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# Barking, Havering and Redbridge University Hospitals NHS Trust Fellowships in Clinical Leadership Programme

An evaluation

Céline Miani, Sonja Marjanovic, Molly Morgan Jones, Martin Marshall,  
Samantha Meikle, Ellen Nolte



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RAND Europe

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# Preface

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This report presents the findings of an evaluation of the Barking, Havering and Redbridge University Hospitals NHS Trust Fellowships in Clinical Leadership Programme, an initiative developed to improve clinicians' leadership skills and allow them to transfer those skills into practice through the implementation of quality improvement projects. Using a theory-of-change-led realist evaluation approach, this study sought to describe the impacts of the Programme on individuals and the organisation. The report highlights enablers and challenges that facilitated or hindered the success of the Programme. Findings will inform the design of future leadership and quality improvement initiatives in healthcare settings and will be of interest to healthcare commissioners, clinicians, NHS managers and members of the public who have an interest in leadership and quality of care.

The evaluation was commissioned by NHS London and the London Deanery. It was undertaken by RAND Europe in collaboration with Improvement Science London.

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This report has been peer-reviewed in accordance with RAND's quality assurance standards.

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## Summary

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Leadership is widely seen to be central to improving the quality of healthcare and existing research suggests that absence of leadership is related to poor quality and safety performance. Leadership training might therefore provide an important means through which to promote quality improvement and, more widely, performance within the healthcare environment. This report presents an evaluation of the Fellowships in Clinical Leadership Programme, which combines leadership training and quality improvement initiatives with the placement of temporary external clinical champions in Barking, Havering and Redbridge University Hospitals NHS Trust. We assessed impacts of the Programme on individual and organisational change, alongside core enablers and barriers for Programme success. Analyses drew on the principles of a theory-of-change-led realist evaluation, using logic modelling to specify the underlying causal mechanisms of the Programme. Data collection involved a stakeholder workshop, online questionnaires of programme participants, senior managers and support staff (n=114), and follow-up in-depth semi-structured interviews with a subsample of survey participants (n=15).

We observed that the Programme had notable impacts at individual and organisational levels. Examples of individual impact included enhanced communication and negotiation skills or increased confidence as a result of multi-modal leadership training. At the organisational level, participants reported indications of behaviour change among staff, with evidence of spill-over effects to non-participants towards a greater focus on patient-centred care.

One core feature of the Programme was protected time for participants to engage in quality improvement activities, which was perceived as one of the key enablers of Programme success, along with the strong support by members of senior management. Other reported enablers included dedicated project management support, and the commitment of the programme participants. Key challenges included financial and time constraints, staff resistance to change, and short programme duration.

Our findings suggest that there is potential for combined leadership training and quality improvement programmes to contribute to strengthening a culture of care quality in healthcare organisations. Our study provides useful insights into strategies seeking to achieve sustainable improvement in NHS organisations.



# Table of Contents

---

Preface.....	iii
Summary.....	v
Table of Contents.....	vii
Figures.....	viii
Tables.....	ix
Acknowledgements.....	x
<b>1. Background and context.....</b>	<b>11</b>
1.1. Leadership and quality improvement.....	11
1.2. Barking, Havering and Redbridge University Hospitals NHS Trust.....	12
1.3. The Fellowships in Clinical Leadership Programme.....	12
1.4. Aims and objectives of this report.....	13
<b>2. Methods.....</b>	<b>15</b>
2.1. Principal approach.....	15
2.2. Methods.....	16
<b>3. Findings.....</b>	<b>21</b>
3.1. Understanding the Programme and identifying indicators of success.....	21
3.2. Working as or with a Fellow: perspectives and experiences.....	27
<b>4. Discussion.....</b>	<b>45</b>
<b>References.....</b>	<b>49</b>
<b>Appendix A: Workshop agenda and attendance list.....</b>	<b>51</b>
<b>Appendix B: Logic model.....</b>	<b>53</b>
<b>Appendix C: Interview protocols.....</b>	<b>54</b>

## Figures

---

Figure 1 The logic model approach.....	16
Figure 2 Composition of survey respondents in round 1 (August/September 2012) and round 2 (February 2013).....	18
Figure 3 Respondents' views on the value of the combination of clinical duties and learning activities (%) .....	28
Figure 4 Respondents' views on the value of training activities for developing leadership skills (%).....	29
Figure 5 Respondents' views on the value of Programme features for conducting QI projects (%) .....	31
Figure 6 Respondents' views on whether QI projects were going to achieve goals (%).....	32
Figure 7 Proportion of respondents who were aware of internal dissemination of findings from their QI projects, by medium (%) .....	33
Figure 8 Proportion of respondents who were aware of external dissemination of findings from their QI projects, by medium (%) .....	34
Figure 9 Views of programme participants on whether the Programme made them feel more or less empowered (%) .....	35
Figure 10 Impact of the Programme on job satisfaction of participants (%) .....	36
Figure 11 Views of respondents on whether they had support from senior staff (%) .....	37
Figure 12 Views of respondents on whether they had support from staff outside the Programme (%).....	37
Figure 13 Views of respondents on whether the Programme had an impact on the behaviour of colleagues not directly participating in the Programme (%).....	38
Figure 14 Views of participants on the contribution of the Programme to wider improvements across the Trust (%).....	40
Figure 15 The Programme logic model.....	53

## Tables

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Table 1 Composition of interviewees in interview round 1 (November/December 2012) and round 2 (March/April 2013) .....	19
Table 2 Assumptions underlying the Fellowships in Clinical Leadership Programme as identified by workshop participants (July 2012) .....	22
Table 3 Enablers, challenges and potential future risks as identified by workshop participants (July 2012) .....	24
Table 4 Types of issues to explore through indicators and shared success criteria as identified by workshop participants (July 2012) .....	26
Table 5 Enablers and challenges to delivering QI projects as identified by participants .....	32
Table 6 Examples of improvements in caring for patients reported by respondents .....	41
Table 7 Workshop attendance list.....	51

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# 1. Background and context

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## 1.1. Leadership and quality improvement

Leadership has been described as an important component of high performing organisations,<sup>1, 2</sup> while lack of leadership has been associated with organisational failure.<sup>3</sup> Indeed, leadership is widely seen to be central to improving the quality of healthcare.<sup>4</sup>

Concepts of leadership vary however, and so do perspectives on quality of care and quality improvement. For example, the understanding of leadership has evolved over the years, moving from a singular focus on personalities, and individual leadership traits and behaviours, to a broader concept which emphasises that different contexts call for different leadership approaches.<sup>5</sup> Such an understanding is reflected in an early definition of leadership by Stogdill (1950) cited by Hartley et al. (2008) ‘as the process (act) of influencing the activities of an organised group in its efforts towards goal setting and goal achievement’.<sup>4, 6</sup>

Likewise, the literature on quality and quality improvement (QI) in healthcare is extensive, reflecting, in part, the wide range of activities and interventions that can be considered as seeking to improve quality.<sup>7</sup> Ovretveit (2010) further highlighted that the term ‘improvement’ can refer both to an activity – using methods and systems to enhance care – and to an outcome – the end result of a given service which is judged to be better.<sup>8</sup> Batalan and Davidoff (2007) broadly defined quality improvement as ‘the combined and unceasing efforts of everyone... to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning)’.<sup>9, 10</sup> Reflecting this broad scope, QI initiatives can be classified in different ways, distinguishing, for example, three levels in the health system: the micro or health professional level (leadership, certification, revalidation), the meso or organisational level (industrial QI approaches such as six sigma, lean thinking, plan-do-study-act (PDSA)), or the macro or system level (target setting, competition, incentives, commissioning policy).<sup>7, 11</sup> Accordingly, developing and implementing adequate and effective quality improvement initiatives require an understanding of systems, measurement and variation, ‘theories of change’ and the social and behavioural sciences.

Empirical evidence of direct causal links between leadership and quality improvement remains underdeveloped.<sup>4</sup> However, existing research suggests that absence of leadership is related to poor quality and safety performance, supporting the view that leadership is important for improvement.<sup>8</sup> This view is further strengthened by evidence on the effects of effective leadership on the culture or climate of an organisation or team, so reinforcing the notion of leadership as a key prerequisite for improvement.<sup>2</sup> It is against this background that leadership training might provide an important means through which to promote quality improvement and, more widely, performance within the healthcare environment.<sup>12, 13</sup>

## 1.2. Barking, Havering and Redbridge University Hospitals NHS Trust

Barking, Havering and Redbridge University Hospitals NHS Trust (the Trust) serves a demographically diverse population of around 700,000 in outer north east London. Operating across two main sites, its services comprise general and emergency services, as well as some specialist services including a cancer centre, regional neuroscience centre and specialist stroke services. Following registration with the Care Quality Commission (CQC) in 2010, the Trust has been subject to a series of inspections relating to concerns about the level of care provided.<sup>14, 15</sup> A CQC investigation during 2011 reported that, despite some signs of improvement, there remained concerns about patient care, particularly maternity services, with ongoing concerns in emergency care and radiology.<sup>14</sup> The CQC identified a need for widespread improvement concerning patients' experiences, patient flows, the management of complaints, staff recruitment and governance. In response, the Trust has implemented a number of improvement initiatives targeting in particular the safety and quality of care in maternity and radiology services, alongside changes in governance and leadership structures, and the development and embedding of a culture of patient-centred care across the system.<sup>16</sup> As part of the changes to governance, in collaboration with NHS London and the London Deanery the Trust introduced the Fellowships in Clinical Leadership Programme to strengthen clinical engagement.

## 1.3. The Fellowships in Clinical Leadership Programme

The Fellowships in Clinical Leadership Programme (the Programme), introduced in March 2012 for a period of 12 months, involved the appointment of clinicians (doctors, nurses, midwives) on a one-year contract at the Trust to lead on a range of diverse quality improvement (QI) projects.<sup>15</sup> Clinical Fellows from outside the Trust (external Fellows) were joined by clinical Fellows from within the Trust (internal Fellows), and spent respectively two days and four days a week carrying out clinical tasks. The remainder of their time was dedicated to leading on QI projects in various clinical areas, including surgery, paediatrics, anaesthetics and general medicine, as well as maternity. As part of the scheme, clinical Fellows were paired with established senior staff (clinical leads or clinical directors) of whom some acted as mentors to support the implementation of Fellows' projects.

Overall, 60 clinical Fellows and senior staff participated in the Programme and attended a leadership development course, delivered by QFI Consulting, with the aim of developing (or strengthening) individual leadership skills while learning about change implementation and organisational management. The combination of learning activities, clinical duties and QI project work sought to enable participants to transfer and manifest new competencies in their QI projects, and improve the quality of care within the Trust. Overall, the Programme aimed to:<sup>17</sup>

- enable the Trust to rapidly improve and exceed quality care requirements
- develop internal capabilities and foster a culture of quality improvement
- develop a group of NHS consultants who could lead improvement-oriented change elsewhere.

The programme comprised two schemes, with Scheme A (10 external Fellows, 20 senior clinicians) involving clinicians from a variety of specialties while Scheme B (4 external Fellows, 8 internal Fellows, 6

neonatal nurses, 12 senior clinicians) focused on maternity services in particular and involved mainly midwives and nurses.

There was an expectation that the scheme would leave the Trust 'with a legacy of well-developed projects, 60 staff acting as champions for change and leading work to address poor care and attitudes in the organisation'.<sup>15</sup> It was also anticipated that if the scheme was successful it could be rolled out to other trusts.

## 1.4. Aims and objectives of this report

To better understand the impact of the Fellowships in Clinical Leadership Programme, both on individual and group behaviours as well as on service quality improvement or organisational development, NHS London commissioned RAND Europe, in collaboration with Improvement Science London, to conduct an evaluation of the Programme. Specifically, the evaluation sought to:

- identify the main enablers and challenges facilitating or hindering the development of leadership skills at the individual level and the implementation of QI projects at the service level, over the course of the Programme
- capture the main Programme impacts on individual and organisational development, including personal and inter-personal development and perceived quality of care
- contribute to learning across the Trust and NHS London more widely through incorporating a formative component in the evaluation approach
- develop recommendations for the further development of the Programme to enhance its impact for individuals and healthcare organisations.

This report is structured as follows. Following an introduction to the topic in Chapter 1, Chapter 2 provides an overview of the evaluation approach and the methods used. Chapter 3 presents the findings drawing on the various sets of data collected throughout the evaluation. We close with Chapter 4, which discusses our key findings and presents a set of recommendations for managers and policymakers with an interest in developing similar programmes.



## 2. Methods

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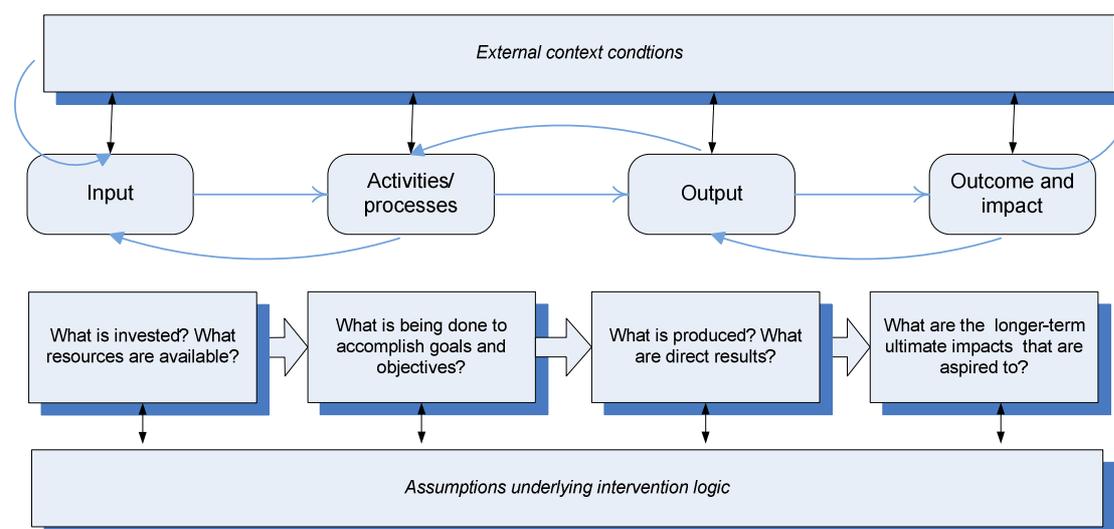
### 2.1. Principal approach

We used a real-time evaluation-based approach, which is rooted in a theory-of-change-led realist evaluation framework. In brief, a theory-of-change-driven approach sets out the building blocks needed to deliver on a programme goal, through a pathway of interventions, and based on a range of assumptions about the logic underlying the Programme.<sup>18, 19</sup> In a realist approach, the components of the evaluation are designed to capture the specificities of the context within which the Programme is implemented. Such an approach seeks to inform more effective practice, and to contribute to the knowledge about successful interventions.

Logic modelling provides a practical tool in theory-of-change-led evaluation approaches. As illustrated in Figure 1, logic models can help stakeholders identify, specify and organise thinking around:<sup>20</sup>

- the expected *outcomes* (longer-term expected consequences) of activity
- expected direct *outputs* from activities (shorter-term achievements)
- core interventions (*processes*) through which outputs and outcomes are being pursued
- the variety of *input* resources in place to pursue them.

The principles of a logic model as shown in Figure 1 further highlight the dynamic nature of relationships between the different components, emphasising that the ‘logic’ of a given programme does not necessarily follow a deterministic, unidirectional path but allows for feedback loops between inputs, processes, outputs and outcomes. Such an understanding is particularly important where a given intervention is strongly dependent on the context within which it is being implemented, as we anticipated to be the case for the Fellowships in Clinical Leadership Programme.

**Figure 1 The logic model approach**

In the context of the evaluation presented here, we drew on work by the US Institute for Healthcare Improvement (IHI) to identify measures of quality improvement<sup>21</sup> as well as the Kirkpatrick model for evaluating leadership interventions and the NHS Leadership Framework to inform measures of learning as a result of the leadership element of the Programme.<sup>22, 23</sup> For example, the Kirkpatrick model distinguishes four levels at which to assess leadership interventions:

- the degree to which participants react favourably to the training
- the extent to which participants acquire the intended knowledge, skills, attitudes and commitment
- how participants apply what they have learned when they are back on the job
- the degree to which targeted outcomes occur as a result of the learning.<sup>22</sup>

These approaches informed assessment of participants' experiences and progress towards improving leadership capabilities and capacities, and changed individual and group behaviours and contributions of the Fellowships scheme to broad, aggregate level quality improvement and organisational development.

## 2.2. Methods

The study used a combination of desk research, a workshop, interviews and a survey to collect data to inform the evaluation, which we describe in detail below.

### 2.2.1. Desk research

To better understand the context within which the Fellowships in Clinical Leadership Programme was implemented, and to inform the subsequent steps of the evaluation, we conducted a rapid and targeted review of the background documentation that was made available to the evaluation team by Barking, Havering and Redbridge University Hospitals NHS Trust and NHS London. This included documents outlining the concept of the Programme, the Statements of Work intended to the Programme provider,

QFI Programme information and schedule, and the lists of participants and projects. It enabled us to capture the nature and extent of Programme activities, and to identify the various groups of individuals involved in its implementation. We also carried out four informal interviews with key stakeholders involved in the design or the delivery of the Programme to complement our understanding of Programme design and of the involvement of the different stakeholders. Stakeholders included representatives of the Trust's senior executive leadership, NHS London, and QFI Consulting, which delivered the leadership development support programme.

### *2.2.2. Stakeholder workshop*

A stakeholder workshop sought to further specify the 'theory of change' guiding the Programme, to build with participants a shared understanding of the Programme logic, and to identify qualitative indicators to inform the evaluation framework. It aimed to identify key assumptions, enablers and challenges as perceived by stakeholders, and factors associated with the wider environment within which the Trust operates considered by stakeholders as likely to impact on the success of the Programme.

The workshop was held in July 2012. The list of potential participants invited to the workshop included a representative sample of Programme stakeholders reflecting a broad range of specialties, roles and seniority levels, including programme participants and persons involved in delivering the Programme. A total of 35 persons were invited, of whom 19 attended (54 percent), including external Fellows (n=6), internal Fellows (7), mentors (1) and representatives of senior leadership including the London Deanery (5). A full list of workshop participants is presented in Appendix A. Workshop discussions were facilitated by members of the evaluation team, following a structured protocol as detailed in the workshop agenda (Appendix A). Discussions as documented by workshop participants (flipcharts) and facilitators (notes) provided the principal data points that were organised to further inform the logic model and a preliminary set of indicators guiding the next phase of the evaluation.

### *2.2.3. Survey of programme participants*

We conducted an online survey of programme participants and affiliated staff. The survey sought to capture a broad range of factors related to progress through evaluation indicators and success criteria. The survey instrument was developed in the light of findings from desk research, informal discussions and the workshop described in the preceding section. It was further informed by existing instruments developed by team members in the context of an evaluation of leadership programmes in health research.<sup>24</sup> It was designed to assess the perceived impacts of Programme components, including the leadership development support programme as well as the factors that enabled or hindered carrying out quality improvement projects. To capture change over time as the Programme evolved, the survey was carried out at two points in time and the survey instrument adapted accordingly while retaining core questions to enable assessment of trends.

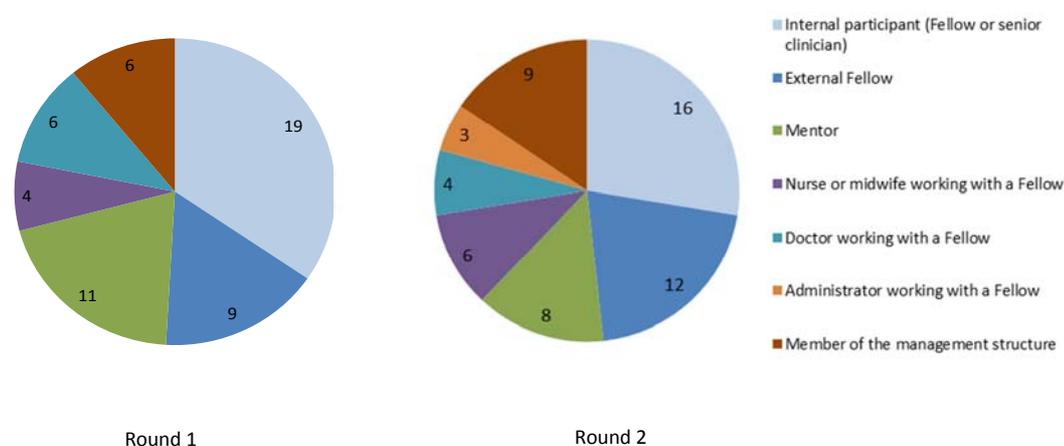
The questionnaire was piloted with two Fellows and one senior member of the Trust, and we carried out cognitive (telephone) interviews with the three individuals to ensure understanding and clarity of the questions. The questionnaire was further adapted in the light of suggestions and comments. Modifications were mostly around simplifying the language to avoid the use of jargon, and simplifying the structure of

questions. The survey was subsequently rolled out online, first in August and September 2012, with a second round undertaken in February 2013. The responses of those involved in the pilot were not included in the final analysis (see below); instead, the three individuals were invited to participate in the final version of the survey.

We identified potential participants through discussions with the Programme Director and invited them to participate by email. We sent them a direct link to the online survey, hosted by Select Survey, alongside an accompanying letter of support by the Programme Director and the chief executive of Barking Havering and Redbridge University Hospitals NHS Trust; there were three follow-up reminders. Of 86 potential participants invited in each round, 55 (64 percent) responded in the first round; in the second round, 58 (67.5 percent) individuals responded, but only 43 completed the full questionnaire. However, we included all responses to round 2 in our analysis, using the data available from complete and incomplete questionnaires. Responses were fully anonymised.

Figure 2 presents the composition of survey participants in each round. Internal participants (Fellows and senior clinicians) and external Fellows accounted for the largest number of respondents in both rounds, at just over half in round 1 (50.9 percent) and 48.2 percent in round 2, followed by mentors<sup>1</sup> (20 percent and 14 percent), clinicians (doctors, nurses, midwives) working with a Fellow (18 percent and 17 percent) and senior leaders (11 percent and 15 percent).

**Figure 2 Composition of survey respondents in round 1 (August/September 2012) and round 2 (February 2013)**



We analysed questionnaire data using StataIC 12 software and Excel 2010. Analyses involved descriptive statistics and qualitative analysis (for open-ended questions).

#### 2.2.4. In-depth interviews

To further understand individual participants' experiences and views of the Fellowships Programme, we carried out two rounds of in-depth interviews with a small, randomly selected sample of the survey

<sup>1</sup> Mentors were internal to the Trust; for the purposes of this study, mentors were identified as a separate participant category.

respondents described in the preceding section. The selection of interviewees was intended to ensure representation of programme participants, trust senior leadership and support staff (clinical or administrative staff not directly involved in the Programme) to explore the potentially diverse range of perspectives on Programme success. The evaluation team contacted interviewees directly with prior agreement of the Trust.

The team carried out interviews by telephone at two points in time, following the survey, in November or December 2012 and March or April 2013. Interviews were semi-structured in nature and lasted an average of 40 minutes. The interview protocol was adapted between the two rounds of interviews to reflect learning and capture progress over time (interview protocols are presented in Appendix C). The majority of interviews were conducted by one researcher from the evaluation team, and all interviews were recorded and transcribed with prior permission of the interviewee.

We sought to achieve a sample size of eight interviewees for each round. Of those approached for interview, seven agreed to participate in round 1 and eight in round 2, representing a range of clinical specialties and levels of seniority (Table 1).

**Table 1 Composition of interviewees in interview round 1 (November/December 2012) and round 2 (March/April 2013)**

<i>Round 1</i>	<i>Round 2</i>
Senior management (n=2)	Senior management (n=3)
	Support staff
External Fellow, scheme A	External Fellow, scheme A
External Fellow, scheme B	External Fellow, scheme B
Internal Fellow, scheme A	Internal Fellow, scheme A
Internal Fellow, scheme B	
Mentor, scheme A	Mentor, scheme B
<b>Total: 7</b>	<b>Total: 8</b>

We analysed interview transcripts using a structured data extraction template, involving manual coding and re-coding of data through a series of reflexive steps. Codes were initially generated from the questionnaire results and the interview guide, with additional codes added as data were analysed. A numbered identifier was allocated to each interview, and quotes were anonymised.

Questionnaire responses and transcripts were analysed for each round and comparisons drawn between first and second round data to explore potential changes as a result of the Programme implementation.



## 3. Findings

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This chapter provides an overview of the findings of the evaluation of the Fellowships in Clinical Leadership Programme. We begin, in Section 3.1, by describing Fellows' and other stakeholders' understanding of the Programme three months into the implementation of the initiative as explored through the stakeholder workshop, including anticipated enablers and challenges to the Programme, alongside proposed indicators and criteria suitable to assess Programme impact. Informed by these initial insights, and drawing on survey and interview data, Section 3.2 then examines in detail stakeholders' views and experiences as the Programme evolved, seeking to understand and explain perceived and observed successes and shortcomings of the Programme.

### 3.1. Understanding the Programme and identifying indicators of success

#### *3.1.1. Refining the logic model*

Informed by the document review, the initial discussions with key stakeholders, and group work at the stakeholder workshop, the evaluation team created a model describing the Programme logic. This representation of the inputs that were invested in the Programme and of the expected outputs, outcomes and impacts of the Programme processes is shown in Appendix B. These outputs, outcomes and impacts are to be considered in light of the Programme assumptions described in the next section.

#### *3.1.2. Assumptions about the Programme*

In order to understand the assumptions underlying the Programme and its logic, the evaluation sought to identify key stakeholders' views on and understanding of the Programme at a workshop three months into its implementation. Table 2 provides a summary overview of assumptions as they relate to Programme logic and the perceived mechanisms that would allow achieving desired results as noted by workshop participants.

**Table 2 Assumptions underlying the Fellowships in Clinical Leadership Programme as identified by workshop participants (July 2012)**

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Local ownership is a key to success: ensuring suppliers, commissioners, local trusts all share the same view

Scheme will be successful despite the financial, political environment (tests the assumption that the course is robust enough)

Some form of sustainability should be achieved

Clinician education and training about QI and leadership needs to be enhanced so they can shape, develop and implement effective change in their work settings

Clinicians need to be prepared for a bigger role beyond clinical duties, including management, commissioning and service redesign in order to meet the expectations for high-quality and cost-efficient patient care

The combination of taught learning modules and clinical duties is needed to anchor the theoretical learning from leadership development programmes into daily medical practice

The leadership programme will help improve the financial situation of the Trust through efficiency gains and cost savings

Combining external and internal Fellows in the same programme helps share perspectives from people with different professional backgrounds and experiences, and enables cross-fertilisation

A leadership development programme will increase staff motivation and trigger change in the Barking, Havering and Redbridge University Hospitals NHS Trust (BHRT), as the skills and activities are essential for improving BHRT performance and addressing CQC ratings

Dedicated management time and support from administrative functions in the Trust are needed for the Programme to deliver its goals

Ring-fenced time for participation in the Programme is needed for the Programme to deliver its goals

Leadership development is more efficient when linked to organisational development; therefore, combining taught modules with QI projects and clinical activity is important

The Programme needs to enable the development of QI initiatives from within the Trust, so as to increase the likelihood of it leading to sustained change

Clinical time for external Fellows will allow them to understand the BHRT context

Reaching a critical mass of Fellows who complete the Programme is important for the success of QI aspects of the Programme, but critical mass is challenging to define

The Programme can be seen to fulfil two functions: to support a 'failing' trust, and to help redesign clinical roles towards more systematic incorporation of QI into roles

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When considering the workshop participants' statements listed in Table 2 Assumptions underlying the Fellowships in Clinical Leadership Programme as identified by workshop participants (July 2012), it is important to keep in mind that many had already been exposed to the Programme, directly as a Fellow or mentor, or indirectly as support staff or a senior leader. As a result, several of the assumptions listed reflect observations or actual experiences influencing perspectives and views on the Programme. Therefore, there is already some sense of the key enablers that would be required to achieve success such as local ownership, and dedicated time for management and quality improvement projects, factors which we will further explore in the following section.

Overall, there was an assumption that the combination of having external and internal Fellows in the same programme would enable them to share experiences and perspectives, with the potential for cross-fertilisation across disciplines and professionals. Furthermore, there was an assumption that the combination of taught learning modules and clinical duties formed a requirement to anchor the learning from leadership development into daily clinical activity, so linking learning more effectively to organisational development. A number of workshop participants voiced an expectation that the Programme would help the Trust to improve its 'financial situation' although there was a common perception that this did not constitute a priority of the Programme. There was also an expectation that the Programme would increase staff motivation and trigger change in the Trust, so contributing to the Trust's performance overall. Therefore, as summarised by one participant, the Programme could be seen to 'fulfil two functions: (i) to support a 'failing' trust, and (ii) to help redesign clinical roles towards more systematic incorporation of QI into roles'. We explore further in Section 3.2 to what extent these assumptions and expectations were confirmed by participants as the Programme evolved.

### *3.1.3. Enablers, challenges, potential future risks*

The success of any complex intervention such as the Fellowships Programme is determined by a range of enablers and challenges inherent in the Programme structure and design, and by the overall context within which a given intervention is being implemented. Knowledge and understanding of enablers, challenges and risks are useful in interpreting evaluation evidence over time, and can also assist those involved in the Programme to reflect on how enablers can be sustained, challenges addressed and risks mitigated.

Workshop participants considered some of the current enablers and challenges associated with the Programme, as well as potential future risks that could influence the achievement of the Programme's long-term goals. A summary of the main factors identified is presented in Table 3. We have grouped factors according to the main areas of concern mentioned by participants, including the actual design of the programme, organisational factors, human resources and working culture, time management and context.

**Table 3 Enablers, challenges and potential future risks as identified by workshop participants (July 2012)**

Enablers	Challenges	Potential future risks
<b><i>Programme design</i></b>		
A focused yet flexible programme	Need to coordinate schemes A and B	Uncertainty about the continuity of the QI projects, and how they will be embedded in the Trust
Hybrid working – taught modules and learning by doing	Recruitment issues for scheme B	QI projects might not meet their original scope and objectives as external Fellows start looking for new positions early on
Multidisciplinary input	Lack of clarity whether the Programme was needed	‘Taking advantage’ of new Fellows: asking too much from them may make them feel ‘exploited’
One year programme: deadline gives motivation to reach goal	Lack of joint ownership at the set-up stages of the Programme	Policy landscape impacting on the uptake of QI efforts
Development of a network of participants, and optimisation of knowledge sharing across levels of seniority and disciplines	Need for more nurses on programme because of their role in the QI agenda in BHRT	
QFI coaching models and networking: development of different sets of ‘soft skills’	Insufficient authority of Fellows	
Expert help available from QFI, London Deanery and internal help	Some QFI modules scheduled too late: participants had to use skills before training	
Fresh thinking opportunities – bringing together external and internal participants leads to cross-fertilisation of ideas	Lack of clarity regarding the coordination of QI projects and how they can be articulated	
<b><i>Organisational factors</i></b>		
Financial support to enable implementation (note: some QI projects are cost neutral)	Bureaucracy: levels of ‘red tape’	Uncertainty about the new Board. Will there be good support for the Programme in the future?
Shared vision within senior executive levels (and among those ‘conceiving’ the Programme at NHS London and Deanery); senior buy-in	Collaboration can be difficult. Need for conflict resolution skills	Lack of clarity on some executive roles and responsibilities
	Financial challenges to maximise impact from QI projects	
	Not enough financial and admin staff to support QI projects	<i>Logistics</i>
	Venture fatigue: is it yet another project?	Lack of a long-term investment in IT; changes in IT software hindering effectiveness of training
	<i>Logistics</i>	
	Slow IT system	
	Infrastructure (lack of meeting rooms)	
<b><i>Human resources and working culture</i></b>		

Enablers	Challenges	Potential future risks
<p>Desire and sense of urgency to make a change</p> <p>Enthusiasm, knowledge, commitment and patience of staff working with QI leads</p>	<p>Low staff morale and perception of disempowerment; fear that Programme will fail</p> <p>Staff perception (real and actual) about their increased workloads</p> <p>Resistance of staff not involved in the Programme</p> <p>'Blame culture': incidents and errors are always noticed, while good actions are never rewarded</p> <p><i>HR constraints and instability</i></p> <p>HR instability at staff level and senior management level</p> <p>Issue of staff retention and therefore commitment to Programme</p> <p>Lack of lead in some areas within QI projects</p>	<p>Uncertainty in job security impacts on commitment</p> <p>Role models: where can Fellows be champions? Risk to not identify and develop the key expertise that is needed</p> <p>Reintegration of external participants into the health system: will their new skills be welcomed? ('double edged sword of being a pioneer')</p> <p>Risk of developing a two-tier workforce: highly qualified staff who benefited from the Programme vs. staff who did not participate</p> <p>Cultural shift may never happen</p>
<b>Time</b>		
<p>Protected time for participants</p> <p>Clinical workload spread between staff members</p> <p>In some cases, secondment of midwives can ease pressure of needing to find new job</p> <p>Dedicated programme manager</p>	<p>Not all clinical sessions are releasing internal time for 'protected time'</p> <p>Time constraints: threat to continuity because of the time-limited nature of the Programme</p> <p>NHS patterns are not about meeting deadlines or using management skills or tools</p>	
<b>Context</b>		
	<p>Catchment population: high deprivation levels in Romford and population size</p> <p>Patient expectations</p> <p>Trust benchmarked against high standards</p>	<p>Uncertainty about the future of the Trust more generally</p> <p>Risk that media will keep on publicising poor performance</p>

It is important to emphasise that factors identified in Table 3 are perceptions of participants and we sought to capture the diversity of views across those involved in the Programme. In a minority of cases, participants perceived a specific factor as an enabler and functioning well, while others viewed the same factor as a barrier. An example is the degree to which the Trust was seen to be receptive to change. These divergent views helped us place the evolution of the Programme and its potential impacts into context and informed subsequent data analyses. Most of the enablers described by participants were related to the design of the Programme (protected time, dedicated project management, shared vision), which suggests that participants found it appropriate and fit for purpose. Of major concern for most participants was uncertainty about the future of the Trust and of staff working at the Trust as a consequence of a range of

internal and external pressures. Overall, in the areas of working culture and context, participants perceived or anticipated challenges or risks to outweigh potential enablers. This illustrates the importance of the context within which the Trust sought to implement change. There was a perception that context was impacting on staff morale with anticipated challenges for establishing a positive working culture and staff behaviours conducive to change as foreseen by the Programme.

### 3.1.4. Exploring indicators and shared success criteria

Workshop discussions further sought to explore the types of output and outcome indicators that could be used to evaluate the realisation of Programme goals and commitments over time, and that could inform learning. It was emphasised that indicators needed to meet multiple evaluation aims: accountability, capturing and demonstrating achievements, and learning. Table 4 lists the key issues workshop participants identified as requiring exploration through success criteria and indicators.

**Table 4 Types of issues to explore through indicators and shared success criteria as identified by workshop participants (July 2012)**

<b>The Fellowships in Clinical Leadership Programme: perceptions</b>
Nature and extent of contribution of the Programme to greater awareness about the importance of leadership skills across BHRT
Nature and extent of influence of participation or engagement in the Fellowships Programme on job satisfaction
Nature and examples of perception of supportive attitudes to the Programme by different stakeholders in BHRT, including staff and senior leadership
<b>Structure of the Programme: core taught elements</b>
Extent and perceived value of the integration of the Programme elements with clinical duties
Extent of the role of training activities in the development of leadership skills
Extent of the role of training activities in transferring leadership skills into clinical practice
Nature and extent of the influence of the Programme on the development of (new) leadership skills
<b>Structure of the Programme: quality improvement focus</b>
Extent of the contribution of the Programme to greater awareness of quality improvement processes across BHRT
Extent and perceived value of the role of training activities in the development and implementation of QI projects
Nature and extent of the importance of teamwork components in delivering QI projects
Nature and extent of key enablers to delivering QI projects
Nature and extent key challenges to delivering QI projects
Extent of capacity to transfer leadership development skills in designing and implementing QI projects
Nature and extent of influence of the new leadership skills on implementation and delivery of QI projects
<b>QI projects outputs and outcomes</b>
Extent of the influence of the Programme on the attitudes to quality improvement (attitudes of Fellows and of colleagues)
Nature and extent of impact on the home organisation: measure of receptiveness and interest in the Programme
Nature and extent of the impact on the service quality
Nature of outreach: adoption of QI projects findings across and beyond the Trust
<b>Working with patients</b>

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Nature and extent of the influence of participation or engagement in the Fellowships Programme on the development of new skills regarding working with patients and delivery of high quality care

Contribution of the Programme to improving patient experience

Contribution of the Programme to improving patient safety

**Efficiency**

Contribution of the Programme to reducing waste of resources

Contribution of the Programme to improving management processes

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The types of output and outcome indicators considered by participants as suitable to assess Programme success listed in Table 4 mainly constitute ‘soft’ measures, with many centring around assessing the nature and the extent of the components of Programme impact as perceived by participants. Shared success criteria capture all those themes that emerged from the first three months of the Programme, from the potential impact on individual skills, to perceived changes in the quality of care.

### 3.2. Working as or with a Fellow: perspectives and experiences

As noted in the introduction to Chapter 3, this section examines in detail stakeholders’ views and experiences as the Programme evolved. In particular, it seeks to understand and explain perceived and observed successes and shortcomings of the Programme. Drawing on survey and in-depth interview data, we identified four main themes:

- The design of the Programme, and the usefulness of QFI Consulting’s activities for participants
- QI project progress
- Cultural change within the Trust
- Wider organisational impacts

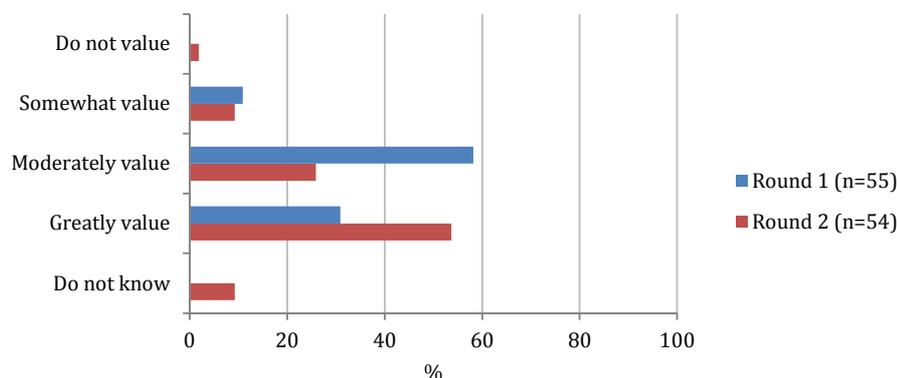
In the following sections, we explore each of these themes in detail.

#### *3.2.1. An innovative Programme, designed to suit the needs of participants*

Dedicated learning and clinical time were highly valued by participants

The majority of questionnaire respondents and interviewees in both rounds greatly valued the uniqueness of the scheme, which combines dedicated learning and development time with dedicated project time and with clinical work (Figure 3).

**Figure 3 Respondents' views on the value of the combination of clinical duties and learning activities (%)**



There appeared to be a tendency for a greater number of respondents to value the specific design of the Programme over time, with the proportion of those responding that they greatly valued the combination of clinical duties and learning activities increasing from 31 percent in round 1 to 53 percent in round 2. The combination of learning and clinical sessions was seen as an opportunity to directly transfer into practice the newly acquired skills (Int1), and to combine theoretical and applied learning (Int6).

In addition, clinical duties were seen as a valuable way (Int2) to facilitate the integration of the external Fellows within the Trust and among internal teams:

It's very good for the Trust because [external Fellows] are seen as part of the organisation, rather than just somebody that's coming to do something to us. (Int14)

QFI training was considered as useful and adequate by most programme participants

Feedback about the learning activities delivered by QFI Consulting was, overall, very positive. Most of the interviewees found it useful, appropriate, context relevant and directly applicable to work. Some would recommend QFI as a leadership training provider in healthcare settings. One internal participant commented in particular on 'rewarding learning opportunities':

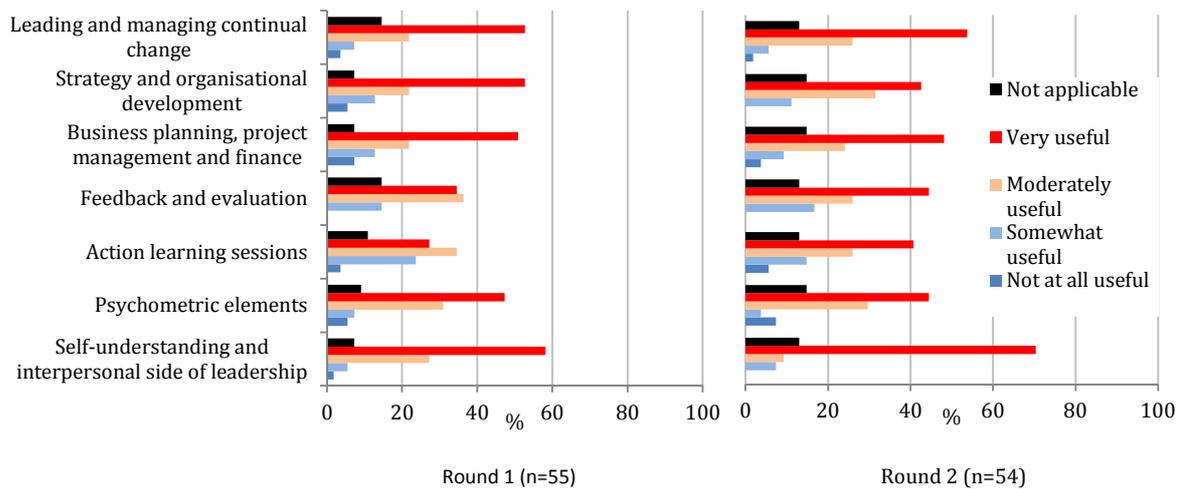
The support from the QFI has been extremely helpful. If they were offering other courses outside the Programme, and even if I had to pay for it, I would seriously consider it. (Int7)

Figure 4 illustrates how some learning activities were considered to be especially useful and there was some suggestion that components such as 'self-understanding and interpersonal side of leadership' increased in perceived value over time. Participants emphasised the importance of self-understanding in order to improve working with others:

The module where they tried to understand people, their personalities and the way they behave and how to interact with people was very useful because sometimes somebody may have difficulties, so [understanding] how to approach people and why they are reacting the way they are was very useful. (Int15)

Of the activities assessed in the survey, action learning sessions appeared to have been rated as among the least useful (Figure 4), at least initially, although the proportion of those rating these sessions as useful increased over time. This might suggest that participants were able to make better use of this learning tool as their involvement in the Programme evolved.

**Figure 4 Respondents' views on the value of training activities for developing leadership skills (%)**



While we were not able to confirm this hypothesis in our interviews, it may be useful to note that some participants found them very useful, because they offered the opportunity to be 'honest and open' (Int12) and to interact with colleagues and share concerns with them, which contributed to make participants feel less 'isolated' (Int11). However other interviewees found that despite being a 'confidential arena' (Int9), they did not feel they could say whatever they felt like saying (Int10). This was mainly attributed to the composition of individual groups, and in action-learning sessions that were composed of individuals working together on a daily basis, participants felt 'restricted in what they said' (Int9). Yet one other interviewee noted that action-learning sessions were 'repetitive' and did not teach them anything 'new' (Int6).

### The learning activities contributed to leadership skills development

Participants reported that the taught modules mostly contributed to developing their leadership in areas such as confidence, communication skills, negotiation skills and team management skills.

For example, the taught element was reported by one internal Fellow to have improved 'resilience and bravery', making individuals 'more persistent' and that 'when [individual] go[es] into making an argument, [individual is] armed with knowledge to defend [individual's] position' (Int6). This was confirmed by one external Fellow who noted how the course had 'boosted... confidence', especially in approaching senior people, a task that seemed 'daunting' previously. The Fellow concluded that the course had helped 'selling yourself' (Int4), a view that was shared by two other Fellows (Int1, 7).

Skills were further developed by means of one-to-one coaching sessions delivered by QFI, alongside more informal coaching provided by mentors. One interviewee noted how individual coaching had 'helped

understand yourself; and this is part of being a leader' (Int4), while another Fellow commented on the value of coaching being 'flexible' and tailored to the needs of the individual (Int1). Although several interviewees noted that the mentors' role had not been clearly defined, other participants reported on their positive experiences of the relationship between mentor and mentee (Int2, 5, 7, 11):

I was supporting the Fellows when they were having difficulties sorting things, if they found the[re] was an obstruction with senior member of staff I would deal with that. I would deal with issues preventing them from doing something. I could have this supporting role, or help them identify things. They came to me quite frequently. But I had the time to be able to help them. There were issues in the beginning, as there always are when a new team start, but as soon as we became a team, they knew they could discuss anything with me. (Int10)

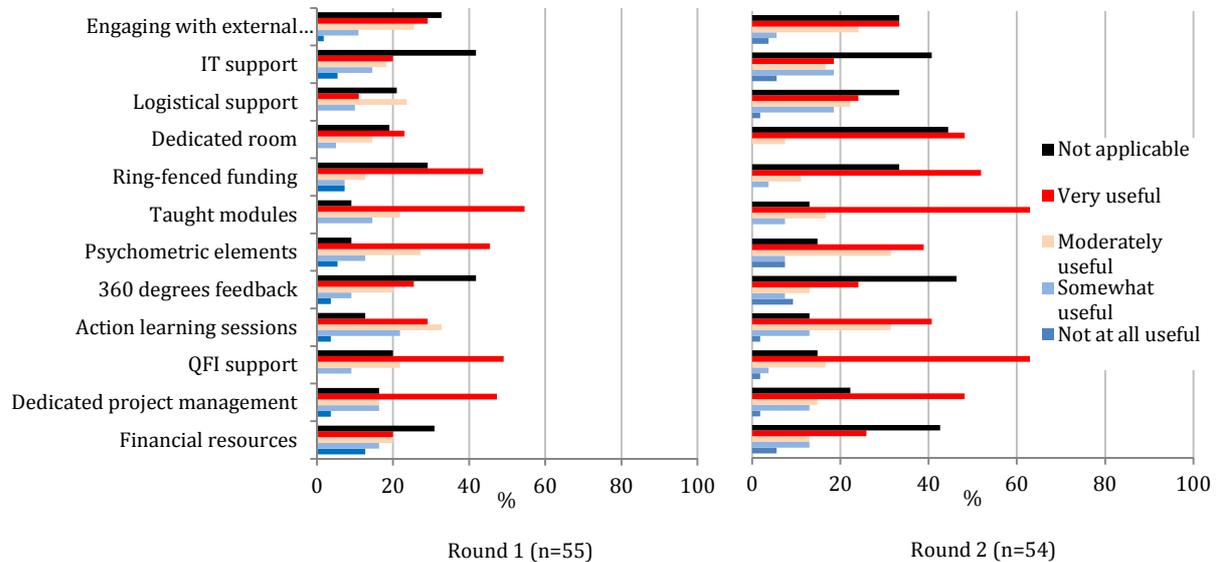
The level of commitment by mentors appeared to have varied however, with one Fellow reporting on having received 'better support' among non-officially assigned mentors who had stepped in in place of designated mentors (Int13).

### The Programme features helped participants during the implementation but not the design phase of the QI projects

When asked about the value of the Programme activities in relation to the delivery of QI projects (Figure 5), some features of the Programme were seen as very useful. These included the dedicated project management support and the taught sessions on project management and business planning:

I personally think that the Programme was fantastic. I think it was an excellent opportunity to have an overview of the leadership around the patient flow, and the processes, and how that works, the financial [side]... all the business stuff. (Int11)

Interviewees further highlighted the role of mentors in supporting the delivery of QI projects, with two participants commenting how mentors were able to facilitate relationships between members of the Trust and to link with senior staff or non-clinical departments (Int5, 10). Protected time for QI projects was also seen as essential, as it brought some 'focus' (Int15) on quality of care.

**Figure 5 Respondents' views on the value of Programme features for conducting QI projects (%)**

There was concern among some participants about the timing of some aspects of the taught Programme, which was perceived as being scheduled too late in the lifetime of the Programme to helpfully inform QI projects. Several interviewees (Int1, 9, 12) noted that some of the project management tools discussed in one of the modules would have been welcome earlier in the Programme and would have saved a time on some aspects of the QI projects. One respondent mentioned that the project management course should have been scheduled prior to the project initiation phase (Int1).

As shown in Figure 5, a comparatively large number of respondents reported for 360 degrees feedback to not having been applicable in relation to conducting QI projects. However interviews captured that some form of feedback was in place, since external Fellows typically met on a monthly basis with the Programme Director, the Clinical Director contributing to the project, and their mentor to assess QI project progress, reflect on potential problems or challenges, and identify next steps (Int8, 9).

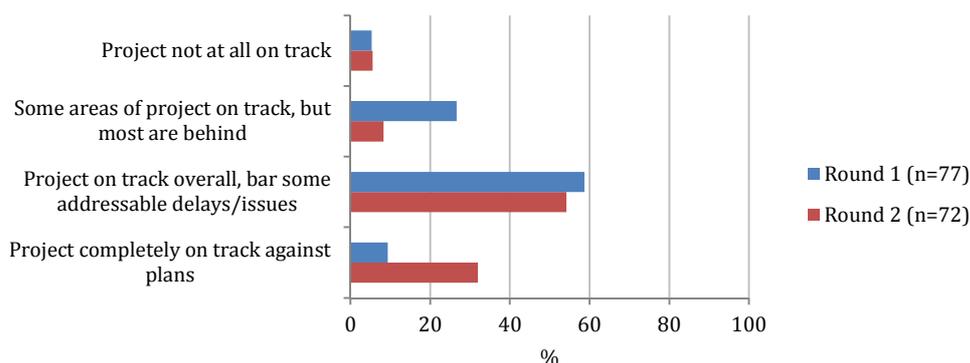
Finally, several interviewees emphasised how they had valued the participation of external speakers in QFI modules as part of the training. There was a perception that using external speakers would demonstrate how skills and good practice can be embedded in the delivery of high quality care. One interviewee commented on the 'inspirational' (Int5) intervention by the CEO of one hospital trust other than BHRT, which was corroborated by other interviewees, who also commented on how it offered a valuable 'perspective on life' (Int12).

### 3.2.2. Quality improvement project progress

#### Most QI projects were on track

Progress on QI projects advanced as the Programme evolved. At around six months into the Programme, about one-quarter of projects were reported to be only partly 'on track', but this proportion fell to under 10 percent close to the completion of the Fellowships Programme in February 2013 (round 2 of the survey, Figure 6).

**Figure 6 Respondents' views on whether QI projects were going to achieve goals (%)**



Note: In this figure 'n' is the number of projects, not the number of respondents as respondents could be involved in several projects.

### Enablers and challenges to delivering QI projects were clearly identified

Participants identified a number of key enablers and challenges to delivering their QI projects. The most frequently mentioned enablers included: dedicated time to conduct the project, the contribution of motivated individuals, availability of resources, support from other staff, senior buy-in, teamwork or collaboration with other Fellows and participants, and QFI support. The main identified challenges mirrored the enablers, including time constraints, lack of financial resources, resistance of other staff, lack of middle and/or senior management support, limited duration of the Programme, and staff shortages (Table 5).

**Table 5 Enablers and challenges to delivering QI projects as identified by participants**

Enablers	Challenges
Support from senior management and from other staff	Resistance to change
Ring-fenced time	Time constraints
Networking and teamwork	Difficulties in accessing data
QFI and mentors support	Bureaucracy
Commitment of participants	Length of the Programme – too short
Availability of extra resources	Difficulties in unblocking resources (human resources and financial resources)

Some of the identified challenges were perceived to be overcome by co-existing enablers. For example, 'red tape' was seen to be addressed by support provided by QFI and the mentors with regard to relationship building and communication within the Trust across services. In the same way, some Fellows reported to having had difficulties in accessing relevant datasets for their projects; however, some acknowledged that networking opportunity provided by the Programme had provided means to overcome this challenge. Programme participants commented on a perceived persistence and entrepreneurial behaviour of external

Fellows which was seen to be a strong enabler for the delivery of QI projects. This was also reflected in the views of some participants who noted that Programme success was dependent on individuals' 'personalities' (Int8). Others commented on the commitment and support of internal senior staff (Clinical Directors and senior management) as an important enabler that allowed mobilising resources, bringing focus on the Programme, and winning over resistant staff members. The role of senior support will be discussed in more detail in Section 3.2.3.

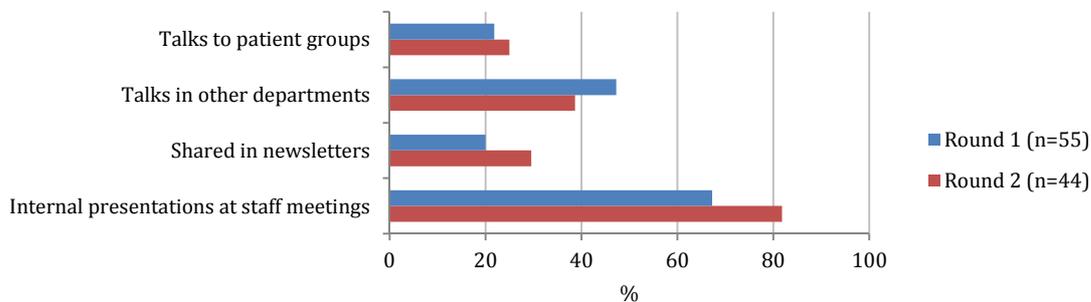
### Participants reported some direct projects outputs

Participants reported on a series of key outputs from their QI projects; these included better team-working and increased communication within and across teams (see Section 'Working better as teams'). It was beyond the scope of the evaluation to systematically collect data on quantifiable outcome measures of individual QI projects. However, programme participants did report on measurable clinical outputs that contributed to improvements in the quality of care. Given the nature of the evaluation and to maintain respondents' confidentiality, we here refrain from directly citing individuals' experiences, and instead document a small selection of high-level experiences. For example, one internal Fellow noted how their QI project had substantially enhanced patient experience in maternity services, which was seen as an important achievement by Scheme B participants. Other QI projects in maternity were also reported by some participants to have equally led to tangible measures of success, such as relieving some of the pressures in the maternity ward through greater use of ambulatory services. Similar successes were reported by scheme A participants.

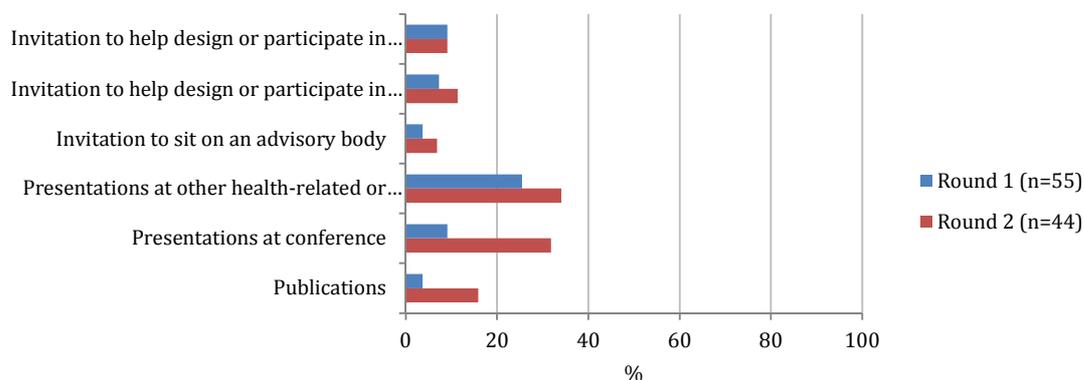
### Dissemination of QI projects' findings improved over time but remained limited

In an attempt to assess the extent to which the changes developed through QI projects were communicated, Figure 7 and Figure 8 present the proportion of respondents who reported that the findings from their QI projects were adopted or disseminated, with a breakdown by type of dissemination mechanism.

**Figure 7 Proportion of respondents who were aware of internal dissemination of findings from their QI projects, by medium (%)**



**Figure 8 Proportion of respondents who were aware of external dissemination of findings from their QI projects, by medium (%)**



Although the majority of interviewees in Round 1 felt it to be too early to consider dissemination of findings of QI projects, some were able to identify early indications of adoption such as sharing new ways of working with other staff members. Towards completion of the Programme, over 80 percent of participants reported presentations at staff meetings, alongside weekly emails and newsletters (Int8, 9 and 12). There appeared to be a relative lack of external dissemination of QI project findings (Figure 8), which was noted by one interviewee as presenting one of the weaknesses of the Programme (Int15), in particular against the perceived aims of the Programme to contribute to improving the Trust’s reputation (see Appendix B). While overall the level of external dissemination of QI project findings was lower compared to internal dissemination mechanisms (Figure 7), Figure 8 highlights that dissemination activities did increase as the Programme evolved, with around one third of participants reporting to have given external presentations towards the completion of the Programme.

### 3.2.3. Cultural change

A third theme which emerged from the evaluation was the potential for wider cultural change within the Trust as a result of the skills being acquired and personal awareness and confidence-building of individual participants.

#### Working better as teams

Programme participants reported that teamwork, interpersonal relationship building and interpersonal communication skills were among the most important skills required for successful delivery of the QI projects. Over 70 percent of respondents noted that they found these elements very important (data not shown). This finding was supported in interviews, with mentions of opportunities to work better as a team (Int7) and to improve people management considered a strength of the Programme:

The team work, the group work, I mean talking about different people and how we impact, how we think about making changes for the benefit of the patient. All this is happening as well and I think this is a good change and if we keep doing that it will make a huge difference in the communication and eventually it will make a great difference to the patient. (Int15)

Getting together was also perceived to represent an opportunity to strengthen ‘a sense of belonging’ to a team and the relationships within a team (Int6):

We achieve more as a team, and it gives you a glow of pride, a glow of satisfaction, and it can be seen from other areas. There are some long standing colleagues that I've always admired, and this is nice to see them thrive in this environment. (Int5)

Several participants commented on the value of being offered, by the Programme, in relation to the opportunity to meet and work with other staff they had not previously worked with. Improved collaboration was seen by some participants as one way to maximise efficiency through understanding how other staff in the Trust operate (Int5, 9), overcoming silos (Int4, 9, 12) or avoiding duplication of efforts (Int6).

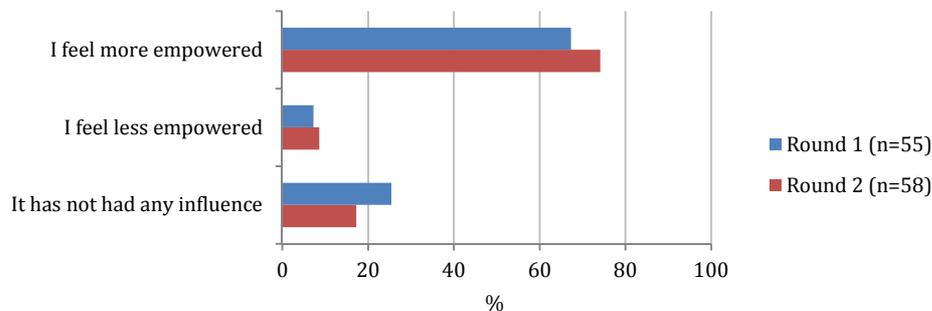
### Empowerment and job satisfaction

On a personal development level, almost all programme participants who were interviewed reported feeling more empowered. They spoke about feeling ‘braver’, ‘more daring’, being ‘better equipped’ to achieve goals, and being ‘more persistent’:

I have the tools with which to do the job, so that’s empowerment. (Int7)

This notion of ‘empowerment’ as a result of the Programme is further illustrated in Figure 9.

**Figure 9 Views of programme participants on whether the Programme made them feel more or less empowered (%)**

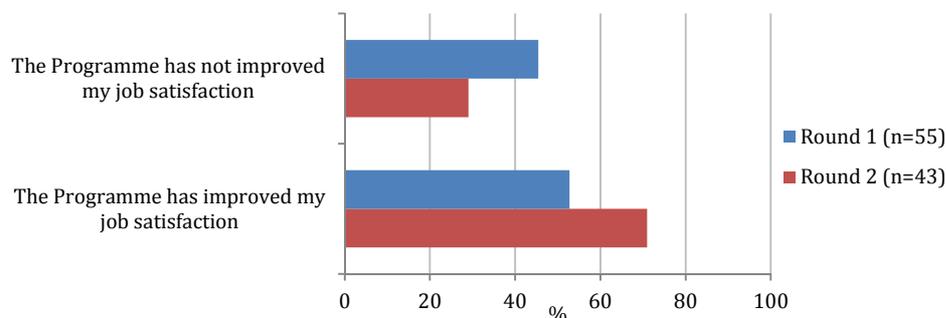


There appeared to have been an increase in the proportion of those reporting to feel more empowered as the Programme progressed (Figure 9), suggesting that some individuals may have ‘come around’ (Int4 and10) over time. Some interviewees provided insights into reasons for staff feeling less empowered; although they only constituted a small minority of respondents, the views of these interviewees may provide important pointers for the further development of the Programme. For example, there was a suggestion that the Programmes may have added to the workload and stress levels of some individuals, who as a consequence had felt overwhelmed and under pressure rather empowered.

The impact of the Programme on job satisfaction was slightly more difficult to discern, as many frustrations and issues remained in the job environment, beyond the scope of the Programme. There was

no clear view regarding job satisfaction among survey respondents although there was some indication that satisfaction levels increased over time, as shown in Figure 10.

**Figure 10 Impact of the Programme on job satisfaction of participants (%)**



When commenting in interviews, participants noted that job satisfaction was linked to empowerment and the positive feeling of reaching objectives and improving the quality of care:

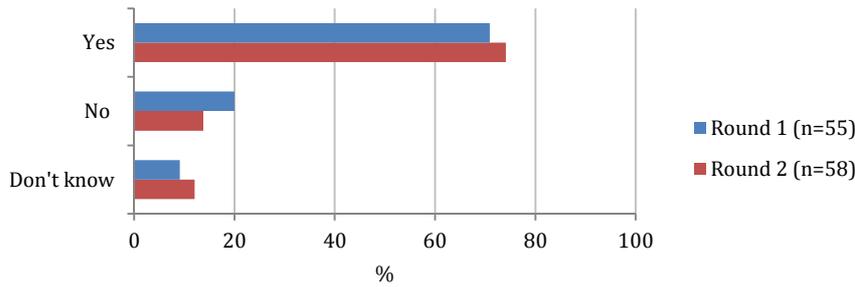
My experience historically is when you're given a bit of space, allowed to do some development, some reflection, and actually improve what is going on around you, that's hugely satisfying and a lot of doctors are driven by that. (Int13)

It was a real eye-opener for me and actually I feel happier that I got involved with this project... I feel more positive. I think I can do better now. (Int15)

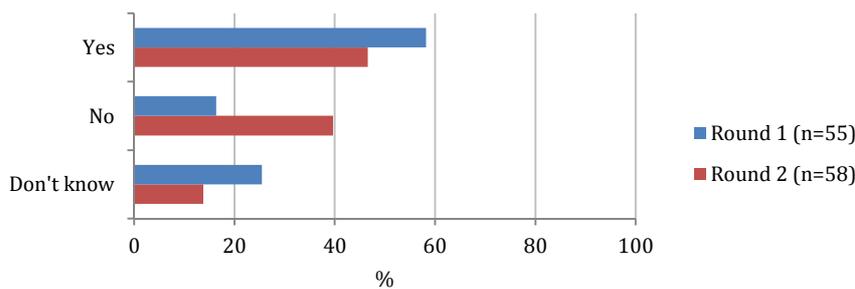
Some senior people also reported feeling more satisfied because the Programme had contributed to accelerating changes within the Trust and had made their job (such as reaching quality targets) 'easier' (Int12).

### Organisational support and staff resistance

There appeared to be consensus among programme participants that the level of support provided by senior management in the Trust was instrumental in the development and achievements of Programme goals. Interviews in particular highlighted the role of the chief executive officer (CEO) whose support was reported to be perceived as strong and visible, demonstrated in her attending some of the training sessions (Int12) and adopting an 'open door policy' for external Fellows (Int10). Other members of senior management were also acknowledged to provide important support. These views were echoed by the survey findings (Figure 11).

**Figure 11 Views of respondents on whether they had support from senior staff (%)**

Conversely, the views on support from other staff (who did not participate in the Programme) were more mixed (Figure 12) and interviewees mentioned attitudes ranging from indifference to active animosity. Some commented on experiencing 'suspicion' and negative attitudes from senior clinical staff (some consultants or clinical directors; Int11), middle management and front line staff (Int10, 15).

**Figure 12 Views of respondents on whether they had support from staff outside the Programme (%)**

At the same time, there appeared to be a trend for negative attitudes from staff outside the Programme to have fallen over time, with the number of respondents reporting not having experienced disapproval from others increasing from under 20 percent to almost 40 percent as the Programme evolved.

Reported reasons for lack of support and resistance towards programme participants included a perceived general resistance to change and scepticism towards new ideas that some considered to be inherent in clinicians' culture:

[For clinicians] being positive is being naïve, being young and inexperienced, not wise, somewhat foolish, innocent, contemptible. (Int5)

Furthermore, there was some perception that support staff might have viewed the Programme as a threat that would increase pressures and strain already scarce resources (Int2, 4). Some respondents noted that resistance from staff not directly involved in the Programme might reflect some form of 'envy' as some individuals were selected to be part of the Programme, and others were not. Interviewees attributed some of these views to a perceived lack of transparency in the recruitment of internal participants, for example, that the scheme was not advertised, which might have contributed to create initial defiance (Int10).

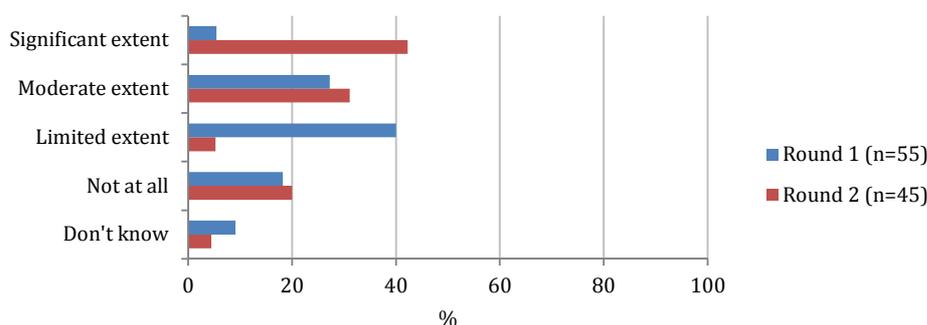
### Changing behaviours

There was an overarching view that a perceived proactive and positive attitude of Fellows may have contributed to cultural change in the Trust. Interviewees reported that they tried to share what they had learned and so influence the work culture at the Trust (Int1, 5 and 7):

I have been able to pass these skills on to my colleagues too. (Int7)

This notion was supported by respondents to the survey, as illustrated in Figure 13.

**Figure 13 Views of respondents on whether the Programme had an impact on the behaviour of colleagues not directly participating in the Programme (%)**



Survey findings indicate there is a trend towards a substantial shift in reported impacts of the Programme on behaviours of those not directly participating in it, with over 40 percent reporting ‘significant’ indications of such change towards the end of the Programme (round 2). While the survey data do not permit further disentangling of the underlying reasons for and types of changed behaviours, insights from interviews suggest that the presence of external Fellows and their successful integration into the Trust might have been an important contributor. Respondents commented that, in addition to their clinical expertise, external Fellows had brought ‘a pair of fresh eyes’, and the ability to challenge the status quo (Int2, 12). Being external appeared to have facilitated change. However, some participants suggested that there were some tensions due to the difference in status between internal and external Fellows in favour of the latter (Int11): external Fellows could spend more days on QI projects (Int10) and benefited from better support as they reportedly ‘made theirs’ the meeting room for programme participants (Int12), and received more support from the senior management structure (Int10).

#### 3.2.4. Wider organisational impacts

##### A programme ‘worth investing in’

There was an overarching view among interviewees that the Programme was worth investing in (Int2, 3, 5 and Int9). Interviewees commented that the Programme was seen to provide better investment than other initiatives implemented by the Trust, because of its combination of external support and internal commitment, which was seen to have imported ‘freshness’ and expertise from the outside and reinforced the pool of skills from the inside (Int2, 7). Interviewees particularly valued that the Programme involved members of staff with the support of external clinicians:

[The Clinical Fellows] are probably the ones who could influence the change more, they have the clinical background and the shop-floor knowledge, which is something that get[s] lost in all the other projects who have all very good PR... Clinical Fellows understand the clinical flows and the clinical pathways that the patients are on. While some of these big consultancies don't necessarily understand it so well. (Int14)

The Programme was also seen to have contributed to improving the 'marketability' of a cohort of Fellows by enhancing their managerial skills and developing their abilities as clinicians. Interviewees noted that the Trust sought to capitalise on this achievement by offering positions to several of the external Fellows (two in scheme B, one in Scheme A, locum positions for two other Scheme A external Fellows under consideration; Int8). Other external Fellows were reported to be able to secure consultant level posts in other NHS trusts. It would therefore seem that the Programme has had a positive impact on the career of most of the external Fellows. One respondent noted that such an achievement could be seen to enhance the reputation of the Trust within the NHS. Career perspectives appeared more limited for internal participants as they were not systematically offered promotions or new roles within the Trust (Int8, 12), but it was reported that two internal Fellows (Scheme B) were promoted by the end of the Programme (Int8).

Overall, the Programme was seen as an opportunity for development at the individual level and for quality improvement at the Trust level. Several interviewees noted that the Programme had brought the 'focus' on what, in their view, should always be at the core of what they do – improving the quality of care (Int8, 11, 13).

#### Identified shortcomings for further consideration

While generally positive about the Programme, participants identified several areas for its future development. For example, some participants commented that the leadership course was 'basic' and perhaps more appropriate for junior staff. This was a particular concern among more senior staff who had previously participated in leadership courses.

As indicated earlier, there was some concern about the lack of transparency in the recruitment process, which made it difficult for potentially eligible participants to apply or be considered for the Programme (Int10). This may have created tensions that were sustained throughout the Programme, including potential resentment from internal staff who were not selected (Int15); potential tensions between internal and external Fellows, with internal Fellows potentially less motivated (Int9, 11); or external Fellows possibly given a different status as they were selected through a formal process (Int11).

Some participants and managers reported that some non-clinical functions could have been better integrated into the Programme in order to enhance outcomes (Int6, 9). Examples included involving the IT team, the finance team and the communications team in the development of QI projects so that within those teams members would be 'dedicated to the requests [they] make from the projects' (Int8). It was suggested that such an approach might facilitate the implementation and delivery of QI projects, and also facilitate the conduct of cost-benefit assessments of individual projects because of increased data sharing.

Several interviewees shared the view that the duration of the Programme of 12 months was perhaps too short for the successful implementation of QI projects and for seeing the results of work undertaken (Int2, 7, 15). There was some perception that because of the limited duration of the Programme, external Fellows had to start looking for a new position six months before the end of the Programme and this might have diverted focus from QI projects (Int2). Also, the majority of interviewees noted that if the Programme had had clearer goals and role allocation from the beginning and a better timing of the learning activities (Int1, 9), participants would not have ‘lost’ several months’ worth of work (Int3, 6).

Duration of the Programme was closely linked to the sustainability of Programme outputs. Most participants expressed concerns over the sustainability of their initiatives and the possibility that with the end of the Programme, focus and resources which facilitated progress might be diverted:

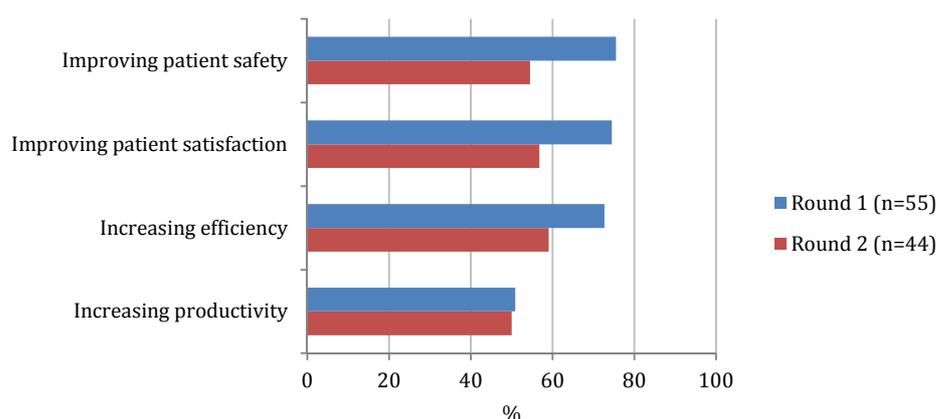
It’s about how we maintain that through... But I am conscious of workload, and because we do not have time to do it... I hope it’s not going to fall apart; all the things that they’ve put in place will hopefully stay here, but it is about how we embed that process. (Int12)

Sustainability of the changes was seen to be critical in assessing the value of the Programme and justifying its promotion within the NHS more widely. One opportunity to sustain change was seen in designing projects that aim to improve a given process but would not require additional financial and human resources to maintain that process, as exemplified by some QI projects within the Programme (Int8).

### One step closer to improving patient experience and care standards

Figure 14 illustrates the perceptions of programme participants regarding the contribution of the Programme to wider improvements across the Trust.

**Figure 14 Views of participants on the contribution of the Programme to wider improvements across the Trust (%)**



It is notable that respondents appeared to become less positive about the contributions of the Programme to wider improvements as the Programme evolved. This might suggest that participants had, over time, become more realistic about what the Programme can or cannot achieve. The majority of participants

believed that the work conducted within the Programme contributed to a notable extent to improving patient safety and patient experience, and to enhancing efficiency and productivity.

Although at the time of data collection measurable outcomes were available for all projects, programme participants reported on evidence of Programme successes at the organisational level as well as on the quality of services delivered to patients. Some examples of impact reported by respondents are presented in Table 6.

**Table 6 Examples of improvements in caring for patients reported by respondents**

Examples of improvement in working with patient	Examples of improvement in delivering quality care	Examples of improvement in patient experience	Examples of improvement in patient safety
'This is my first Consultant job and so being the leader of the clinical team is also new. Being more responsible for the clinical team (being adequate and understanding their role) is a development.'	'I think I have more confidence in my own and others' ability to effect change. For many years poor attitude in midwives, and to certain extent in doctors, went unchallenged. Now I would be far more likely to challenge such attitudes.'	'Development of seamless pathways in gastroenteritis has made a significant impact on parents.'	'Decrease in waiting times to be reviewed in triage'
'I think I have become more patient and a better listener to patients. I think I offer them more choice – I am less likely to impose a single solution (my solution on them). I am more likely to check to see if they accept and understand my viewpoint.'	'I have developed a greater understanding into risk and serious incident reporting. This has changed the way in which I practice and improved my communication to patients.'	'Triage, high risk pathway, more normalisation of low risk births, more water births, improved communication of neonatology to Antenatal clinics.'	'The Acute Kidney Injury (AKI) e-alerts are improving the recognition of AKI by doctors across the Trust leading to quicker more pro-active and effective care and hopefully prevention of the need for dialysis or intensive care.'
'Greater participation in dealing with patient complaints and improving patient information.'	'Project management skills and use of audit data to provide evidence of the need for changes in the service.'	'The patient experience antenatally and postnatally has been improved. The level of care received is more streamlined and individualised.'	'The high risk pathway has resulted in fewer women coming in "off the street" for C-section. Low risk births are left to labour undisturbed. More water births mean less intervention.'
'Greater understanding of the links between patient needs, strategic objectives and stakeholders.'	'Developing patient focussed pathways.'	'Reduction in delays for elective caesarean sections.'	'Improvements in maternal/foetal observations performance & improvements in WHO checklist compliance. ALTHOUGH full compliance has yet to be achieved.'

Examples of improvement in working with patient	Examples of improvement in delivering quality care	Examples of improvement in patient experience	Examples of improvement in patient safety
'A greater awareness of patient perspective in relation to care received in acute medical and surgical units. A greater appreciation of patients' journey from admission to discharge.'	'Improving parent involvement in decision making and care planning.'	'Reduction in complaints, improvement in patient flow.'	'Less clinical incidents in the areas where projects conducted.'
'Developing self-awareness.'	'Ability to focus on patient-care in projects to re-design services and not get bogged-down in bureaucratic processes.'	'Elective C-section booking process.'	'Self-referral process improves speed of referral, staff training improving availability of water use and births.'
'Able to advise patients on goal-orientated approaches.'	'Introduced a streamlined and an efficient appointment system for the women attending the Obstetric Assessment Unit.'	'Women choices re accessing services and water birth options have improved and the number of unnecessary contacts in the antenatal period has also decreased.'	'Patients' outcomes have improved considerably and patient stay is shorter. Programme allowed it to be prioritised and time given to ensure success.'
'Communication skills, time and project management.'	'By visiting mothers on the antenatal ward and showing them around the neonatal unit this has put their mind at rest. We have had very good feedback from parents.'	'Improved knowledge of water births and increased use of pools, improved self-referral process and discharge process.'	'C-section list is legally compliant now and service is not overstretched as much.'
'Communication skills - listening, understanding the family's needs, re-evaluate at the end of the day, the way I teach has changed.'	'Everything is evidence based, I now challenge when I am unsure.'	'Clinical pathways [and] improvement in results of critically unwell children.'	'Guidelines written have been passed by trust ensuring all staff comply, parents given information regarding their baby's progress. Better understanding of their baby's needs.'
	'Greater understanding of service options.'	'Reduction in unnecessary hospital appointments.'	'Reduced or no cancellations for elective work, out patients inductions.'
	'Reduced risks for elective cases.'	'Children who require HD [high dependency] care have safely been cared for within Trust rather than a transfer to another hospital for this care.'	'Improved training in rhesus skills and team working in critically ill children.'
	'Increased examination and analysis of audit findings, increasing my knowledge and awareness of other services.'	'Feedback from those using the service prior to the new system, stating that [it] is a nicer experience now, less likely to need additional	'Clear data and information on the elective list, traceability and control of case load by controlling the elective calendar.'

Examples of improvement in working with patient	Examples of improvement in delivering quality care	Examples of improvement in patient experience	Examples of improvement in patient safety
		interventions.'	
	'Appreciation of individual patient needs.'	'Reduced waiting times, consultant eye casualty led care.'	'Better patient flow through the area using the RAG (Red Amber Green) system.'
		'We provide more Kanagroo care. Babies are now monitored for pain where as we did not previously; positioning and handling of babies has improved.'	
		'Waiting time for elective surgery on day of admission by admitting twice a day.'	

These examples illustrate some perceived improvements in the way care is delivered, and perceived changes in care processes and attitudes, and the use of improved processes (pathways, triage, booking and discharge processes). Respondents also referred to the emergence of evidence-based practice, through the use of data and the conduct of audits. Respondents' perception of quality improvement was reinforced by an increased awareness of guidelines and quality standards, and reports on positive feedback from patients ('verbal and written appreciation'), from parents of hospitalised children, and from the CQC, which produced a 'very positive report'.



## 4. Discussion

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This report has documented the findings of an evaluation of the Fellowships in Clinical Leadership Programme at Barking Havering and Redbridge University Hospitals NHS Trust. The evaluation primarily sought to identify the main enablers and challenges facilitating or hindering the development of leadership skills at individual level and the implementation of QI projects at service level, and to capture the main impacts on individual and organisational development, including personal and inter-personal development and perceived quality of care. We find that among those participating in the Programme, and reporting back through surveys and interviews, learning and development activities have contributed to develop and enhance the leadership skills of participants. Respondents reported to have increased confidence and perceptions of empowerment in carrying out their clinical and non-clinical duties as a result of their participation in the Programme. Our findings suggest that the Programme was perceived as particularly rewarding for the Fellows (nurses, midwives and junior consultants), who reported to have benefited from accelerated learning and support from more senior staff.

Our findings indicate that Programme benefits at individual level have potential to contribute to organisational change, with reported evidence of shared learning and changed behaviours. There was a perception that the commitment to quality of programme participants, combined with the reported improvements in various services, will likely influence staff morale and working culture within the Trust. Among the main enablers of the delivery of programme goals identified by programme participants was the strong and continuing support of the senior executive leadership over the course of the Programme. This was seen as instrumental in facilitating relationships and communication across departments and in overcoming organisational and cultural blockages within the Trust. The evaluation identified some of these blockages as financial and time constraints, alongside difficulties to communicate across services within the organisation.

One important finding that appears to be emerging from our evaluation is that, in contrast with the high level of support provided by senior leadership, middle management and front line staff were reported to have been less supportive and perceived as being resistant to change. Transforming the working culture and obtaining organisation-wide buy-in are critical in maximising the impact of a leadership and quality improvement intervention. Achieving this appeared to be even more challenging in the BHRT environment where perceived venture fatigue and external pressures were seen to reinforce sceptical and reluctant attitudes. These observations are important for the future development of the Programme, implying the need for a more active involvement of those not directly participating in order to promote ownership and an overall supportive environment.

Reports on observed improvements in the quality of care delivered to patients and patient experience suggest that the Programme did benefit the organisation overall, although it is important to keep in mind that the Fellowships in Clinical Leadership Programme was one among other improvement initiatives implemented by the Trust to promote quality of care. Therefore it is difficult, on the basis of the data collected within this evaluation, to be certain about causal relationships between the Programme and improved outcomes at organisational level.

The evaluation of the Fellowships in Clinical Leadership Programme adds to the growing body of knowledge of promising approaches in leadership development that seek to promote quality improvement in healthcare settings. We noted earlier how empirical evidence of direct causal links between leadership and quality improvement remains comparatively weak,<sup>8</sup> and while the design of the evaluation presented in this report does not permit definite conclusions about the impact of the Programme on improvement outcomes, our findings resonate with other indirect evidence reported in the peer-reviewed literature. For example, we note how participants in the Programme reported on instances of resistance to change, a challenge reported to be inherent to many healthcare organisations. For example, Parvizi et al. (2011) identified cultural inertia to be among the main obstacles to the effective implementation of QI initiatives,<sup>25</sup> while Morrow et al. (2012) pointed to the importance of engaging all staff to maximise the impact of quality of care initiatives.<sup>26</sup> Clark (2012) emphasised the need to engage clinicians in efforts to promote organisational performance and patient outcomes;<sup>27</sup> and the instrumental role of the executive senior leadership in supporting and facilitating quality improvement is also recognised widely.<sup>28, 29</sup> More recent evidence has also highlighted the role of networking skills<sup>30</sup> and empowerment as strong enablers of change.<sup>31</sup>

In light of our findings, we propose a set of recommendations for the further development of the Programme to enhance its likely impact on individuals and healthcare organisations:

- Our findings suggest that in order to enhance local staff buy-in and support, recruitment into the Fellowships Programme should seek to adopt transparent mechanisms that allow potentially eligible candidates to apply for positions or else help understand selection criteria so that candidates' profiles correspond to the needs of the Trust (in specialty, expected level of knowledge in leadership and management, clinical expertise).
- Given the time required for setting up and operating quality improvement initiatives, the programme design might wish to consider extending the duration of the Programme to enable change.
- In order to enhance the complementarity of taught modules and QI work, and the transfer of leadership and management skills into practice, particular attention might be required in aligning learning activities with the development of QI projects so as to optimise support for the design and implementation of projects.
- Considering the diversity of seniority of staff involved in the Programme, it might be helpful to consider adapting the contents of learning activities to the range of learning needs, to maximise learning benefit.
- To reduce potential tensions between external and internal Fellows, Programme managers may want to seek to offer similar levels of support to all participants.

- Since resistance of staff not directly involved in the Programme appeared to be one of the main challenges to the Programme, appropriate involvement of staff in Programme development to ensure buy-in and support at an early stage could help reduce resistance and enhance collaboration.
- In an attempt to streamline relationships and improve communication and efficiency across services, there might be benefits in involving non-clinical teams (finance, IT, communications) in the design and implementation of the Programme.
- Given the instrumental role attributed to the executive senior leadership in providing support and resources required to achieve Programme objectives, efforts should be made to initiate and sustain engagement of the senior leadership throughout the Programme.
- Programme implementers may wish to consider at an early stage future opportunities for career development of programme participants, so that the new skills and expertise developed by participants are captured and retained by the Trust.

The evaluation of the Fellowships in Clinical Leadership Programme presented here helped inform methods for pragmatic evaluations of service interventions that could be used in the future within NHS healthcare settings. While the methods used were small in scale, they were rigorously conducted and theory driven. It is important to note, however, that data collected during the evaluation represent the views and perceptions of those actively involved in the Programme, including programme participants and BHRT leadership. An independent audit of additional data that would have allowed for scoping the wider context within which the Programme was implemented, or else of data suitable to measure actual outcomes such as patient satisfaction, safety incidents, admission rates and related indicators, was outside the scope of this project. Findings reported here will thus have to be interpreted with caution, in particular as they relate to attributing impacts such as clinical outcomes to specific activities of the Programme, or to the Programme as a complex intervention in its own right. As noted earlier, the Fellowships Programme formed one of several initiatives implemented by BHRT to improve the quality of services delivered as well as patient outcomes.<sup>2</sup> Therefore, measures of impact as reported by programme participants need to be interpreted in this context and the design of the evaluation does not permit systematic disentanglement of these effects. While the Programme is perceived as contributing to changes at the Trust level, it is likely not the sole driver of change.

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<sup>2</sup> Other interventions included: Accident and Emergency care pathway redesign work by McKinsey, and financial audit by Ernst & Young. Some Band 7 nurses had also recently attended a leadership training course. In addition, the maternity services were intensely remodelled with the closing down of the labour ward at King George Hospital.



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## Appendix A: Workshop agenda and attendance list

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### Box 1 Workshop Agenda

9:00–9:15	Welcome and introductions
9:15–9:30	Overview of the evaluation approach and outline of the plans for the day
9:30–10:45	Co-developing and specifying the BHRT Fellowships in Clinical Leadership Programme Logic Model, including discussion of relationships between different programme strands
10:45–11:00	Coffee/Tea break
11:00–11:20	Key assumptions about the intervention logic: identifying the explicit and implicit assumptions related to the programme and to perceived mechanisms for achieving desired results
11:25–12:25	Key context influences on the programme: existing enablers, existing challenges and or potential future barriers and/or associated risks
12:30–13:00	Lunch
13:00–14:30	Developing evaluation indicators based on the logic model
14:30–14:40	Coffee
14:40–15:00	Next steps and wrap-up

**Table 7 Workshop attendance list**

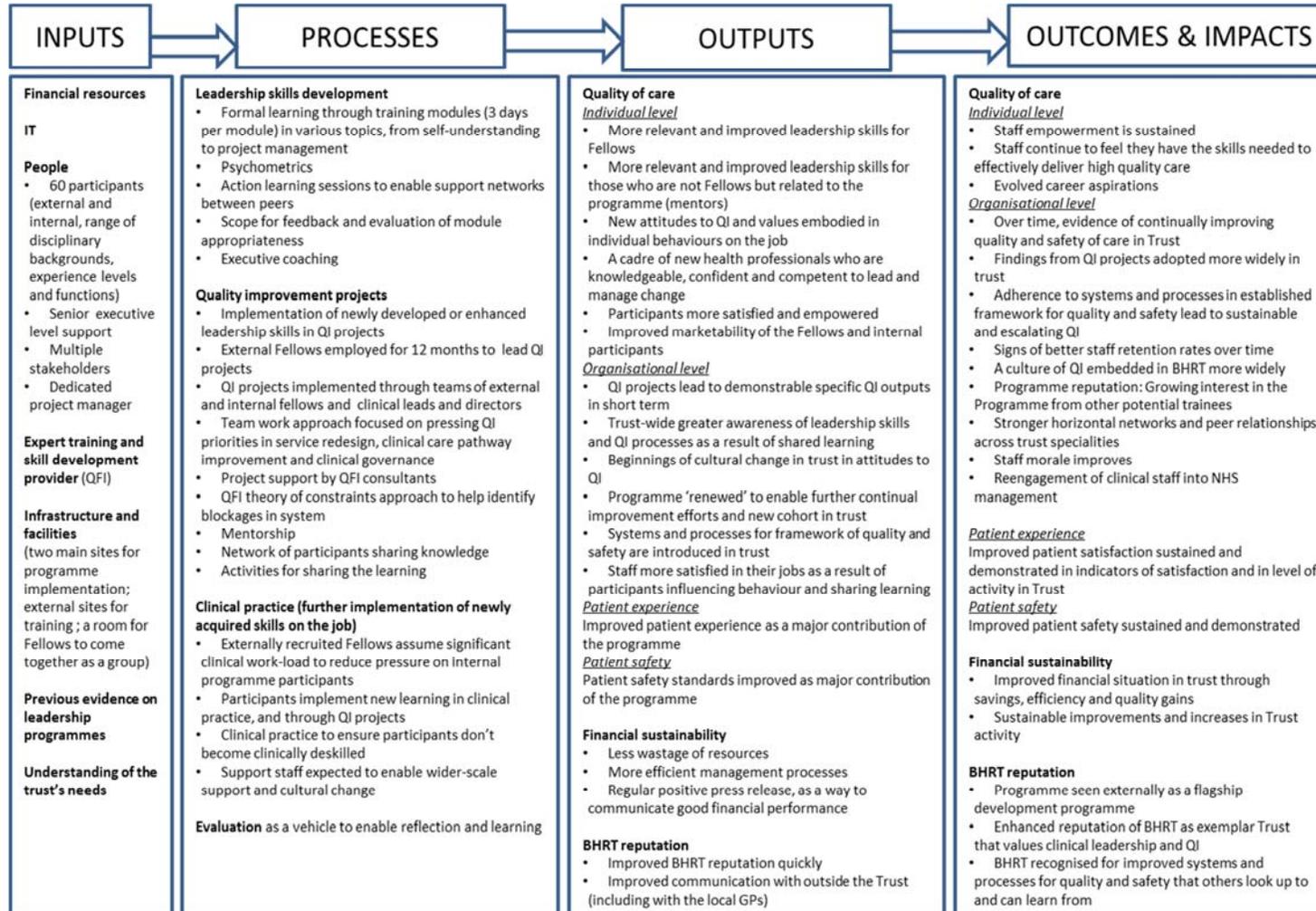
Name	Position in Programme
Alison Crombie	Senior management
Dorothy Hosein (came at two points in time)	Senior management
John Alcolado	Senior management
Ronke Akerele	Senior management
Stephen Burgess	Senior management
Tim Swanwick	Senior management
Dr Dipankar Mukherjee (came for the indicators session)	Internal
Dr Geraldine Soosay	Internal
Dr Shweta Mehta	External
Dr Arpiita Ray	External
Leye Thompson (in and out for most of the day)	Internal
Julie Wright	Internal
Dr Sarah De Freitas	External

## RAND Europe

Maureen Ross	Internal
Dr Ajith James (came for the indicators session)	Internal
Dr Sara Tacci (came for the indicators session)	External
Sharlene Daly	External
Baljit Wilkhu	Internal
Marilyn Smith	Internal
Jacqueline Gabriel-King	External

# Appendix B: Logic model

Figure 15 The Programme logic model



## Appendix C: Interview protocols

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The protocols below were designed to conduct interviews of individuals directly involved in the Programme (Fellows and senior staff). The Round 2 protocol presents some modifications that were informed by the findings of the first round. Similar protocols have been designed for interviews with the executive senior leadership and support staff.

### Topic guide –Direct participants to the Programme

#### Barking Havering Redbridge Hospitals Trust (BHRT) Fellowships in Clinical Leadership Programme Evaluation

#### Round 1

1. **Can you briefly describe your role at the Trust and how you are involved in the Fellowships in Clinical Leadership Programme?** *[probe whether involvement is as an internal or external fellow/trainee, mentor, support staff for QI projects, other]*
2. **Structure of the Fellowships in Clinical Leadership Programme and fit within wider work context – learning about most and least useful elements**
  - a) How useful have you found the different aspects of the Fellowship Programme developing your leadership skills? Why? *[probe issues like taught training modules; action learning sessions; psychometric elements; coaching; career advice, actually doing QI projects, project management and logistical support]*
  - b) Which new or improved leadership skills specifically have you developed? *[probe skills like critical thinking, resilience, lateral thinking, influencing skills, project management, financial management, interpersonal communication, confidence, self-understanding, understanding of the organisation, negotiation skills, skills for working with patients...]* Please give examples of how this is displayed in your activities and behaviour.
  - c) Which aspects of the Programme have been most useful for delivering on your QI project specifically? Why? Concrete examples of how the Programme has had an effect on your QI project work and on clinical practice? (Probe also on changes in on the job behaviour)
  - d) What about least useful aspects of the Programme, and why?
3. **Overall, has the Programme had any influence on how you feel about your job – in terms of job satisfaction and how empowered you feel? If yes, in what way?**
4. **How important is the interaction/networking with other Programme participants been? Specifically in terms of your personal development and for your QI project goals? Why? Any**

concrete examples of how this has been useful? [*Probe also on whether having different levels of seniority, different clinical specialties and external fellows and mentors is useful in this regard*]

5. Levels and nature of organisational support for the Programme and how this is manifested in practice:
  - a) Based on your experience to date, do you think the nature and level of support for the Fellowship Programme from senior leaders in BHRT is appropriate? Why or why not? How is this support/lack of it manifested in practice?
  - b) Do you think that **colleagues outside the Programme, (but working in BHRT)** are supportive enough of the programme? Why or why not? How is this support/lack of it manifested in practice?
  
6. **QI project progress:**
  - a) Would you say your QI project(s) is (are) on track and likely to succeed?
  - b) If so, what do you consider to be the key achievements (milestones realised) to date?
  - c) If you feel your project is not on track or that there is a high chance of it not meeting overall objectives, is there anything feasible that can be done to change this?
  - d) Based on your experience to date, what do you feel are the key enablers and challenges to delivering your QI project(s)? (Please focus on up to 3 key ones).
  
7. **QI projects – wider dissemination, adoption and impacts:**
  - a) Are the findings of your project(s) being disseminated inside the Trust? How?
  - b) Are they being adopted by the Trust – e.g. in clinical practice? Why (not)? Please give examples in support of the answer.
  - c) What about externally? (probe for both dissemination and adoption)
  - d) What would you consider to be the key impacts of your projects to date (if applicable, depending on previous answers) [*probe: concrete examples of impact on working with patients, patient safety, patient satisfaction, efficiency, productivity... probe also on evidence/examples of changing behaviours in the Trust*]
  
8. **Question for external fellows:** If applicable, is your home organisation (i.e. the Trust you were working at before the Programme) receptive and interested in the new skills you have gained as a result of being a participant in the Programme? How do they show this? [e.g. is your home organisation creating a new role for you?]
  
9. **Overall reflections**
  - a) Overall, what do you see the key successes of the Fellowship Programme so far to be? (top 3) [*This question might have been answered already*]
  - b) With the benefit of hindsight and with a potential Programme sustainability agenda in mind, is there anything you think could have been differently in terms of wider programme design and implementation? Why? How?
  - c) Are you aware of or participating in other similar initiatives in BHRT (e.g. related to quality improvement and leadership)? Please give examples? What works well about having these multiple initiatives and what are the challenges? Do you think any are better (more valuable) than others? Why?
  - d) Do you see this Programme, or similar initiatives, as a good investment for BHRT? Do you think any are better (more valuable) than others? Why?

- e) Has the Programme had any other benefits/challenges that we have not addressed so far? Is there anything else important to discuss about the Programme?

### Topic guide –Direct participants to the Programme

#### Barking Havering Redbridge Hospitals Trust (BHRT) Fellowships in Clinical Leadership Programme Evaluation

#### Round 2

1. **Can you briefly describe your role at BHRT and how you are involved in the Fellowships in Clinical Leadership Programme?** *[probe whether involvement is as an internal or external fellow/trainee, mentor, support staff for QI projects, other]*
2. **Structure of the Fellowships in Clinical Leadership Programme and fit within wider work context – learning about most and least useful elements**
  - a) What value do you see in the combination of clinical sessions with training elements of the Programme? Can you explain using an example from the Programme?
  - b) How useful have you found the different aspects of the Fellowship Programme in developing your leadership skills? Why? *[probe issues like taught training modules; action learning sessions; psychometric elements; coaching; career advice, actually doing QI projects, project management and logistical support]*
  - c) Which new or improved leadership skills specifically have you developed? *[probe skills like critical thinking, resilience, lateral thinking, influencing skills, project management, financial management, interpersonal communication, confidence, self-understanding, understanding of the organisation, negotiation skills, skills for working with patients...]* Please give examples of how you think this is displayed in your activities and behaviour.
  - d) Which aspects of the Programme have been most useful for delivering on your QI project specifically? Why? Concrete examples of how the Programme has had an effect on your QI project work and on clinical practice? *[Probe also on changes in on the job behaviour]*
  - e) What do you consider have been the least useful aspects of the Programme, and why? *[probe are there any skills you feel would be useful to develop and that were not addressed by the Programme?]*
  - f) Specific probes *[this is to understand better some findings from the survey]:*
    - i. Probe on business planning and project management if not mentioned until now, as from survey they seem to be seen as ‘not useful’ or ‘not important’
    - ii. Probe on action learning sessions if not mentioned until now, as it seems there isn’t consensus regarding the value they bring to the Programme
    - iii. Probe on value of external speakers interventions if not mentioned until now. Why are they useful? Which specific topic did you find particularly relevant to your job?
    - iv. Probe on the 360 feedback if not mentioned until now, as it seems that it didn’t systematically happen. What is the value of 360 feedback if received? If not, would you have liked to receive this kind of feedback and why?

3. **Overall, has the Programme had any influence on how you feel about your job – in terms of job satisfaction and how empowered you feel? If yes, in what way?**
4. **How important has the interaction/networking with other Programme participants been? Specifically in terms of your personal development and for your QI project goals? Why? Any concrete examples of how this has been useful? [Probe also on whether having different levels of seniority, different clinical specialties and external fellows and mentors is useful in this regard]**
5. Levels and nature of organisational support for the Programme and how this is manifested in practice:
  - a) Based on your experience to date, do you think the nature and level of support for the Fellowship Programme from senior leaders in BHRT is appropriate? Why or why not? How is this support/lack of it manifested in practice? How is it helping you/hindering you from delivering your projects? *[try get a bit more nuance and clarification on what/who the senior leaders are – not asking for names but more in terms of organisational structure i.e. difference between managerial and clinical leaders]*
  - b) Do you think that **colleagues outside the Programme, (but working in BHRT)** are supportive of the Programme? Why or why not? How is this support/lack of it manifested in practice?
6. **How motivated and committed to the Programme do you think Programme participants have been over time?**
  - a) Please give examples of how commitment (or lack thereof) was manifested in practice.
  - b) Did you see a difference between external and internal participants?
7. **Do you think the behaviour you exhibit in work has changed as a result of the Programme? Please give examples.**
  - a) Have you noticed changes in the behaviours colleagues (participating and not participating in the Programme) exhibit on the job as a result of the Programme? Please give examples.
8. **QI project progress:**
  - a) Would you say your QI project(s) is (are) on track and likely to succeed?
  - b) If so, what do you consider to be the key achievements (milestones realised) to date?
  - c) If you feel your project is not on track or that there is a high chance of it not meeting overall objectives, is there anything feasible that can be done to change this?
  - d) Based on your experience to date, what do you feel are the key enablers and challenges to delivering your QI project(s)? (Please focus on up to 3 key ones).
9. **QI projects – wider dissemination, adoption and impacts:**
  - a) Are the findings of your project(s) being disseminated inside the Trust? How?
  - b) Are they being adopted by the Trust – e.g. in clinical practice? Why (not)? Please give examples in support of the answer.
  - c) What about externally? (probe for both dissemination and adoption)
  - d) What would you consider to be the key impacts of your projects to date (if applicable, depending on previous answers) *[probe: concrete examples of impact on working with patients, patient safety, patient satisfaction, efficiency, productivity... probe also on evidence/examples of changing behaviours in the Trust]*

10. Is your home organisation (i.e. the Trust you were working at before the Programme) receptive and interested in the new skills you have gained as a result of being a participant in the Programme? How do they show this? [e.g. is your home organisation creating a new role for you?]

**11. Overall reflections**

- a) Overall, what do you see the key successes of the Fellowship Programme so far to be? (top 3)  
*[This question might have been answered already]*
- b) With the benefit of hindsight, is there anything you think could have been differently in terms of wider Programme design and implementation? Why? How?
- c) Are you aware of or participating in other similar initiatives in BHRT (e.g. related to quality improvement and leadership)? Please give examples? What works well about having these multiple initiatives and what are the challenges? Do you think any are better (more valuable) than others? Why?
- d) More generally, are there specific elements of the wider environment at BHRT which have influenced how the Programme has evolved and its impacts? *[Probe which elements of the external context have had an influence on the programme]*
- e) Do you see this Programme, or similar initiatives, as a good investment for BHRT? Do you think any are better (more valuable) than others? Why?
- f) Has the Programme had any other benefits/challenges that we have not addressed so far? Is there anything else important to discuss about the Programme?