An evaluation of the implementation of the NHS Culture and Leadership Programme

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Summary

This report describes an evaluation of the Culture and Leadership Programme (CLP), developed by NHS Improvement, The King's Fund and the Center for Creative Leadership, designed to support NHS organisations to assess their existing cultures, and develop strategies to create cultures of high-quality care.

Quantitative analyses of data from trusts that engaged with the CLP, was examined for trends over time, as well as against national averages. This included:

- CQC inspection ratings
- Single Oversight Framework ratings,
- Staff engagement,
- Nursing turnover

Trusts engaged with the CLP improved on all of these indices. On average they showed greater improvements on these indicators in comparison with the national average for all trusts in England.

Semi-structured, qualitative interviews with key people who supported trusts through the CLP, identified enablers and barriers to the success of the programme.

Key themes emerging from these interviews were:

- The importance of board support and engagement
- board team functioning and maturity
- the recruitment and functioning of the change team
- organisation development capacity for the change team
- the use of the tools, their face validity and the robust evidence base
- the relationship with NHSI
- the focus on equality, diversity, and inclusion in culture
- maintaining momentum

Introduction and background

A major research programme on organisational culture in NHS trusts was launched by the Department of Health following the inquiry into serious care failings and avoidable patient deaths in Mid Staffordshire NHS Trust. It was funded (2010-2012, £1.45 million) by the Department of Health Policy Research Programme The aim was to determine the extent to which there were cultures of high quality care across the NHS. The underpinning research, led by Professor Michael West at Lancaster University, and including interdisciplinary researchers (including psychology, anthropology, policy studies, statistics) from five other universities and the National Association for Patient Participation, comprised a large, mixed-method research programme involving seven sub-studies.

These included 300 interviews with senior level executives, managers, and frontline staff; numerous patient, carer and team surveys; hundreds of sets of board minutes and published datasets on performance across all NHS trust types (hospital, mental health, ambulance); and cultural (ethnographic) case studies (of e.g., hospital wards, primary care practices, emergency care departments), totalling 650 hours of observation. Ten years of data from the NHS National Staff Survey was analysed, using responses from over 250,000 respondents annually. The analysis of all the data showed that there were many 'bright spots' of excellent care, practice, and innovation across the NHS in England. But it also indicated 'dark spots' of poor care, harried, distracted staff, and evidence of poor leadership, structural and cultural factors which threaten the quality and safety of care.

Key findings and issues included: unclear/disjointed goals in NHS organisations leading to 'priority thickets,' which eat up resources but which provide little coherent strategy; excessive box ticking to comply with external requirements rather than improve services; multiple regulatory bodies and external agencies serving different but overlapping functions, leading to ambiguity, fragmentation, and competing pressures; poor intelligence on which to base decisions/improvements; highly variable staff support and a lack of respect and appreciation; 'comfort-seeking' behaviours,' which focus on making a good external impression and view staff who raise concerns as trouble-makers; a lack of integration, leading to time-wasting, frustrating barriers, and gaps in care; indiscriminate use of quality improvement management techniques and 'magical thinking' that isolated initiatives will solve many problems quickly and easily.

Research recommendations for high quality care and patient safety in the NHS:

- Clear national and local-level direction setting focused on quality and safety.
- Compassionate and collective leadership at all levels.
- Staff engagement which was the key factor key in organisations that deliver high quality care, good financial performance and high patient satisfaction.
- Change programmes that ensure that the patient perspective is the key source of intelligence.
- Senior staff nurturing cultures in which front line innovation can flourish, ensuring work pressures do not crowd out space for quality improvement.
- NHS staff working in well-structured teams with clear, challenging, and measurable team objectives; better communication and coordination within and between teams; and encouraging teams to regularly take time out to review their performance
- Burdensome systems for data collection should be avoided; so too should a culture of using data simply for comfort-seeking.

Drawing directly on the research, NHS Improvement, committed to building an open-source programme of support for healthcare organisations. In 2015/2016, NHSI began developing the Culture and Leadership Programme (CLP). The intent was to support NHS organisations to understand their culture using evidence-based tools, and to nurture compassionate, inclusive and collective leadership. This in turn would support NHS organisations to develop cultures that enable and sustain continuously improving, safe, high quality, compassionate and inclusive care. The programme is entirely based on the elements identified by the prior research.

It focused on five key culture elements: vision and values, goals and performance, support and compassion, learning and innovation, team and cross-boundary working. A sixth – equity and inclusion – was added in 2021.

This report sets out the findings of an evaluation project analysing the impact of the CLP on the performance of Trusts using publicly available outcome data and data provided by NHSI. The project was commissioned by NHSI, and led by Dr Thomas West (Affina Organisation Development/University of Bristol) in collaboration with Professor Michael West CBE (King's Fund/Lancaster University), and Dita Ghosh (NHSI).

This report provides an evaluation of the extent to which the programme has been successful, common factors in its successful implementation, and barriers to its success.

The key aims of the evaluation are:

1. To identify differences in key outcomes between CLP trusts and comparison trusts.
2. To identify the most potent aspects of the implementation process in affecting positive outcomes.

Overview of programme

The Mid Staffordshire NHS Foundation Trust Public Inquiry, published in 2013, highlighted the need to improve organisational culture as a key recommendation.

NHS Improvement, The King's Fund and the Center for Creative Leadership developed and piloted the CLP in 2015 in collaboration with three NHS trusts (Northumbria, East London Foundation Trust and Central Manchester University Hospitals Foundation Trust (now Manchester University Foundation Trust).

The programme and associated tools of the CLP were published in 2016, and made freely available for NHS organisations to use, with continued refinements based on trusts' experience and feedback. Now under the aegis of NHS England (NHSE) and NHS Improvement (NHSI), the extensive guidelines on processes and many associated tools are freely available at
https://www.england.nhs.uk/culture/culture-leadership-programme/

Drawing from the research evidence and best practice, the CLP emphasises compassionate, diverse and inclusive leadership as key to enabling culture change, and creating conditions which

- *deliver high quality care and value for money while supporting a healthy and engaged workforce*
- *create a greater sense of belonging for all staff, changing the lived experience for all disadvantaged groups and those who experience discrimination, bullying and unfairness (2019 Workforce Race Equality Standard Report)*

- *enable staff and leaders to show compassion, to speak up, to continuously improve and create an environment where there is no bullying, racist or unfair treatment, where there is learning, quality and system leadership*

The evidence base for the programme is detailed at: https://www.england.nhs.uk/culture/culture-leadership-programme/the-evidence-base/

The CLP consists of four phases: Scoping, Discovery, Design, and Delivery, with the 'Scoping Phase', recently introduced as a preparatory step for the Discovery Phase. Each phase is designed to prepare the organisation for the next phase, and the CLP team at NHSI supported (and continue to support) organisations through the phases of the programme.

However, given the tools are open access, it is unclear how many organisations have engaged with the CLP, as multiple NHS trusts used some or all of the tools, independent of NHSI. Based on NHSI's records, and interviews with those involved with the CLP implementation, it is clear at least 35 trusts have undertaken the programme in full, or at least a significant proportion of it. As of August, 2021, a further 33 trusts were recorded as having some involvement with the programme, though at that stage had not worked through enough of it to warrant inclusion in this research.

Trust engagement has been limited by the impact of the COVID-19 pandemic with several trusts pausing CLP work whilst they respond to the ongoing crisis.

Project approach

This report examines data from 35 NHS Trusts in England, comprising of 28 acute trusts, 5 mental health trusts, and 2 community trusts.

The evaluation consisted of two parts: quantitative and qualitative.

To conduct the quantitative analysis, key indicators were identified. Objective, external ratings as well as staff experience indicators were selected. The data identified for inclusion were:

- CQC inspection ratings
    - overall, well led, safe, effective, caring, and responsive
- Single Oversight Framework ratings (SOF)
- Registered nurse turnover
- Staff engagement derived from the National Staff Survey data

For CQC, SOF and staff engagement, data was collected from the years 2017/18 and 2019/20 as these were the data sets available. The turnover data was collected from 2015/2016 and 2019/20 as this was available and coincided with the implementation of the CLP. Data from 2020/21 was not included as data is likely to be influenced by the pandemic.

Qualitative analysis was also conducted, based on data gathered during semi-structured interviews. Initially, based on the NHSI records, key people who had supported trusts through the programme were identified, and contacted to see if they would be happy to provide information regarding their involvement. These people were also asked if they could recommend anyone else they knew of who would have knowledge of the programme implementation. In total, 20 people were contacted, and of those, 12 agreed to take part, all of whom had detailed knowledge of the CLP implementation in one or more NHS trusts.

The interviews were conducted online, lasting approximately 1 – 1.5 hours each. The interviews began with a focus on two key questions. "What are the factors which result in trusts implementing

the programme well?", "what are the factors which result in the programme being implemented less well?". Interviews then explored the factors highlighted for each question in depth.

Key Findings

Quantitative analyses

CQC ratings

Overall, between 2018 and 2020, CQC ratings improved for trusts who engaged with the Culture and Leadership Programme. In 2018, 35% of CLP trusts were rated as good or outstanding. That had increased to 50% by 2020, a 15% increase. In 2018, five trusts (15%) were rated inadequate. By 2020, no trusts were rated inadequate. Table 1 shows these percentages.

	2018 (n=35)	2020 (n=35)	Percentage difference
Outstanding	5.88	5.88	0
Good	29.41	44.12	+14.71
Requires Improvement	50	50	0
Inadequate	14.71	0	-14.71

Table 1: Percentage of CLP trusts' CQC overall rating, and percentage difference across years

As a comparison, we also looked at CQC ratings for all acute, mental health, and community trusts in England. Between 2018 and 2020 there was a 9% increase in trusts rated good or outstanding, compared with a 15% increase in CLP trusts. Between 2018 and 2020, the proportion of trusts rated inadequate reduced (by 3%), though some remained in this bracket, whilst in the same period, no CLP trusts were rated inadequate. Table 2 shows these figures.

	2018 (n=205)	2020 (n=195)	Percentage difference
Outstanding	4.39	10.77	+6.38
Good	47.80	50.256	+2.45
Requires Improvement	43.90	37.95	-5.95
Inadequate	3.90	1.03	-2.88

Table 2: Percentage of all trusts' overall rating, and percentage difference across years

Analysis of the data for the CQC rating domains - well led, caring, effective, responsive, and safe - revealed an increase in average ratings for all CLP trusts across the period for all domains. Table 3 shows CLP trusts average score for each domain, the average change in these scores over time, as well as the average change in scores for all trusts in England.

	2018 (n=35)	2020 (n=35)	Score difference	National average change in same period
Well led	2.47	2.71	**+0.24**	+0.20
Caring	3.09	3.24	**+0.15**	+0.09
Effective	2.56	2.74	**+0.18**	+0.16
Responsive	2.38	2.56	+0.18	**+0.19**
Safe	2.12	2.32	**+0.20**	+0.14

Table 3: Average of CLP trust CQC domain ratings, and average change in scores for CLP trusts and all trusts in England.

Analysis of the data from all other trusts (excluding the 35 CLP trusts) revealed that on average, CLP trusts showed greater improvements in all but one domain, in comparison with the national average for all trusts in England.

Single Oversight Framework

Next, we looked at the Single Oversight Framework (SOF)1. The Single Oversight Framework was designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding'. The Framework does not give a performance assessment in its own right. The Framework helps identify NHS providers' potential support needs across five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability

NHS England and NHS Improvement segment individual trusts according to the level of support each trust needs. The regional teams at NHS England and NHS Improvement can then signpost, offer or mandate tailored support as appropriate. Trusts are given a rating of 1 to 4, based on the level of support providers are deemed to require, as identified by NHSI. The least favourable ratings is 'Special measures' (4), followed by 'Mandated support' (3), 'Targeted support' (2) and 'Maximum autonomy' (1).

Overall, CLP trusts improved their SOF ratings between 2018 and 2020. The largest change was in those trusts identified as being in special measures, then coming out of special measures to the next SOF rating (mandated support). There was also an increase in trusts moving from level 3 (mandated support), to level 2 (targeted support), though this was smaller. Table 4 shows these figures.

In comparison, for the same period, across all acute, mental health, and community trusts, there was an increase of trusts in special measures (2.47%) compared with a 12% reduction for CLP trusts. There was also a reduction across all trusts given a rating of maximum autonomy (-3.59%) whilst the number of CLP trusts remained stable. Table 5 shows the figures for all trusts SOF ratings.

	2018 (n=35)	2020 (n=35)	Percentage difference
Special Measures 4	32.35	20.59	-11.76
Mandated support 3	29.41	38.24	+8.82
Targeted support 2	20.59	23.53	+2.94
Maximum autonomy 1	17.65	17.65	0.00

Table 4: Percentage of CLP trusts' SOF rating, and percentage difference across years

[1] This has been superseded by the 'System Oversight Framework', ensuring Integrated Care Systems are included.

	2018 (n=205)	2020 (n=195)	Percentage difference
Special Measures 4	6.19	8.66	+2.47
Mandated support 3	28.57	28.14	-0.43
Targeted support 2	44.76	46.32	+1.56
Maximum autonomy 1	20.48	16.88	-3.59

Table 5: Percentage of all trusts' SOF rating, and percentage difference across years

Staff engagement and nurse turnover

We also looked at the levels of staff engagement for 2017/18 and 2019/20, as well as organisational registered nurse turnover rates for 2015/16 and 2019/20.

Table 6 shows the average National Staff Survey engagement score for CLP trusts, as well as the average nurse turnover rates. The data here show that CLP trusts improved on average for both indicators.

Reported levels of staff engagement improved by .07 for CLP trusts (national average improvement was .03). Similarly, levels of turnover for registered nurses in CLP trusts reduced by 1.41 between 2015/16 and 2019/20 (national average turnover reduced by 0.8).

	CLP trusts	National average
Engagement 2017/18	6.96	7.00
Engagement 2019/20	7.03 (+.07)	7.03 (+.03)
RN Turnover % 2015/16	14.13	12.20
RN Turnover % 2019/20	12.72 (-1.41)	11.40 (-.8.)

Table 6: Average staff engagement and registered nurse turnover rates for CLP trusts, as well as national averages

Overall, the data shows that trusts who engaged with the CLP, on average, improved on all the indicators assessed. The data suggests that CLP trusts showed consistently greater improvements than the national average for trusts on all indicators.

Qualitative analysis

Twelve semi-structured interviews were conducted to investigate factors contributing to the successful implementation of the CLP, as well as to identify hindrances. The results of these interviews were grouped according to themes: board engagement, board functioning, the change team, organisation development capacity, clinical engagement, leadership sponsor, strategic integration, use of the tools, relationship with NHSI, focus on equality, diversity and inclusion, and maintaining momentum. Each of these is briefly described below.

Board Engagement

The theme of board engagement was highlighted in every interview as critical. Gaining support at the board level at the outset is fundamental to success. Specifically, for the CLP to be successful, the board needs to understand and endorse the vision of the CLP, to have clear and active roles, both individually and as a team, and to make a long-term commitment to the success of the programme. One interviewee observed that when a board has all these elements, they “are much more likely to

be able to focus on the things which lead to success, as well as being able to block out some of the noise."

Having CEO support communicates the importance of the CLP to the rest of the board. Similarly, having support from the HR and medical directors is also influential.

Board Team Functioning

The extent to which the Board are aligned and operate as a cohesive team is also critical. Board members should not work in silos, but rather as an integrated team, with individual members having oversight over each other's portfolios in order to effectively and collectively support the CLP.

Related to this is the level of stability of the Board. Interviewees described boards which had a 'churn of executives', undermining the stability of the programme, largely because of a lack cohesiveness, stability and maturity in their focus on culture and leadership.

Cohesive, stable and more mature boards are more prepared to be exposed to uncomfortable messages and to understand the importance of this as a stimulus for culture change. The board must be open and receptive, acting on these messages, and showing the change team (and their organisation) that they have heard the message, understand it, and are acting in response to bring about culture and leadership change.

The Change Team

The change team are a group of people (staff, patient representatives, partners) who carry out the culture and leadership programme within an organisation or system. The change team is a crucial vehicle for staff engagement and it is most effective if it is multidisciplinary and diverse – championing a compassionate, diverse and inclusive leadership approach. They work to engage colleagues across the organisation, listen to their experiences and collate these, disseminate learning and influence the future culture of the organisation.

- *Recruitment*

The change team is central to the success of the CLP and most interviewees highlighted the importance of how this team is recruited. The most effective change teams are highly representative of their organisation, across a range of functions, roles, and across levels of seniority. One interviewee commented, "the best change teams had hospital porters having two-way discussions with senior clinical consultants and working together to come up with solutions".

Most interviewees emphasised the value of recruiting by open advert. This both ensures good representation from across the organisation, as well as communicating that the organisation is making a serious commitment to involving everyone in culture change. Some interviewees also suggested that the board should be engaged with the recruitment of the change team for the team to feel empowered from the outset.

- *Relationship with Board*

A key role of the board is to empower the change team. The change team should have access and be free to talk openly and honestly with board members, and feel confident to deliver their messages, however uncomfortable. Similarly, board members should be available to be interviewed by change team members. One interviewee said, "the team becomes a proper change team when they see the board are willing to be asked questions, and that there is transparency about the similarities and discrepancies between board perceptions of culture, and those in their organisation."

We also heard that where boards were unwilling to be interviewed by 'junior staff' in the change team, this was seen as a major 'red flag' to those supporting the trust with their CLP implementation, and invariably was associated with lower success rates.

- *Support and resources*

The board must also ensure that the team have the appropriate resources for their work. This includes providing adequate funding and freed-up time. Describing key barriers to success, one interviewee gave the example of clinical staff on the change team not being released from their clinical duties and their roles not being back-filled.

Organisation Development Capacity

Providing the team with appropriate training was frequently emphasised in interviews and this depended on the organisation development (OD) capacity within the trust. This includes having an experienced, effective OD team to provide centralised support to the change team. For example, the OD team may provide support by training the change team to run focus groups and conduct board interviews.

Clinical Engagement

Clinical leadership supporting the CLP within the change team and wider organisation was seen as important to success, but interviewees frequently cited this as challenging to achieve in practice. Ensuring the medical director, and other key clinical leaders are supportive is important, as they influence the clinical workforce who may otherwise be disengaged or cynical about change initiatives. Support from this group was forthcoming because of the strong evidence base for the CLP, demonstrating how compassionate and collective cultures in NHS trusts lead to quality improvement and effectiveness.

Leadership Sponsor

Having a key leader at executive level to endorse and oversee the programme is helpful, particularly at the start of the programme This person can coordinate, and act as a gatekeeper, facilitating access to the board as well as helping to integrate and embed the CLP across the organisation.

One interviewee, commenting on the importance of this position mentioned, "when they leave the organisation, the CLP gets derailed." Interestingly, some interviewees reported that key leaders had submitted their resignation in response to a perceived lack of organisational commitment to the CLP, including board level leaders.

A key task for this person is to ensure a transition for the CLP from being a top-down programme to a more collective, bottom-up approach, reflecting the ethos of the CLP as well as reducing the dependency of the programme on leadership sponsors alone.

Strategic Integration

The CLP and its messaging must be integrated with the values, mission, strategy and objectives of the Trust. It must be a collective, organisation-wide approach, endorsed and supported from the top of the organisation.

Use of the Tools

"The tools are more than the sum of their parts. They provide trusts with a broad framework, from which to have a conversation about culture", stated one interviewee.

A key strength of the tools are their evidence base. This not only provides trusts with a reliable source of data to inform culture change, but helps with communication or marketing about the process. The evidence base was powerful in reassuring staff and in gaining the confidence of key leaders who then championed the programme.

Some interviewees commented on variation in the value of the tools and noted the need to continuously improve them. For example, we heard that some trusts collect patient experience data in a way that is more sophisticated than the CLP guidelines. Similarly, we heard that trusts sometimes struggled to undertake a leadership workforce analysis and to use the dashboard effectively.

One interviewee suggested that the maturity of the board influenced how the tools were used. Where boards were mature and already focused on culture, trusts were better able to adapt the tools and their work on culture in an integrated and intelligent way. Less fortunate trusts were advised to stick more closely to using the tools as described in the CLP.

Some interviewees cautioned that trusts who deviate from the advice on which tools to use and how to use them, often did so to stay in 'comfort zones' focusing their efforts in areas where they were already relatively strong (such as recruitment). Interviewees argued for the value of using all the tools and with relative fidelity. One said, "when trusts followed all the tools in full, this always led to conversations which were not expected, areas which were not uncovered, and always led to improvements." Another described how "the design of the tools means that anybody can use them. They have been set up in way that surgeon and porter can deploy them. The user experience is good – and this is important."

Overall, the learning that appears to emerge is of the need to strike a balance between intelligent adaptation of the tools, having the courage to undertake the full programme, not replicating work that has already gone on in the trust, integrating the tools with existing OD strategies where appropriate, and using existing *high quality* data where this has already been gathered, rather than wasting resources on gathering new data.

Relationship with NHSI

One theme reiterated in every interview, was the importance of the relationship trusts have with NHSI and other arm's length and regulatory bodies. Interviewees commented on an historical perception that the messaging from arm's length bodies, and NHSI in particularly, can be inconsistent and confusing. For example, we frequently heard about the CLP NHSI team making the case for a compassionate and collective culture, whilst separately, another NHSI department aggressively communicates the need for trust to prioritise reducing their budget deficits, to respond to The People Plan, or to take direction from the NHSI improvement director in relation to hitting imposed targets.

The history of a trust's relationship with NHSI in some cases undermined healthy engagement with the CLP. Individuals described the boards of some trusts as feeling apprehensive about *not* using the toolkit as it was an 'NHSI initiative'. It could be seen as a mandatory direction from NHSI rather than a helpful offer of support. There is a danger that trusts engage with the CLP in order (as they perceive it) to satisfy their accountability to NHSI, rather than as a as a way of working together with NHSI to develop culture. These observations suggest a need in the future for the culture of NHSE&I to model the principles of the CLP both internally and in NHSE&I's relationships with trusts. Some interviewees were very clear that the problem is not simply the historic perception of NHSI as a

regulator (the old 'Monitor'), but is a consequence of a perceived bureaucratic, hierarchical, target driven culture at the top of the system, directly contradicting the ethos of the CLP.

NHSI is seen as a very 'outward facing' organisation, neglecting the health of its own internal culture. To effectively communicate the ethos of the CLP, process and content should be aligned. This fundamentally requires NHSE&I to implement the CLP with high fidelity, commitment and sophistication and sustaining that effort over the course of the next five to ten years.

Focus on Equality, Diversity and Inclusion

Historically, the emphasis on equality, diversity and inclusion (ED&I) was emphasised in a wide variety of tools within the (then) five culture domains (vision and values, goals and performance, support and compassion, learning and innovation, team and cross-boundary working). However, it became clear from an evaluation by the Universities of Manchester and Birmingham (Formative Evaluation of NHS England and NHS Improvement's Culture and Leadership Programme - https://www.research.manchester.ac.uk/portal/files/176191809/CLP_Evaluation_Final_Report_300220_FINAL_2.0.pdf) that trusts were often failing to focus sufficiently on this issue, so fundamental to compassionate and inclusive culture. It became apparent that the CLP did not adequately address ED&I issues, and there needed to be an explicit focus in this area, making equity and inclusion an element in its own right.

The new approach was seen very favourably by the majority of those we interviewed.

Maintaining Momentum

"The best trusts do not 'finish the programme. Once they get to the end of the process, they start again. The best trusts never stop." This comment reflected the view amongst interviewees that there is no 'magic pill' for changing and sustaining high quality care cultures. Long term commitment requires the board and change team to constantly revisit and sustain their approach. This also requires sustained and transparently open, two-way communication with staff. Indeed, for the CLP to transition from being led to a collective approach, staff voice must be at the centre of culture change. One interviewee commented that "it is vital people understand that *they* are integral to culture and culture change." Another said, "the senior leadership are important as they provide the framework, but it is really the staff who lead it."

In order for staff to engage, they must feel they are listened to, and that their message is acted upon (by senior leadership) and this must be a sustained cultural characteristic reflecting the commitment to compassionate, collective and inclusive leadership. Culture change must be seen as an ongoing quality improvement initiative involving all in the organisation for the long term future. Several interviewees highlighted how having a good internal communications team can help maintain momentum, by facilitating the on-going conversation between staff and organisational leadership.

Conclusion

This evaluation examined the CLP through a quantitative and qualitative lens. Whilst the quantitative data available here do not lend themselves to more sophisticated analysis, the trends clearly suggest that engagement with the CLP is associated with improvements in external ratings of performance, as well as in staff experience, and turnover. In addition, the qualitative evidence provides insights and information regarding key factors which are important to the success of the programme. The CLP team and trusts can learn a great deal from this to help sustain the programme in service of ensuring high quality care cultures.

Almost all interviewees emphasised how felt the programme helped them as individuals as well as members of staff across the trusts. Many now embodied the approach in their own working lives, changing the way they worked, relationships with those they worked with and their career trajectories. One commented “working on the culture programme was one of the best things I’ve ever done in my career.”

All of the interviewees were clear that the programme is highly effective, especially when it is implemented with fidelity and comprehensively in a sustained way. The trends in the data also support this view, and based on the results of this evaluation, the programme should undoubtedly be sustained, trusts must continue to be supported with implementation, and the learning from the work should be marshalled in order that the tools and the process can continue to be improved. The process should also continue to be adapted and implemented to support integrated care systems (ICSs).

Finally, it is vital that NHSE&I embark in a comprehensive and wholeheartedly committed way to implementing the programme themselves, taking heed of the key recommendations our interviewees highlighted for programme success. This should help to facilitate organisational knowledge learning and sharing, by providing a new experiential lens through which to view the programme. It will also ensure greater credibility and connection between NHSE&I and the trusts they are there to guide and support. All of this will in turn, translate ultimately into high quality, continually improving and compassionate care for patients and high quality, continually improving and compassionate support for staff. This has never been more important than now across the NHS.