What sort of impact? How do you know? How would a service user's experience be different after the change?)
- Sustainability – How do you envisage the future of this improvement work? (Probe: how much is the change dependent on you or other individuals?)

C. Leadership enactment

We are seeking to understand the activities with which you were personally involved in undertaking these changes.

We would like to talk this through sequentially and trace each step, occasionally asking for more detail or clarifying how your role may have linked to others. There is no sense of testing you or an expected right way – we just want to understand as far as possible what was involved.

To start, what was the first step in your involvement in the improvement work?

D. Scheme specific evaluation

Di) What was your motivation for joining this scheme?
(Probe: Was there any particular QI objective?)

Dii) To what extent did the scheme enable you to realise your aims?
How?
What aims were achieved/not achieved?

Diii) Taking an overall view of yourself, at this point in time, to what extent would you say that your behaviour has changed as a result of the Health Foundation scheme? (For example, in your approach to leadership and/or QI.)
A little 1 2 3 4 5 6 A lot
Comments on this rating:

Div) What changes have become evident to you in the way you behave as a leader?
In your approach to QI?
Examples?

Dv) What, if any, changes have been noticed by others around you? (For example, your staff, manager, colleagues, who may

have responded differently to you or commented about any changes.)
Examples?

Dvi) Was any scheme-related activity – at or away from work – of particular value to you?
Which one(s)?
How?
Why?
What difference did it make to your behaviour/mindset/approach?

Dvi) What have the key factors been in helping or hindering you in transferring your learning from the scheme to work?

Dvii) Can you give any examples to specify or quantify the impact of your leadership/QI approach at work?

Dix) Value for money
Do you know what it costs Health Foundation to put you through this programme? If not, what would your estimate be?

Dx) Overall, to what extent do you think your participation on the Health Foundation scheme represented good value for money?
In terms of:

Personal development?	Low	1 2 3 4 5 6 7 8 9 10	High
Better clinical outcomes?	Low	1 2 3 4 5 6 7 8 9 10	High
More effective leadership?	Low	1 2 3 4 5 6 7 8 9 10	High
Better patient experience?	Low	1 2 3 4 5 6 7 8 9 10	High
Organisational benefits?	Low	1 2 3 4 5 6 7 8 9 10	High
Overall?	Low	1 2 3 4 5 6 7 8 9 10	High

Dxi) Was there any particular incident or situation which stands out in your mind when you look back over your time on the programme? A particularly difficult or breakthrough situation? A light-bulb moment?

Dxii) How strongly would you recommend this programme to a colleague at the same level as you in your organisation?
A little 1 2 3 4 5 6 A lot

Dxiii) Finally, thinking of yourself as a leader of quality improvement, what are the essential two or three aspects of your approach which make you effective?

Thank you for your cooperation

Appendix 11

IQL© key behavioural competencies and underpinning behavioural indicators

Competency area 1: interacts authentically

a) Seeks, understands and values the viewpoint of others

i. Solicits all points of view and uses these perspectives to build consensus

ii. Regularly initiates discussion and facilitates open sharing of opinions

iii. Harnesses different opinions and capitalises on the benefits of diversity

iv. Takes other people's perceptions seriously and empathises with their feelings

v. Encourages the differing and preferred working styles of individuals

b) Understands personal impact and influence on others

i. Anticipates how other parties may react to the content of personal communication

ii. Makes convincing and balanced arguments, tailored to others' needs and expectations

iii. Takes account of others' reactions re: tones of voice, gestures and facial expressions

iv. Monitors others' understanding of what is discussed and corrects misunderstandings

v. Interprets the face-to-face impact of own conduct on others' behaviour and responses

c) Values the skills and expertise of others

i. Capitalises on the range of skills and talents present in the organisation

ii. Identifies and nurtures talent to build capacity and capability

iii. Offers support, rewards achievements and celebrates success

iv. Gives clear constructive feedback, timely praise and focused recognition

v. Delegates work to provide challenge and opportunities to learn and develop

d) Creates networks for the creation and sharing of ideas

i. Identifies and consults with key stakeholders to obtain buy-in for ideas

ii. Build and enthuses a wide base of support for innovation and change

iii. Develops and sustains a diverse range of internal and external relationships

iv. Invests time to establish, sustain and broaden information and intelligence networks

v. Engages the support and allegiance of informal networks in formal situations

e) Builds structures that facilitate cooperation and collaboration

i. Sets up and maintains open communication channels to promotes information exchange

ii. Facilitates cooperation within and between organisations by sharing information

iii. Implements a range of formal and informal team-building development activities

iv. Establishes cross-agency working and encourages collaborative partnerships

v. Develops cooperation and teamwork by encouraging key stakeholders to work together

f) Creates strategies to influence others through persuasive reasoning

i. Constructs persuasive arguments to facilitate the acceptance and adoption of change

ii. Conveys his/her position convincingly even when faced with strong opposition

iii. Uses influence and persuasive skills to involve, engage and gain others' support

iv. Helps others create their own solutions to facilitate ownership and commitment

v. Provides clear, constructive and timely guidance to shape others behaviour

g) Builds confidence and trust in others

i. Anticipates dissent and uses appropriate strategies to resolve conflict when it arises

ii. Asks open-ended questions that encourage authentic and honest communication

iii. Shows trust and confidence in staff by acknowledging their effort and contribution

iv. Demonstrates honesty in interactions by matching deeds to words

v. Listens carefully to others to gain a real insight into their issues and concerns

h) Empowers others to inspire and create commitment

i. Explains the need for change and inspires commitment to the process

ii. Communicates a common compelling vision for the future organisation

iii. Demonstrates commitment to innovation and to continuous improvement

iv. Presents as a role model of creativity, innovation, and learning

v. Ensures organisation has a culture of promoting commitment and engagement

i) Communicates in a clear and compelling way

i. Delivers messages in a clear, concise and articulate manner without using jargon

ii. Creates meaning for the audience by using events and stories to illustrate key points

iii. Uses anecdotes and analogies to illustrate ideas and bring messages to life

iv. Pitches messages to focuses on key points and facilitate desired outcomes

v. Maximises personal communication strengths while minimising weaknesses

j) Adapts style of communication to audience

i. Seeks to understand others' non-verbal cues and adjusts presentation style accordingly

ii. Anticipates the likely reaction and selects communication style to meet audience needs

iii. Explains complex information using a level of language appropriate for the audience

iv. Maintains an awareness of peoples' personalities and motivations and adapts to this

v. Asking clarifying questions and reflects back to ensure message has been understood

Competency area 2: acts effectively

a) Identifies project implications

i. Specifies the task requirements and identifies the likely outcomes of plans

ii. Assesses the feasibility and acceptability of translating policies into operational plans

iii. Takes into account the personal and emotional costs of organisational change to staff

iv. Determines necessary resources (money, people, and materials) for project success

v. Makes sense of organisational events by inferring causes and consequences of interventions

b) Specifies roles, tasks, and performance standards

i. Specifies clear organisational goals, priorities and performance objectives

ii. Sets performance standards and shows concern that they are met or surpassed

iii. Conducts regular reviews and constructively addresses under-performance.

iv. Establishes structures that delineate authority with clear lines of accountability

v. Holds both self and others accountable for effective delivery of results

c) Aligns people, tasks and resources

i. Ensures that all organisational sub-systems effectively support the business plan

ii. Controls projects by ensuring plans, people and resources are appropriately mobilised

iii. Unites staff around an inspiring vision and aligns staff capacities with planned activities

iv. Ensures coordination of values, mission, strategy, structure and day-to-day performance

v. Links achievement of goals with appropriate rewards and recognition

d) Responsive to changing or emerging internal or external context

i. Initiates organisational responses as required and maintains the pace of change.

ii. Keeps alert to a wide range of signals that may indicate important shifts in conditions

iii. Anticipates organisational change and knows when, why and how to adapt quickly

iv. Understands that the effects of organisational change are both planned and unplanned

v. Reacts quickly and confidently to contain, control or capitalise on rapidly-changing events

e) Identifies risks and opportunities

i. Seeks out opportunities to try out new ideas or innovative schemes

ii. Plans ahead and recognises that services can and should change for the better

iii. Keeps alert to all possibilities to identify the potential of positive change

iv. Spots chances and opportunities to apply or transfer innovative practices

v. Anticipates and reduce risks by knowing organisational strengths and weaknesses

f) Makes important decisions in a timely manner

i. Identifies and consults with the appropriate key decision makers on emerging issues

ii. Demonstrates understanding of units/departments and factors this into any decisions

iii. Anticipates barriers to rapid decision making and takes steps to remove these

iv. Selects the best time to announce a decision to maximise positive impact

v. Draws on own knowledge and experience to make balanced and timely judgments

g) Explores new suggestions and solutions

i. Encourages others to produce novel suggestions and solutions to organisational problems

ii. Analyses the future potential of new schemes to improve work practices and services

iii. Encourages novel approaches which have the promise to deliver improved outcomes

iv. Generates creative and valuable suggestions with the potential to improve service delivery

v. Envisions the ways in which potential innovations may influence current working practices

h) Tolerates ambiguity to promote creative solutions

i. Prefers to promote promising initiatives and approaches rather than maintain the status quo

ii. Encourages others not to reject new ideas because their benefits may not be immediate

iii. Explores imaginative solutions and considers new approaches to enhance effectiveness

iv. Pursues worthwhile new initiatives even when there is ambiguity and uncertainty

v. Challenges accepted behaviour and pushes forward even under difficult circumstances

Competency area 3: conceptualises issues

a) Articulates and formulates key issues clearly

i. Identifies staff attitudes, concerns and opinions relevant to the issue at hand

ii. Disentangles the fundamental reasons and root causes of organisational problems

iii. Identifies the specific information needed to solve a problem efficiently

iv. Prioritises important issues and tease out the dependencies between them

v. Maintains up-to-date knowledge about the organisational structures and processes

b) Structures, analyses and integrates hard and soft data

i. Transforms available data into meaningful information to inform and illuminate

ii. Blends and integrates disparate types of hard evidence and soft intuition

iii. Uses experience, logic and empathy to derive acceptable and cost effective solutions

iv. Explores the underlying meaning behind incomplete and ambiguous staff feelings

v. Balances the productivity, needs and demands of different parts of the organisation

c) Manipulates complex facts and opinions

i. Thinks flexibly and creatively under rapidly evolving or unexpected circumstances

ii. Derives new ideas and innovative strategies within a useful timescale

iii. Pinpoints critical factors to explain the meaning and implication of events

iv. Grasps the evolving and overlapping patterns of complex events as they unfold

v. Shifts perspectives and focus to deal with concerns from various stakeholders

d) Creates clarity from diverse perspectives

i. Structures loose threads of ideas and opinions into coherent explanations

ii. Clarifies problems by actively examining relationships between components

iii. Produces focused suggestions and strategies from dissonant viewpoints

iv. Assembles a rich picture through discussion with diverse members of staff

v. Discerns organisational risks and opportunities from a complex set of factors

e) Evaluates options to create powerful decisions

i. Prioritises and weighs up the pros and cons of situations to make good decisions

ii. Distinguishes key priorities from supporting or peripheral sub-priorities

iii. Focuses on all critical factors including hard-to-measure emotional issues

iv. Probes staff reactions to proposed alternative options and decisions

v. Considers the organisation's priorities when making decisions or suggesting solutions

f) Identifies the links between the wider system and its components

i. Takes a 'helicopter view' of the system to oversee both short and longer-term issues

ii. Assesses whether the local picture is aligned to and supports the wider vision of change

iii. Examines how the values of various staff groups fit within the organisational mission

iv. Ensures that local operational goals support the organisational strategy mission and vision

v. Highlights key priorities for action by understanding where the future organisation should be

Appendix 12

Survey questionnaire

Health Foundation programme evaluation

Instructions

As many of you will be aware from other contacts ORCNI is in the process of conducting a thorough evaluation across the Health Foundation's development schemes, delivered over the past few years. We have met many of you over the past 18 months, obtaining good qualitative information. In an attempt to gather some simple quantitative data, allowing comparison across the various schemes, we would be grateful if you could kindly complete this evaluation questionnaire.

Scheme in which you participated: _____

Name: _____

Date: _____

In terms of your experience of this programme please indicate the degree to which you agree with each of the statements below placing a single line on the dimension in the example below:

Example

The UK should adopt compulsory voting to counter the decline in democracy.

Strongly disagree — Strongly agree

1 — **10**

Section A

Scheme evaluation measure

1) Met my expectations in terms of delivering on the stated aims and objectives

Strongly disagree — Strongly agree

1 ——— **10**

2) Stimulated me to think differently about my work

Strongly disagree — Strongly agree

1 ——— **10**

3) Provided an opportunity for personal growth and development

Strongly disagree — Strongly agree

1 ——— **10**

4) Enhanced my understanding of the concept of leadership

Strongly disagree — Strongly agree

1 ——— **10**

5) Helped me recognise my own strengths and weaknesses

Strongly disagree — Strongly agree

1 ——— **10**

6) Improved my understanding of the contribution of others

Strongly disagree — Strongly agree

1 ——— **10**

7) Enabled me to implement concepts from the scheme into practice

Strongly disagree — Strongly agree

1 ——— **10**

8) Helped me to undertake real service improvement

Strongly disagree — Strongly agree

1 ——— **10**

9) Was a well organised, well run scheme

Strongly disagree — Strongly agree

1 ——— **10**

10) Enhanced my knowledge of a number of key policy issues

Strongly disagree — Strongly agree

1 ——— **10**

11) Allowed me to develop my leadership potential

Strongly disagree — Strongly agree

1 ——— **10**

12) Made me a better team worker

Strongly disagree — Strongly agree

1 ——— **10**

13) Felt more self-confident and assured at work

Strongly disagree — Strongly agree

1 ——— **10**

14) Became aware of different approaches to leadership

Strongly disagree — Strongly agree

1 ——— **10**

15) Felt more able to influence others

Strongly disagree — Strongly agree

1 ——— **10**

16) Enabled me to undertake sustainable change in my organisation

Strongly disagree — Strongly agree

1 ——— **10**

17) Improved my motivation and sense of 'can do' attitude

Strongly disagree — Strongly agree

1 ——— **10**

18) More ambitious about the impact I can make to improve services

Strongly disagree — Strongly agree

1 ——— **10**

19) Emphasised the need for effective teamwork in achieving my goals

Strongly disagree — Strongly agree

1 ——— **10**

20) Made me believe I could have more influence on others

Strongly disagree — Strongly agree

1 ——— **10**

21) Made me feel more committed to innovation and service improvement

Strongly disagree — Strongly agree

1 ——— **10**

22) Felt more able to critically evaluate and challenge service standards

Strongly disagree — Strongly agree

1 ——— **10**

23) Gave me an understanding of the methods and approaches to quality improvement

Strongly disagree — Strongly agree

1 ——— **10**

24) Enabled me to feel I could unite my team around a future goal

Strongly disagree — Strongly agree

1 ——— **10**

25) I am better able to understand the workings of my organisation

Strongly disagree — Strongly agree

1 ——— **10**

26) Pulled together ideas and opinions into coherent explanations

Strongly disagree — Strongly agree

1 ——— **10**

Section B

Please identify three components of the scheme that you believe had a particularly positive impact upon your development. (Please illustrate where possible).

1)

2)

3)

Please identify three aspects of the scheme you feel could have been improved.

1)

2)

3)

Section C

1) Has your participation in the scheme:

a) Changed your personal career ambition:
☐ No change ☐ Increased my personal ambition

b) Resulted in career enhancement through career change or promotion:
☐ No ☐ Yes (please give details)

2) I would strongly recommend the scheme to colleagues

Strongly disagree — Strongly agree

1 ——————————————— **10**

3) If you had to place a per participant cost on your scheme do you think it is likely to be:
☐ £0–£10,000
☐ £10,001–£20,000
☐ £20,001–£50,000
☐ £50,001–£100,000
☐ £100,001+

4) In relation to this monetary value you have now identified, to what extent would you say your participation in the scheme represented value of money:

a) To you personally:
- ☐ Outstanding
- ☐ Good Value
- ☐ Reasonable
- ☐ Costly

b) To your organisation:
- ☐ Outstanding
- ☐ Good Value
- ☐ Reasonable
- ☐ Costly

5) From your experience of working in quality improvement do you believe the leadership skills to support this task are:
a) Specific and distinct to service improvement ☐
b) The same as leadership in any context ☐
c) Not sure ☐

Please use the space below to add any clarifying remarks particularly in relation to the questions in Section C:

Thank you for taking the time to complete this survey

Please return to following address:

Health Foundation Survey
ORCNI Ltd
First Floor
248 Oxford Gardens
Stafford

Appendix 13

Worked example of the process for rating a QI project

Description of the improvement project

In this worked example, the QI work being undertaken by the Health Foundation programme participant was introducing one-stop day surgery for minor surgical conditions. This involved patients being given one single hospital appointment post-referral (preceded by a telephone pre-assessment) and all necessary diagnostics being carried out at the single appointment prior to the day case procedure itself being carried out. The aim was for patients to be discharged on the same day, and provided with follow-up telephone contact rather than any follow-up hospital appointments.

This improvement work replaced a pathway whereby patients previously had to attend hospital on separate occasions for diagnostics and pre-assessment, and then a further visit for the procedure (sometimes waiting hours for a procedure which took only minutes to perform). A further hospital appointment was then required for follow-up. The improvement work redesigned the pathway to streamline all these processes into one single hospital appointment.

Assigning a QI type rating

The process for assigning a QI type rating to the project was based on extracting data from the SSI transcription, usually in the form of verbatim quotes. Data relevant to each dimension of the QI type measure (focus, level, process and outcome) were noted.

For this worked example, each of these dimensions is detailed below.

1. Level

The data from the SSI relevant to this dimension were not verbatim in this case, but rather were interpreted by the interviewer. From the interviewee's explanation of the improvement work, it was clear that the level at which it was happening was within one surgical day case list in the day surgery unit. The QI type grid was then used to determine a rating for this (see figure A3):

Degree of compexity	**1**	**4**	**7**
Level	The improvement is focused within a single ward, department or general practice.	The scope of the improvement covers several departments or care pathways within a single health economy.	The improvement covers several national and/or international agencies or organisations.

Figure A3: Use of the QI type measure to determine a rating for the level dimension

In the worked example, this improvement appears to fit with the description of rating 1. However, other data from the SSI reveals that the improvement involved liaison with other departments as well as day surgery, such as diagnostics, outpatients and the IT department, for the purposes of making the changes required to the care pathway. This meant that a rating of 1 was too low. A rating of four was too high, because while several departments were involved, only one care pathway was being altered. An assessment therefore needed to be made as to whether this QI was at level two or level three. The level three rating was aimed at a level below a single health economy, namely, within a single organisation, but spanning many parts of a whole organisation. This worked example was at a more local, departmental level than this. Therefore, level two was agreed as being the appropriate rating.

2. Focus

The data from the SSI relevant to this dimension were:

> *'Patients having day surgery for intermediate things like, you know, hernias, varicose veins, and complex things like laproscopic colonectomies and laproscopic incision of hernia repairs. Oh, simple things moles, toenails, lumps, and bumps.'*

These verbatim data were then assessed against the QI type grid to ascertain an appropriate rating for the focus dimension (figure A4):

Degree of complexity	1	4	7
Focus	The improvement is aimed at a defined group of people and is limited to a single clinical condition or one aspect of a clinical pathway.	The improvement is aimed at a wide group of people with a range of clinical needs.	The improvement is intended to benefit unlimited numbers of people with unlimited clinical needs.

Figure A4: Use of the QI type measure to determine a rating for the focus dimension

In this case, the focus rating would be higher than a one because the focus was wider than a single clinical condition. However, it would be lower than a four because the group of patients affected by the improvement could not be classed as a wide group of people. The people affected by this change were those on a single operating list, so the range was quite narrow, limited to a few clinical conditions, and limited to a single clinical pathway. If more than one clinical pathway had been involved, this would have been assigned a rating of three, but given that a single pathway was being addressed, the rating two for focus was appropriate in this case.

3. Process

The data relevant to the process dimension related to the type of change involved, the range of stakeholders and the influencing process. For the worked example, the data are shown below, in verbatim form.

Type of change/scale of change

(Innovative) I am not aware of this being done anywhere else on an all-comers basis.'

Range of stakeholders

Outpatient nurses, theatre staff, consultant surgeons, day case ward staff, patient admin people, managers, anaesthetic team, IT people.

Influencing

Because now we have a model pathway and it then has to match up with various people's thinking, it has to, you know, the Trust shouldn't lose money on this, the computer system should match up, the consultants surgeon should agree, the anaesthetist should agree, because when you say 'all comers', people immediately worry…get worried that, you know, somebody off the road is going to come up

and ask for a heart transplant or something like that, you know, even though that is clearly not the case.

So first we had to get agreement from the surgical team, we had to agreement from the anaesthetic team…

Outpatient nurses, they were very worried because they are losing business, they were worried that, you know, some of them might get unemployed or outpatient might fall to…you know, numbers may fall, day case ward nurses, they were worried that, you know, we are not outpatients so why are these patients who have not been checked before going to come here, and if they needed follow ups and all that, you know, how are we going to arrange that.

The computer systems …….. the patient admin people said, you know, this will not work with the computer systems because the system is designed for outpatient pre-assessment, TCI, discharge, follow up, it will never do it within one day, where's the outpatient? And I said, in that case tweak the system, he was going 'no you can't, because there is…this is not an authorised pathway'.

For instance, two tries at the patient admin 'choose and book' computer systems just didn't work at all. They sat and listened to me in great appreciation but it still didn't happen.

So, you know, these are all the types of hurdles which we had to deal with one step at a time.

These data were assessed against the dimension descriptors on the QI type measure, shown below in figure A5.

For the worked example, the process rating fell clearly into the four domain. While the one-stop day case list was common in some parts of the country, these lists would only be for one condition at a time. In the case of the Health Foundation programme participant,

Degree of complexity	1	**4**	**7**
Process	The change involves small improvements to existing practice. It only involves influencing one or two specific, identifiable individuals, and the task involved in this is extremely easy.	Some aspects of the change involve different ways of doing or thinking about things. Influencing is both direct and indirect, involving identifiable individuals and identifiable groups of people. Some of this influencing is problematic.	The change is entirely innovative, with completely new ways of doing or thinking about things. It involves influencing a range of people so diverse that it is virtually impossible to define them all; a task as complex and difficult as it could possibly be.

Figue A5: Use of the QI type measure to detrmine a rating for the process dimension

some of the work was therefore towards the more innovative end of the spectrum: in that it created a one-stop day case list covering a range of surgical procedures, and this list was managed dynamically during the operating session to reduce patient waiting time to a minimum. The stakeholder influencing involved some direct persuasion of stakeholders (such as certain consultants, anaesthetists and theatre staff) and also indirect influencing of day case ward nurses and patient admin staff. Some but not all of this influencing proved problematic.

4. Impact

The data relevant to the impact dimension related to the direct effect of the change on patient experience and health outcomes, as well as the likelihood of the change being sustainable. For the worked example, the data are shown below, in verbatim form.

Health outcome

Oh yes, from referral to discharge, we are about three or four weeks, that's our average time. Our re-admission rates are as good or better than the national average. Our inadvertent stay…overnight stays – you know, they come in as day cases but they end up staying – and that is far better than the national average.

We are using more and more local anaesthetics.

But apart from that, you know, the incidents of…we have monitored all clinical parameters, like post-operative bleeding, post-operative pain…bleeding and pain, I think are 0%,. Ah, no, actually one out of 130 patients had bleeding and one out of 130 patients stayed in bed due to pain, one had drowsiness, one had nausea. So the results are actually… the clinical results are very good.

And we have some recent audit results which shows that, you know, about 80%-85% we achieve day case, which is very good because the government target, so called target, is 75% and our internal standard was also 75%. So we have clearly exceeded that.

Patient experience

We have a protocol. If the nurses are happy with the protocol they discharge the patient, and then we don't give them a follow-up appointment, instead we give them a telephone number if it's working time they ring if they have any concerns. If they say we need to see a nurse or a doctor in the hospital, we guarantee them a 48 hours… appointment within 48 hours. But, I don't think that anyone has actually taken that up, but quite a few people ring, but nobody actually takes…has actually taken that opportunity to come and see us within 48 hours.

See, when I thought of this and actually got speaking to various people, they said: 'No, patients won't like it and it can't be done' etc, which from experience we find when we do a surgical clinic, what we find for small problems, you know, if you have a little mole and a patient turns up in a surgical clinic and you tell them that you're going to put them on the waiting list, they always say 'Oh, I thought it was going to be done straight away, it's only such a small problem'.

That's what their thinking was. Who put that thinking into their mind nobody knows, but the patients seem to think 'If I have such a small problem, why can't you do it straight away?' It's a very valid question. And then patients come back for follow up after the operation, if it's a hernia or varicose veins or whatever, most of the time its 'Okay, lets see the scar…okay the scar looks fine, go away.' It's 30 seconds or a minute, and for this they come all the way, they park the car, and whatever else that goes on with it.

Patient satisfaction is excellent. And it is excellent, but we still had complaints and the complaints were 'I waited two hours before I had my surgery', and I want to tell them but I don't, I don't mistake me for it, I mean you would have waited 17 weeks yeah, and you are waiting two hours. But you see, you see the frame of mind when you change the frame…

Sustainability

By the end of the project by the end of the year it was done, embedding was done.

So it's well embedded but not rolled out. Every time when I go and speak, they say: 'Oh this is fantastic, keep doing it, what about doing it…' Does anybody else want to do it? 'Oh no, no, no, not for us, you keep doing it, that's fine. Well done.'

These data were assessed against the dimension descriptors on the QI type measure, shown in figure A6.

The worked example was attributed a rating four for the impact dimension. On the first aspect of the dimension, the rating would fall in the five or possibly six domain, due to the significant impact the improvement has had on patient experience and on clinical outcomes. However, the sustainability aspect of the dimension falls below a level five. The changes that have been put in place are embedded into the way of doing day case surgery, but only for the programme participant's day case list, as an individual surgeon. The new approach will continue as long as this surgeon remains in the organisation. However, if the surgeon leaves the organisation, there is low likelihood that the revised pathway will continue as none

Degree of complexity	1	**4**	**7**
Intended impact	The change does not appear to be making any direct difference to the health, wellbeing or overall experience of service users. It appears to have no sustainability beyond its initial iinput phase.	It appears that the improvement has had a direct impact on improving the health, wellbeing or overall experience of service users. Some aspects of the improvement appear sustainable beyond its initial input phase.	It appears that the improvement has had a direct impact on improving the health, wellbeing or overall experience of service users, and is sustainable indefinitely.

Figure A6: Use of the QI type measure to determine a rating for the impact dimesion

of the other day surgery surgeons have adopted the approach. For this reason, the improvement is largely dependent on the Health Foundation programme participant as an individual. On the basis of lack of sustainability, the improvement does not warrant an impact rating above four.

In summary, the overall QI type rating for this worked example was 2244.

Appendix 14

Data range of QI types

ID	QI type	ID	QI type
1	1121	19	4444
2	1221	20	4455
3	1234	21	4533
4	1332	22	4542
5	2242	23	4542
6	2344	24	4551
7	2244	25	4554
8	2445	26	4554
9	2446	27	4664
10	3334	28	5344
11	3335	29	5354
12	3341	30	5355
13	3343	31	5366
14	3452	32	5421
15	3535	33	5444
16	3543	34	5542
17	4346	35	5554
18	4354	36	5554

Appendix 15

Example section of coded SSI transcript

Interview with ID *** (Leaders for Change)

(cont…)

JH: So during your time on Leaders for Change, then, what…was there a particular piece of work that you put energy into in terms of improvement?

ID: So what I did – I mean this is a project that's still in use. What I did is I chose a small pathology patient, somebody who had a little problem and literally begged the theatre, begged the ward nurses to get it done that day afternoon. So we do the clinic in the morning and theatres in the afternoon. So I said I have a patient right now, it is *not* an urgent or an important, you know, it's not an emergency problem but I want to do this patient this afternoon, just one case. **1d v**

So we did that. I immediately called a few managers, you know, the service managers and the nurse managers and asked them to interview the patient about what their expectations were and whether their expectations were met or not by this time of shortcut, rapid method. **3b ii**

JH: But presumably the patient didn't know she was going to be subjected to anything different.

ID: No, the patient thought it was going to be done this afternoon or straightaway. The patient did not realise that normally they would go on a waiting list, unless you tell them. So, I mean it was kind of genuinely a small problem, you know, four/five minutes, a local anaesthetic, and done! And then…

(cont…)

JH: So, how difficult would you say it has been to actually influence all the stakeholders? It sounds as if some were easer than others.

ID: Absolutely. I think a lot runs on personal relationships, a lot runs on contacts… I mean, you wouldn't expect the NHS to run like that because it's a government formal system, but its true, you know. For instance, two tries at the patient admin 'choose and book' computer systems just didn't work at all. They sat and listened to me in great appreciation but it still didn't happen. Then, when we are going on digging on, you know, which person is actually capable of doing it, we found a lady who was one of our secretaries in the past – for me and my boss – and then we rang her and said, you know, this is what we want to do and she was like 'yeah, what's the problem, I'll do it'. So in about three week's time she took the initiative and she was hounding us for information about the inclusion/exclusions and all that, and that was on.

1d v

ID: So, you know, a lot of it depends on relationships. A lot of it also depended for NHS non-medical staff, non-doctors. It depended on a fairly emotional argument. I would go to a resistant nurse – and there were a few – I would go up to them and say: 'If you had varicose veins, and if you had a choice, and if you wanted it done the same day, if somebody were to stop you, how would you feel about that?' Or I would also say, 'If you had your dad or grandad aged 85 wanting to have a hernia done and was made to come to the hospital six times on the pretext of ECG, blood tests, Wafarin control, whatever, whereas it can be done in one day, safely, you know, almost assured safety, what would you feel about that and would you like it that way?' And most of the time they reflect on it and they use what I recently learnt as 'deficit thinking'. You know, what are the problems with that? But then they eventually come back and say, 'Yeah, okay, if you can do it safely that's the way we want it'.

1f ii

So that's for non-doctor NHS clinical staff that works, theatre people, nurses. For non-clinical... for the managerial staff it's *absolutely* the financial argument. You know, you have to use different arguments for different people. For service managers, business managers and finance managers its like 'this is the pathway, my calculation is that it saves somewhere between £350–£500 per patient for you, and about £50–£75 for the PCT – because we don't follow up. So, and they said can you prove it? Is it nominal or is it actual? Which bed do we close, which light bulb…?' I said 'That's not up to me, that's up to you to decide where, you know, whether you want to remove a bed and sack the nurse, or you want to fill that up with another patient of some other sort. You're going to get more business.'

1j ii

But, you know, they looked at it really carefully. In fact, then they unofficially said that my estimates were actually very conservative; we actually saved a fair bit more money than that.

For the performance staff it's the argument about delivering what they would normally deliver on the 16th or 17th week, because your toe nails and your lumps and bumps and hernias don't get priority; they get put off till the 17th week when your cancers and aneurisms are done.

JH: Yeah.

ID: I said: 'Okay, but those are the ones which you get penalised for, if you breach them, you know, the SHA or the PCT or somebody is going to give you the stick.' So they at least can be done quite simply at a cheaper cost, which is none of their botheration, within three weeks. And the future is that, you know, if we had enough demand, we'll open another day like that. Right now we're doing one day. **1i ii**

(cont…)

Appendix 16

Example of a summary document of SSI IQL© behavioural data

Behavioural data summary from SSI with ID *** (Leaders for Change) from transcript

Leadership behavioural data

1. Interacts authentically

a) Seeks, understands and values the viewpoint of others

—

b) Understands personal impact and influence on others

—

c) Values the skills and expertise of others

i) But if any of our junior staff wants to write and publish it they'll have my full support.

v) I now, not regularly, because of the leave and I'm not too regular myself these days, but I do get a fairly experienced person and many times I just stand back and watch these relatively young doctors running the system. And it is a great boost to their confidence that they can run the system, and just my experience alone doesn't matter. It goes to show that anyone can run the system. They have, you know, two good years of surgical experience. I mean, they can do a hernia, they don't have to follow-up their patients and the patients do well [39:34]. So it really boosts their confidence.

iii) is I share my data; anybody who wants to study this process and write about it. And there is one or two other fairly special things

that we are doing, like this one-stop. But I share that as well, you know. If you want to study it and do an audit or do a post or do a publication, you want to include my name/don't want to include my name; I really don't care, go and do it.

iii) What I mean by that is this project in my hospital, I would never call it my project, it always goes in at least three names: two consultants and me. For example, local radio and our Trust has a link up, and when they want to speak about one-stop surgery I don't grab all the chance often even though I run that service, there's an anaesthetist who goes, there's a service manager who goes, you know.

d) Creates networks for the creation and sharing of ideas

v) What I did is I chose a small pathology patient, somebody who had a little problem and literally begged the theatre, begged the ward nurses to get it done that day afternoon. So we do the clinic in the morning and theatres in the afternoon. So I said I have a patient right now, it is not an urgent or an important, you know, it's not an emergency problem but I want to do this patient this afternoon, just one case.

iii) I would send off... absolutely send of an email to anyone about stuff that I do, whether they respond/don't respond whatever, and I will always look for opportunities — can I come and explain this to you, can I come and talk to your forum, can I come and do this, can I do this presentation?

So, you see, I keep my exposure level fairly high, there is another reason I do that, you know. The thing is I use my exposure as a measure of transparency because nobody is going to turn around and say you did this without permission because they already knew it. So I use that for a defensive purpose as well. But the positive purposes, I go out there and look for these opportunities. A lot of people don't like to do that, a lot of people hate me for doing that, but I go out there and push myself out there, keep my head above the wall, you know, say 'yeah, this is what I'm doing' and I'm willing to talk about it.

e) Builds structures that facilitate cooperation and collaboration

—

f) Creates strategies to influence others through persuasive reasoning

ii) I would go to a resistant nurse — and there were a few — I would go up to them and say: 'If you had varicose veins, and if you had a choice, and if you wanted it done the same day, if somebody

were to stop you, how would you feel about that?' Or I would also say, 'If you had your dad or grandad aged 85 wanting to have a hernia done and was made to come to the hospital six times on the pretext of ECG, blood tests, Wafarin control, whatever, whereas it can be done in one day, safely, you know, almost assured safety, what would you feel about that and would you like it that way?' And most of the time they reflect on it and they use what I recently learnt as 'deficit thinking'. You know, what are the problems with that? But then they eventually come back and say: 'Yeah, okay, if you can do it safely that's the way we want it'.

iii) So you go and give the relevant arguments for relevant people and if you go and speak about finance to doctors and nurses, they hate it, so they turn around and say: 'Well if you're doing this for saving the money, we're not being any part of it', and whatever, you know, this is the wrong approach and they'll find even stronger arguments not to do it. So it's a different chapter of the book for every person.

g) Builds confidence and trust in others

—

h) Empowers others to inspire and create commitment

iv) So, I had no authority… I had no hierarchical power, I had, you know, I mean in an academic sense I had no power of punishment, I had now power of reward, and I had no designation, no title to go with it. So it was a kind of personal power, personal impact, and that's in terms of academic leadership things.

So that's the sort of skill, you know, doing, leading by doing.

i) Communicates in a clear and compelling way

ii) I said: 'Okay, but those are the ones which you get penalised for, if you breach them, you know, the SHA or the PCT or somebody is going to give you the stick.' So they at least can be done quite simply at a cheaper cost, which is none of their botheration, within three weeks.

j) Adapts style of communication to audience

ii) For non-clinical... for the managerial staff its absolutely the financial argument. You know, you have to use different arguments for different people. For service managers, business managers and finance managers it's like: 'This is the pathway, my calculation is that it saves somewhere between £350–£500 per patient for you, and about £50–£75 for the PCT'.

2. Acts effectively

a) Identifies project implications

—

b) Specifies roles, tasks, and performance standards

—

c) Aligns people, tasks and resources

—

d) Responsive to changing or emerging internal or external context

—

e) Identifies risks and opportunities

—

f) Makes important decisions in a timely manner

—

g) Explores new suggestions and solutions

—

h) Tolerates ambiguity to promote creative solutions

i) I think every time and go and interact with the wider world my conviction grows but my flexibility is also growing. That doesn't mean I won't push things forward, I won't…I still wont take no for an answer, but I can… I can turn around those no's, I mean there is a capital 'NO' and a small 'no', you know, I can turn that from a capital NO to a small no perhaps, you know.

3. Conceptualises issues

a) Articulates and formulates key issues clearly

—

b) Structures, analyses and integrates hard and soft data

ii) I immediately called a few managers, you know, the service managers and the nurse managers and asked them to interview the patient about what their expectations were and whether their expectations were met or not by this time of shortcut, rapid method.

c) Manipulates complex facts and opinions

iii) I'm also aware that when the model is actually worked, when like theoretical paper description of a model is actually worked, it may not actually work. So I want to know whether it works or not.

d) Creates clarity from diverse perspectives

—

e) Evaluates options to create powerful decisions

—

f) Identifies the links between the wider system and its components

Appendix 17

SSIs IQL© behaviour frequencies at level of 24 key competencies

ID	Programme	Interacts authentically										Acts effectively								Conceptualises issues						Total ALL	Total authentic	Total effect	Total concept
		a	b	c	d	e	f	g	h	i	j	a	b	c	d	e	f	g	h	a	b	c	d	e	f				
1	QIF	1	0	0	0	3	2	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	8	6	0	2
2	QIF	0	0	0	3	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0	0	7	4	1	2
3	LF	0	0	0	1	2	1	0	2	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	8	6	2	0
4	LFC	0	0	1	0	0	1	2	0	0	0	0	3	0	0	0	1	0	4	1	0	0	0	0	0	13	4	8	1
5	LF	1	0	2	0	0	3	2	2	1	1	0	0	0	0	0	0	0	0	0	0	0	0	2	1	15	12	0	3
6	LFC	0	0	4	2	0	2	0	1	1	1	0	0	0	0	0	0	0	1	0	1	1	0	0	0	14	11	1	2
7	LFC	0	1	0	1	2	3	1	0	1	1	1	1	0	0	1	0	1	0	1	0	0	1	0	1	17	10	4	3
8	LF	1	0	1	1	0	0	0	0	0	0	1	0	0	0	0	0	0	2	0	0	0	0	0	1	7	3	3	1
9	LFC	0	0	2	1	0	0	0	1	0	0	0	0	0	0	1	1	0	2	0	1	0	0	0	0	9	4	4	1
10	LF	1	0	5	2	1	2	2	1	1	1	1	3	1	0	1	0	1	1	2	0	0	0	3	0	29	16	8	5
11	LFC	3	1	2	0	1	0	0	0	0	0	1	1	0	0	0	0	1	0	0	0	2	2	1	0	15	7	3	5
12	LF	4	1	1	0	0	2	1	0	0	0	0	2	1	0	0	0	1	0	0	0	0	0	0	0	13	9	4	0
13	LFC	0	0	0	1	1	1	2	0	0	1	0	0	1	0	0	0	0	0	0	0	1	1	0	0	9	6	1	2

ID	Scheme	Interacts Authentically										Acts Effectively								Conceptualises Issues						Total ALL	Total Authentic	Total Action	Total Concept
		a	b	c	d	e	f	g	h	i	j	a	b	c	d	e	f	g	h	a	b	c	d	e	f				
14	LF	2	1	0	0	1	2	3	1	0	3	2	0	0	0	1	1	2	8	1	0	0	0	1	1	30	13	14	3
15	LFC	5	2	0	2	1	1	0	0	1	0	3	0	3	1	0	0	0	1	0	3	0	1	0	3	27	12	8	7
16	QIF	0	0	2	1	1	2	0	3	2	0	0	2	1	0	0	0	1	1	0	0	0	1	0	1	18	11	5	2
17	LFC	3	2	1	0	0	2	0	1	0	1	0	1	0	0	0	0	1	0	0	0	0	1	0	0	13	10	2	1
18	LFC	3	0	5	1	1	1	4	0	1	1	0	2	2	0	0	0	1	0	1	0	0	0	0	0	23	17	5	1
19	LFC	0	0	0	0	1	0	0	0	2	0	4	0	0	0	1	0	0	3	0	1	0	0	0	1	13	3	8	2
20	LFC	4	4	3	3	4	4	4	3	0	1	1	0	0	1	4	1	1	2	1	0	1	2	1	0	45	30	10	5
21	LF	1	0	1	0	1	4	1	4	0	0	0	2	1	1	1	0	0	0	0	0	0	1	1	1	20	12	5	3
22	LFC	0	0	2	0	1	1	1	0	0	0	1	1	0	0	0	0	2	0	0	0	0	0	0	0	9	5	4	0
23	LFC	2	0	0	1	0	0	0	0	0	1	1	1	1	0	1	0	1	0	0	0	0	0	0	2	11	4	5	2
24	LF	1	0	3	1	0	1	2	0	0	0	1	0	1	0	1	2	2	3	0	0	0	0	0	1	19	8	10	1
25	LFC	0	0	2	2	1	1	0	1	0	0	1	1	0	0	0	0	2	2	0	0	0	0	0	0	13	7	6	0
26	LF	1	1	5	1	0	0	3	2	0	2	2	1	1	0	0	0	1	0	0	0	2	1	0	2	25	15	5	5
27	LF	1	1	1	0	0	2	0	0	0	2	0	0	1	0	0	0	0	0	0	1	0	0	0	0	9	7	1	1
28	QIF	1	1	1	1	0	2	0	1	1	0	1	0	0	0	0	0	0	3	0	0	1	0	1	2	16	8	4	4
29	LFC	3	2	1	2	0	2	4	1	0	5	2	0	0	0	1	3	1	0	2	0	0	1	1	1	32	20	7	5
30	LF	3	0	3	2	4	3	0	0	0	0	3	1	1	0	0	0	1	2	1	0	0	0	0	1	25	15	8	2
31	LFC	3	0	2	1	4	3	1	1	0	1	2	2	4	2	2	1	0	1	1	1	1	1	0	1	35	16	14	5
32	LFC	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	2	1	0	1
33	LF	2	0	1	0	1	1	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	7	5	2	0
34	LF	1	0	0	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	7	5	0	2
35	LFC	0	1	0	1	3	0	1	0	1	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	9	7	1	1
36	LF	0	0	0	0	2	1	0	0	0	0	0	0	0	0	3	0	0	1	0	1	0	0	0	0	8	3	4	1
		48	18	51	32	39	50	34	26	12	22	28	26	19	6	19	10	20	39	12	12	9	14	11	23	580	332	167	81

Appendix 18

SSIs, IQL© and type full dataset for correlation purposes

ID	Prog	Interacts authentically										Acts effectively								Conceptualises issues						Total ALL	Total authentic	Total effect	Total concept	1–7 ORCNI QI measure
		a	b	c	d	e	f	g	h	i	j	a	b	c	d	e	f	g	h	a	b	c	d	e	f					
1	QIF	1	0	0	0	3	2	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	8	6	0	2	1121
2	QIF	0	0	0	3	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0	0	7	4	1	2	1221
3	LF	0	0	0	1	2	1	0	2	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	8	6	2	0	1234
4	LFC	0	0	1	0	0	1	2	0	0	0	0	3	0	0	0	1	0	4	1	0	0	0	0	0	13	4	8	1	1332
5	LF	1	0	2	0	0	3	2	2	1	1	0	0	0	0	0	0	0	0	0	0	0	0	2	1	15	12	0	3	2242
6	LFC	0	0	4	2	0	2	0	1	1	1	0	0	0	0	0	0	0	1	0	1	1	0	0	0	14	11	1	2	2244
7	LFC	0	1	0	1	2	3	1	0	1	1	1	1	0	0	1	0	1	0	1	0	0	1	0	1	17	10	4	3	2344
8	LF	1	0	1	1	0	0	0	0	0	0	1	0	0	0	0	0	0	2	0	0	0	0	0	1	7	3	3	1	2445
9	LFC	0	0	2	1	0	0	0	1	0	0	0	0	0	0	1	1	0	2	0	1	0	0	0	0	9	4	4	1	2446
10	LF	1	0	5	2	1	2	2	1	1	1	1	3	1	0	1	0	1	1	2	0	0	0	3	0	29	16	8	5	3334
11	LFC	3	1	2	0	1	0	0	0	0	0	1	1	0	0	0	0	1	0	0	0	2	2	1	0	15	7	3	5	3335
12	LF	4	1	1	0	0	2	1	0	0	0	0	2	1	0	0	0	1	0	0	0	0	0	0	0	13	9	4	0	3341
13	LFC	0	0	0	1	1	1	2	0	0	1	0	0	1	0	0	0	0	0	0	0	1	1	0	0	9	6	1	2	3343

ID	Scheme	Interacts Authentically										Acts Effectively								Conceptualises Issues						Total ALL	Total Authentic	Total Action	Total Concept	1–7 ORCNI QI Measure
		a	b	c	d	e	f	g	h	i	j	a	b	c	d	e	f	g	h	a	b	c	d	e	f					
14	LF	2	1	0	0	1	2	3	1	0	3	2	0	0	0	1	1	2	8	1	0	0	0	1	1	30	13	14	3	3452
15	LFC	5	2	0	2	1	1	0	0	1	0	3	0	3	1	0	0	0	1	0	3	0	1	0	3	27	12	8	7	3535
16	QIF	0	0	2	1	1	2	0	3	2	0	0	2	1	0	0	0	1	1	0	0	0	1	0	1	18	11	5	2	3543
17	LFC	3	2	1	0	0	2	0	1	0	1	0	1	0	0	0	0	1	0	0	0	0	1	0	0	13	10	2	1	4346
18	LFC	3	0	5	1	1	1	4	0	1	1	0	2	2	0	0	0	1	0	1	0	0	0	0	0	23	17	5	1	4354
19	LFC	0	0	0	0	1	0	0	0	2	0	4	0	0	0	1	0	0	3	0	1	0	0	0	1	13	3	8	2	4444
20	LFC	4	4	3	3	4	4	4	3	0	1	1	0	0	1	4	1	1	2	1	0	1	2	1	0	45	30	10	5	4455
21	LF	1	0	1	0	1	4	1	4	0	0	0	2	1	1	1	0	0	0	0	0	0	1	1	1	20	12	5	3	4533
22	LFC	0	0	2	0	1	1	1	0	0	0	1	1	0	0	0	0	2	0	0	0	0	0	0	0	9	5	4	0	4542
23	LFC	2	0	0	1	0	0	0	0	0	1	1	1	1	0	1	0	1	0	0	0	0	0	0	2	11	4	5	2	4542
24	LF	1	0	3	1	0	1	2	0	0	0	1	0	1	0	1	2	2	3	0	0	0	0	0	1	19	8	10	1	4551
25	LFC	0	0	2	2	1	1	0	1	0	0	1	1	0	0	0	0	2	2	0	0	0	0	0	0	13	7	6	0	4554
26	LF	1	1	5	1	0	0	3	2	0	2	2	1	1	0	0	0	1	0	0	0	2	1	0	2	25	15	5	5	4554
27	LF	1	1	1	0	0	2	0	0	0	2	0	0	1	0	0	0	0	0	0	1	0	0	0	0	9	7	1	1	4664
28	QIF	1	1	1	1	0	2	0	1	1	0	1	0	0	0	0	0	0	3	0	0	1	0	1	2	16	8	4	4	5344
29	LFC	3	2	1	2	0	2	4	1	0	5	2	0	0	0	1	3	1	0	2	0	0	1	1	1	32	20	7	5	5354
30	LF	3	0	3	2	4	3	0	0	0	0	3	1	1	0	0	0	1	2	1	0	0	0	0	1	25	15	8	2	5355
31	LFC	3	0	2	1	4	3	1	1	0	1	2	2	4	2	2	1	0	1	1	1	1	1	0	1	35	16	14	5	5366
32	LFC	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	2	1	0	1	5421
33	LF	2	0	1	0	1	1	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	7	5	2	0	5444
34	LF	1	0	0	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	7	5	0	2	5542
35	LFC	0	1	0	1	3	0	1	0	1	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	9	7	1	1	5554
36	LF	0	0	0	0	2	1	0	0	0	0	0	0	0	0	3	0	0	1	0	1	0	0	0	0	8	3	4	1	5554
		48	18	51	32	39	50	34	26	12	22	28	26	19	6	19	10	20	39	12	12	9	14	11	23	580	332	167	81	

Appendix 19

58 statements used in Q sort relating to perceived programme benefits

1. I understand more clearly my leadership role and its impact on my organisation
2. I feel more confident in my own leadership capabilities
3. I gained powerful insights into my own strengths and weaknesses
4. I have a greater understanding of how genuine communication, can bring commitment from others
5. I developed new interpersonal skills
6. I have increased my flexibility to adapt my leadership approach to task
7. I have built stronger networks in my areas of interest which have enabled me to be more effective
8. I have honed my communication skills, using both face-to-face and remote approaches
9. I feel more able to build organisational leadership capacity: for example, developing staff into new positions and establishing extended roles
10. I achieved an improved balance of reflection and action in my role
11. I am better at interpreting team dynamics and am thus able to make teams work more effectively
12. I am more ambitious to progress in my career, pursuing more senior roles

13. I feel more ambitious concerning the degree of impact I can individually make to improve services
14. I feel safer and more receptive to peer learning environment: for example, action learning
15. I understand the need to influence the future direction of my service, establishing a clear vision for service development
16. I have learnt which professional development opportunities work best for me
18. I am increasingly able to work outside my comfort zone, taking calculated risks
19. I am better at leading change through others
20. I pay extra attention to the emotional state of staff: for example, by showing openness, genuine sensitivity and giving due praise
21. I understand how models and theories can inform my leadership practice
22. I am now able to enact transformational leadership behaviours as part of my repertoire
23. I feel more confident and assertive in the workplace, doing things I previously shied away from
24. I have learnt to share my leadership role with others e.g. by delegating power and decision making
25. I am better able to motivate and instil a 'can do' attitude in others
26. My leadership style is more collaborative, involving key stakeholders in service development activities
27. I feel more empowered to lead others
28. I now handle difficult situations in a calmer, more considered manner
29. I am now more willing to resolve conflict and difficulties: for example, between departments and across organisational boundaries
30. I feel more comfortable saying 'no'
31. I feel more confident in encouraging others to solve problems/ difficulties
32. I feel more determined to challenge outdated organisational norms

33. I now conduct and chair meetings more effectively
34. I am more proactive in tackling behavioural and performance dysfunction
35. I feel able to develop and sustain a culture of innovation
36. I am better able to facilitate consensus, when faced with divergent staff views
37. I feel more influential at a strategic level both locally and regionally
38. I have learnt to appreciate and work with a diversity of perspectives
39. I am better able to cope with ambiguity and uncertainty within my service
40. I have a better knowledge of, and approaches to, organisational development
41. I am more outward looking: for example, I have an increased awareness of the importance of partnership and inter-agency working
42. I have increased awareness of organisational politics and the corporate strategic agenda
43. I am more willing to initiate contact with external partners
44. I feel better motivated to drive for service improvement
45. I feel more comfortable holding corporate accountability and responsibility
46. I feel better equipped to identify and overcome barriers that have historically prevented service improvement
47. Since attending the course I feel other people are more responsive towards me
48. I have become more decisive since attending the course
49. I have developed more effective multidisciplinary team working across my service
50. I have gained increased access to, support from and dialogue with senior staff
51. I have benefited from the multidisciplinary nature of the scheme
52. I have developed my ability to negotiate with other departments/services

53. I have deeper understanding of the workings of my organisation and how to facilitate effective corporate decision making
54. I am now able to prioritise my time more effectively
55. I have learnt how to be more competitive and entrepreneurial in the 'new NHS'
56. I have achieved a healthier work-life balance
57. I am more conscious of the importance of high quality, qualitative and quantitative data to inform decision making
58. I am better equipped to scrutinise and redesign care pathways, using appropriate tools and techniques
59. I have greater knowledge of NHS financial systems and therefore feel able to influence the financial viability of my services

Appendix 20

120 Q sort statements relating to leadership behaviours

1. Solicits all points of view and uses these perspectives to build consensus
2. Regularly initiates discussion and facilitates open sharing of opinions
3. Harnesses different opinions and capitalises on the benefits of diversity
4. Takes other people's perceptions seriously and empathises with their feelings
5. Encourages the differing and preferred working styles of individuals
6. Anticipates how other parties may react to the content of personal communication
7. Makes convincing and balanced arguments, tailored to others' needs and expectations
8. Takes account of others' reactions regarding tones of voice, gestures and facial expressions
9. Monitors others' understanding of what is discussed and corrects misunderstandings
10. Interprets the face-to-face impact of own conduct on others' behaviour and responses
11. Capitalises on the range of skills and talents present in the organisation
12. Identifies and nurtures talent to build capacity and capability
13. Offers support, rewards achievements and celebrates success
14. Gives clear constructive feedback, timely praise and focused recognition

15. Participants work to provide challenge and opportunities to learn and develop
16. Identifies and consults with key stakeholders to obtain buy-in for ideas
17. Build and enthuses a wide base of support for innovation and change
18. Develops and sustains a diverse range of internal and external relationships
19. Invests time to establish, sustain and broaden information and intelligence networks
20. Engages the support and allegiance of informal networks in formal situations
21. Sets up and maintains open communication channels to promotes information exchange
22. Facilitates cooperation within and between organisations by sharing information
23. Implements a range of formal and informal team-building development activities
24. Establishes cross-agency working and encourages collaborative partnerships
25. Develops cooperation and teamwork by encouraging key stakeholders to work together
26. Constructs persuasive arguments to facilitate the acceptance and adoption of change
27. Conveys his/her position convincingly even when faced with strong opposition
28. Uses influence and persuasive skills to involve, engage and gain others' support
29. Helps others create their own solutions to facilitate ownership and commitment
30. Provides clear, constructive and timely guidance to shape others behaviour
31. Anticipates dissent and uses appropriate strategies to resolve conflict when it arises
32. Asks open-ended questions that encourage authentic and honest communication

33. Shows trust and confidence in staff by acknowledging their effort and contribution
34. Demonstrates honesty in interactions by matching deeds to words
35. Listens carefully to others to gain a real insight into their issues and concerns
36. Explains the need for change and inspires commitment to the process
37. Communicates a common compelling vision for the future organisation
38. Demonstrates commitment to innovation and to continuous improvement
39. Presents as a role model of creativity, innovation, and learning
40. Ensures organisation has a culture of promoting commitment and engagement
41. Delivers messages in a clear, concise and articulate manner without using jargon
42. Creates meaning for the audience by using events and stories to illustrate key points
43. Uses anecdotes and analogies to illustrate ideas and bring messages to life.
44. Pitches messages to focuses on key points and facilitate desired outcomes
45. Maximises personal communication strengths while minimising weaknesses
46. Seeks to understand others' non-verbal cues and adjusts presentation style accordingly
47. Anticipates the likely reaction and selects communication style to meet audience needs
48. Explains complex information using a level of language appropriate for the audience
49. Maintains an awareness of peoples' personalities and motivations and adapts to this
50. Asking clarifying questions and reflects back to ensure message has been understood
51. Specifies the task requirements and identifies the likely outcomes of plans

52. Assesses the feasibility and acceptability of translating policies into operational plans
53. Takes into account the personal and emotional costs of organisational change to staff
54. Determines necessary resources (money, people, and materials) for project success
55. Makes sense of organisational events by inferring causes and consequences of interventions
56. Specifies clear organisational goals, priorities and performance objectives
57. Sets performance standards and shows concern that they are met or surpassed
58. Conducts regular reviews and constructively addresses under-performance
59. Establishes structures that delineate authority with clear lines of accountability
60. Holds both self and others accountable for effective delivery of results
61. Ensures that all organisational sub-systems effectively support the business plan
62. Controls projects by ensuring plans, people and resources are appropriately mobilised
63. Unites staff around an inspiring vision and aligns staff capacities with planned activities
64. Ensures coordination of values, mission, strategy, structure and day-to-day performance
65. Links achievement of goals with appropriate rewards and recognition
66. Initiates organisational responses as required and maintains the pace of change
67. Keeps alert to a wide range of signals that may indicate important shifts in conditions
68. Anticipates organisational change and knows when, why and how to adapt quickly
69. Understands that the effects of organisational change are both planned and unplanned

70. Reacts quickly and confidently to contain, control or capitalise on rapidly changing events
71. Seeks out opportunities to try out new ideas or innovative schemes
72. Plans ahead and recognises that services can and should change for the better
73. Keeps alert to all possibilities to identify the potential of positive change
74. Spots chances and opportunities to apply or transfer innovative practices
75. Anticipates and reduces risks by knowing organisational strengths and weaknesses
76. Identifies and consults with the appropriate key decision makers on emerging issues
77. Demonstrates understanding of units/departments and factors this into any decisions
78. Anticipates barriers to rapid decision making and takes steps to remove these
79. Selects the best time to announce a decision to maximise positive impact
80. Draws on own knowledge and experience to make balanced and timely judgments
81. Encourages others to produce novel suggestions and solutions to organisational problems
82. Analyses the future potential of new schemes to improve work practices and services
83. Encourages novel approaches which have the promise to deliver improved outcomes
84. Generates creative and valuable suggestions with the potential to improve service delivery
85. Envisions the ways in which potential innovations may influence current working practices
86. Prefers to promote promising initiatives and approaches rather than maintain the status quo
87. Encourages others not to reject new ideas because their benefits may not be immediate

88. Explores imaginative solutions and considers new approaches to enhance effectiveness
89. Pursues worthwhile new initiatives even when there is ambiguity and uncertainty
90. Challenges accepted behaviour and pushes forward even under difficult circumstances
91. Identifies staff attitudes, concerns and opinions relevant to the issue at hand
92. Disentangles the fundamental reasons and root causes of organisational problems
93. Identifies the specific information needed to solve a problem efficiently
94. Prioritises important issues and tease out the dependencies between them
95. Maintains up-to-date knowledge about the organisational structures and processes
96. Transforms available data into meaningful information to inform and illuminate
97. Blends and integrates disparate types of hard evidence and soft intuition
98. Uses experience, logic and empathy to derive acceptable and cost effective solutions
99. Explores the underlying meaning behind incomplete and ambiguous staff feelings
100. Balances the productivity, needs and demands of different parts of the organisation
101. Thinks flexibly and creatively under rapidly evolving or unexpected circumstances
102. Derives new ideas and innovative strategies within a useful timescale
103. Pinpoints critical factors to explain the meaning and implication of events
104. Grasps the evolving and overlapping patterns of complex events as they unfold
105. Shifts perspectives and focus to deal with concerns from various stakeholders

106. Structures loose threads of ideas and opinions into coherent explanations
107. Clarifies problems by actively examining relationships between components
108. Produces focused suggestions and strategies from dissonant viewpoints
109. Assembles a rich picture through discussion with diverse members of staff
110. Discerns organisational risks and opportunities from a complex set of factors
111. Prioritises and weighs up the pros and cons of situations to make good decisions
112. Distinguishes key priorities from supporting or peripheral sub-priorities
113. Focuses on all critical factors including hard-to-measure emotional issues
114. Probes staff reactions to proposed alternative options and decisions
115. Considers the organisation's priorities when making decisions or suggesting solutions
116. Takes a 'helicopter view' of the system to oversee both short and longer-term issues
117. Assesses whether the local picture is aligned to and supports the wider vision of change
118. Examines how the values of various staff groups fit within the organisational mission
119. Ensures that local operational goals support the organisational strategy mission and vision
120. Highlights key priorities for action by understanding where the future organisation should be

Appendix 21

How mindsets about leadership behaviours were derived

Mindset 1: engagement

The key defining statements for this mindset are:

36. Explains the need for change and inspires commitment to the process*
1. Solicits all points of view and uses these perspectives to build consensus*
35. Listens carefully to others to gain a real insight into their issues and concerns*
33. Shows trust and confidence in staff by acknowledging their effort and contribution*
42. Creates meaning for the audience by using events and stories to illustrate key points*
43. Uses anecdotes and analogies to illustrate ideas and bring messages to life*

* Indicates significance at P <0.01

The qualitative quotes by participants who prioritised these statements as +4 or +5 are displayed below.

Candidate 42, Quality Improvement Fellowships:

> *Need to build a guiding coalition of leaders from different disciplines in order to achieve transformational change. Seen examples where this has been key factor in success.*

Candidate 23, Leadership Fellows:

> *Appropriate trust, confidence and acknowledgement essential to QI.*

Candidate 15, Leadership Fellows:

> *Empowerment is critical and acknowledgement of effort energises – personal motivation to impress.*

Candidate 6, Leaders for Change:

> *My personal strength is in collaborative working and find that I get ownership when I use this style. This is important for me to ensure that the team is working towards a common goal. Listening to others is very useful to be in their shoes – perspective. Important to me to ensure that I address their concerns. I find it easy to relate to anecdotes and analogies to illustrate ideas from a different but related perspective. This is important to me as it is a good way to communicate effectively.*

Candidate 20, Leadership Fellows:

> *This is essential to set the context and begin to create the vision. It is important that the vision is shared and not simply that of the leader to ensure it will work and will be implemented and maintained long term.*

Candidate 19, Leadership Fellows:

> *Starting point for the view 'can and should change for the better' but also explains the need for change and inspiring commitment.*

Candidate 49, Harkness Fellowships:

> *It takes communication and the role of leadership – lighting the flame for change in others. Without this there is no culture change.*

Candidate 46, Harkness Fellowships:

> *This is the key leadership task (given standing still is not an option).*

Candidate 18, Leadership Fellows:

> *Using stories to illustrate key points is the most poignant and effective strategy for communicating the need for positive change within the NHS. It conveys meaning on multiple levels in a non-judgemental way.*

Candidate 12, Leaders for Change:

> *The local picture is an important element in supporting and bringing about change.*

Mindset 2: enhanced performance

The key defining statements for this mindset are:

63. Unites staff around an inspiring vision and aligns staff capacities with planned activities*
12. Identifies and nurtures talent to build capacity and capability*
60. Holds both self and others accountable for effective delivery of results*
11. Capitalises on the range of skills and talents present in the organisation
58. Conducts regular reviews and constructively addresses under-performance*
116. Takes a 'helicopter view' of the system to oversee both short and longer-term issues*
13. Offers support, rewards achievements and celebrates success*
14. Gives clear constructive feedback, timely praise and focused recognition*
59. Establishes structure that delineate authority with clear lines of accountability*

* Indicates significance at $P < 0.01$, otherwise $P < 0.05$.

The qualitative quotes by participants who prioritised these statements as +4 or +5 are displayed below.

Candidate 3, Leaders for Change:

> *It's important that individual skills and talents are recognised and that these are utilised rather than always using the same people. This motivates people and helps them develop.*

Candidate 15, Leadership Fellows:

> *Identifying and nurturing talent is critical to improving quality of sources for patients. Building capability takes years/ lots of experience and reflection. The best QI ideas in my services are from staff whose talent I've nurtured over years and I identify new staff who'll question and critically appraise in patient centred way.*

Candidate 27, Leadership Fellows:

> T*alent spotting and nurturing v. important to me.*

Candidate 40, Quality Improvement Fellowships:

> *Build and develop what you have. Need to improve capability.*

Candidate 37, Leading Practice through Research:

> *Engaging with all talents in a team is important.*

Candidate 43, Quality Improvement Fellowships:

> *Positive reinforcement and reward are critical to motivating individuals, teams and organisations to move forward.*

Candidate 7, Leaders for Change:

> *It is important to me that people display and act with honesty and integrity and for the right reasons. If leaders act in this way people will want to follow – to do things and be like them.*

Candidate 48, Harkness Fellowships:

> *Where are we going, where we are now and where have we been. I prefer to lead from the front to facilitate ongoing awareness of challenges and barriers and buy-in from other staff.*

Candidate 6, Leaders for Change:

> *What people do, and what actually happens, is the most important thing. What they say, and how they say it, matters far less (in my view).*

Candidate 2, Leaders for Change:

> *Having an overview of the strategic long term and immediate needs enable one to better plan, prepare and understand the needs of a service and demands placed on it. Gain respect and trust and you gain engagement and minimise the politics.*

Candidate 6, Leaders for Change:

> *Integrity is a key personal trait that builds relationships. This is important to gain respect from people I interact with.*

Candidate 23, Leadership Fellows:

> *Honesty, deeds and words essential to leadership of QI, any dishonesty will lead to lack of following.*

Candidate 17, Leadership Fellows:

> *Leadership requires integrity and the ability to lead by example to inspire followers.*

Candidate 18, Leadership Fellows:

> *Honesty is the most important leadership value to demonstrate as it promotes respectful working relationships.*

Candidate 46, Harkness Fellowships:

> *Accountability is key to get people to deliver input.*

Candidate 10, Leaders for Change:

> *I believe that as a leader/role model you must provide clarity of your roles and responsibilities in delivering quality improvement and should expect the same from others. Quality improvement in patient care is the fundamental role of all healthcare workers.*

Candidate 4, Leaders for Change:

> *Talks of uniting staff – not just about one person but about everyone being involved in quality improvement. This statement captures many aspects of leadership.*

Candidate 28, Leadership Fellows:

> *Every organisation needs a vision and in organisations where there is not a common vision staff are often disjointed which can adversely affect quality. Organisations which succeed draw on the skills of their staff, engage and empower them in the agenda.*

Candidate 9, Leaders for Change:

> *Uniting staff and inspiring vision as feel leadership hinges on the ability to inspire others to want to do something differently plus need a shared vision to bring about quality improvement. Believe without vision it's difficult to bring about change.*

Candidate 30, Leading Practice through Research:

> *Sense of common purpose, shared vision with a rational approach to achieving this using staff ability and specific activities – ideals plus pragmatism.*

Candidate 13, Leaders for Change:

> *My understanding of what leadership is.*

Candidate 38, Leading Practice through Research:

> *I consider the ability to bring staff together around a vision is a prerequisite for other strategies, involving a complete mix of influence, action, reward and communication skills. I am developing this capacity currently.*

Candidate 16, Leadership Fellows:

> *People in the health service are interested in serving the public – creating vision based on community values and evidence based reasons for practice bring good care, cared for staff and good outcomes for health.*

Candidate 20, Leadership Fellows:

> *The leader needs to retain the 'helicopter view' others will focus on the detail using their strengths. This is the 'oversight' role.*

Candidate 34, Leading Practice through Research:

> *The 'helicopter view' is paramount – always need to have a holistic view otherwise leadership becomes tunnel visioned and unbalanced.*

Candidate 44, Harkness Fellowships:

> *I think 'good' leadership requires a good overview of the short and long term aims for effective planning – 'a meaningful vision'.*

Candidate 8, Leaders for Change:

> *Leader needs to have an overall view while empowering others and facilitating quality improvement.*

Mindset 3: innovation

The key defining statements for this mindset are:

39. Presents as a role model of creativity, innovation and learning*
28. Uses influence and persuasive skills to involve, engage and gain others' support*
101. Thinks flexibly and creatively under rapidly evolving or unexpected circumstances*
76. Identifies and consults with the appropriate key decision makers on emerging issues*
18. Develops and sustains a diverse range of internal and external relationships*
71. Seeks out opportunities to try out new ideas or innovate schemes*
26. Constructs persuasive arguments to facilitate the acceptance and adoption of change*

* Indicates significance at $P < 0.01$

The qualitative quotes by participants who prioritised these statements as +4 or +5 are displayed below.

Candidate 29, Leading Practice through Research:

> *Essential that a leader is a visible role model with creative idea for projects/research/ ways of working. Also that the leader is able to come up with shared ideas in order to help facilitate learning of those ideas.*

Candidate 30, Leading Practice through Research:

> *Importance of aspirational role models.*

Candidate 8, Leaders for Change:

> *Key to leading improvement is to ensure buy-in' Stakeholder buy-in is necessary to ensure sustained improvement. Flexibility is essential – adaptation to change.*

Candidate 39, Leading Practice through Research:

> *Breeding the right culture for improvement demonstrates what is acceptable and expected for change/improvement to occur themselves.*

Candidate 48, Harkness Fellowships:

> *Pilots, trials, evaluation and publication are essential.*

Candidate 18, Leadership Fellows:

> *Good leaders are always conscious of the fact that innovation is possible and achievable.*

Candidate 14, Leaders for Change:

> *The ability to think on your feet, anticipate, react and remain positive I see as key attributes of a leader in today's NHS and enable the enactment of quality improvement.*

Candidate 35, Leading Practice through Research:

> *Thinking and reading on 'feet' vital in new NHS – very political.*

Appendix 22

Perceptions of programme benefits: qualitative data provided by Q sort participants

The headings below are the Q sort statements, under which are listed all the responses provided by participants, irrespective of scheme.

I understand more clearly my leadership role and its impact on my organisation

The programme in all its different components has enabled me to see that I can lead on quality and have been able to see the impact on the organisation in how we are moving forward.

I feel more confident in my own leadership capabilities

Prior to the programme I lacked confidence in my ability and tended to under-value my knowledge and skills. Coaching was really helpful in building my confidence.

The outstanding benefit has been not only an increased confidence that I feel but the increased confidence in leadership capabilities that others around me perceive in me.

The scheme enabled me to not feel like I was continually barking up the wrong tree and to have the courage of my convictions in terms of challenging status quo and aiming for the highest quality possible. As a result I feel more confident in my ability as a leader.

Having undertaken the programme I developed a number of additional skills which increased my personal confidence.

This had the impact of allowing me to develop in other areas which were outside my comfort zone.

'I can lead and still be me' – this statement for me, sums up the overall greatest benefit of the fellowship to me. All parts of the scheme, but principally the guidance/introduction to psychological theories and literature contributed to this as well as the liberation of learning that my existing behaviours contributed to my being an effective leader.

I gained powerful insights into my own strengths and weaknesses

Most enlightening to have Myers Briggs to explain why I respond the way I do and how to adapt my behaviour to build on strengths.

I have a greater understanding of how genuine communication, can bring commitment from others

The important of building relationships through genuine communication has enabled me to develop highly productive networks that are going to rise to lead change in both practice and policy (the area is building real research capacity in the NHS). This was an unexpected development of my award but one that was made possible through the flexible approach and the possibility of seizing opportunities.

I have built stronger networks in my areas of interest which have enabled me to be more effective

One of my key aims for the award was to develop practice in a field that I had limited influence. The award spurred me to apply and make contact with organisations which I would not have had the confidence to do otherwise. This has had many positive spin-offs.

Mentorships through the programme has meant I now have a national profile within children's nursing also finance to attend conferences e.g. RCW research conferences. Allowed networking – working with others with a shared goal, shared vision seems key

I used some of the money from my award to establish an all Wales network of midwifery and reproductive health researchers – multidisciplinary and involving clinicians, academics and service users. The group has continued after the end of my award (2006) – has gained additional small

posts of funding and Welsh Assembly Government external reference group status. The group is thinking and beginning to grow – I'm now ready to hand over the role of chair. The group has definitely raised my profile within Wales and the UK.

Networks – absolutely the number one thing, no question. Networks in UK; NHS Inst, King's Fund, Nuffield, and the Health Foundation! And in the US – Commonwealth Fund, Boston Health, Policy Community, the providers I researched. I can call up 10-15 of US 'top 50 in healthcare' and they'll return my call. That's amazing and all down to the fellowship.

I achieved an improved balance of reflection and action in my role

I take time out to consider before I leap in, making me more effective and calmer and less 'fire fighting' at times.

I am more ambitious to progress in my career, pursuing more senior roles

I am due to start a new job in July – promotion and taking me out of my professional background (therapist) into general management. Confidence gained from cohort feedback and inc exposure to elements that I was good at.

Opened my eyes to a whole new world. Made me come back to UK chomping at the bit to be involved in policy. This has grown and grown subsequently from this whole scheme.

I feel more ambitious concerning the degree of impact I can individually make to improve service

The scheme provided me with the opportunity to become more confident in my ability as a leader and the opportunity to reflect on existing skills and re-direct them. I am very ambitious when it comes to improving quality of care for patients. The action learning sets have continued to be useful for this.

The degree of impact: for example, my capabilities in terms of working with others and watching them listen to me has been profound.

I understand the need to influence the future direction of my service, establishing a clear vision for service development

I can see how things can be developed and have some skills – listening, organisation development, negotiating to do this.

I am increasingly able to work outside my comfort zone, taking calculated risks

The leaders of change scheme enabled me to realise and respect the transferability of skills from my usual comfort zone to external areas of practice both within and without the NHS.

I am better at leading change through others

I believe that this statement summarises the outcome of attending the programme for me. It best describes leadership for me and my role as 'change agent' to unlock potential for change and improvement.

I have really learnt a great deal about how to work through others, gaining the confidence to stand back and set parameters and facilitate/support others to make change. I have also worked on not feeling guilty about not doing it myself.

I understand how the models and theories can inform my leadership practice

Using the different models on the course ('visit' days) and applying them to my project and other areas of my work has been a great benefit.

I have learnt to share my leadership role with others: for example, by delegating power and decision making

I am clinical lead within a very diverse group of the workforce including admin and private contractors – I feel roughly that all areas are now empowered to take responsibility for decisions and development.

My leadership style is more collaborative, involving key stakeholders in service development activities

Recognition of the important value and effectiveness of this inclusive approach and also the consequences of not adopting it.

Expert patient involvement our seminars opened my eyes to ways of engaging these stakeholders and the more rounded discussions, suggestions for service and quality improvement that could have real impact.

I feel more empowered to lead others

Leader of a charity currently therefore issue is very important – individual training – training days – contact with others on scheme.

I handle difficult situations in a calmer, more considered manner

Use of the insight, emotional intelligence to sense situation and use objective view and evidence as well as influencing to deal with difficult situation.

The scheme enabled me to be more confident at challenging decisions I did not agree with and therefore strategies for doing something about them.

I feel more confident in encouraging others to solve problems/difficulties

Collective problem-solving. I think the scheme ALS has honed my skills in this area.

I feel more determined to challenge outdated organisational norms

Remain eager to make change to improve QIPP.

I think the acknowledgement of the roles of power, politics and culture within organisations as part of the Leaders for Change module learning was extremely useful, as was the work on addressing them. Have always been concerned regarding institutionalisation within NHS as a barrier to progress/develop – it gave me a tool to articulate the issues.

I have a better understanding of how organisational norms are established and no longer assume that there is a 'good' reason for such things.

The research process gave me an increased awareness of common outdated barriers across different programmes operating across the country. This was causing ridiculous wastage in terms of poorly performing programmes.

A wide perspective, including other systems, international comparisons have given me more information, understanding of the potential for UK system, organisational performance and norms.

I feel able to develop and sustain a culture of innovation

Innovation is very strong in US and so had good opportunity to observe plus tied in with key "Darzi" theme on my return.

I feel more influential at a strategic level both locally and regionally

Important to me as best way of influencing/improving patient care and ensuring things are embedded and not just 'fads'. Taught organisational theory sessions/models; the site visits to analyse as teams and the direct assertions skills course.

I have been able to drive the patient safety agenda in Northern Ireland and my opinion is frequently sought and listened to at Deptartment of Health level.

I feel more influential as evidenced by national/regional policy changes. I enjoy strategic influence and have valued the discussions around improving quality at this level to impact services, users/carers ultimately. The mentorship aspect of the award has been pivotal.

I am better able to cope with ambiguity and uncertainty within my service

The role and organisation that I work within has poor org structure and leadership. I have had to learn to work in a role that supports and facilitates a national policy decision/ delivery over which I have no direct control.

I have increased awareness of organisational politics and the corporate strategic agenda

Understanding politics and managing/influencing up and across have been most useful aspect of learning – safe peer environment and 'time out' has made this learning possible.

I feel better equipped to identify and overcome barriers that have historically prevented service improvement

The mental health trust I work for suffers from a culture of mediocrity. The ability to analyse, adapt and sustain change in this setting has been helped particularly by the coaching and action learning set aspects of the fellows scheme.

Since attending the course I feel other people are more responsive towards me

Health Foundation 'brand' and respect for the IHI as an organisation changes other people' perceptions of you and means that your views are included in leadership debates.

I have gained increased access to, support from and dialogue with senior staff

Scheme facilitated very good access to senior leaders and decision makers who knew of and respected the scheme so made time available to meet and talk. Ongoing relationships and collaborations have ensued which are of benefit to my current role. Placement in a prestigious academic environment was enormously important.

I have benefited from the multidisciplinary nature of the scheme

Taught me many things – relationships/different thought processes of clinicians vs. managers and how to maximise this for product benefit – how the NHS works e.g. PCTs/ acute trusts relationships and organisational factors, how the Department of Health works. These lessons are constantly used in my practice as a leader but go to the grass roots level of how we are all working for patient care.

Multidisciplinary nature the biggest bonus for me – shared learning across clinical networks/specialities, reflective learning on my wide discipline, key contacts/network, and my ability to shape the thinking of my fellows.

I have learnt how to be more competitive and entrepreneurial in the 'new NHS'

In the USA I looked at AIDs prevention at the state level and its relationship to factors known to be important in prevention and public health. I also did an MPH at Harvard School of public health and took courses at MIT and Harvard Business School. Together both have assisted in meeting this standard.

I have achieved a healthier work–life balance

For too long I have had a work–work balance and my life came secondary. While I still have significant energy and drive I have now regained my life – I am now less stressed and looking at work from different perspective. Coaching and action learning helped to achieve this benefit

I am more conscious of the importance of high quality, qualitative and quantitative data to inform decision making

A lot of decisions on how projects are taken forward are based on high quality, qualitative and quantitative data within my organisation. Quality improvement day – York. Important to me to ensure that my project collects this data.

I am better equipped to scrutinise and redesign care pathways, using appropriate tools and techniques

Main reason for undertaking Quality Improvement Fellowships was to learn tools/methodologies. My previous role involved care pathway. Redesign; programmes attended; 90-day project; visiting different centres of excellence.

Main role within my work enhanced by change learning at Lancaster University.

Appendix 23

How groupings about programme benefits were derived

Group one: influencer

The key defining statements for this mindset are:

32. I feel more determined to challenge outdated organisational norms*

57. I am more conscious of the importance of high quality, qualitative and quantitative data to inform decision making*

41. I am more outward looking e.g. I have an increased awareness of the importance of partnership and inter-agency working*

27. I feel more empowered to lead others*

* Indicates significance at P <0.01

The qualitative quotes by participants who prioritised these statements as +3 or +4 are displayed below.

Candidate 2, Leaders for Change:

> *I believe in my own abilities so encourage others to take my guidance, instilling confidence in their abilities.*

Candidate 40, Quality Improvement Fellowships:

> *I have learnt of the importance of data as a management tool to influence others.*

Candidate 4, Leaders for Change:

> *I think the acknowledgement of the roles of power, politics and culture within organisations as part of the Leaders for Change module learning was extremely useful, as was the work on addressing them. Have always been concerned*

regarding institutionalisation within the NHS as a barrier to progress /develop – it gave me a tool to articulate these issues.

Candidate 18, Leadership Fellows:

I have a better understanding of how organisational norms are established and no longer assume that there is a "good" reason for such things.

Candidate 34, Leading Practice through Research:

Greatly raised my awareness of the impact I have on motivating, influencing and empowering others. The research process gave me an increased awareness of common outdated barriers across different programmes operating across the country. This was causing ridiculous wastage in terms of poorly performing programmes.

Candidate 41, Quality Improvement Fellowships:

Gaining a wider perspective, including international comparisons have given me more information, understanding the potential by which UK systems and organisations can establish new norms of performance.

Candidate 48, Harkness Fellowships:

Knowledge about other models of care have helped a lot to challenge practice.

Group two: effective manager

The key defining statements for this mindset are:

28. I handle difficult situations in a calmer, more considered manner*
49. I have developed more effective multidisciplinary team working across my service*
54. I am now able to prioritise my time more effectively*
56. I have achieved a healthier work-life balance*
14. I feel safer and more receptive to peer learning environments*
33. I now conduct and chair meetings more effectively*
20. I pay extra attention to the emotional state of staff e.g. by showing openness, genuine sensitivity and giving due praise*

* Indicates significance at $P < 0.01$

The qualitative quotes by participants who prioritised these statements as +3 or +4 are displayed below.

Candidate 17, Leadership Fellows:

> *My own composure and comfort have improved with greater confidence – largely due to coaching conversations.*

Candidate 5, Leaders for Change:

> *Use of the insight, emotional intelligence to sense situation and use objective view and evidence as well as influencing to deal with difficult situation.*

Candidate 20, Leadership Fellows:

> *MD working – thinking differently and learning from others. Important as this is the essence of patient focused care. The scheme enabled me to be more confident at challenging decisions I did not agree with and therefore strategies for doing something about them.*

Candidate 47, Harkness Fellowships:

> *Better able to participant and trust other people's skills – this came about from observation of others in my placement environment.*

Candidate 20, Leadership Fellows:

> *For too long I have had a work-work balance and my life came secondary. While I still have significant energy and drive I have now regained my life – I am now less stressed and looking at work from different perspective. Coaching and action learning helped to achieve this benefit.*

Candidate 18, Leadership Fellows:

> *Action learning sets have introduced to me the power of group reflective practice.*

Candidate 6, Leaders for Change:

> *Action learning sets have helped me talk through issues in confidence with colleagues.*

Group three: change agent

The key defining statements for this mindset are:

19. I am better at leading change through others*

58. I am better equipped to scrutinise and redesign care pathways, using appropriate tools and techniques*

6. I have increased my flexibility to adapt my leadership approach to task*

46. I feel better equipped to identify and overcome barriers that have historically prevented service improvement*

9. I feel more able to build organisational leadership capacity: for example, developing staff into new positions and establishing extended roles*

40. I have a better knowledge of, and approaches to, organisational development*

11. I am better at interpreting team dynamics and am thus able to make teams work more effectively*

* Indicates significance at P <0.01

The qualitative quotes by participants who prioritised these statements as +3 or +4 are displayed below.

Candidate 1, Leaders for Change:

> *I believe that these statements summarise the outcome of attending the programme for me. It best describes leadership for me and my role as "change agent" to unlock potential for change and improvement.*

Candidate 21, Leadership Fellows:

> *I have really learnt a great deal about how to work through others, gaining the confidence to stand back and set parameters and facilitate/support others to make change. I have also worked on not feeling guilty about not doing it myself.*

Candidate 47, Harkness Fellowships:

> *Identifying change skills in others from backgrounds dissimilar to mine has been important.*

Candidate 8, Leaders for Change:

> *To become an agent of change is the ultimate outcome of a leadership scheme.*

Candidate 42, Quality Improvement Fellowships:

> *Main reason for undertaking Quality Improvement Fellowships was to learn tools/methodologies as my role involved care pathway redesign. Programmes assisting knowledge transfer included: 90-day project and visiting different centres of excellence.*

Candidate 13, Leaders for Change:

> *Main role within my work has been enhanced by my change learning at Lancaster University.*

Candidate 45, Harkness Fellowships:

> *My learning is about hard improvement skills, overall IHPs PDSA, measurement etc.*

Candidate 46, Harkness Fellowships:

> *Scheme has given me a breadth of appreciating diff leadership styles and flexibility.*

Candidate 7, Leaders for Change:

> *I am now in a role where I visit many organisations to facilitate change to achieve targets – I have to adapt by working with executive teams, then doctors, then admin etc. This scheme has helped me grow into this role.*

Candidate 8, Leading Practice through Research:

> *The mental health trust I work for, suffers from a 'culture of mediocrity'. The ability to analyse, adapt and sustain change in this setting has been helped particularly by the coaching and action learning set aspects of the fellows scheme.*

Candidate 21, Leadership Fellows:

> *I have increased understanding of the cultural barriers to overcome.*

Group four: service leader

The key defining statements for this mindset are:

2. I feel more confident in my own leadership capabilities*
13. I feel more ambitious concerning the degree of impact I can individually make to improve services*

53. I have a deeper understanding of the workings of my organisation and how to facilitate effective corporate decision making*

39. I am better able to cope with ambiguity and uncertainty within my service*

34. I am more proactive in tackling behavioural and performance dysfunction*

* Indicates significance at P <0.01

The qualitative quotes by participants who prioritised these statements as +3 or +4 are displayed below.

Candidate 3, Leaders for Change:

> *Prior to the programme I lacked confidence in my ability and tended to under-value my knowledge and skills. Coaching was really helpful in building my confidence.*

Candidate 19, Leadership Fellows:

> *The outstanding benefit has been not only an increased confidence that I feel but the increased confidence in leadership capabilities that others around me perceive in me*

Candidate 28, Leadership Fellows:

> *The scheme enabled me to not feel like I was continually barking up the wrong tree and to have the courage of my convictions in terms of challenging status quo and aiming for the highest quality service possible. As a result I feel more confident in my ability as a leader.*

Candidate 18, Leadership Fellows:

> *Another fellow on my scheme came from the same organisation and has helped me to better understand the structure and systems.*

Candidate 25, Leadership Fellows:

> *The role and organisation that I work within has poor organsisational structure and leadership. I have had to learn to work in a role that supports and facilitates a national policy decision/ delivery over which I have no direct control.*

Candidate 4, Leaders for Change:

> *Important because individuals/groups can be destructive/ disruptive.*

Candidate 12, Leaders for Change:

> *Have the skills to tackle difficult behaviour and performance and have used them successfully.*

Candidate 12, Leaders for Change:

> *Having undertaken the programme I developed a number of additional skills which increased my personal confidence. This had the impact of allowing me to develop in other areas which were outside my comfort zone.*

Candidate 23, Leadership Fellows:

> *"I can lead and still be me' – This statement for me, sums up the overall greatest benefit of the fellowship to me. All parts of the scheme, but principally the guidance/introduction to psychological theories and literature contributed to this as well as the liberation of learning that my existing behaviours contributed to my being an effective leader in my organisation.*

Candidate 10, Leaders for Change:

> *The scheme provided me with the opportunity to become more confident in my ability as a leader and the opportunity to reflect on existing skills and re-direct them. I am very ambitious when it comes to improving quality of service for patients. The action learning sets have continued to be useful for this.*

Candidate 29, Leading Practice through Research:

> *The degree of impact: for example, my capabilities in terms of working with others and watching them listen to me has been profound.*

Candidate 18, Leadership Fellows:

> *The program has given me license to be a QI champion within my service and organisation.*

Candidate 39, Leading Practice through Research:

> *Learnt a lot about how NHS organisations work which I did not know before.*

Group five: networker

The key defining statements for this mindset are:

12. I am more ambitious to progress in my career, pursuing more senior roles*

7. I have built stronger networks in my areas of interest which have enabled me to be more effective*

47. Since attending the course I feel other people are more responsive towards me*

50. I have gained increased access to, support from and dialogue with senior staff*

* Indicates significance at P <0.01

The qualitative quotes by participants who prioritised these statements as +3 or +4 are displayed below.

Candidate 2, Leaders for Change:

> *I am due to start a new job in July – promotion and taking me out of my professional background (therapist) into general management. Confidence gained from cohort feedback and inccluded exposure to elements that I was good at.*

Candidate 49, Harkness Fellowships:

> *Opened my eyes to a whole new world. Made me come back to UK 'chomping at the bit' to be involved in policy. This has grown and grown subsequently from this whole scheme.*

Candidate 35, Leading Practice through Research:

> *I have climbed the rungs to become first consultant AHP in NHS.*

Candidate 15, Leadership Fellows:

> *Ambitious career – calibrating self against fellows – being encouraged, realising my ability – increasing my confidence. Access to senior staff – being a Health Foundation Fellow – allows influence strategically.*

Candidate 46, Harkness Fellowships:

> *This is being part of a policy/research community that I was not part of before my fellowship.*

Candidate 37, Leading Practice through Research:

> *One of my key aims for the award was to develop practice in a field that I had limited influence. The award spurred me to apply and make contact with organisations which I would not have had the confidence to do otherwise. This has had many positive spin-offs.*

Candidate 32, Leading Practice through Research:

> *Mentorships through the programme has meant I now have a national profile within children's nursing also finance to attend conferences. For example, RCW research conferences. Allowed networking – working with others with a shared goal, shared vision seems key.*

Candidate 30, Leading Practice through Research:

> *I used some of the money from my award to establish an all Wales network of midwifery and reproductive health researchers – multidisciplinary and involving clinicians, academics and service users. The group has continued after the end of my award (2006) – has gained additional small posts of funding and Welsh Assembly Government external reference group status. The group is thinking and beginning to grow – I'm now ready to hand over the role of chair. The group has definitely raised my profile within Wales and the UK.*

Candidate 45, Harkness Fellowships:

> *My view carries more weight. Networks – absolutely the number one benefit, no question. Networks in UK; NHS – inst, King's Fund, Nuffield, and the Health Foundation! And US – Commonwealth Fund, Boston Health, Policy Community, and the providers I researched. I can call up 10–15 of US 'top 50 in healthcare' and they'll return my call. That's amazing and all down to the fellowship.*

Candidate 43, Quality Improvement Fellowships:

> *Health foundation 'brand' and respect for the IHI as an organisation changes other people' perceptions of you and means that your views are included in leadership debates.*

Candidate 47, Harkness Fellowships:

> *Scheme facilitated very good access to senior leaders and decision makers who knew of and respected the scheme so made time available to meet and talk. Ongoing relationships and collaborations have ensued which are of benefit to*

my current role. Placement in a prestigious academic environment was enormously important.

Candidate 20, Leadership Fellows:

Access to senior staff allows me to influence more, increase my recognition and contribution and learn more corporately – scheme itself opened doors to chief executive, workshop allowed showcasing and coaching gave me courage.

Appendix 24

Blind study trial pilot report

Blind trials pilot – summary report
Case studies one and two

Context

This summary report sets out the key points arising from the blind trials pilot conducted at English hospitals to explore the link between leadership behaviours and quality improvement. The report also highlights some of the issues associated with the blind trial process. The name of the hospital and any other indentifying features has been deleted for reasons of confidentiality.

The interviews were conducted by Stephen Oliver, Rachel Robertson and Peter Tonks between 6 July and 30 July 2009. The interview process broadly followed the approaches suggested in the initial briefing given by Jonathan Shapiro. The phase one interviews were conducted blind and the targeted projects only identified at the commencement of phase two interviews.

The pilot was concerned with two targeted projects and 10 people were interviewed.

The interview team did not discuss these projects with each other at any stage and the only contact to identify the targeted projects was with a member of the core Orcni team following the first phase interviews. The notes of the interviews are attached in order to provide a more comprehensive picture of the individual discussions.

Project	Identified	Not identified
Project one	1	4
Project two	3	2
Total	4	6

Figure A.7: Project identification

Chain of attribution

During the first phase of interviews, mixed results were achieved in identifying the targeted projects as shown below in figure A.7:

Project one

At the start of the phase two interviews for project one, some respondents indicated that they had not identified this project because it had been introduced some time ago; others commented on the large number of current change projects in department involved as the reason for the omission. Nonetheless one person did identify this project and the other four clearly recognised the project when it was mentioned at the start of the second interview. All respondents were able to identify and describe this project in some detail and were also able to identify the project lead.

Project two

This project was slightly easier to identify which may be something to do with the scale and nature of the service change. However, the two who failed to identify this project were familiar with it when mentioned at the start of the second interview. All respondents were again able to identify with and describe the project in detail together with accurately naming the project lead.

This provides some evidence of a chain of attribution as both projects were identifiable within the overall process.

Typology of quality improvement

From the interview notes it can be seen that the projects were broadly described within the QI framework.

Focus was often described reasonably well in terms of whether the project was aimed at a defined group or intended to benefit unlimited numbers. Both projects were seen to have a more or less defined focus but most indicated that within that definition the service was available to all who needed it.

Process factors were clearly identifiable from the discussions and a difference can be seen between the complexity of the two projects in terms of the number of people and organisations involved. Project one has a clear process focus within the trust and the work to introduce this change involved engagement and influencing of clinicians and administrative staff together with parents and children. The project was seen as innovative although it was recognised by some that this was an adaptation of something that existed elsewhere.

Project two involved a broader range of people across the region but was a nationally inspired project. Work on this project involved engaging with and influencing a number of players both in and outside the trust. It was seen as innovative in that it provided a centre(s) of excellence with expertise being contained within the network.

Outcomes were identified by the respondents but the nature of the interviews meant that the claims regarding the actual benefits realised for patients were largely anecdotal. No supporting evidence was asked for or provided to the interviewers. Project one was seen to have [deleted to preserve confidentiality], enabled staff to be more informed and knowledgeable about patients and eliminated the need to ask repeat questions. Equally patients now associate with project one and readily volunteer this to staff.

Project two is seen to have considerably improved the patient experience. Instead of being treated by less specialised staff various locations the project has meant that expertise is concentrated in one service with provision being offered across the whole area involved.

Leadership input

The project leads for both projects were identified during the process without any additional prompting. Some respondents identified other people who played supporting roles but the leadership behaviours identified were attributed to the behaviours exhibited by the project lead.

In project one, positive behaviours were identified but this aspect was more difficult to identify within project two. The project lead was criticised by four out of five respondents; the fiifth respondent, although more positive, highlighted some difficulties around communication style.

Both the positive indicators and contra indicators have been included in the interview notes as this provides some important information linked to the IQL©. The negative behaviours described were essentially made 'off the record'. It is therefore, quite difficult to identify the characteristics within the framework but an attempt has been made below.

It is important to note that the IQL© was not looked at in detail with interviewees; rather interviewees were asked to provide examples of leadership behaviour using their own words. As can be seen from the list of leadership behaviours highlighted in each interview it is possible to link these to the IQL©. The bullet points below represent a sample of the leadership behaviours identified and for illustrative purposes have been clustered under the IQL© headings.

Interacts authentically

A number of the descriptions of behaviour fell within this category. A sample selected from from the interview notes include the following:

Positive behaviours

- Good involvement of key stakeholders in the trust.
- Understanding people.
- Holding people to account for their work and follow up.
- Adapted style to meet needs.
- Focused, committed, passionate and energetic so empowers and inspires others to achieve.
- Encouraging and involving and prepared to give time to people.
- Makes people believe what can be achieved through strong presentation and influencing behaviours. Knows when to push and when to cajole.
- Understands and values other views.
- Self aware and knows how to react in different situations.
- Sense of humour.

Contra indicators

- Difficult style and controlling.
- Not adaptable and likes things done her way.
- Predominantly task focused and needs to balance this with people focus.
- Doesn't understand her personal impact on others.

Acts effectively

A range of responses fell into this category some of which are highlighted below:

Positive behaviours

- Identifies what needs to be done and who should do it.
- Identifies key players to be influenced.
- Thinks outside the box and is creative and innovative.
- Understands change processes.
- Creates strong links with other systems/people.
- Preparedness to expose self: for example, risk.

Contra indicators

- Doesn't always explore new suggestions made by others.
- Certain key people omitted.

Conceptualises issues

Respondents less identified with the behaviours falling in this category. There was a tendency for interviewees to focus much more on behaviours linked to interpersonal skills. Nonetheless several behaviours did emerge:

Positive behaviours

- Evaluates options to make decisions.
- (S)he has done it herself by seeking funding as there is no quality budget (structures and analyses information to make a case).
- Conceptual and also able to turn work into 'learned papers' published nationally.
- Clear roles and responsibilities.

Contra indicators

- Partially identified links between the wider system and its components but issues were not always resolved.
- Internal focus.

Generally the interviewees found describing leadership behaviours quite hard though all attempted to do this. Interestingly both projects were considered to be a success by those interviewed though quite different leadership behaviours have been reported. In project one, a range of behaviours were identified within each dimension of the IQL©. In project two, the focus appears to be more on the conceptual aspects and acting effectively. The behaviours concerned with acting authentically were less observed in this project and it was in this area that most contra indicators were found.

Blind trial process – pilot

Some themes and issues for consideration emerged during the pilot phase as detailed below:

- The access person needs to be identified at an earlier stage and a check needs to be made that the information provided to that person has been sent out to the interviewees in readiness for the first contact call. Several interviewees indicated that the first contact they had was the initial telephone call and at least one asked for proof of who we were.
- In any subsequent studies work needs to start earlier to set up the interview dates so that these can be planned in advance and tight timelines observed. This also reduces the likelihood of discussion occurring between the interviewees between the stages.
- Cross contamination between candidates once the first interviews have been carried out was not evident but difficult to legislate against given the timeline between some interviews.
- A pragmatic approach had to be taken to the use of either face to face interviews or telephone contact. The experience of this pilot suggests that greater empathy can be created by face-to-face contact and therefore higher quality information is likely to be obtained. Notwithstanding this the telephone interviews did work satisfactorily if not the preferred option.
- Some ethical issues arose in the process simply because part of the exercise was to identify those people leading the projects. This meant that the focus was necessarily on specific individuals who to our knowledge have not been approached to give their permission. This also raises the issue of confidentiality of the information captured. It is imperative that the narrative contained in this report is anonymised so that no link can be made to individuals.
- To what extent would it be helpful to provide a rating assessment as well as qualitative information regarding the QI process? Also would it be helpful to add a simple rating process to the IQL© to provide a focus for the interviewees and obtain some comparative data? The latter has some obvious benefits but it does also mean that people are led to these dimensions and so are bound to identify with them to some degree.

Conclusion

Despite some of the issues described above the blind process has worked reasonably well and does seem to offer a further tool to be added to our evaluation methodology. Further discussion should take place within the wider team to learn from the process so that this approach can be developed into a more rigorous process for use on other studies.

For the purposes of the Health Foundation project every attempt needs to be made to tighten up the process in the ways described above. Equally, consideration needs to be given to this report to ensure that the content and format is what is required.

Appendix 25

Qualitative data provided by participants for the top 10 ranked leadership behaviours

Rank 1. Identifies and nurtures talent to build capacity and capability (statement 12)

Candidate 15, Leadership Fellows:

> *Identifying and nurturing talent is critical to improving quality of sources for patients. Building capability takes years/ lots of experience and reflection. The best QI ideas in my services are from staff whose talent I've nurtured over years and I identify new staff who'll question and critically appraise in patient centred way.*

Candidate 27, Leadership Fellows:

> *Talent spotting and nurturing is very mportant to me.*

Candidate 40, Quality Improvement Fellowships:

> *Build and develop what you have. Need to improve capability.*

Rank 2. Capitalises on the range of skills and talents present in the organisation (statement 11)

Candidate 3, Leaders for Change:

> *It's important that individual skills and talents are recognised and that these are utilised rather than always using the same people. This motivates people and helps them develop.*

Candidate 37, Leading Practice through Research

> *Engaging with all talents in a team is important.*

Rank 3. Demonstrates honesty in interactions by matching deeds to words (statement 34)

Candidate 2, Leaders for Change:

> *Gain respect and trust and you gain engagement and minimise the politics.*

Candidate 11, Leaders for Change:

> *Integrity is a key personal trait that builds relationships. This is important to gain respect from people I interact with.*

Candidate 23, Leadership Fellows:

> *Honesty, deeds and words essential to leadership of QI, any dishonesty will lead to lack of following.*

Candidate 17, Leadership Fellows:

> *Leadership requires integrity and the ability to lead by example to inspire followers.*

Candidate 18, Leadership Fellows:

> *Honesty is the most important leadership value to demonstrate as it promotes respectful working relationships.*

Candidate 7, Leaders for Change:

> *It is important to me that people display and act with honesty and integrity and for the right reasons. If leaders act in this way, people will want to follow – to do things and 'be like them'.*

Candidate 48, Harkness Fellowshipsness Fellowships:

> *I prefer to lead from the front to facilitate ongoing awareness of challenges and barriers and buy-in from other staff.*

Candidate 6, Leaders for Change:

> *What people do, and what actually happens, is the most important thing. What they say, and how they say it, matters far less (in my view).*

Rank 4. Explains the need for change and inspires commitment to the process (statement 36)

Candidate 20, Leadership Fellows:

> *This is essential to set the context and begin to create the vision. It is important that the vision is shared and not*

simply that of the leader to ensure it will work and will be implemented and maintained long term.

Candidate 19, Leadership Fellows:

Starting point for the view 'can and should change for the better' but also explains the need for change and inspiring commitment.

Candidate 49, Harkness Fellowships:

It takes communication and the role of leadership – lighting the flame for change in others. Without this there is no culture change.

Candidate 46, Harkness Fellowships:

This is the key leadership task (given standing still is not an option).

Rank 5. Demonstrates commitment to innovation and to continuous improvement (statement 38)

Candidate 15, Leadership Fellows:

Model desired behaviour – constant and continuous improvement.

Candidate 33, Leading Practice through Research:

A commitment to innovation and creativity are central to aspiring for positive change as well as engaging people in processes.

Candidate 47, Harkness Fellowships:

Without demonstrable leadership commitment, QI fails.

Candidate 23, Leadership Fellows:

Unless leader demonstrates their commitment to continuous improvement follower will be unlikely to enact QI. A leader should always be striving for improvement and encouraging innovation.

Rank 6. Unites staff around an inspiring vision and aligns staff capacities with planned activities (statement 63)

Candidate 4, Leaders for Change:

Talks of uniting staff – not just about one person but about

everyone being involved in quality improvement. This statement captures many aspects of leadership.

Candidate 28, Leadership Fellows:

Every organisation needs a vision and in organisations where there is not a common vision staff are often disjointed which can adversely affect quality. Organisations which succeed draw on the skills of their staff, engage and empower them in the agenda.

Candidate 9, Leaders for Change:

Uniting staff and inspiring vision as feel leadership hinges on the ability to inspire others to want to do something differently plus need a shared vision to bring about quality improvement. Believe without vision it's difficult to bring about change.

Candidate 30, Leading Practice through Research:

Sense of common purpose, shared vision with a rational approach to achieving this using staff ability and specific activities – ideals plus pragmatism.

Candidate 13, Leaders for Change:

My understanding of what leadership is.

Candidate 38, Leading Practice through Research:

I consider the ability to bring staff together around a vision is a prerequisite for other strategies, involving a complete mix of influence, action, reward and communication skills. I am developing this capacity currently.

Candidate 16, Leadership Fellows:

People in the health service are interested in serving the public – creating vision based on community values and evidence based reasons for practice bring good care, cared for staff and good outcomes for health.

Candidate 19, Leadership Fellows:

Without staff on board likely to be a struggle.

Candidate 23, Leadership Fellows:

Unless united and inspired and capacity, QI will not happen.

Rank 7. Takes a 'helicopter view' of the system to oversee both short and longer-term issues (Statement 116)

Candidate 20, Leadership Fellows:

> *The leader needs to retain the 'helicopter view' others will focus on the detail using their strengths. This is the 'oversight' role.*

Candidate 48, Harkness Fellowships:

> *Where are we going, where we are now and where have we been.*

Candidate 34, Leading Practice through Research:

> *The 'helicopter view' is paramount – always need to have a holistic view otherwise leadership becomes tunnel visioned and unbalanced.*

Candidate 2, Leaders for Change:

> *Having an overview of the strategic long term and immediate needs enable one to better plan, prepare and understand the needs of a service and demands placed on it.*

Candidate 44, Harkness Fellowships:

> *I think 'good' leadership requires a good overview of the short and long term aims for effective planning – 'a meaningful vision'.*

Candidate 8, Leaders for Change:

> *Leader needs to have an overall view while empowering others and facilitating quality improvement.*

Rank 8. Helps others create their own solutions to facilitate ownership and commitment (Statement 29)

Candidate 41, Quality Improvement Fellowships:

> *Ownership, engagement and pride in achieving success is vital – improvement is not about the leader's CV, it is about allowing others to resolve their own challenges.*

Candidate 7, Leaders for Change:

> *Key for long term sustainable change.*

Candidate 46, Harkness Fellowshipsness:

> *Leadership is enabling.*

Candidate 37, Leading Practice through Research:

> *Facilitating the development of ideas to solutions in any team is key.*

Rank 9. Offers support, rewards achievements and celebrates success (Statement 13)

Candidate 7, Leaders for Change:

> *People need motivation, focus on positives.*

Rank 10. Gives clear constructive feedback, timely praise and focused recognition (Statement 14)

Candidate 43, Quality Improvement Fellowships:

> *Positive reinforcement and reward are critical to motivating individuals, teams and organisations to move forward.*

Appendix 26

Ranked 120 leadership behaviours

The statements are grouped into three distinct categories:

Universal benefits: benefits perceived (on average) by all participants.

Common benefits: benefits perceived by the majority of participants.

Peripheral benefits: benefits perceived by a minority of participants.

Statement		Rank
	Universal priority behaviours **Essential to all**	
12.	Identifies and nurtures talent to build capacity and capability	1
11.	Capitalises on the range of skills and talents present in the organisation	2
34.	Demonstrates honesty in interactions by matching deeds to words	3
36.	Explains the need for change and inspires commitment to the process	4
38.	Demonstrates commitment to innovation and to continuous improvement	5
63.	Unites staff around an inspiring vision and aligns staff capacities with planned activities	6
116.	Takes a 'helicopter view' of the system to oversee both short and longer-term issues	7
29.	Helps others create their own solutions to facilitate ownership and commitment	8
13.	Offers support, rewards achievements and celebrates success	9
14.	Gives clear constructive feedback, timely praise and focused recognition	10
16.	Identifies and consults with key stakeholders to obtain buy-in for ideas	11
28.	Uses influence and persuasive skills to involve, engage and gain others' support	12
37.	Communicates a common compelling vision for the future organisation	13
81.	Encourages others to produce novel suggestions and solutions to organisational problems	14
90.	Challenges accepted behaviour and pushes forward even under difficult circumstances	15
101.	Thinks flexibly and creatively under rapidly evolving or unexpected circumstances	16
3.	Harnesses different opinions and capitalises on the benefits of diversity	17
33.	Shows trust and confidence in staff by acknowledging their effort and contribution	18
60.	Holds both self and others accountable for effective delivery of results	19
76.	Identifies and consults with the appropriate key decision makers on emerging issues	20

Statement		Rank
	Universal priority behaviours **Essential to All** *continued*	
1.	Solicits all points of view and uses these perspectives to build consensus	21
2.	Regularly initiates discussion and facilitates open sharing of opinions	22
17.	Build and enthuses a wide base of support for innovation and change	23
25.	Develops cooperation and teamwork by encouraging key stakeholders to work together	24
35.	Listens carefully to others to gain a real insight into their issues and concerns	25
39.	Presents as a role model of creativity, innovation, and learning	26
72.	Plans ahead and recognises that services can and should change for the better	27
	Important behaviours **Essential to the majority of participants**	
74.	Spots chances and opportunities to apply or transfer innovative practices	28
83.	Encourages novel approaches which have the promise to deliver improved outcomes	29
88.	Explores imaginative solutions and considers new approaches to enhance effectiveness	30
120.	Highlights key priorities for action by understanding where the future organisation should be	31
26.	Constructs persuasive arguments to facilitate the acceptance and adoption of change	32
41.	Delivers messages in a clear, concise and articulate manner without using jargon	33
48.	Explains complex information using a level of language appropriate for the audience	34
50.	Asking clarifying questions and reflects back to ensure message has been understood	35
53.	Takes into account the personal and emotional costs of organisational change to staff	36
56.	Specifies clear organisational goals, priorities and performance objectives	37
64.	Ensures coordination of values, mission, strategy, structure and day-to-day performance	38
4.	Takes other peoples' perceptions seriously and empathises with their feelings	39
15.	Participants work to provide challenge and opportunities to learn and develop	40
24.	Establishes cross-agency working and encourages collaborative partnerships	41
32.	Asks open-ended questions that encourage authentic and honest communication	42
67.	Keeps alert to a wide range of signals that may indicate important shifts in conditions	43
68.	Anticipates organisational change and knows when, why and how to adapt quickly	44
70.	Reacts quickly and confidently to contain, control or capitalise on rapidly changing events	45
71.	Seeks out opportunities to try out new ideas or innovative schemes	46
86.	Prefers to promote promising initiatives and approaches rather than maintain the status quo	47
87.	Encourages others not to reject new ideas because their benefits may not be immediate	48
91.	Identifies staff attitudes, concerns and opinions relevant to the issue at hand	49
96.	Transforms available data into meaningful information to inform and illuminate	50
109.	Assembles a rich picture through discussion with diverse members of staff	51

Statement		Rank
	Important behaviours **Essential to the majority of participants** *continued*	
111.	Prioritises and weighs up the pros and cons of situations to make good decisions	52
117.	Assesses whether the local picture is aligned to and supports the wider vision of change	53
18.	Develops and sustains a diverse range of internal and external relationships	54
19.	Invests time to establish, sustain and broaden information and intelligence networks	55
27.	Conveys his/her position convincingly even when faced with strong opposition	56
31.	Anticipates dissent and uses appropriate strategies to resolve conflict when it arises	57
40.	Ensures organisation has a culture of promoting commitment and engagement	58
42.	Creates meaning for the audience by using events and stories to illustrate key points	59
54.	Determines necessary resources (money, people, and materials) for project success	60
58.	Conducts regular reviews and constructively addresses under-performance	61
65.	Links achievement of goals with appropriate rewards and recognition	62
73.	Keeps alert to all possibilities to identify the potential of positive change	63
84.	Generates creative and valuable suggestions with the potential to improve service delivery	64
85.	Envisions the ways in which potential innovations may influence current working practices	65
92.	Disentangles the fundamental reasons and root causes of organisational problems	66
115.	Considers the organisation's priorities when making decisions or suggesting solutions	67
5.	Encourages the differing and preferred working styles of individuals	68
6.	Anticipates how other parties may react to the content of personal communication	69
8.	Takes account of others' reactions re: tones of voice, gestures and facial expressions	70
9.	Monitors others' understanding of what is discussed and corrects misunderstandings	71
10.	Interprets the face-to-face impact of own conduct on others' behaviour and responses	72
21.	Sets up and maintains open communication channels to promotes information exchange	73
43.	Uses anecdotes and analogies to illustrate ideas and bring messages to life	74
75.	Anticipates and reduce risks by knowing organisational strengths and weaknesses	75
80.	Draws on own knowledge and experience to make balanced and timely judgments	76
82.	Analyses the future potential of new schemes to improve work practices and services	77
102.	Derives new ideas and innovative strategies within a useful timescale	78
119.	Ensures that local operational goals support the organisational strategy mission and vision	79
7.	Makes convincing and balanced arguments, tailored to others' needs and expectations	80
22.	Facilitates cooperation within and between organisations by sharing information	81
49.	Maintains an awareness of peoples personalities and motivations and adapts to this	82
57.	Sets performance standards and shows concern that they are met or surpassed	83

Statement		Rank
	Important behaviours **Essential to the majority of participants** *continued*	
78.	Anticipates barriers to rapid decision making and takes steps to remove these	84
94.	Prioritises important issues and tease-out the dependencies between them	85
108.	Produces focused suggestions and strategies from dissonant viewpoints	86
114.	Probes staff reactions to proposed alternative options and decisions	87
30.	Provides clear, constructive and timely guidance to shape others behaviour	88
44.	Pitches messages to focuses on key points and facilitate desired outcomes	89
47.	Anticipates the likely reaction and selects communication style to meet audience needs	90
69.	Understands that the effects of organisational change are both planned and unplanned	91
93.	Identifies the specific information needed to solve a problem efficiently	92
95.	Maintains up-to-date knowledge about the organisational structures and processes	93
97.	Blends and integrates disparate types of hard evidence and soft intuition	94
98.	Uses experience, logic and empathy to derive acceptable and cost effective solutions	95
103.	Pinpoints critical factors to explain the meaning and implication of events	96
104.	Grasps the evolving and overlapping patterns of complex events as they unfold	97
105.	Shifts perspectives and focus to deal with concerns from various stakeholders	98
112.	Distinguishes key priorities from supporting or peripheral sub-priorities	99
113.	Focuses on all critical factors including hard-to-measure emotional issues	100
45.	Maximises personal communication strengths while minimising weaknesses	101
46.	Seeks to understand others' non-verbal cues and adjusts presentation style accordingly	102
	Peripheral behaviours **Essential only to a minority**	
51.	Specifies the task requirements and identifies the likely outcomes of plans	103
59.	Establishes structures that delineate authority with clear lines of accountability	104
107.	Clarifies problems by actively examining relationships between components	105
110.	Discerns organisational risks and opportunities from a complex set of factors	106
52.	Assesses the feasibility and acceptability of translating policies into operational plans	107
66.	Initiates organisational responses as required and maintains the pace of change	108
77.	Demonstrates understanding of units/departments and factors this into any decisions	109
118.	Examines how the values of various staff groups fit within the organisational mission	110
20.	Engages the support and allegiance of informal networks in formal situations	111
23.	Implements a range of formal and informal team-building development activities	112
79.	Selects the best time to announce a decision to maximise positive impact	113
89.	Pursues worthwhile new initiatives even when there is ambiguity and uncertainty	114

Statement		Rank
	Peripheral behaviours **Essential only to a minority** *continued*	
100.	Balances the productivity, needs and demands of different parts of the organisation	115
106.	Structures loose threads of ideas and opinions into coherent explanations	116
62.	Controls projects by ensuring plans, people and resources are appropriately mobilised	117
99.	Explores the underlying meaning behind incomplete and ambiguous staff feelings	118
61.	Ensures that all organisational sub-systems effectively support the business plan	119
55.	Makes sense of organisational events by inferring causes and consequences of interventions	120

Appendix 27

Qualitative data provided by participants for the top 10 ranked programme benefits

Rank 1. I feel more confident in my own leadership capabilities

Candidate 3, Leaders for Change:

> *Prior to the programme I lacked confidence in my ability and tended to under-value my knowledge and skills. Coaching was really helpful in building my confidence.*

Candidate 19, Leadership Fellows:

> *The outstanding benefit has been not only an increased confidence that I feel but the increased confidence in leadership capabilities that others around me perceive in me.*

Candidate 28, Leadership Fellows:

> *The scheme enabled me to not feel like I was continually barking up the wrong tree and to have the courage of my convictions in terms of challenging status quo and aiming for the highest quality service possible. As a result I feel more confident in my ability as a leader.*

Candidate 12, Leaders for Change:

> *Having undertaken the programme I developed a number of additional skills which increased my personal confidence. This had the impact of allowing me to develop in other areas which were outside my comfort zone.*

Candidate 23, Leadership Fellows:

> *'I can lead and still be me'. This statement for me, sums up the overall greatest benefit of the fellowship to me. All parts of the scheme, but principally the guidance/introduction to psychological theories and literature contributed to this as well as the liberation of learning that my existing behaviours contributed to my being an effective leader in my organisation.*

Rank 2. I gained powerful insights into my own strengths and weaknesses

Candidate 8, Leaders for Change:

> *Most enlightening to have Myers Briggs to explain why I respond the way I do and how to adapt my behaviour to build on strengths.*

Candidate 37, Leading Practice through Research:

> *As part of the course I did a leadership course which I found very beneficial and gave me really good insights into my own strengths and weaknesses.*

Candidate 35, Leading Practice through Research:

> *Again 360 degree feedback and a plan achieved the goals set.*

Candidate 2, Leaders for Change:

> *Action learning sets – very helpful in building a picture of my actual abilities and how others see me.*

Rank 3. I have built stronger networks in my areas of interest which have enabled me to become more effective

Candidate 34, Leading Practice through Research:

> *Enabled good practice to come together across the county – provided fantastic joint learning and impetus to improve the quality of delivery.*

Candidate 40, Quality Improvement Fellowships:

> *Collaborative working.*

Candidate 46, Harkness Fellowships:

> *This is being part of a policy/research community that I was not part of before my fellowship.*

Candidate 37, Leading Practice through Research:

> *One of my key aims for the award was to develop practice in a field that I had limited influence. The award spurred me to apply and make contact with organisations which I would not have had the confidence to do otherwise. This has had many positive spin-offs.*

Candidate 32, Leading Practice through Research:

> *Mentorships through the programme has meant I now have a national profile within children's nursing and also finance to attend conferences, for example, RCW research conferences. Allowed networking – working with others with a shared goal, shared vision seems key.*

Candidate 30, Leading Practice through Research:

> *I used some of the money from my award to establish an all Wales network of midwifery and reproductive health researchers – multidisciplinary and involving clinicians, academics and service users. The group has continued after the end of my award (2006) – has gained additional small posts of funding and Welsh Assembly Government external reference group status. The group is thinking and beginning to grow – I'm now ready to hand over the role of chair. The group has definitely raised my profile within Wales and the UK.*

Candidate 45, Harkness Fellowships:

> *Networks – absolutely the number one benefit, no question. Networks in UK; NHS – inst, King's Fund, Nuffield, and the Health Foundation! And US – Commonwealth Fund, Boston Health, Policy Community, the providers I researched. I can call up 10-15 of US 'top 50 in healthcare' and they'll return my call. That's amazing and all down to the fellowship.*

Rank 4. I feel more ambitious concerning the degree of impact that I can individually make to improve services

Candidate 10, Leaders for Change:

> *The scheme provided me with the opportunity to become more confident in my ability as a leader and the opportunity to reflect on existing skills and re-direct them. I am very ambitious when it comes to improving quality of care for patients. The action learning sets have continued to be useful for this.*

Candidate 29, Leading Practice through Research:

> *The degree of impact: for example, my capabilities in terms of working with others and watching them listen to me has been profound.*

Candidate 18, Leadership Fellows:

> *The program has given me license to be a QI champion within my service and organisation.*

Candidate 7, Leaders for Change:

> *I have data to prove results and get feedback from people.*

Rank 5. I am better able to motivate and instil a 'can do' attitude in others

Candidate 2,Leaders for Change:

> *I encourage others to have a go – calculate risk and be confident.*

Candidate 7, Leaders for Change:

> *My current role requires this every day with new teams I may not have met before.*

Rank 6. My leadership style is more collaborative, involving key stakeholders in service development activities

Candidate 26, Leadership Fellows:

> *Recognition of the important value and effectiveness of this inclusive approach and also the consequences of not adopting it.*

Candidate 17, Leadership Fellows:

> *Expert patient involvement our seminars opened my eyes to ways of engaging these stakeholders and the more rounded discussions, suggestions for service and quality improvement that could have real impact.*

Candidate 46, Harkness Fellowships:

> *I now think more explicitly of range of stakeholders – outside a box.*

Rank 7. I feel more empowered to lead others

Candidate 31, Leading Practice through Research:

> *Increased confidence in own abilities, as above.*

Candidate 34 Leading Practice through Research:

> *Greatly raised my awareness of the impact I have on motivating and empowering others.*

Candidate 22, Leadership Fellows:

> *Confidence in my own abilities.*

Candidate 2, Leaders for Change:

> *I believe in my own abilities so encourage others to take my guidance instilling confidence in their abilities.*

Rank 8. I feel better motivated to drive for service improvement

Candidate 6, Leaders for Change:

> *The award has helped me to hone my skills to help me drive for service improvement. Influencing skills, power and politics.*

Candidate 24, Leadership Fellows:

> *Motivation important driver for me – 'making a difference' scheme fellows work was inspiring, seeing you can make a difference.*

Rank 9. I have benefited from the multidisciplinary nature of the scheme

Candidate 22, Leadership Fellows:

> *Taught me many things – relationships/different thought processes of clinicians vs managers and how to maximise this for product benefit – how the NHS works. For example, PCTs/acute trusts relationships and organisational factors, how the Department of Health works. These lessons are constantly used in my practice as a leader but go to the grass roots level of how we are all working for patient care.*

Candidate 24, Leadership Fellows:

> *Multidisciplinary nature the biggest bonus for me – shared learning across clinical networks/specialities, reflective learning on my wide discipline, key contacts/network, and my ability to shape the thinking of my fellows.*

Candidate 20, Leadership Fellows:

> *MD nature of scheme – diversity of our content – action learning sets and whole scheme.*

Candidate 31, Leading Practice through Research:

> *All professions and schemes same 'boat' problems and solutions.*

Candidate 17, Leadership Fellows:

> *Multiple perspectives and experiences equals greater learning.*

Rank 10. I understand more clearly my leadership role and its impact on my organisation

Candidate 45, Harkness Fellowships:

> *Given me confidence and clarity of direction of where I want to lead my organisation.*

Candidate 12, Leaders for Change:

> *The programme gave me an understanding of leadership and how I can use my skills to influence.*

Candidate 44, Harkness Fellowships:

> *The programme in all its different components has enabled me to see that I can lead on quality and have been able to see the impact on the organisation in how we are moving forward.*

Appendix 28

Ranked 58 programme benefits

The statements are grouped into three distinct categories:

Universal benefits: benefits perceived (on average) by all participants.

Common benefits: benefits perceived by the majority of participants.

Peripheral benefits: benefits perceived by a minority of participants.

Statement		Rank
	Universal benefits **Achieved by all**	
2.	I feel more confident in my own leadership capabilities	1
3.	I gained powerful insights into my own strengths and weaknesses	2
7.	I have built stronger networks in my areas of interest which have enabled me to be more effective	3
13.	I feel more ambitious concerning the degree of impact I can individually make to improve services	4
24.	I am better able to motivate and instil a 'can do' attitude in others	5
25.	My leadership style is more collaborative, involving key stakeholders in service development activities	6
26.	I feel more empowered to lead others	7
43.	I feel better motivated to drive for service improvement	8
50.	I have benefited from the multidisciplinary nature of the scheme	9
1.	I understand more clearly my leadership role and its impact on my organisation	10
17.	I am increasingly able to work outside my comfort zone, taking calculated risks	11
18.	I am better at leading change through others	12
22.	I feel more confident and assertive in the workplace, doing things I previously shied away from	13
31.	I feel more determined to challenge outdated organisational norms	14
36.	I feel more influential at a strategic level both locally and regionally	15

Statement		Rank
	Common benefits **Achieved by the majority**	
10.	I achieved an improved balance of reflection and action in my role	16
15.	I understand the need to influence the future direction of my service, establishing a clear vision for service development	17
42.	I am more willing to initiate contact with external partners	18
45.	I feel better equipped to identify and overcome barriers that have historically prevented service improvement	19
5.	I developed new interpersonal skills	20
6.	I have increased my flexibility to adapt my leadership approach to task	21
23.	I have learnt to share my leadership role with others: for example, by delegating power and decision making	22
27.	I now handle difficult situations in a calmer, more considered manner	23
30.	I feel more confident in encouraging others to solve problems/difficulties	24
40.	I am more outward looking: for example, I have an increased awareness of the importance of partnership and inter-agency working	25
41.	I have increased awareness of organisational politics and the corporate strategic agenda	26
4.	I have a greater understanding of how genuine communication, can bring commitment from others	27
34.	I feel able to develop and sustain a culture of innovation	28
37.	I have learnt to appreciate and work with a diversity of perspectives	29
56.	I am more conscious of the importance of high quality, qualitative and quantitative data to inform decision making	30
57.	I am better equipped to scrutinise and redesign care pathways, using appropriate tools and techniques	31
9.	I feel more able to build organisational leadership capacity: for example, developing staff into new positions and establishing extended roles	32
14.	I feel safer and more receptive to peer learning environments: for example, action learning	33
19.	I pay extra attention to the emotional state of staff: for example, by showing openness, genuine sensitivity and giving due praise	34
20.	I understand how models and theories can inform my leadership practice	35
28.	I am now more willing to resolve conflict and difficulties: for example, between departments and across organisational boundaries	36
35.	I am better able to facilitate consensus, when faced with divergent staff views	37
51.	I have developed my ability to negotiate with other departments/services	38
8.	I have honed my communication skills, using both face-to-face and remote approaches	39
11.	I am better at interpreting team dynamics and am thus able to make teams work more effectively	40

Statement		Rank
	Common benefits **Achieved by the majority** *continued*	
12.	I am more ambitious to progress in my career, pursuing more senior roles	41
33.	I am more proactive in tackling behavioural and performance dysfunction	42
39.	I have a better knowledge of, and approaches to, organisational development	43
48.	I have developed more effective multidisciplinary team working across my service	44
53.	I am now able to prioritise my time more effectively	45
16.	I have learnt which professional development opportunities work best for me	46
	Peripheral benefits **Achieved only by a minority**	
21.	I am now able to enact transformational leadership behaviours as part of my repertoire	47
29.	I feel more comfortable saying 'no'	48
32.	I now conduct and chair meetings more effectively	49
52.	I have deeper understanding of the workings of my organisation and how to facilitate effective corporate decision making	50
38.	I am better able to cope with ambiguity and uncertainty within my service	51
46.	Since attending the course I feel other people are more responsive towards me	52
47.	I have become more decisive since attending the course	53
49.	I have gained increased access to, support from and dialogue with senior staff	54
54.	I have learnt how to be more competitive and entrepreneurial in the 'new NHS'	55
55.	I have achieved a healthier work-life balance	56
44.	I feel more comfortable holding corporate accountability and responsibility	57
58.	I have greater knowledge of NHS financial systems and therefore feel able to influence the financial viability of my services	58

Appendix 29

Blind studies – example summary report

Context

This report sets out the results of the blind interviews carried for Project 3 during October 2009.

The interviews were conducted by Peter Tonks following the agreed approach: phase one interviews were conducted blind and the targeted project only identified at the commencement of the phase two interviews. The access person identified seven people to interview and all but one of these agreed to participate in the blind study. All first phase interviews and four second phase interviews were conducted face-to-face. Of the remaining two second phase interviews, one was conducted by telephone due to the respondent's work commitments and it was not possible to complete the final second phase discussion with one interviewee. A brief summary of each interview is attached at appendix 1 of this blind study report.

Chain of attribution

The targeted project was concerned with *[deleted to preserve confidentiality]*.

During the first phase of interviews this project was not specifically identified by any of the interviewees. A number of projects were identified but none of the interviewees referred to *[deleted to preserve confidentiality]*. The Trust is going through major change and a large scale improvement project is currently being undertaken with five major work streams. This is about whole system sustainable change and this was where the interviewees focus tended to be.

At the start of the phase two interviews, respondents were informed about the specific project being evaluated. Their responses to the project were mixed. One consultant considered the project to be an extension of the team's work and so did not identify with the *[deleted to preserve confidentiality]* as a project. A second consultant

commented that he had zero recollection of the project but was aware of the morning meetings and a third consultant was not aware of this as a distinct project. The other two interviewees commented that they were aware of the work to *[deleted to preserve confidentiality]* but had concentrated on the major work on improvement that is now being undertaken across the Trust and Emergency Department.

When questioned about the leadership of the project three respondents identified two people as playing a primary role. The consultant who did not recall the project was equally unable to identify who led this work. One other consultant was also not aware that a specific person led on this. The two people identified as playing a lead role were *[deleted to preserve confidentiality]*. The overall vision and drive behind the project was attributed to *[deleted to preserve confidentiality]* who was identified as leading the operational elements. Four of the five interviewees at the second phase interviews were able to identify C as managing the project in overall terms.

Typology for QI

Three respondents were able to identify the project sufficiently to make a link to the QI framework.

Focus

The project was seen to be of benefit to all patients being admitted and not restricted to a defined group. The project was seen to have a defined aim of improving patient care through a more efficient *[deleted to preserve confidentiality]* allowing national targets to be achieved. At the outset these targets were met but in recent times this has not been the case; hence the Trust has now established a major improvement programme.

The other two interviewees were unable to comment on the process issues although they did identify with the purpose of the bed meetings and the approach being taken.

Process

The project was largely seen as an extension of existing practice but with the aim of *[deleted to preserve confidentiality]* across Directorates within the Trust. Although this was new departure for the Trust it was not perceived by the respondents to be highly innovative but rather a way of seeking to improve existing

processes. Three of the interviewees suggested that the initial work to *[deleted to preserve confidentiality]* involved discussions with Directorates and that effort was required to push the change forward to secure cooperation. The presence of a senior manager with responsibility for *[deleted to preserve confidentiality]* and to drive the project forward was seen as a key factor.

Outcome

The responses to questions around sustainable improvement were mixed. The respondents generally felt that the project was helpful in dealing with day to day issues but considered it less effective in dealing with the more strategic issues around *[deleted to preserve confidentiality]*. Several interviewees mentioned that longer term planning was still a problem and that not all directorates were sufficiently cooperative or engaged.

During the past year the Trust has commenced a change management programme to attend to a number of major issues concerned with service and financial management. AB has left and CD who was seen as a driving force behind the initiative has also left. While several participants recognised that those remaining were doing a good job, they did not have sufficient power or resources to keep the momentum going. There was also a suggestion that senior level focus was now on other pressing issues.

Leadership input

The interviewees were asked to identify leadership behaviours using their own words. The responses to this question were variable given the comments set out above. Several interviewees felt unable to identify specific leadership behaviours while two suggested the following:

Positive behaviours

- persuading and influencing at a strategic level
- visibility
- providing a sense of direction
- forceful when required
- responsive to the needs of others
- leading by example
- walking the talk
- flexibility in responding to different situations, for example, did some night shift work to explain changes to night staff
- effective communication and follow up.

In overall terms the interviewees found it hard to identify specific leadership behaviours. A general theme that emerged was the need for senior level leadership to provide focus and to overcome obstacles. Some felt that this was not now so apparent although upcoming changes might be beneficial.

Conclusion

The results of the interviews were variable with mixed responses received at each stage of the process. All respondents failed to identify the specific project and only two were able to identify specific leadership behaviours. All interviewees were able to comment on the project and while some progress was confirmed a number of issues were described which have had an adverse impact on meeting targets. There was also the suggestion that some irectorates were engaged to a greater or lesser extent with the project and that further work was needed to improve involvement, engagement and sign up.

As far as the blind process was concerned, the interviewees engaged in the process willingly and were very welcoming and interested in the evaluation study. They gave their time and most interviews were conducted face-to-face. Unfortunately one person could not be interviewed for the second time due to work commitments and holidays. As an exercise in attributing leadership behaviour, the results are a little thin.

The Health Foundation is an independent charity working to continuously improve the quality of healthcare in the UK.

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