A process evaluation of Leading Change, Adding Value: a framework for nursing, midwifery and care staff.

NHS England INFORMATION READER BOX		
Directorate		
Medical	Operations and Information	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Strategy & Innovation
Finance		

Publications Gateway Reference:	**07220**
Document Purpose	Other (see Description)
Document Name	A process evaluation of Leading Change, Adding Value: a framework for nursing, midwifery and care staff.
Author	Edge Hill University
Publication Date	13 November 2017
Target Audience	Available as a resource to access by all health and care organisations that co-produced and co-deliver the framework
Additional Circulation List	
Description	This evaluation reports on the first year of the Leading Change, Adding Value framework for nursing, midwifery and care staff, (LCAV) and its implementation, thus far.
Cross Reference	Leading Change, Adding Value: a framework for nursing, midwifery and care staff
Superseded Docs (if applicable)	N/A
Action Required	N/A
Timing / Deadlines (if applicable)	**N/A**
Contact Details for further information	

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

Document Title: A process evaluation of Leading Change, Adding Value: a framework for nursing, midwifery and care staff.

20 November 2017

Prepared by: Edge Hill University

Classification: OFFICIAL

Contents

1 Executive summary

1.1 Introduction

This evaluation reports on the first year of the Leading Change, Adding Value framework for nursing, midwifery and care staff, (LCAV) and its implementation, thus far. Case studies have provided evidence to inform the translation of LCAV into practice by frontline staff. These case studies have illustrated optimal practice for addressing unwarranted variation aligned to the 10 Commitments. Twenty interviews with key stakeholders from across the health and social care sectors were undertaken. With a focus on leading everyday change, perceptions were gathered on how LCAV has been, and may be, used by frontline staff. Recommendations have been made on how to measure and explore LCAV becoming "business as usual" to meet the triple aim outcomes of improving outcomes, experience and better use of resources and support closing the three gaps, health and wellbeing, care and quality and funding and efficiency as outlined in the Five Year Forward View (FYFV), over the next two years.

1.2 Main Findings

Using a rigorous Thematic Framework Analysis methodology, a three-theme paradigm was established:

- **'Past – Where has this come from?'**

The main theme of 'Past' had three sub-themes: 'Existing Work' – this was how LCAV was perceived to be built on previous successful strategies; 'Value & Impact' – how areas which require change in health and social care could be addressed using LCAV; and 'Framework Positives' – whereby the benefits of the framework could be seen in frontline practice.

- **'Present – Where is it now?'**

This theme incorporated sub-themes of: 'Dissemination Strategy' – how key stakeholders have been "spreading the word" to date; 'Levels and Meaning of Unwarranted Variation' – noting how LCAV has brought unwarranted variation to the fore of practice; and 'Inclusivity' – enabling cross-institutional, multi-professional, and cross-boundary synergies for better patient care.

- **'Future – Where is this going?'**

The final theme generated five sub-themes: 'Enhancement, Not Additional Work' – where LCAV was seen as a way of working, and not a distraction from practice; 'Culture Change' – entrenching LCAV into the hearts and minds of frontline staff; 'Leadership' – noting the requirement for strong, national, and identifiable leadership; 'Embedding LCAV' – methods for providing longevity for LCAV; and 'Barriers to Embedding LCAV' – identifying the possible challenges to LCAV's implementation and maintenance in practice.

1.3 Conclusions

Understanding of LCAV: Enhancing frontline staff's understanding of LCAV reinforces the principles within LCAV demonstrating its value and impact.

Frontline Staff Awareness: Previous events have been well-received. A programme of conferences, workshops, and webinars, with informal networking opportunities are deemed beneficial.

Good Practice Sharing: Case studies of innovative practices have positive impacts on understanding LCAV by frontline staff and should continue.

"Spreading the Word": LCAV will continue to benefit from publicity via social media which has already proved useful.

LCAV Crossing Boundaries: Networks of frontline staff engaging with LCAV and supporting each other could facilitate best practice sharing and multi-professional working.

Making LCAV "Business as Usual": Both vertical and horizontal leadership is key to frontline staff developing a strong commitment to LCAV.

Providing the 'Right Education': The drive to create everyday leaders within nursing, midwifery and care staff requires tailored approaches to staff development.

1.4 Recommendations

Future evaluations should take a summative approach which will provide findings to key stakeholders at the end of year 2 (interim report) and the end of year 3 (final evaluation) which will allow an assessment of the development and implementation of LCAV. This should be benchmarked against the triple aim outcomes of better experience, better outcomes and better use of resources emphasising the need for us to place the same importance on quantifying and measuring improvements, as to the significance of always demonstrating quality at the centre of all that we do. Qualitative data collection, through open text commentary via a survey and through interviews would assess how frontline staff are driving change through everyday leadership. Finally, an adapted pro forma has been proposed which will provide a more rigorous approach to collecting best practice case studies which identify and address unwarranted variation in practice, for the LCAV webpages.

2 Evaluation team

Kate Zubairu: [Lead Author] Senior Lecturer in Adult Nursing, Department of Adult Nursing, Faculty of Health & Social Care, Edge Hill University.

Sergio A. Silverio: Research Assistant, Evidence-based Practice Research Centre, Faculty of Health & Social Care, Edge Hill University.

Jill Fillingham: Senior Lecturer in Adult Nursing, Department of Adult Nursing, Faculty of Health & Social Care, Edge Hill University.

Axel Kaehne: Reader in Health Services Research, Evidence-based Practice Research Centre, Faculty of Health & Social Care, Edge Hill University.

John Sandars: Professor of Medical Education, Postgraduate Medical Institute, Faculty of Health & Social Care, Edge Hill University.

Lynda Carey: Senior Lecturer in Strategic & Operational Leadership, Postgraduate & Professional Education, Faculty of Health & Social Care, Edge Hill University.

Jeremy Brown: [Principal Investigator] Professor of Clinical Education, Evidence-based Practice Research Centre/Postgraduate Medical Institute, Faculty of Health & Social Care, Edge Hill University.

3 Acknowledgements

The authors would like to acknowledge and thank all key stakeholders, contributors, and interviewees who have taken part in this evaluation.

4 Introduction

‘Leading Change, Adding Value’ (LCAV) is a national framework for all nursing, midwifery and care staff (NHS England, 2016a). The LCAV national framework positions nursing, midwifery and care staff as leaders both individually and collectively, to design the future of our services and to use their influence to manage the challenges of today. The principles embodied within the LCAV national framework emphasise the importance of working across professional boundaries, benchmarking and sharing good clinical practice and empirically measuring the value added by those improvements in practice.

4.1 Context

LCAV was launched by Professor Jane Cummings, Chief Nursing Officer, England on 18 May 2016. LCAV follows the success of Compassion in Practice and positions all nursing, midwifery and care staff as leaders who will shape the actions needed to meet the challenges of today and the changing health and care landscape of the future. One of the great legacies created through Compassion in Practice is the 6Cs and these remain the foundation of the value base, and central to identifying and addressing unwarranted variation in practice.

The framework is aligned to the Five Year Forward View (NHS England, 2014) and explains how nursing, midwifery and care staff, whatever their role or wherever they work can align their work to lead in narrowing the three gaps of health and well-being, care and quality, and funding and efficiency. Central to the LCAV framework is the focus on reducing unwarranted variation, and the ability of staff to meet the triple aim measures of better outcomes, experiences and use of resources. Unwarranted variation is described as variations in health and care outcomes, individuals' experience and use of resources that cannot be justified by reasons of geography, demography, or infrastructure.

LCAV is underpinned by 10 aspirational Commitments (https://www.england.nhs.uk/leadingchange/about/commitments/) developed by staff and people who use and care about health and care services. These commitments help align efforts to areas where unwarranted variation is recognised and support the transition needed to build sustainable services of the future.

4.1.1 Examples of dissemination events

Dissemination to frontline staff is an important part of improving awareness of the LCAV framework. LCAV was developed after extensive consultation and wide engagement that included contributions from frontline staff, the public, academics, nursing, midwifery and care staff leaders across the health and care system. The launch was live-streamed via the internet to a number of events across England and internationally – e.g. New Zealand, which were accessed by frontline staff. Workshops have also been organised focussing on the 10 Commitments within LCAV.

A further example of dissemination to frontline staff was a conference held in London in February 2017 for Health Care Assistants (HCA) and Care Staff to raise awareness and improve understanding of LCAV which attracted 274 delegates from across the country. Feedback was positive in terms of the extent to which delegates felt the conference had improved their understanding of LCAV. Examples of the comments from those featured in the film include how the conference has improved knowledge of LCAV and the integral role of frontline staff, in this case HCAs and care staff, to LCAV.

Whilst not an exhaustive list, these examples give a sample of the events which have taken place over the first year following the launch of the framework and illustrate the value of engagement with frontline staff regarding LCAV. Further events and campaigns are planned which aim to provide a range of 'opportunities for staff to better understand the framework and how their role is vitally important in leading change and adding value across the health and care sector' (Aitkenhead, March 2017).

4.1.2 Scoping exercise

A scoping exercise was conducted to create the context for the evaluation and help inform the development of data collection tools. The search terms 'Leading change, adding value' were used (further details available upon request).

Given the relatively recent genesis of LCAV, the literature was confined to policy news and commentary, editorials and dissemination papers in professional journals across nursing, midwifery and care sector professions. No empirical studies were available. However, the literature accessed gave examples of how LCAV has been outlined to communicate its context (Practice Nursing, 2016; Longhurst, 2016a), its essential features (Evans, 2016a and 2016b) and how it might be utilised within specific specialities (Beckford-Ball and Evans, 2016; Mann, 2016; Harrison, 2016).

The British Journal of Healthcare Assistants published a monthly focus on LCAV highlighting its key features such as unwarranted variation and the 10 Commitments, in addition to providing examples of case studies illustrating the 10 Commitments in action (NHS England 2016b, 2016c, 2016d, 2016e, 2016f, 2017a). LCAV featured in several journal editorials that introduced the framework and considered its potential impact (Brown, 2016; Blakemore, 2016; Scott, 2016; Stephen-Haynes, 2016). LCAV has also been considered in terms of how there may be areas of learning in relation to its implementation borne out of evaluating Compassion in Practice (Kendall-Raynor, 2016; Serrant, 2016). The emphasis within LCAV on engaging frontline staff has been acknowledged (Blakemore, 2016; Longhurst, 2016b). Furthermore, professional associations welcomed LCAV positively (Care England, 2016; Royal College of Midwives [RCM], 2016; Royal College of Nurses [RCN], 2016).

5 Methods

5.1 Aims

To explore how LCAV has been understood, adopted, and disseminated in its first year. Recommendations will be made in relation to methodologies for capturing the embeddedness of LCAV and how it is used in clinical practice through years two and three.

5.2 Design

Twenty qualitative, semi-structured, telephone interviews were conducted to explore the interviewees' perceptions of the LCAV national framework. Case studies provided to Edge Hill University (EHU) have been made into synopses and mapped against the 10 commitments.

5.3 Research governance process

NHS England, on behalf of the LCAV National Governance Board, declared this study a process evaluation and provided a governance letter to this effect (Appendix 3). The Chair of the Research Ethics Committee in the Faculty of Health and Social Care, EHU ratified this letter. Processes of recruitment, consent, confidentiality, and storage of data observed Edge Hill University's Framework for Research Ethics.

5.4 Participants

The LCAV Operational Team provided EHU with a list of 38 eligible participants for the qualitative interviews. The potential interviewees were a representative sample

including LCAV regional leads, unwarranted variation programme leads, arms-length body partners, professional organisations, unions, and academic associates.

All participants were contacted via e-mail by the EHU evaluation team to invite them to take part in a semi-structured telephone interview lasting approximately 30 minutes. In total, all 20 participants who volunteered were interviewed.

5.5 Data collection

Interviews were semi-structured and conversational in style. Discussion topics covered the following areas:

- The participant's role and involvement with LCAV;
- Their sense of LCAV in terms of its components and context;
- Accountability in relation to establishing the framework together with thoughts on launching it with frontline staff;
- Consideration of how LCAV fits with other organisational changes;
- Communication and dissemination strategies;
- Reflection on the barriers and enablers in relation to moving LCAV forward; and
- An evaluative perspective in terms of LCAV currently in addition to its potential evaluation moving forward into years 2 and 3.

5.6 Qualitative data analysis

The LCAV Operational Team provided EHU with material identified as quality assured 'case studies'. These case studies provided valuable exemplars of LCAV in clinical practice, by frontline staff. Some of these case studies have previously been made into short film vignettes on the LCAV web pages, as a way to spread optimal clinical practice in an easily digestible format for frontline staff. The EHU evaluation team summarised each case study into less-than-50-word synopses, mapping them, where possible, onto the 10 Commitments.

The interview transcripts were analysed using a Thematic Framework Analysis method (Ritchie, Spencer & O'Connor, 2003) and after analysts discussed occurring themes the analyses suggested that LCAV spanned across three stages in time: 'Past – Where has this come from?', 'Present – Where is it now?', and 'Future – Where is this going?'

6 Findings

6.1 Case study findings

The importance of providing case studies as real-life examples to demonstrate work already undertaken or in progress is illustrated by their inclusion in the LCAV webpages (https://www.england.nhs.uk/leadingchange/ NHS England, 2016).

Case studies to date have covered (in full or in part) most of the 10 Commitments, as described below.

6.1.1 Case study synopses (which of the 10 Commitments are met)

The Five Point Huddle – Cuckoo Lane (4, 6)
Twice-daily briefing discussing clinical, operational, and practical issues, keeps staff aware of initiatives, promotes excellence, minimises risk, whilst reducing complaints.

Flexible Visiting – Aintree (5)
Visiting hours changed from fixed 1-hour visits at set-times to a core-hour system from 1:30pm-7:30pm across the Trust, reducing pressure on carpark and complaints, whilst improving experience for patients, relatives, carers, and staff.

Care Navigation & Social Prescribing – Central Gateshead (5, 9)
Health Care Assistant and receptionist roles altered to reflect "Primary Care Navigator" role to 'Communicate', 'Guide', 'Support', & 'Develop' with carers of patients with dementia improving screening & reducing staff burden.

Respiratory Futures – Leeds (3, 10)
Free educational meetings, mailing list, and use of social media for new guidance to reduce costs to patient and practice and improve quality of care.

Small Improvements, Big Impact – Berkshire (2, 4, 9)
Provided authority and autonomy to staff to deliver service to patients on older adult mental health inpatient wards, improving patient care.

Weight Management Group – Durham (1, 3)
Nurses developed a programme, collated resources, and ran an evening group for weight management to offer a structured, accessibly programme in the evenings.

6.2 Interview findings

Table 1 outlines the findings. Exemplar quotes are provided per (sub-) theme. Further details and examples are available upon request.

Table 1: Table of themes and quotes from qualitative interviews

Theme	Sub-theme	Exemplar Quote (1)	Exemplar Quote (2)
Past – Where has this come from?'	Existing Work	"I looked at it and as a nurse I actually thought this is an initiative, this is a programme that isn't asking us to do something else, my first thought is gosh there's something going on around this all the time, it links back to the 6 C's" (Participant 1-B)	"… was clearly developed in conjunction with lots of national partners, and I think it's significantly more developed than Compassion in Practice was, I think it's more measurable, and in relation to other strategies and policies, I mean clearly it links very firmly with the Five Year Forward View, and the triple aim and unwarranted variation." (Participant 5-C)
	Value & Impact	"…it's very much a document of its time… because of the way the NHS is at the moment, and the pressures that we're feeling we need to do different things, in the Five Year Forward View I think currently Leading Change, Adding Value absolutely fits into that, and it's a real challenge" (Participant 2-H)	"…people just weren't getting it in the room, it was just going back to the NHS, and it was just disappointing really, but we did get something in there and that's a positive, and maybe it's all about incremental steps to move forward, if you know the first time a national nursing framework has actually recognised social care, so maybe that is the ultimate positive thing it's actually got it in there…" (Participant 17-O)
	Framework Positives	"It's a framework, it's not a strategy, I think it builds on the previous strategy the 6C's and obviously Compassion in Practice, and so I think it sits well, I think it has a good reception, and being received well across most sectors…" (Participant 18-A)	"I think in some ways it's probably a bit more practical…… but I think one of the criticisms sometimes of nursing, has been that its strategy isn't always in line with what's really happening in practice" (Participant 7-M)
'Present – Where is it now?'	Dissemination Strategy	"The more strategic you get, the harder it becomes for operational colleagues to understand and engage with it. So I think the closer you can get to the actual real work going on, highlighting how that's	"…we need to make this everyone's business, so as I said we're slightly behind where I think we should be on that, then we've got a job to do to get it out there, so it's keep talking about it, and starting to talk

		being approached by real people so you know the case studies… they've been with the frontline operational people…… that's really important that, that grounding…" (Participant 6-G)	about the successes on the website, so making sure we've got some signposts to that, and we keep that up to date…" (Participant 2-H)
	Levels and Meaning of Unwarranted Variation	"…it's something that has frankly dogged the health service probably for all the time I've worked in it…… I think the frustration always has been that in what appeared to be the same set of variables, in terms of the patient and the level of rapport and the knowledge about the approach to care, nonetheless you can still get completely different outcomes…… in terms of quality. In terms of the way a resource is utilized. So it's something about how do we ensure we have that basic line of quality and consistency…" (Participant 20-F)	"I think how it translates into practice is that if I use the maternity analogy; we really should not have a postcode lottery whereby… women from a socially economically disadvantaged background are fifty percent more likely to have their pregnancy end in still birth. And that goes for social economically disadvantaged and BME population that's just one example of unwarranted variation." (Participant 8-I)
			"…we know that we deliver services very differently with very inconsistent outcomes across England…… we need to learn from where it is done well and spread that if at all possible, the NHS is really very poor at spreading what it knows well" (Participant 9-R)
	Inclusivity	"There's definite synergy in relationships there, I think there's an important consideration for the group around its overarching ambitions that do already kind of align quite closely to other things, so particularly for example one of the biggest areas that focuses around addressing unwarranted variation or trying to address variation in care delivery and particularly then the focus around nursing, midwifery and care staff, and this is very similar to	"…it's about joint up thinking, it's also about changing the organisational culture of the NHS, it's about giving local governments proper status within the changes because if one of the gaps that they want to address is health inequalities then they're clearly not going to do that by just providing better health care are they, they're going to have to engage and address social determinants of health as well as the issues of standards in health care." (Participant 16-P)

		also work being delivered by NHS Right Care…" (Participant 13-J)	
'Future – Where is this going?'	Enhancement, Not Additional Work	"…I think the Commitments about working in partnership with patients and their families and that whole element of co-production to ensure that whatever we are developing and promoting is ultimately informed and grounded with the patient experience and what the patient needs, and not in someone's job title or the hierarchy that currently exists…" (Participant 20-F)	"I don't think there's an excuse with Leading Change, Adding Value, but there's often an immediate push back from frontline particularly frontline staff around the anxieties of the demands and pressures that are exerted on most health and care staff I think working in the system at the moment and often feeling one of which there isn't any spare capacity to do anything else, and so I think again it's really important in the framing for Leading Change, Adding Value going forward about it not being seen as another ask, but actually it's about a way of working, or a methodology and a principle." (Participant 13-J)
	Culture Change	"…this is a really important framework because we are also focusing quite heavily on the workforce and how the whole health and care workforce that's not exclusive to nurses, or midwives, or care staff, but across the whole sector, so pharmacists, GP's, allied health professionals, local colleagues and various professional groups that work in the health and care system to expect about how do we extend improved knowledge that will allow them to embed improved prevention and protection in the health and wellbeing…" (Participant 13-J)	"…wherever you sit in an organisation or whatever role you fulfil we have a responsibility especially as registered nurses, not only to fulfil our nursing and midwifery council code of conduct that we are registered for, but to translate that into practice and to walk it, live it, talk it." (Participant 18-A)
	Leadership	"…if we're going to empower patients then we're going to have empower staff, I think people who don't feel that they are empowered as frontline staff are not going	"I think it needs to be driven within a collective leadership style out through the system and everybody should be able to contribute to the frame by meeting the

		to feel enabled to empower patients and carers…" (Participant 16-P)	ambitions of the framework in some way and that takes leadership from the top, through the providers, through the arm length bodies into the undergraduates at pre-registration level and so on so that it is truly integrated into the system." (Participant 8-I)
	Embedding LCAV	"…the way that the framework is also using evidence-based approach is, I think, it does mirror what we are trying to achieve in the NHS right care and learning disabilities programme." (Participant 10-Q)	"At the end of the 3 years I'd like to see it as business as usual, that we route out unwarranted variation, we use the framework to drive the transitional change and to bring about the outcomes that we're trying to deliver, it can't be right that we've a district nurse in London doing what we know to be very well researched evidence based leg ulcer management, somebody in Newcastle is doing it completely different" (Participant 4-S)
		"I think we've got a real opportunity, which I'm going to be exploring with a couple of our regions about whether we can do some joint work with one of the other organisations around looking at some quality improvement on capability-capacity development for staff in one of the regions, perhaps test that out." (Participant 3-T)	"…it's a very good framework, and I think we have to hold to it and use it in our communication, in our language, we have to make it part and parcel of the conversations that we're having, what I think would be fundamentally wrong, would be to sort of sweep this one away and bring in another policy document, or another policy framework to replace this, and again sadly I do think that if one looks back over the health and social care services landscape, we very often see that happening, before the policy has actually really had a chance to embed and start to drive change, because we politically and in media terms we're very impatient to see change, we don't give these things time to have that impact…"

			(Participant 20-F)
	Barriers to Embedding LCAV	"…it requires multi-professional work. Cross-professional boundary working. And so I think there's maybe a question, or a challenge to the evolution of Leading Change, Adding Value along with other strategies or programmes of work like NHS Right Care. And addressing what is clearly seen as a major aspiration is addressing that unwarranted variation. And we maybe just need to be mindful about the risks of it being seemed to be just professionally led by nurses and midwives than care staff." (Participant 13-J)	"I think one of the challenges is getting people to understand that it's got some relevance for them. So, you know, there are useful things in there which are about the workforce and about the values that underpin health and social care…" (Participant 19-E)

7 Discussion

The national LCAV framework has a clear policy context. It builds upon existing strategies such as 'Compassion in Practice' (Cummings and Bennett, 2012) and contributes to achieving the aims set out in the Five Year Forward View (NHS England, 2014). This has meant that rather than being viewed as a further change in ways of working it can be embraced as a progression and compliment to enhance work already ongoing. In this sense it can be seen as "Business as Usual". This is important given the workload pressures and staff shortages within the health and care sector and will aid engagement with LCAV. Service improvement could also be informed by involving those that are being cared for in reviewing the services. This would show how processes and improvements impact on the patient experience together with providing increased satisfaction and motivation to staff (Serrant, 2016).

The value of LCAV seems to extend, in part, from its use as a flexible framework that enables transformation and new ways of working rather than prescribing them. It is this flexibility which contributes to it being a driver of change in terms of sharing best practice. The emphasis on evidence to support best practice ensures it can bolster and sustain enhancements in practice in the face of competing financial and resource demands in line with the triple aim outcomes. However, it is important that staff have the knowledge and skills to be able to produce, record and evaluate this evidence as set out in the 10 Commitments. This provides clarity as to how unwarranted variation can be recognised and addressed in clinical practice across nursing, midwifery and the care sector.

In terms of disseminating the key messages of LCAV it is important to be able to illustrate its application and value to frontline staff. Indeed, it has been argued that for LCAV to have any impact on service delivery, patient care and staff morale, buy-in from nurses at all levels is essential (Blakemore, 2016). One of the key ways to do this is by using case studies to illustrate how LCAV has been used to encompass and enhance good practice. Frontline staff have been identified as key people to lead change and enhance patient care (Serrant, 2016). It is encouraged they can do this by addressing the triple aim outcomes and utilising the 10 Commitments when tackling unwarranted variation in practice.

This evaluation has enabled a rigorous assessment of the current status of LCAV in practice. Case Studies have been found as useful tools to share best practice around tackling unwarranted variation to frontline staff and have mapped onto the 10 Commitments showing a variety of ways groups of staff are working.

Qualitative interviews have enabled the evaluation team to gain insight into how LCAV is understood and perceived by strategic leads across health and care sectors. Using a 'Past', 'Present', 'Future' paradigm sub-themes emerged around how LCAV was built upon existing strategies. It is portrayed as enhancing rather than adding to workloads, which has contributed to how well-received it has been to date. A major positive of LCAV is its inclusiveness of the care sector, but also how it has been written for frontline staff to be the figureheads of leading change and adding value to patient care. Finally themes around how dissemination, impact, meaning of unwarranted variation in practice, and leadership of LCAV is viewed has provided examples of how to further embed LCAV as a culture.

Confirmation that LCAV has longevity beyond the 3 years would help further embed and foster commitment towards it. This is important from the 'top down' within strategic management leading the health and care sectors. Moreover, developing and harnessing leadership amongst frontline staff is central to LCAV. In doing so LCAV highlights the potential of nursing, midwifery and care staff to shape the future of care delivery. However, in order to meet this potential, investment in education is needed along with support to get the best value from their skills (RCN, 2016). The need for staff to feel included as drivers for change at a regional level or within their own areas of practice is imperative (Serrant, 2016).

One area that could be developed further as LCAV moves forward is that of engagement and inclusion, particularly with the care sector. The social care sector are represented within the LCAV Governance Board and helped co- develop: 'Leading Change, Adding Value: what it means for nurses and care staff working in social care' (NHS England, 2016g). However, sustained appreciation of the varied needs of the care workforce is essential to maintain its relevance for care staff as well as nursing and midwifery in acute and private care settings.

8 Limitations of the evaluation

Twenty interviews were performed as part of this evaluation. This was valuable as it gave an overview of LCAV from different perspectives. However, it must be recognised there are some limits to the generalisability of findings from twenty interviews. These twenty interviews were of participants who are already engaged strategically with LCAV and who have had knowledge and understanding of LCAV from its origin. Further background material supplied by NHS England, for example, case studies, dissemination event information and contextual information, mitigated the issues around generalisability and offered context wider than the strategic level. A further potential limitation was that the evaluation of year one was conducted only 8-9 months after its inception – which may have been premature, something on which multiple participants commented.

9 Conclusions of the year 1 evaluation

Understanding of LCAV: There is continued emphasis on the engagement of frontline staff across the health and social care sector with LCAV. In order to facilitate this engagement it would be useful to develop a shorter summary of the key points within LCAV in jargon-free language which would be easily understandable and accessible for frontline staff. Enhancing understanding of LCAV amongst frontline staff is important as it reinforces the principles within LCAV and demonstrates its value.

Frontline Staff Awareness: National events for frontline staff have been received positively. Future events should include more formal conferences, workshops, or webinars, but also more informal, networking opportunities at a local level. The ability of staff to access these events need to be considered in terms of time, location, and feasibility of attendance.

Good Practice Sharing: Examples of good practice sharing around the core principles of LCAV have so far been well-received by participants engaged in this evaluation as digestible illustrations of how to meet the triple aim outcomes. Future initiatives could include local and national awards, champions of LCAV, and scholarships.

"Spreading the Word": There is a need to continue to develop use of different modes of media to be able to increase access to information and raise awareness of LCAV. Social media and other digital formats have proved useful and should be sustained. Examples include further use of the #Lead2Add on Twitter and the development of the LCAV webpages.

LCAV Crossing Boundaries: Further work is required to ensure inclusion and engagement with social care staff. The current ethos that *"Everyone can lead change; no matter what their role and wherever they work"* has been welcomed and should be maintained for all nursing, midwifery and care staff; extending as well to their colleagues outside of these professions to tackle unwarranted variation across all sectors. Establishing networks of staff to engage and support one another could aid in sharing best practice, mutual support and promote working across traditional boundaries.

Making LCAV "Business as Usual": For frontline staff to be inspired to fully engage in LCAV principles, it requires strong, national, and identifiable leadership which is well communicated and publicised to nursing, midwifery and care staff. This provides opportunity to provide a clear vision of how LCAV can be embedded as "Business as Usual" in practice for Years 2 & 3.

Providing the 'Right Education': Aiming to create a culture of everyday leaders within nursing, midwifery and care staff. Further staff training and professional development is required to ensure that nursing, midwifery and care staff have the requisite skills and attributes needed to encourage alignment to the 10 Commitments.

10 References

Aitkenhead, S. (2017) Blog 2 March 2017. *Everyone can lead change, no matter what their role and where they work.* Available at https://www.england.nhs.uk/blog/susan-aitkenhead/ (date accessed 20th March 2017).

Beckford-Ball, J. and Evans, K. (2016) Leading change, adding value. *Journal of Clinical Nursing*. Vol 30. No 4. 10-12.

Blakemore, S. (2016) A more inclusive nursing strategy. *Nursing management.* Vol 23. No3. 5.

Brown, D. (2016) Do we really know how good we are? *Practice nursing*. Vol 27. No 7. 309.

Care England (2016) *Leading change, adding value.* Available at http://www.careengland.org.uk/leading-change-adding-value (date accessed 20th March 2017)

Cummings, J. & Bennett, V. (2012) *Compassion in Practice.* Available at http://www.england.nhs.uk/nursingvision/ (Accessed 12th January 2017).

Evans, N. (2016a) Leading change, adding value. *Nursing Children and Young People.* Vol 28. No 7. 11.

Evans, N. (2016b) Leading change, adding value. *Emergency Nurse*. Vol 4. No 24. 9.

Harrison, P. (2016) Leading change, adding value: implications for gastrointestinal nurses. *Gastrointistinal Nursing*. Vol 14. No 5. 45.

Kendall-Raynor, P. (2016) Compassion in Practice model lacked junior nurse buy-in. *Nursing Management*. Vol 23. No 3. 10-11.

Longhurst, C. (2016a) NHS England launches new framework to guide staff. *Nursing Management*. Vol 23. No 3. 7.

Longhurst, C. (2016b) Leadership and efficiency- chief nurses vision for better outcomes. *Nursing Standard*. Vol 30. No 39. 12-13.

Mann, A. (2016) Practice nurses key influencers in moving care in the right direction. *Practice Nursing.* Vol 27. No 8. 401.

NHS England (2014) *Five Year Forward View.* Available at https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf (Accessed 12th January 2017).

NHS England (2016a) *Leading Change, Adding Value*: *A framework for nursing, midwifery and care staff.* Available at https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-framework.pdf (Accessed 12th January 2017).

NHS England (2016b) Leading change, adding value*. British Journal of Healthcare Assistants*. Vol 10. No 6. 302-3-3

NHS England (2016c) NHS England: Leading change, adding value, Part 2. *British Journal of Healthcare Assistants.* Vol 10. No 8. 402-407

NHS England (2016d) NHS England: Leading change, adding value, Part 3. *British Journal of Healthcare Assistants*. Vol 10. No 9. 454-459

NHS England (2016e) Leading change, adding value: NHS England's commitments. *British Journal of Healthcare Assistants*. Vol 10. No 10. 502-505

NHS England (2016f) Leading change, adding value: NHS England's commitments and case studies. *British Journal of Healthcare Assistants*. Vol 10. No 11. 562-567.

NHS England (2016g) *Leading change, adding value: what it means for nurses and care staff working in social care*. Available at https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-what-it-means.pdf (date accessed 20th March 2017).

NHS England (2017a) Leading change, adding value: NHS England case studies 5-9. *British Journal of Healthcare Assistants.* Vol 11. No 1. 43-47.

Practice Nursing (2016) New Framework supports practice nurses to lead change. *Practice nursing.* Vol 27. No 6. 266.

Ritchie J., Spencer L., O'Connor W. (2003) Carrying out qualitative analysis. IN: Ritchie J., Lewis J. (eds.) *Qualitative research practice: a guide for social science students and researchers*. London, Sage Publications.

Royal College of Midwives (2016) *RCM welcomes new framework for nursing, midwifery and care staff.* Available at https://www.rcm.org.uk/news-views-and-analysis/news/rcm-welcomes-new-framework-for-nursing-midwifery-and-care-staff (date accessed 20th March 2017)

Royal College of Nursing (2016) *RCN welcomes the publication of NHS charter for nursing, midwifery and care staff.* Available at https://www.rcn.org.uk/news-and-events/news/new-framework-encourages-nursing-staff-to-lead-change (accessed 20th March 2017)

Scott, G. (2016) New framework should be given a fair chance. *Nursing Standard.* Vol 30. No 38. 3.

Serrant, L. (2016) *Compassion in Practice: Evidencing the impact.* Available at https://www.england.nhs.uk/wp-content/uploads/2016/05/cip-yr-3.pdf (date accessed 22nd March 2017).

Stephen-Haynes, J. (2016) Making change work. *British Journal of Nursing*. Vol 35. No 15. Tissue Viability Supplement. S3.