

# Leading Change, Adding Value: a framework for nursing, midwifery and care staff: a final service evaluation

Final (Year 3) report August 2019

Publishing Approval Reference: 000282

**NHS England and NHS Improvement**



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Published: August 2019

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## **Glossary of terms**

Edge Hill University (EHU): EHU has been commissioned to undertake a service evaluation of years 1, 2 and 3 of the Leading Change, Adding Value (LCAV) programme. This year 3 evaluation presents a short series of focus groups and a survey with nursing, midwifery and care staff at the point of care to explore how the LCAV framework has been understood and whether it can be embedded in practice. EHU has provided a rigorous, academic approach to the evaluation of this national framework.

Researcher: Staff at Edge Hill University who conducted the service evaluation; undertook information collection and analysis and wrote the final report.

The [Triple Aim](#) (Berwick, Nolan and Whittington, 2008): A framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimising health system performance. IHI believes new designs must be developed to simultaneously pursue three dimensions that provide a benchmark for the quality of services: better outcomes for individuals and populations, better experience and better use of resources.

The [NHS Five Year Forward View](#) (FYFV; NHS England, 2014): The NHS FYFV set out opportunities and priorities for the NHS to deliver a better, more joined-up and more responsive NHS in England. In 2017, the [NHS FYFV next steps](#) set out how to continue in the progress to deliver health and high-quality care – now and for future generations.

[Leading Change, Adding Value](#) (LCAV; NHS England, 2016): Leading Change, Adding Value is a framework for all nursing, midwifery and care staff to be used by everyone, wherever they work and whatever their role. It was commissioned by the previous Chief Nursing Officer, Professor Jane Cummings in 2016. Developed with a wide range of national organisations, staff representatives, people we care for, carers and the public. The framework highlights the huge capability, contribution and leadership that nursing, midwifery and care staff bring to transforming health and care, supporting delivery of national programmes of transformational change and the Long Term Plan (2019). The Leading Change, Adding Value programme formally ended on 31 March 2019.

[Long Term Plan](#) (LTP; NHS England, 2019): Published in January 2019, the NHS Long-Term Plan has been developed by health and care staff at the point of care, patients and their families and other experts. It is an ambitious plan for how the NHS will continually move forward in the next 10 years, as medicine advances, health needs change and society develops. The plan strives to set out priorities for giving everyone the best start in life; delivering world-class care for major health problems, such as cancer and heart disease, and helping people age well.

'Unwarranted variation': Also known as unexplained local variation is defined as 'where differences in services and care outcomes cannot be justified by reasons of geography or other local circumstances'. By seeing where care is not equal and

taking steps to address that variation, everyone can receive the same highest standards of better outcomes, better experiences and better use of resources. Unwarranted variation was prominent in the FYFV and remains a significant focus in the NHS LTP.

'The LCAV 10 Commitments': The LCAV framework offered 10 aspirational commitments supporting nursing, midwifery and care staff to focus on narrowing the three gaps as described in the FYFV, address unwarranted variation and help demonstrate the triple aim outcomes. They were designed to be applied locally in any environment and at any level.

The national [Atlas of Shared Learning \(AoSL\)](#): This is a collection of case studies in practice which clearly illustrate and quantify the contribution of nursing, midwifery and care staff to national, regional and local initiatives within the transformation agenda. The AoSL provides a range of case study examples demonstrating the principles of LCAV in action – hosting over 180 (and increasing) case study examples which clearly position the professions as leaders in implementing the priorities of the NHS Long Term Plan.

The LCAV e-learning tool. The LCAV e-learning tool, co-developed and hosted by [e-Learning for Healthcare](#), provides an opportunity for individuals to build or strengthen current knowledge and skills in the key principles of LCAV so that they can implement the principles of the framework in their practice.

[The research portfolio](#): The research portfolio (exemplars of transformational change led by nursing, midwifery and care staff across health and care) has been developed in partnership with the Council of Deans of Health and Health Educational Institute (HEI) partners to increase the visibility and demonstrate the impact of nursing and midwifery research. The research portfolio (published June 2019) aims to showcase nursing, midwifery and care staff-led research in relation to identifying and addressing unwarranted variation in practice.

[Compassion in Practice](#) (Cummings & Bennett, 2012): A national programme of work launched in 2012 by Professor Jane Cummings, the previous Chief Nursing Officer for England. A strategy for nursing, midwifery and care staff, Compassion in Practice was built on the values of the 6Cs (Care, Compassion, Communication, Courage, Competence, Commitment).

The LCAV Operational Team: The LCAV Operational Team supported the delivery of Leading Change, Adding Value, on behalf of the office of the Chief Nursing Officer.

LCAV Partnership Board: LCAV was developed with a wide range of national organisations (across health and social care, including arm's-length bodies), staff representatives, people we care for, carers and the public. The Partnership Board was established to ensure continued co-implementation and provide strategic leadership, expertise and advice for the programme.

NHS England: The commissioner and funder of this evaluation for the office of the Chief Nursing Officer, England. Sometimes referred to as 'The Commissioner' or 'The Funder'.

*\*Professor Jane Cummings launched the framework in May 2016. Her tenure ceased in December 2018. Dr Ruth May became the Chief Nursing Officer for England in January 2019. The commissioning of LCAV continued to the formal conclusion of the co-implementation phase of the programme (31 March 2019).*

## Introduction/background

### Introduction

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Leading Change, Adding Value (LCAV; 2016) is the national framework for nursing, midwifery and care staff in England. It specifically highlights the capability and contribution to transformation work that this part of the health and care workforce brings. Following extensive consultation and feedback, the framework was developed to help support nursing, midwifery and care staff working in this time of transformation across all health and care sectors. It aims to truly demonstrate and share the leadership and practice that is undertaken every day. Throughout the framework, from co-development, launch and landing, towards co-implementation in practice, the LCAV framework has demonstrated strong partnership working. There has been whole system endorsement and LCAV is a shared national publication for nursing, midwifery and care staff.

LCAV aims to support the professions to look at reducing 'unwarranted variation' and highlights the need to quantify the impact of their work in relation to the triple aim of improved outcomes, experience and better use of resources. Indeed, the framework asks that nursing, midwifery and care staff apply the same importance to

'quantifying' and 'measuring' the outcomes of their work, as we do to demonstrating the quality and compassion they are already recognised for. These should not be mutually exclusive: the framework explains how nursing, midwifery and care staff, whatever their role, wherever they work, can look at what needs to change or could be changed to improve services, experiences and outcomes for patients, individuals and populations.

Since the launch of the national framework in May 2016, it has been clear that many colleagues are already identifying unwarranted variation as part of their everyday practice, however, much of this essential work can often remain hidden or misunderstood, as some of it is not easily measured, captured, or shared. However, it has also been clear that for many, this has been a new way of working and that some of the language and principles may be unfamiliar. The next section describes the 'products' of the framework which aim to support colleagues to lead transformational change.

For the context of this year 3 (final) service evaluation, we provide a brief overview of the evaluation reports of years 1 and 2. The Year 1 (May 2016 – May 2017) process evaluation explored how LCAV had been received by key stakeholders from across the nursing, midwifery and care sectors in its first year. Important aspects of establishing transformational change included how the framework had been disseminated, understood and embedded.

The year 1 evaluation report emphasised the continued engagement of staff at the point of care across health and social care as vital and that the co-implementation approach of LCAV supported all nursing, midwifery and care staff. Following on the year 1 evaluation, the year 2 'interim report' described and evaluated the work undertaken in year 2 (May 2017 to May 2018), to continue to disseminate LCAV in a matrix fashion at national, regional and local levels and to support its co-implementation.

The year 2 evaluation comprised a qualitative narrative of the work that has been carried out under LCAV and its achievements, a focused analysis of a series of good practice case study examples led by nursing, midwifery and care staff, identifying key themes and provided a summarised conclusion of the successes and ongoing progress of LCAV.

This year 3 report will present a short series of focus groups with nursing, midwifery and care staff at the point of care, to further investigate how LCAV has been understood and whether the principles could be embedded in practice. This was followed by the dissemination of a short survey.

## **Products**

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Leading Change, Adding Value has three products:

- the LCAV e-learning tool
- the National Atlas of Shared Learning
- the research portfolio: exemplars of transformational change led by nursing, midwifery and care staff across health and care.

### **The LCAV e-learning tool**

The e-learning tool was launched on 26 March 2018. It was developed by Health Education England, NHS England and LCAV partners, working alongside e-learning for Healthcare. The e-learning tool aims to provide an opportunity to build or strengthen current knowledge and skills in understanding the impact of 'unwarranted variation' on individuals and populations and then help lead the change required to address this. It consists of a 20-25-minute e-learning session for all nursing, midwifery and care staff. Completing the e-learning tool supports nursing, midwifery and care staff to understand LCAV and to support colleagues to implement LCAV in practice. To date (almost 12 months post-launch), there have been over 2350 launches for the LCAV e-learning tool. For ease of access, a pdf version was developed and distributed to nursing, midwifery and care staff working across both health and care at their request.

### **The National Atlas of Shared Learning**

The National Atlas of Shared Learning demonstrates how nursing, midwifery and care staff across the system have led and contributed to narrowing the gaps in health and wellbeing, care and quality and funding and efficiency and their essential input to national, regional and local programmes of transformation. With over 180 small and large-scale quality assured case studies published online to date, the AoSL enables colleagues to share practice and learning on how unwarranted variation in practice has been identified and addressed through nursing, midwifery and care staff leadership and the resulting improvements.

## **The Research Portfolio; Exemplars of transformational change led by nursing, midwifery and care staff across health and care**

The Research Portfolio (June 2019) is the third and final product of the framework. Developed in collaboration with partners across the health and care system, it aims to increase the visibility and promote nursing, midwifery and care staff research. It has been developed and overseen by a task and finish group. A range of nursing and midwifery research leads from higher education institutes (HEIs) across England formulated the group, representing wide ranging excellence in nursing and midwifery, co-chaired by NHS England and the Council of Deans of Health.

Small and large-scale peer-reviewed, published research was considered by the Task and Finish Group to provide a snapshot of the robust evidence base for clinical practice, care provision and policy development that exists and continues to evolve. Indeed, the studies cover a range of health and care areas, clinical and care priorities. The research portfolio is not an all-encompassing database of research, rather it is a resource to clearly articulate the research agenda in nursing and midwifery; to act as a stepping stone in continuing to promote research and the principles of research to a wider audience in a bid to making it mainstream. In that vein, studies were submitted by authors for inclusion in the research portfolio and reviewed by colleagues on the task and finish group. The studies provide a glimpse of the wealth of research across the fields of nursing, midwifery and care and the research portfolio will signpost to the full article, providing a brief abstract for each piece included.

The research portfolio will aim to demonstrate how the professions' leadership position going forward can help deliver the LTP. Supporting nursing, midwifery and care staff to continue to lead on evidence-based practice, the portfolio will complement the AoSL.

### **Moving forwards**

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The ambition of the LCAV framework has been to help nursing, midwifery and care staff demonstrate and quantify the professions' contribution to national, regional and local programmes of work. A further ambition was to underpin the framework with academic credibility while simultaneously exploring any ways the framework has supported nursing, midwifery and care staff to apply an evidence base to making changes in practice. As already described, the framework promotes leadership at all levels and encourages the use of experience and influence to

affect change across the health and care landscape of the future. The published LTP sets out ambitions for improvement over the next decade and there is potential opportunity to build on the foundation work achieved by LCAV and position the professions at the centre of LTP delivery.

## Background literature

As a key information gathering exercise at the end of the first-year evaluation of LCAV, a literature search was conducted to identify published literature supporting the understanding of key principles embedded in the framework. The review and evaluation are available [here](#). The first year, and indeed subsequently during the implementation of this programme, much of the work focused on supporting the dissemination and understanding of the principles in the framework. The literature was primarily policy news, commentary, editorials and dissemination papers in professional journals across nursing, midwifery and care. Examples included how the context of LCAV had been communicated (*Practice Nursing*, 2016; Longhurst, 2016a), its essential features (Evans, 2016a and 2016b) and how it could be used within specific specialties (Beckford-Ball and Evans, 2016; Mann, 2016; Harrison, 2016). A series of papers highlighted the key elements of LCAV (NHS England 2016b, 2016c, 2016d, 2016e, 2016f, 2017a) together with editorials that introduced the framework and considered its potential impact (Brown, 2016; Blakemore, 2016; Scott, 2016; Stephen-Haynes, 2016).

In December 2018, a second scoping exercise was conducted. The search terms 'Leading change, adding value' were used and dates were limited to March 2017 to December 2018. The Leading Change, Adding Value process evaluation represented the sole empirical study (Zubairu et al, 2018). A small number of articles demonstrate the principles of LCAV in action. For instance, Adderley et al. (2017) focused on wound care and developments to reduce unwarranted variation in the assessment and treatment of wounds, with reference to how the principles of the LCAV framework had supported this programme. King et al. (2018) built on this, notably emphasising the need to collect high-quality economic information to support use of resources locally and nationally. In a further example, Johnson et al. (2018) provided a real-world example of how developing and understanding the enhanced use of technology (commitment 10 of the framework) can result in better outcomes, experience and use of resources.

A principle of the framework is to encourage staff to undertake nursing and midwifery research, collecting evidence to help inform and support the sustainability and transformation of services to improve the health and wellbeing of the population. Increasing research capacity and academic leadership across nursing and midwifery is advocated in the framework. Rigorously reviewed, quantitative and qualitative examples of innovation will be showcased in the research portfolio. The research focus of the national framework was explored in a research roundtable event with representatives from across the higher education and health and social care sectors. The Chief Nursing Officer (CNO) research roundtable was independently chaired by the editor of the *British Journal of Nursing* (December 2017). A short series of editorials followed the roundtable (Peate 2018a-f; Aitkenhead, 2018, Kolyva, 2018). Professor Cummings in her previous role as CNO also published a commentary piece. Together, this series re-emphasised the importance of nursing, midwifery and care staff leading on evidence-based practice to demonstrate the quantifiable contribution to the transformational agenda.

## Aims

The aim of this service evaluation was to explore whether LCAV could be adopted as 'business as usual' by nursing, midwifery and care staff. This included considerations of how the framework had been disseminated and collating information on the implementation of the framework where relevant. The evaluation builds on the years 1 and 2 evaluation which depicted the progress of the programme in supporting nursing, midwifery and care staff to apply equal importance to quantifying and measuring the outcomes of their work. By considering how the professions can narrow the three gaps described in the Five Year Forward View (NHS England, 2014), reducing unwarranted variation, they can achieve the triple aim outcomes of better experience, better outcomes and better use of resources (Berwick et al, 2008).

## Evaluation methods

The evaluation used a sequential, mixed-methods approach (Creswell and Clark, 2017). Focus groups provided a qualitative component and a quantitative online survey complemented the information gathering. Further information on the documents described in the subsequent sections is available on request from the Office of the Chief Nursing Officer for England.

## Governance

On behalf of the office of the CNO and with the agreement of the LCAV Partnership Board, NHS England issued a letter of information governance confirmation to EHU. The letter confirmed this report was a service evaluation. This letter and a service evaluation protocol was reviewed by the Chair of the Research Ethics Committee in the Faculty of Health and Social Care at Edge Hill University who also agreed that the work met the criteria of a service evaluation.

## Study population

**Qualitative phase:** A purposive sample of five focus group sites (four NHS trusts and one independent care setting) were identified from their ongoing contribution to the dissemination and implementation of the framework. To ensure the groups demonstrated views across the nursing, midwifery and care staff professions, the sites were a mix of city-centre foundation trust, community healthcare services providing specialist mental health and learning disability services and a combined healthcare trust. At the time of conducting the focus groups, these sites also represented the previous four NHS England regions: North, South, London and Midlands & East.

Part of this evaluation was to gauge whether the framework had the potential to be embedded as 'business as usual' for staff at the point of care. This offers the opportunity to reflect on the current context and whether this could act as a potential barrier to the framework being embedded. Being cognisant of the challenges across the system from the outset of this work, it was acknowledged that the number of sites of participants would be small. An initial target was set of two focus groups at each site, but two of the trusts and the care setting site were unable to participate. Four focus groups were conducted between September and October 2018, two in each of the remaining sites, a representative population of nursing, midwifery and care staff.

**Quantitative phase:** The online survey was distributed across the same sites as described previously during a four-week period (November to December 2018). The survey was distributed to all nursing, midwifery and care staff, and not limited to the focus group participants. The output of the focus groups informed the survey development. Two additional sites distributed the survey to gather further

information: a cohort of final year nursing and midwifery students from an HEI and a further NHS trust.

## Recruitment

**Qualitative phase:** Initial email contact was made to each of the five identified focus group sites to explain the purpose of the service evaluation. Further discussion, information sheets and consent forms were shared. Participants had sufficient opportunity to read the PIS, ask questions and sign the consent forms before being formally recruited into the focus groups. Focus groups were carried out in a quiet room on Trust premises. Each focus group was recorded with a digital audio recorder and lasted approximately one hour.

**Quantitative phase:** An e-mail and information sheets were circulated by EHU and distributed trust-wide for the attention of all nursing, midwifery and care staff. Embedded in the e-mail was a link to the online survey with an explanation of the purpose of the evaluation. Student surveys were distributed via email or an online learning platform facilitated by their programme leads. The EHU evaluation team offered ongoing support and advice.

## Information gathering

The focus group and survey questions and discussion areas included current knowledge of LCAV; how it had been disseminated; local examples of LCAV implementation - any facilitators/barriers; how the principles of the framework can be used by staff and leadership examples. After the initial focus groups had been conducted, the transcripts were reviewed by EHU and it was confirmed that the topics aligned to the aims of the service evaluation.

## Data analysis

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**Qualitative phase:** The audio recordings of the focus groups were transcribed verbatim and anonymised. A thematic framework analysis (Ritchie et al, 2003) method was used, aided by Nvivo qualitative data analysis software (QSR International Pty Ltd, Version 12). Two members of the evaluation team analysed the data independently (CN, KZ). Themes were cross referenced, discussed and agreed with a third member of the team (JB).

**Quantitative phase:** The survey gathered information from both open and closed questions. Quantitative data was anonymised and analysed using SPSS (IBM SPSS Statistics for Windows; Version 20.0. Armonk, NY: IBM Corp). Qualitative data was extracted and reported as a complementary narrative in the findings below.

## Findings

### Qualitative

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Analysis of the qualitative data identified five overarching themes:

- new ways of working:
  - identifying and addressing unwarranted variation in practice
  - language – breaking barriers
  - quantifying the impact of leading change
- nursing, midwifery and care staff leadership
- dissemination/awareness raising
- sharing good practice and learning
- framework positives.

The themes and sub-themes are illustrated by a selection of representative verbatim quotations.

#### **New ways of working**

As part of the original co-development work, stakeholder consultation had requested a different approach to a new professional framework, to clearly demonstrate the key contribution that nursing, midwifery and care staff are bringing to the 'transformative change' work occurring across both health and care sectors within England. LCAV supports nursing, midwifery and care staff in demonstrating what they do, showcasing the quantifiable positive contribution staff can make to the delivery of health and social care. However, it is clear that for many, this may be a new way of working and some of the language and principles may be unfamiliar.

#### **Language**

Quotes demonstrate how understanding of the key principles and language varied among the 24 participants of the detailed focus groups but overall there was an

eagerness to engage with this approach to improve health and care. Participants described their understanding of the framework:

*I think for me it's about working in collaboration with all of those people wrapped around that individual's care and it's having the leadership and ... the autonomy to practise safely, to make sure that we are meeting our outcomes really ... being supported by visible leaders ... changing the cultures and putting the patient at the heart [of service provision]. [P16, FG3]*

Even participants who were not well versed in the framework truly supported and embodied the principles in it. They advocated a shift towards standardising practice where appropriate, to reduce variability in outcomes. Moreover, these principles were often already being used:

*I had a look at the information... it's like a standardised approach to the care that we deliver and the predominant vibe from the paperwork I read through was about getting patients discharged timely and with the correct packages in place. [P6, FG1]*

The e-learning tool was developed to support nursing, midwifery and care staff to understand the principles in the framework and to provide a context. It was described as a useful resource, while recognising that time to complete such tools is limited in practice and that perhaps staff don't always know what is available to support their understanding of national programmes:

*The... e-learning tool ... they are good, but it's just having the time to access that, but I think it's brilliant that it's a free resource but it's just getting that out to the staff really. I don't think it's out there as much as it could be, so I think there's still some work to be done there. [P16, FG3]*

Participants reported that one of the ways staff at the point of care could be encouraged to articulate or lead change was by having leaders, eg line managers, who encourage them to seek out opportunities to be involved in change and identify areas that need change. It is possible that this exposure also contributes to embracing this new language and way of working:

*I've got a really good manager and she's quite supportive about us going to different meetings ... where obviously changes occur and new practices can be ignited ... so I think from my point of view ... I'd be quite confident to talk*

*to anybody on the team and say 'I don't think this is working - could we try it this way'. [P1, FG1]*

## **Identifying and addressing unwarranted variation in practice**

Although some of the language can at times present a barrier, participants reported that the LCAV framework was not an entirely new way of working, but a framework that reinforces what staff are already implementing in everyday practice. Integral to LCAV is supporting nursing, midwifery and care staff to identify unwarranted variation in practice, whatever their role may be or wherever they work:

*So, reducing unwarranted variation. People think huh? But if you say we're trying to do some work to make sure that care is consistent... or we're strengthening the pathways of care from inpatient to community. People start to talk that language and they can articulate the work that they are doing. [P18, FG3].*

*I could feel that shift, I think the different conversations that are happening across the departments, people may not know the language, leading change adding value, but I think they're definitely doing [it]. [P22, FG4]*

The focus groups demonstrated understanding that the framework advocated leadership to identify and address unwarranted variation, at all levels:

*It's empowering staff as well to make those decisions, not feeling like it has to be someone higher up to implement those changes. [P24, FG4]*

Participants also welcomed the description in the LCAV framework of reducing unwarranted variation in practice and how it is a vehicle to tackle quality improvement. For instance, participants provided examples of championing the use of technology (commitment 10 in the LCAV framework):

*It has given a framework to look at things like the use of technology, how can we use that to reduce unwarranted variation ... it gives you that focus and nationally as to where there might be differences in how care is delivered and outcomes in certain areas, whereas I think having this has helped provide that framework to support people to identify it. [P21, FG4]*

## **Demonstrating the quantifiable contribution of nursing, midwifery and care staff**

As described, LCAV supports the professions to look at reducing ‘unwarranted variation’. Measuring outcomes is a key element in highlighting to the professions the importance of demonstrating the impact of their work in relation to the triple aim:

*It's about delivering really good quality care in a way that's efficient and we're looking at how we can drive down costs but actually ensure that we maintain the quality and that at the end of the day looking at what patients are saying about their experiences of care, and how we involve patients, service users in the design of the care and help to co-produce that care with the patient. [P18, FG3]*

Building on this measurement, asking nursing, midwifery and care staff to apply the same importance to ‘quantifying’ and ‘measuring’ the outcomes of their work as to demonstrating the quality and compassion they are already recognised for, was welcomed.

*What we need to get stronger at is how we evaluate some of the work that we do. [P22, FG4]*

*There's something about getting that evaluation as business as usual and so I don't think we're any different to any other NHS trust, but we often think of the evaluation later down the road and thinking, who can help with this. [P19, FG3]*

This focus supported programmes being rolled out further following implementing evaluative principles:

*So now the [let's get kids fit project] it's another course which is called Baby Steps Postnatal Group and we're rolling that out to all first-time parents across the area, which means then we've got five teams delivering it because there's five locality teams, so that's empowering their staff. [P23, FG4]*

*So, using something like the ReQoL [recovering quality of life] tool which we want to bring in, which is a PROM [patient reported outcome measure] so the staff can ... evidence the change they want to see to actually give that as*

*much quantitative research validity as the other kind of accounting we do.  
[P19, FG3]*

Indeed, more attention was now being given to measurement and using evidence from research to improve efficiency and quality of care:

*I think we're looking at more innovative ways of even how we get that feedback ... whether we're using the best methods to get that feedback ... the 'Tell us how we did' isn't it ... so it's causing us to get that qualitative data in a more consistent way ... I'm encouraging [staff] to ... just make sure they do it at the beginning and the end and even straight away. [P23, FG4]*

*We're trying to encourage staff to write things up as service evaluations, it doesn't have to be a massive project, it can just be a very small piece of work to show exactly what you've implemented and exactly the effects that we've had. [P24, FG4]*

### **Nursing, midwifery and care staff leadership**

Focus group participants reflected on the impact of the framework encouraging staff at the point of care to lead and initiate change. This commentary was aligned to an ongoing, positive shift in culture across organisations, building on ongoing improvements and initiatives:

*I think this is a shift in the momentum because it's out there more in the culture of approaching change, thinking about change, leadership at all levels, you don't have to have leader or manager in your title to do that sort of thing, so I feel there is a change in the culture. [P23, FG4]*

*We did actually have some work prior to leading change, adding value, around shaping our future ... and that was ... with the initiative everyone has a voice, and every voice must be heard, so, we're continuing with those approaches really, so there's a lot of work around staff engagement, around staff health and wellbeing. [P22, FG4]*

Staff also explained how LCAV was helping to ensure that leadership was being driven forward and leadership at all levels was becoming the norm. Crucially, this was also inviting shared decision-making and joined-up working in service delivery:

*There's a feeling in this organisation ... that leadership is all levels and so we're doing a lot more co-design, not only with service users but with staff who've got fantastic ideas on how to improve services if you just give them that space to think and to get actively involved so that co-production is at all levels. [P19, FG3]*

It must also be recognised that there remained concern amongst some participants that staff at the point of care couldn't always lead change or make service improvement suggestions:

*It's hard to tell somebody more senior than you what you think would be different, when that's already been set in stone by somebody perhaps at a higher level than you. [P14, FG2]*

As a part of promoting leadership, participants provided examples of staff achievement and success whilst advocating that this is recognised and promoted:

*There are a number of people who are quality improvement coaches already. It's that sustainability isn't it? It's that succession planning ... [Many people] who come into AHP or nursing [have] a degree and [have] done a thesis. Every person who comes to an applied psychology place has got a doctorate, what happens to those skills? ... We have got people who are keen on that. So, it's how do we also start making that the business as usual. [P19, FG3]*

### **Dissemination/awareness raising**

Broadly speaking, the focus group participants welcomed different opportunities to hear and learn about policies and frameworks and feel engaged and empowered to share their own work. However, this was coupled with concern over workplace pressures that meant staff couldn't always attend such events. Various dissemination strategies were reflected on, including several events outreaching to NHS organisations to present on LCAV:

*A launch event where we invited NHS England and Tommy Whitelaw ... and then we also went to one of the regional events. I know (P23, FG4) was there presenting on her obesity work and we also did a poster presentation on our document that we've put together and some of the work that we've done. [P21, FG4]*

*Our healthcare support lead, I know he spoke at lots of groups, he engaged staff out on the wards, out in the community areas, I did presentations at various groups ... just sharing information with the groups, what did it mean in terms of practice. [P22, FG4]*

Participants also identified the importance of disseminating and cascading information within an organisation, to truly support all nursing, midwifery and care staff to be able to lead change and innovation:

*It's just ... supporting the staff ... who are doing the good work and that's why we've created in R&I [research and innovation], a section in our group at the moment where people are able to come and present good practice, ideas for innovation, to really support this [framework] so that we're capturing that stuff that's going on, on the ground and then feeding that back up as well. [P24, FG4]*

Relatedly, it was noted by participants that although in its third year, information about the framework may not have filtered through to all staff at the point of care. One participant was involved locally in dissemination events at the trust and highlighted difficulty in successfully sharing information:

*We would have liked to have done more [dissemination] events or get more people attending the [dissemination] events we're doing... you are sort of relying on people who come to these events, sharing the information and cascading it on. [P21, FG4]*

## **Sharing good practice and learning**

This section of the qualitative thematic analysis is directly aligned to the national Atlas of Shared Learning. Not all examples have been submitting for showcasing in the AoSL, but clear parallels in evidence-based practice and improvement methodology became apparent. Participants reflected on how their organisation made it routine to consider the needs and experience of staff, services users, families and carers:

*One of the pledges... was about making a change in what we ask our staff and patients ... that's a really big change that we've made within our services. So, all our services have a tool now that they use to ask ... that question about what matters to you. [P18, FG3]*

A quality-assured case study now published on the AoSL was an example:

*We did a piece of research around whether the six-week intervention that we delivered had an impact on childhood obesity ... the results were very encouraging ... what needed to change, what did change and got the results. [P23, FG4]*

Similarly, participants reflected on the commitment to lead and drive research to evidence the impact of the nursing, midwifery and care staff contribution. This focus was supporting colleagues to showcase their achievements and successes, building capacity and capability to identify and address unwarranted variation:

*Last year we looked at learning disabilities... the management of epilepsies by the inpatient team because what they found was variation in the quality of the care planning, they put in a range of initiatives ... they re-looked at all the assessment processes, the care plans and put in training for staff. And then they did a re-audit and ... went from ... 30, 40 % compliance to 75 % compliance. [P18, FG3]*

These examples were also being shared locally, for continued, collective learning:

*We took some time ... looking for areas of particular good practice across the organisation, sharing that, looking [at] how we could learn from it. [P21, FG4]*

*It almost gives you permission, this document, to say we're doing something great in this area, let's share it. [P24, FG4]*

## **Framework positives**

In synergy with the shared learning examples described above, participants reflected on 'framework positives', such as empowering staff as leaders to develop and enhance their own skills as well as improving experience and outcomes for patients. Participants reflected that such a framework could strengthen the quality of care and the principles being embedded in practice:

*It's embedding, because when we look at the principles and say it's lessons learnt, but then it's embedding into practice. [P22, FG4]*

*I had a good look at what we said we were doing and for me this is fast becoming business as usual, which is good. [P20, FG3]*

*From the point of view of research as well ... recognising talent in the organisation ... identifying people who have those opportunities to do Masters and PhDs and they may have that under their belt ... to try and engage staff and identify pockets of experience that we can then again use for staff retention and job satisfaction, and really build on those opportunities. [P21, FG4]*

There was also an increase in the number of staff at the point of care sharing new initiatives for physical and mental health improvements:

*I just think some of the groups that I'm sitting on [example of group] and the initiatives that are coming out of there, it's coming from the staff teams, it's coming from the frontline, how can we make this safer, for staff, for patients, the connecting with people, that's come from the staff groups, the implementation has come from there. [P21, FG4]*

Although it is not suggested that the framework is being used universally, there was positivity around these principles. Indeed, participants acknowledged that frameworks were sometimes not embraced because of a 'one-size fits all' approach:

*We looked at making sure we reviewed the policy, we looked at our systems and processes in terms of making sure that this (LCAV) is embedded and long standing rather than sending a couple of people out on training and hoping it's going to be cascaded. It was looking at the whole system around implementing the change. [P21, FG4]*

This links to advocating a multidisciplinary approach that could be built on when considering future initiatives locally, regionally and nationally:

*I think it is looking at the multi professional approach really, and I think because most services now are multi professional aren't they, and I think it helps bring the team together. [P21, FG4]*

Finally, this context was reflected positively in students engaging with the principles of LCAV. Participants noted that students may have gained theoretical knowledge

of the principles of LCAV from their HEI and were then exposed to the framework in practice when working on placement, with other nursing, midwifery and care staff:

*We have a lot of trainee nursing associates and student nurses coming through the bachelor's, master's and foundation degree levels ... we do a lot of good work with them and project work where they're going out ... to evaluate the practice and giving us positive examples of what they've seen and how they link against all 10 of the commitments and it's kind of making the words become a reality for them. [P17, FG3]*

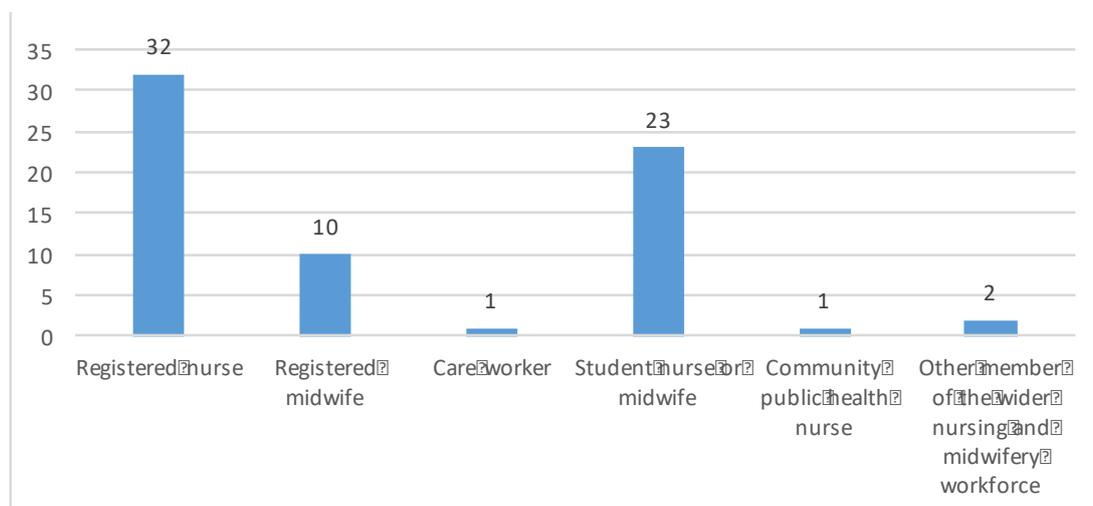
## Quantitative

To complement the focus groups, a survey was distributed to an increased cohort of nursing, midwifery and care staff at the point of care. It consisted of a short series of questions obtaining relevant demographic information of respondents as well as their knowledge, understanding and experience of the principles of LCAV. Findings across these domains are described below.

### Demographics

Sixty-nine individuals responded to the survey. Figure 1 depicts the professional demographic of respondents. A significant proportion were nurses, student nurses or midwives. This is likely a reflection of the dissemination strategy across trusts. Almost all respondents (n=68) worked in the NHS, even though it had been circulated among care sector colleagues.

**Figure 1: Professional demographic of survey respondents**



Of these respondents, the majority of respondents (N=28) worked at the point of care delivery, managerial positions (N=12) or were students in training (N=21). To reflect the diverse profile of nursing and midwifery roles, there were multiple answer options. Of those who selected 'other', the following roles were all selected (N=1): corporate nursing, education and quality improvement, director, nurse manager, practice educator, and working in theatre.

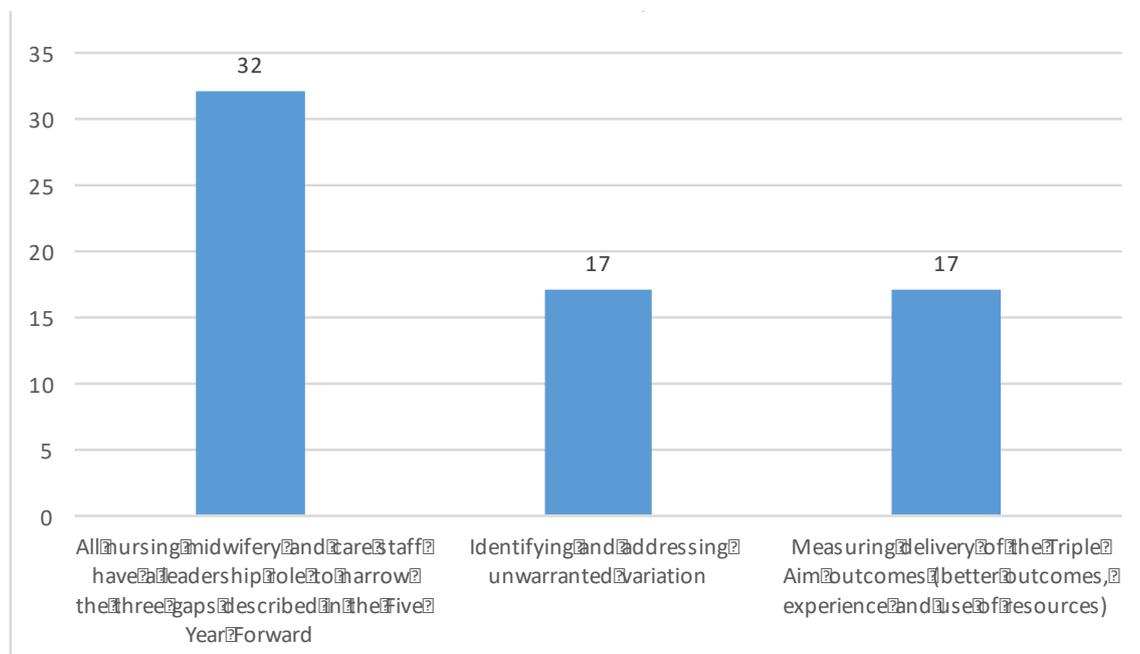
Finally, most respondents reported their working base as the North West of England (N=52), but this reflected a larger number of sites in this region.

### **Knowledge and awareness of LCAV**

A series of closed questions with multiple answer options were used to investigate an awareness of the principles of LCAV. Fifty-six % of respondents had heard of the framework, 38% had not and around 4% were unsure. Building on this, those who had heard of the framework were asked how they knew about it – exploring dissemination and cascading. For this, there were a range of options selected by staff, but most indicated the framework was shared by their organisation through email, newsletter or bulletin.

The survey also sought to establish which principles of LCAV were known to staff. Figure 2 demonstrates the key findings; the largest proportion of respondents were engaged with the principle of their leadership role to narrow the gaps described in the Five Year Forward View (N=32). Interestingly, of those who selected the option 'Identifying and addressing unwarranted variation' (N=17), many also selected 'Measuring delivery of the Triple Aim Outcomes' (N=17). This suggests that when staff had a certain level of familiarity with the principles, this extended across the framework.

**Figure 2: An exploration into the knowledge of LCAV principles**

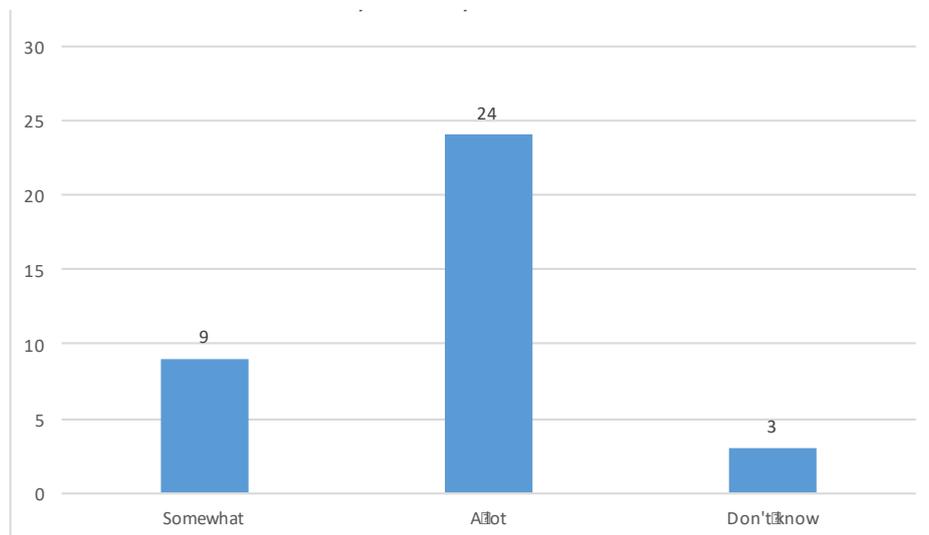


To a lesser extent there was also an awareness of other principles (e.g. 10 aspirational commitments). This included gaining insight into the awareness of the LCAV e-learning tool which only 10 respondents indicated they knew of. It is possible that increasing awareness of the e-learning tool would further enhance understanding of the principles listed in this question.

### Relevance of LCAV to professional practice

There was a question in the survey exploring nursing, midwifery and care staff opinion on whether the principles of LCAV were relevant to their daily work and practice. Thirty-six of the 69 respondents answered this question. Of these, 33 thought it would be at least somewhat relevant. It is difficult to make inferences as not everyone responded, but it does suggest a tendency towards recognising the importance of the principles embedded within LCAV.

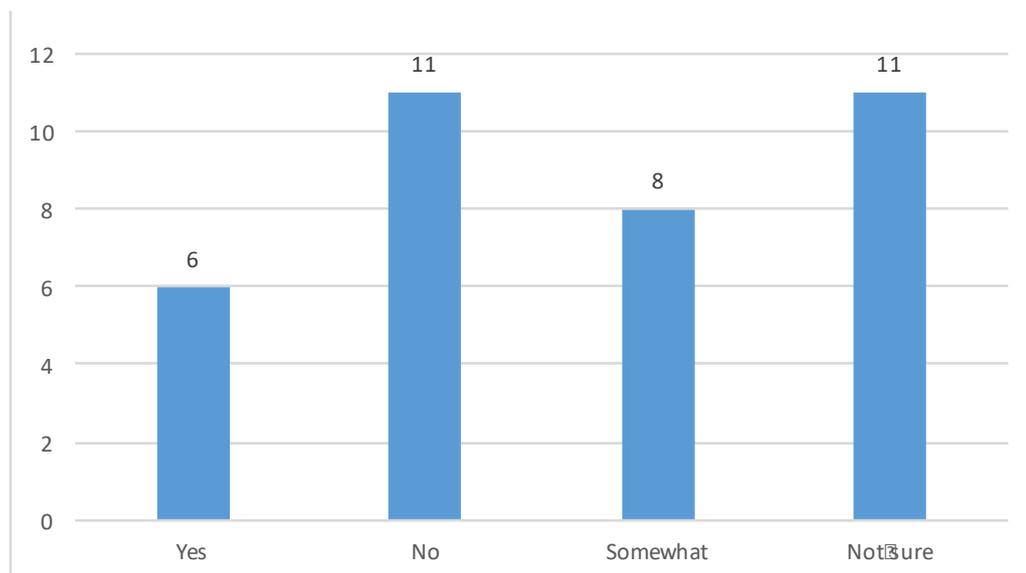
**Figure 3: Survey responses for whether participants felt LCAV was relevant to their work**



### **Impact of LCAV**

It was useful to explore the impact of LCAV within the organisations taking part in the service evaluation, as perceived by the staff. Exploratory questions included how the framework has been used to date and whether daily practice has changed as a result of leadership advocated in the framework. As before, not all participants answered this question. Of the 36 respondents, 14 indicated that they were actively using LCAV in practice or had done so. Eleven of the respondents were not sure whether the framework was being used, which suggests full understanding on the principles is not yet embedded.

**Figure 4: Using the framework to lead change**



Everyone is a leader, wherever they work, whatever their role is a fundamental principle of LCAV. Further exploration into these principles indicated that 61% of respondents had been able to put this into practice in their workplace. A further 30% had demonstrated leadership to a ‘certain extent’, but 27% thought it was unlikely, suggesting there is still work to do to truly advocate leadership at all levels across health and social care.

To finish the survey, respondents were invited to answer a free text question exploring what would support them to embed the framework in practice. Key enablers identified included:

- improving nursing, midwifery and care staff engagement levels (perhaps through continued dissemination between national – regional – local communication)
- advocating multidisciplinary working
- increasing awareness of the principles of LCAV across nursing, midwifery and care staff.

## Discussion

The LCAV framework builds on Compassion in Practice (Cummings and Bennett, 2012) and directly aligns to the Five Year Forward View priorities (FYFV; NHS England, 2014) and the NHS Long Term Plan (NHS England, 2019). This synergy

supports nursing, midwifery and care staff to understand and implement the principles in the framework and complements other national, regional and local initiatives. It truly demonstrates the shared vision towards identifying and addressing unwarranted variation in practice to narrow the three gaps described in the FYFV, demonstrably leading to better outcomes, experience and use of resources. The collaborative, matrix approach to LCAV complements current practice which is an important factor when considering whether a framework can be embedded as business as usual.

This evaluation used both quantitative and qualitative approaches to information gathering. This methodology allowed the evaluation team to explore nursing, midwifery and care staff understanding of the principles of LCAV as well as the continued dissemination of these principles and how to embed them into practice. To inform policy, there was an overarching question to explore whether these principles could be embedded in practice. The LCAV framework has been an intentionally 'slow burn' as for many it is a new way of working – certainly regarding terminology and focus, for example with a specific call to apply the same importance to quantifying our contribution as we do to the quality of care we provide. It is therefore unsurprising that knowledge and understanding were variable. The focus groups suggest that this understanding was associated to dissemination activity and how well the principles were cascaded across an organisation. Where the framework was distributed and shared widely, there were increased examples of it being embedded in practice. This highlights a benefit of effective dissemination, notably a range of dissemination strategies, to engage and support staff.

Building on this, focus group participants who were actively implementing the principles of LCAV identified and shared examples of the framework in action – with an emphasis on promoting an evidence-based approach to identifying and addressing unwarranted variation and leading change in their organisation. A key feature that emerged was advocating an environment embracing quality improvement, leadership at all levels and establishing mechanisms to support staff at the point of care as drivers of change within their own areas of practice (Serrant, 2016).

The discussions in the focus groups suggests that LCAV reflected a framework being 'of its time'. This underscores the importance of incorporating and communicating key elements of earlier policies in current health and social care

policies. It built on previous and existing policies and visions such as Compassion in Practice (Cummings and Bennett, 2012) and demonstrated the contributions of the professions to the delivery of the FYFV (NHS England, 2014). As alluded to previously, LCAV complements the priorities set out in the NHS Long Term Plan (NHS England, 2019).

These findings can be used when exploring synergies in the principles of LCAV and key ambitions of the Long-Term Plan. The Long-Term Plan for the NHS sets out ambitions for improvement over the next decade, and the plans to meet them over the five years of the funding settlement. It is clear that nursing, midwifery and care staff are already leading and improving work in many of these areas, such as prevention and personal responsibility, mental health, healthy childhood and maternal health, primary care, integrated and personalised care for people with long term conditions and the frail elderly. There is a huge opportunity to demonstrate the professions' key part in this transformational change and ensure their leadership position going forward. It is anticipated that this will support colleagues to continue to positively build on their quality improvement practice.

The focus groups and the complementary survey suggest that the e-learning tool and the Atlas of Shared Learning offer the opportunity to further understand LCAV principles and share evidence-based practice of identifying and addressing unwarranted variation respectively. Some participants knew the products, but not all, which reflects again the need for continued matrix working. The tools were well-received by those who were aware of them – indeed several participants had contributed their work to the Atlas of Shared Learning. The national Atlas of Shared Learning has over 130 quality-assured case study exemplars and the e-learning tool has been accessed by over 2000 colleagues nationally so far. The qualitative feedback of those who have completed the tool suggests it truly supports understanding of the key principles of the framework and the principles being embedded in practice.

The principle of nursing, midwifery and care staff leadership is showcased across the case study exemplars and this was discussed during the focus groups. Taking this together, these illustrate clear examples of how nursing, midwifery and care staff have translated the framework into practice.

The importance of demonstrating the quantifiable impact of change was illustrated in the focus group discussions; participants recognised the significance of staff

being supported to implement changes in the face of competing demands. This was also seen in parity with the way organisations were embracing evidence-based change to improving outcomes, experience and use of resources. This discussion also considered the need for staff to have the knowledge, skills and training to evaluate the evidence.

The role of staff development, to get the best from their skills, was also recognised. Interestingly, this is on a par with several contributions to the AoSL which enhance the skillset of the workforce and contribute to significant improvements across organisations. This aspect of workforce development is a significant feature of the LTP (NHS England, 2019).

Working across traditional professional boundaries and embracing multidisciplinary working was positively received and this shift towards joined-up working across health and social care was demonstrated with participants reflecting on ways their organization had worked together with other nursing, midwifery and care sector colleagues as well as other professionals routinely. The focus groups and survey were primarily populated by nursing colleagues and so it is difficult to truly demonstrate the way the principles of the framework have resonated and indeed been implemented by care sector colleagues.

Taking these findings together, the LCAV framework has provided a vehicle for colleagues to lead change in practice. It has been clear that many colleagues were already, or are now, identifying unwarranted variation as a part of their practice. However, for some, this has been a new way of working and support to understand and subsequently embody these principles takes time. The evidence collected through this explorative evaluation suggests this national framework has supported nursing, midwifery and care staff to demonstrate and quantify the professions' contribution to national, regional and local programmes of work.

Participants welcomed the promotion leadership at all levels and using their experience and influence to affect change across the health and care landscape of the future, directly aligned to the Long Term Plan (LTP).

It should be noted that this evaluation was conducted at a time of transformational change with attendant challenges. The evaluation team were mindful and flexible in their approach to information gathering. This had an impact on numbers of

participants and organisation engagement but was welcomed by all parties as an important acknowledgement of current challenges.

## Limitations

The focus groups and survey provide an overview of the LCAV framework from a nursing, midwifery and care staff perspective. There are two key limitations to consider when interpreting the findings. There is potential bias as the cohorts were selected due to organisational knowledge of LCAV and due to reasons mentioned earlier, there were a smaller than anticipated number of focus groups. This means the findings are not generalisable but they do offer an exploratory insight.

The chosen focus group sites were sites that had previously engaged with the dissemination of LCAV. The practical reasoning for this was that it would support the opportunity for exploration of understanding and feedback from participants. It would be difficult to set up focus groups at sites where there was no prior knowledge of the framework, but this must be considered as it cannot be assumed that the feedback provided is true nationally, nor can it be assumed that there is knowledge of the principles across the country. As described, this does introduce a potential bias to positively skewed feedback but, given an aim of the evaluation was to understand the process of dissemination, on balance this was agreed to be a fair approach.

Despite engagement being established with all five (four NHS and one care sector) organisations approached, focus groups were only conducted at two of the sites. Although a limitation, it is felt that the focus groups conducted provided rich data with which to conduct a probing investigation.

This limitation was also reflected in survey responses, although this is not uncommon in NHS settings (Lewis-Beck et al. 2004). Online surveys are considered representative if response rates are in excess of 25% of the circulation. The current survey is unlikely to have met this threshold which may reflect survey fatigue, limited dissemination at the organisation and possibly reduced engagement if participants were not aware of the principles of LCAV. Furthermore, since the survey was facilitated through local service managers, survey responses may contain elements of social acquiescence or social bias. The survey did not contain questions to test social bias, such as content validity or predictive validity test questions.

## Recommendations

This service evaluation describes for colleagues the learning from the dissemination and subsequent implementation of the principles in the LCAV framework.

Given that for many this is a new way of working, it is advocated that organisations continue to support their staff to use evidence-based practice and undertake visible nursing, midwifery and care staff leadership.

The language in national policies and frameworks can at times present a barrier to understanding and this is highlighted as a learning point. However, it was noted that the language was a reflection of the time as the professions move towards truly demonstrating quantifiable contribution to transformational change.

Staff should be supported to continue to share practice locally, regionally and nationally. These principles also truly advocate multiprofessional working as a positive way of delivering care across the system and this ongoing collaboration and engagement is considered beneficial to patients, individuals and populations.

For further policy dissemination, ongoing consideration of the most appropriate dissemination techniques is warranted, including the opportunity to continue the collaborative work between HEIs and health and social care organisations.

## Conclusion

This independent, mixed methods service evaluation has investigated the understanding of the principles of the LCAV framework, considering whether these principles could be (and in places are) embedded in practice by nursing, midwifery and care staff. The information collected as well as the continued progress to establishing the e-learning tool (March 2018), Atlas of Shared Learning (August 2018) and soon the research portfolio (June 2019) are markers for success.

It is proposed that this national framework has supported nursing, midwifery and care staff to demonstrate and quantify the professions' contribution to national, regional and local programmes of work. The evaluation has explored the way the framework has supported nursing, midwifery and care staff to apply an evidence base to making changes in practice. In summary, the framework promotes leadership at all levels and encourages nursing, midwifery and care staff to use their experience and influence to affect change across the health and care

landscape of the future – this is directly aligned to the Long-Term Plan (LTP) and the opportunity to position the professions' leadership going forwards.

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Publishing Approval Reference: 000282

NHS Improvement publication code: R&A 03/19