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**The impact of a coaching approach to improvement in an Acute NHS Hospital Trust:
a narrative evaluation of the Perform programme**

A Dissertation submitted for the award of Masters of Business Administration (MBA)

University of Wales, Trinity Saint David (UWTSD)



Declaration/Statements page

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed James Taylor..... (candidate)

Date 13th April 2020.....

STATEMENT 1

This work is the result of my own investigations, except where otherwise stated.

Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

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STATEMENT 2

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Executive Summary

Recent events such as Brexit and the covid-19 global pandemic have put the NHS firmly front and centre of a national conversation about its importance, capacity and role in British society. Recently the Prime Minister Boris Johnson has gone on record describing how his recovery from coronavirus was driven by the standard of treatment he received, being clear that without the high level of specialist care the outcome for him could have gone either way.

The NHS provides care for 55million people in the UK and is funded at 9.8% of GDP. There is rising annual demand and capacity is already constrained. The requirement to do more within its existing funding framework is a significant challenge for this important organisation. There is an opportunity to utilise systems from other industries to help improve efficiency and effectiveness in the NHS and consequently a rise in improvement initiatives has been observed. In parallel has been the growth in the use of coaching as a tool for workforce development.

Little is known about the impact of coaching and improvement approaches at an organisational level. This study evaluates a proprietary improvement system called 'Perform' using an inductive mixed-methods approach. This study investigated the impact of Perform on organisational outcomes in the healthcare sector using performance metrics and practitioner perspectives to give new insight.

Perform is felt to have had a positive impact on the performance of teams and at organisational level. While there are some issues around the reporting and monitoring of performance metrics there is enough evidence to encourage further monitoring of this programme in future. It is an important recommendation that Perform become both evidence-based and evidence-generating in order to understand its drivers and impact in the longer term.

When the approach is fully defined and success factors better understood there is an opportunity to deploy Perform across the organisation and more widely in the local NHS system. Published ROI for Perform is 1.74 leading to optimism for this programme. Future robust evaluation of Perform and similar interventions across the NHS will allow organisations to do more of what works, and less of what doesn't from an improvement perspective.

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Key abbreviations:

NBT – North Bristol NHS Trust

1 Introduction

Healthcare in the UK is provided universally and free at the point of access by the National Health Service (NHS), the largest publicly funded healthcare provider in the world (DH, 2015). The NHS is confronted with significant challenges and consequently there is much interest in approaches to help improve and transform the safety, quality, or effectiveness of services (NHS England, 2019). This introductory chapter will present a brief overview of the longstanding difficulties faced including rising demand and capacity constraints as well as a summary of improvement approaches and their efficacy in an NHS context.

It is widely accepted that global economic conditions since the early 2000's have been turbulent (Bennett & Lemoine, 2014); subsequently organisations may need to breakaway from established models and business patterns in order to thrive in what are considered increasingly volatile, uncertain, complex and ambiguous (VUCA) times (Millar, et al., 2018). This chapter will also pay particular reference to what the recent COVID-19 global pandemic, the climate emergency and Brexit mean for this important organisation.

Clearly the NHS has a challenging mandate, operating in a testing environment with significant demands on the service. VUCA conditions and recent major events have a considerable bearing on how the organisation operates (Preece & Hunter-Jones, 2018). There will be a brief presentation of why improvement and transformation is therefore an essential activity, as well as a review of what has been done to date from an improvement perspective. The aims, objectives, purpose and expected benefits of this investigation will be described in the section below and the chapter will conclude with the rationale for why this topic and study is important, what value it adds and for whom.

1.1 Purpose, aims and objectives

1.1.1 Purpose

This study critically evaluates the impact of improvement activities a large acute NHS hospital. The programme is delivered through a coaching approach and this study will review the performance of teams with a view to making recommendations for policy and practice.

Much of the evidence of impact in relation to coaching is from the perspective of the participant's personal development – for example to what extent their self-confidence improved (Athanasopoulou & Dopson, 2018). There is evidence in business of coaching improving performance and therefore belief that many benefits could transfer to a healthcare setting (Carey, et al., 2011). This study contributes to addressing an important gap in knowledge, and that is the extent to which coaching influences the performance of teams and organisational outcomes in the healthcare sector.

This study is of benefit to a wide range of stakeholders through advancing understanding of what works from an improvement perspective in the NHS. Evidence-based management can have many benefits including improved team and organisational performance, better staff experience and decision-making (Rousseau, 2006). The link between higher organisational performance and improved patient outcomes in the NHS is well observed (Lakhani, et al., 2005); patients commonly benefiting through reduced waiting times and enhanced safety and quality (Koning, et al., 2006).

The purpose of this study is to enable senior managers to achieve greater understanding of the impact improvement programmes have on key organisational outcomes. This understanding can inform evidence-based decision making which is linked with improved outcomes (Clarke, 1999). This study makes new evidence available that could support evidence-based management, thereby enhancing the decision making process, policy formation and improvement practice.

1.1.2 Stated research aim

To make an original contribution to knowledge *through* evaluating the Perform programme: a coaching approach to Improvement activities delivered in an Acute NHS Hospital in South West England.

The evaluation sets out to answer the following research question and uses mixed methods to understand benefits to the organisation.

1.1.2.1 Research question

What is the impact of using coaching as an approach to improvement in a large NHS hospital?

1.1.3 Objectives

The primary objectives of this study are:

- i. Evaluate the contribution made by the Perform programme to the performance of an NHS hospital
- ii. Critically review the literature pertinent to improvement in an NHS context
- iii. Gain insight into effective and non-effective improvement practice and drivers for these
- iv. Generate recommendations for future practice and policy decisions in relation to coaching and improvement in the NHS
- v. Make a contribution to the evidence base for coaching and improvement in a healthcare setting with a particular focus on organisational outcomes
- vi. Conduct the evaluation research with the requisite academic rigor and ethical approach

1.2 Background

1.2.1 NHS Context

1.2.1.1 Increasing demand and seasonal pressures

The NHS Long Term Plan describes a series of factors that place increasing demand on existing services including an aging population, higher patient acuity, population growth, growing patient expectation, and advances in medicine (thereby increasing the number of conditions, or treatment options open to patients) (NHS England, 2019). There is a steady upwards trajectory in demand for services such as routine operations, GP appointments and diagnostic testing which has taken the system close to maximum capacity (The Kings Fund, 2017), (The Health Foundation, 2019). In addition, the drive to improve patient outcomes by reducing waiting times, for example by offering rapid access to diagnostics for bowel cancer has put additional new requirements on the system that may not be sustainable in the current climate (MacLean, et al., 2020).

The NHS is organised into 3 tiers known commonly as primary, secondary and tertiary care, which provides access to GPs, dentists, pharmacists, hospitals, community services and highly specialised treatments, as well as urgent and emergency care for close to 55 million people in the UK (NHS Providers, n.d.). Growing demand has been documented 'systems-wide' with particular impact in emergency services and A&E departments where year on year rises are estimated to be at around 7% (Jones, 2017), (Iacobucci, 2017). Furthermore there is an annual surge in demand between October and February known as 'winter pressures' which requires hospital beds, GP appointments, and emergency care in particular (de Lusignan, et al., 2019), consequently many services are stretched to their limits and need fundamental change in order to remain viable (Iacobucci, 2019).

1.2.1.2 Capacity and funding

Funding of the NHS is a much contested debate and one at the centre of most election campaigns in UK politics of the last 30 years (Page, 2019). Many stakeholders and observers have lobbied for an end to austerity measures arguing that an annual 1.5% funding increase since 2010 amounts to a

squeeze (Unison, 2019), (The Nuffield Trust, 2019). A new funding deal that tied in with the 70th anniversary of the NHS was announced in 2019. This deal was cited by The Kings Fund as “welcome investment”, however they also reflected it as “not enough” to improve performance beyond current levels (2019).

The department for Health and Social Care budget for 2019/20 is c£140 billion of which just over £133 billion is revenue (day-to-day funding) and £7.1 billion capital (The Kings Fund, 2020). Despite calls for more investment there is robust rebuke from the government who argue that NHS funding has recently received a significant injection (3.3% higher in 2017 than 2016) which has contributed to an increase in the lifetime annual average (ONS, 2019). It is strongly argued using comparative data that the 9.8% of GDP spending on health compares positively with Italy, Spain and The Netherlands; although the source dataset also shows the UK some way behind France & Germany’s spending at 11.2% (OECD, 2020). It is likely that the government considers the deal agreed in 2019 an appropriate level of funding and therefore the NHS will have to cut its cloth accordingly.

1.2.1.3 Recent challenges and associated pressures

The Healthcare industry is particularly impacted by VUCA conditions (Billiones, 2019). The world economy has experienced a relatively turbulent period in the last 20 years (Naisbitt, et al., 2020), with the time since 2000 characterised by cycles of extraordinary growth punctuated by periods of economic implosion (Bajpai, 2020). Particularly notable events such as the dot.com bubble, 9/11, the financial crisis of 2007 and subsequent worldwide “great recession”, as well as European sovereign debt crisis demonstrating some of the economic volatility and challenging conditions and in which organisations are required to operate (O'Rourke, 2019).

1.2.1.3.1 Brexit

The UK officially left the European Union on 31st January 2020; however it isn’t until January 1st 2021 that new rules come into place governing the future relationship between the UK and EU (gov.uk, n.d). Subsequently there is still uncertainty on what ‘form of Brexit’ will take place in 2021 (Craig, 2020). Brexit is described as “bad for health” in all forms, but Fahy, et al. cite some as “worse than others” (p. 949). The uncertainty of what the world might look like in 2021 is particularly bad for the NHS with issues around workforce, medicines supply, legal frameworks, financing, and research and innovation being significant considerations (Fahy, et al., 2019).

1.2.1.3.2 Climate Emergency

There is a well-established link between weather conditions and demand for emergency services. Winter pressures or predictable peaks in demand associated with seasonal variation are a key part of NHS planning (Forchini, et al., 2020). More recently there is new understanding of how other factors associated with the climate emergency may be impacting services, such as wild variation in demand for particular specialties and demographics being driven by small temperate changes such as cardiac, respiratory, psychiatric, paediatric, and fractures (Cocuera Hotz & Hajat, 2020).

Not only is there significant risk in terms of growing annual exposure to usual winter pressures, but the impact of temperature extremes and major weather events year round requires services to be more prepared for the variation in requirements such as flooding, heat waves, and extreme cold and snow (Sangkharat, et al., 2020). Against this backdrop there is pressure for services themselves to become less generating of harmful carbons that drive climate change. It is estimated that healthcare is responsible for up to 10% of greenhouse gases (Wise, 2020), and so providers are being challenged to significantly change the way they deliver care in order to become more sustainable and ‘climate-smart’ (Linstadt, et al., 2020).

1.2.1.3.3 Communicable disease – the COVID-19 pandemic

Described as a situation unprecedented in modern times, a fundamental shift in the way the whole system works is required in order to ensure best preparations are made if it is to cope at the likely peak (Verhagen, et al., 2020). The ramifications of the outbreak are far reaching and every aspect of work in the NHS requires a rapid reorganisation in preparation for a surge of positive covid-19 patients described as imminent (Willan, et al., 2020), (Rodrigues, et al., 2020). There are immediate questions about how the system will cope during this outbreak and whether 'enough' was done, but also around how the NHS recovers from the pandemic and what it means for the future of the organisation and how it is used (Ashton, 2020).

1.2.2 The NHS Long term plan and the case for change

The challenges facing healthcare in the UK are widely recognised and the NHS Long Term Plan (LTP) sets out a series of bold strategies to improve and modernise the service systems wide (NHS England, 2019). The LTP is widely welcomed and praised for the scale of its ambition (The Health Foundation, 2019), (The Nuffield Trust, 2018), however some are cautious about the deliverability of the plan (Alderwick & Dixon, 2019) which is described by the (The Kings Fund) as a "daunting delivery challenge" (2019, p. 1).

The evidence is clear that massive change in the way the system operates has been required for a long time (Bamford & Daniel, 2005). Leading and delivering meaningful change and effective large scale transformation in the health service has proved to be very challenging (McIntosh & Layland, 2019), however this situation is not unique to the NHS. The popular management writings of John Kotter describe up to 80% of attempted changes as failing within the first year, thereby demonstrating that change and transformation is really difficult (Kotter, 1995).

Popular theory describes how a sense of urgency is required to instigate meaningful and impactful change (Connor, 1993), (Kotter, 1995), (Appelbaum, et al., 2012). This short background has outlined some of the key challenges facing the NHS including those that are both longstanding and more recent. It is the conclusion of this chapter given the circumstances described above that there is urgency necessary for whole-systems change.

1.2.3 Improvement methods and activities

Having presented the case for change in health and social care above this short section will describe briefly the types of activities and methods commonly used for improvement, change and transformation in the NHS. Given the massive literature on the subject the section below will serve as an introduction to the topic. A fuller and more focussed exploration of methods for and approaches to improvement will be carried out in the literature review in chapter 2.

1.2.3.1 QI – Quality Improvement, Lean and the Model for Improvement

Quality Improvement (QI) refers to efforts to improve safety, effectiveness and experience through systematic methods of design, test and implementation of small 'tests of change' (Jones, et al., 2019). Boland describes QI in healthcare as increasingly important, documenting the growth in recent years from the foundations of primarily one of two models: 1) The 'Lean' Model and 2) the 'Model for Improvement' (MFI) (2020). QI in healthcare is primarily a clinically driven activity with the most common approach being a distinct small-scale project delivered by a small team or individual usually from a clinical background (Powell, et al., 2009), (Robinson & Gelling, 2020). The most common model of delivery was felt to be MFI (or variants of) (Boland, 2020).

While QI remains popular there is contestedness about the effectiveness and impact of initiatives. Many studies report mainly positive impacts in at least some of their measures with most of these reporting moderate effects on outcomes (Schouten, et al., 2008). The overall picture is uncertain as

evidence is limited and there are therefore questions about the scalability and replicability of many projects. Emerging evidence suggests that QI can be a rewarding and engaging endeavour for many clinicians with obvious benefits for patients and staff and therefore QI is well placed to make a valuable contribution to the improvement goals of many NHS organisations (Mortimer, et al., 2018).

Lean methodology (or Lean six/sigma) is accepted practice in a number of industries and sectors and is increasing in popularity in healthcare (Mazzocato, et al., 2014). Whilst the opportunity for improvement through Lean methods is recognised, the evidence of its effectiveness in healthcare is felt by some to be somewhat limited (Lindsay, et al., 2019), and by others to be very promising (Bancroft, et al., 2018).

Individual studies describe a generally positive impact and adoption across a number of organisations appears to be wide-spread. However, many evaluations lack appropriate rigor and therefore the value of Lean interventions is not fully understood. More high quality research with a focus on outcomes and impact is needed to understand the extent to which Lean will influence improvements in healthcare (Woodnutt, 2018).

1.2.3.2 Conversational improvement approaches: coaching

Coaching is a conversational approach to personal, professional and organisational development (Parker, et al., 2008). The methods are often viewed as similar to counselling and mentoring, with coaching believed to be more grounded in business and commercial sectors, but increasingly recognised and adopted in medicine and education supervision (MacAfee, 2010). Coaching is felt to increase motivation and capability in the workforce and enable more effective teamwork, and is therefore considered to be a key vehicle for driving change and improvement in healthcare organisations (Bhatti & Viney, 2010). Subsequently many NHS organisations have invested in in-house capacity to deliver improvement through a coaching approach (Jones & Woodhead, 2015).

1.3 Rationale and conclusion

Why this topic is important:

The significant challenges facing the NHS and health & social care more widely we have been discussed as well as an argument presented for why improvement activities are important in shaping the way the organisation works. Coaching has been introduced as an approach to improvement and development. This study helps build knowledge about the impact of coaching and improvement and should enable evidence-based decision making about future improvement activities.

Who benefits:

This research will benefit a broad audience, directly helping managers, leaders and decision makers in the trust to understand what works, for whom, and how in terms of improvement. This may lead to a greater role for evidence in the decision-making process that has the potential to improve practice and policy in the organisation. As a result patients may receive safer, higher quality care. This contributes to both short term objectives and long term challenges of providing sustainable high quality healthcare.

This introductory chapter has outlined the challenges in health and social care as well as the opportunities for improvement. Approaches to improvement programmes such as coaching and the Lean and MFI business management systems have been introduced. The aims, objectives and research question were clearly stated and a rationale for the study provided above. In the following chapter a detailed critical examination of the pertinent literature will be presented followed by thorough description of the methodology used and findings, concluding with a discussion around the meaning and implications of this research in relation to current literature and practice.

2 Literature and theoretical background

2.1 Coaching

Coaching is a developmental tool that encourages coachee's to find solutions to goals through structured conversations; it is cited as one of the fastest growing professions in the world (Wright, 2005). Coaching is extensively reported in the literature and has a growing body of research dedicated to describing its benefits (Levenson, 2009). The consensus on tangible organisational outcomes is less clear. There is a lack of robust evaluation routinely embedded in coaching practice and measures of organisational achievement are less frequently reported than personal goal achievements (Phillips & Phillips, 2005).

Many of the evaluations focus on benefits for the coachee's personal development, for example improving coachee's self-efficacy, confidence and motivation (Leonard-Cross, 2010), (Parker-Wilkins, 2006), (Jones, et al., 2016); however they fail to link this to any organisational outcomes or describe a positive performance impact (Jones, et al., 2016). Phillips and Phillips (2005) acknowledge that data is not collected routinely, or with sufficient rigor as part of the coaching process, but contend that demonstrating return on investment (ROI) from executive coaching should be straight forwards and happen more frequently.

Some studies do make efforts to describe ROI, with figures of up to 689% reported in some cases (Parker-Wilkins, 2006). This could be considered a highly attractive return of close to \$3million from a \$19,000 outlay and represent a value for money investment (Dahling, et al., 2016). The evidence in relation to ROI in coaching is somewhat limited but promising and therefore further studies are required to gain a deeper understanding (Phillips & Phillips, 2005), (Boysen, et al., 2018).

Coaching, counselling, and mentoring are often described as similar activities and felt to be predominantly conversational approaches to development that share core skills (Garvey, 2004). The terms are often used interchangeably, however there are differences in purpose, where the expertise lies, the desired outcomes and time orientations (Hicks & McCracken, 2009), (Williams, 2009), (Cameron & Ebrahimi, 2014).

Similarly to mentoring, coaching can be conducted formally or informally and typically supports learners develop skills that can transfer to a range of work-based situations (Viney & McKimm, 2010). Counselling is usually considered to be a therapeutic intervention rather than an improvement activity (Garvey, 2004); and in a healthcare setting counselling is usually delivered by a certified professional in a formal setting. Therefore there are fundamental differences to coaching and mentoring in this sector (2004).

The potential for coaching to positively impact on human performance is well cited and when done well it is described as possibly "the most effective intervention designed for human performance" Gawande in (Smith & Smith, 2017, p. 53), (Knight, et al., 2015). This position supported extensively in the literature (Veale, 1996), (Richards, 2003) (Stevens Jr, 2005), (Mosca, et al., 2010). Not all coaching is therefore equal and it relies on many factors to make it work (Shermand & Freas, 2004). In some cases coaching done badly can make situations far worse than before (Berglas, 2002).

Successful coaching appears to rely on a number of factors including the skills and qualities of the coach (De Souza & Viney, 2014), the extent to which personalities match and therefore the quality of the coach/coachee relationship, and the self-efficacy of the coachee (Bandura & Adams, 1977), (de Haan, et al., 2013). This cluster of factors is described as the "winning conditions" of coaching, of which the extent of openness to change (receptivity) and commitment to change appear to be the most critical (Audet, et al., 2012, p. 527).

It is therefore apparent that the intrinsic motivation of the coachee is an important determinant in the likely success of a coaching relationship (Amorose, 2007). This link is well established and related to classical psychological studies about human motivation and behaviour change such as self-determination theory (SDT) (Deci & Ryan, 2000) and the Transtheoretical Model (TTM) (Prochaska & DiClemente, 1983). Coaching is an important enabler to developing autonomy in a coachee (Schiemann, et al., 2018), and their work finds that coachees have a higher satisfaction with the relationship where this is developed more. These important findings link with the body of research of SDT and the role in intrinsic motivation and are therefore important considerations for this study and coaching practice.

In addition to behavioural and relationship factors there are 4 structural elements to successful coaching which are felt to be: problem defining and goal setting, problem-solving processes, action and transformation, and outcome mechanisms (Carey, et al., 2011). Carey describes the role of coaching models as enabling more effective coaching practice – a view supported by (Redshaw, 2000), (Kilburg & Diedrich, 2007) among many. Good coaching goes beyond alchemy and the role of structure, tools and techniques and their appropriate application is key to development of the coachee (Peterson & Millier, 2007); therefore the role of reflexive evidence-based practice of the coach and the use of structure is important (Carey, et al., 2011). Doing coaching well can therefore be described as part art and part science (Nash & Collins, 2006)

Success in coaching and mentoring relationships can often be viewed by the extent that rapport was generated and the coachee's needs and goals understood (Wright, 2005), (Nash & Scammell, 2010a), (MacAfee, 2010). Some organisations are combining mentoring and coaching approaches which is felt to provide a more rounded experience less focussed on deficit (Sparrow, 2008). This position supported by research suggesting that participants felt the integrated approach to be more asset-focussed, and consequently a more positive experience for their development (Passmore, 2007), (Salter, 2015), (Jarvis, et al., 2017).

There is belief that integrated approaches can lead to failure in learning and development objectives and therefore be detrimental to the participant experience (Fletcher, 2007). Subsequently it is felt that activities should be clearly defined and situation specific (Ives, 2008). Arguments for development of a competency framework for coaching are well versed, however (Ferrari, 2004) contends that the position is impractical and ultimately unbeneficial due to the difficulties and complexity of mapping a competency-based approach. Girvin believes however that it is for the coachee to determine the benefit of participating for themselves and which approach they prefer (1999).

Coaching is widely thought to be effective in helping improve organisational effectiveness (McGovern, et al., 2001), (Wales, 2002), (Oghojafor, et al., 2012), (Grover & Furnham, 2016), with some believing it critical that organisations offer coaching, not only as a way of supporting leaders develop new styles, but of enabling teams and organisations to work in new ways and be more effective (Karsten, 2010). More robust empirical data would enable decisions to invest in coaching to move from assumptions of effectiveness and anecdotal feedback to more evidence-based decision making (Clutterbuck, 2008), (Hill, 2010).

A shift towards more evidence-based practice and rigorous recording and evaluation is needed if the true value and potential benefit of coaching is to be understood and experienced by organisations. An evidence base reliant on assumptions of effectiveness rather than robust empirical data is not sustainable and undermines efforts to professionalise the discipline and increase accessibility. There is therefore a risk that if more high-quality evidence is not available valuable developmental opportunities may be lost (Grant, 2010), (Leonard-Cross, 2010).

Increasingly coaching is used in healthcare settings to support and develop clinical teams, where aims focus on maximising personal learning, team growth, skills development, and improving safety (Nash & Scammell, 2010), (Badowski & Oosterhouse, 2017), (Pradarelli, et al., 2020), (Bell, et al., 2020). It is suggested this is in part due to the flexibility of being able to incorporate clinical practice development and learning into the everyday practice of nursing and medical professionals – regardless of their professional stage as well as being a relatively non-invasive developmental intervention (Nash & Scammell, 2010a), (Rueda, et al., 2011).

The Healthcare system is a fast paced setting and one that relies on the responsiveness, innovation, and resilience of its workforce in order to thrive (Naor & Bernardes, 2016). In the UK VUCA conditions provide significant challenges for healthcare providers (Levey & Levey, 2019), (Wankhade, et al., 2020). Political uncertainty around Brexit (Simpkin & Mossialos, 2017), (Costa-Font, 2017), the global climate emergency (Iacobucci, 2016), (Bancroft, et al., 2018), and most recently the covid-19 viral pneumonia outbreak combine for challenges unprecedented in scale and severity in modern times (Lillie, et al., 2020), (Sohrabi, et al., 2020). Access to developmental activities that can be deployed rapidly and easily transferred to other work based learning situations is therefore extremely beneficial for healthcare environments (Nash & Scammell, 2010) and never more relevant (McIntosh & Layland, 2019).

There has never been a greater need for improvement and change at pace. Existing practices focussing on incremental improvements in operational effectiveness won't be sufficient to meet with VUCA conditions and rapidly escalating demands (Porter, 2002). Significant changes in strategy and approach are needed to stay "in the game" (Mazzucato, 2002, p. 350) and more than ever the NHS will need to rely on the initiative, commitment, and innovation of its workforce to survive today's challenges and be prepared for tomorrow's (Maynard, et al., 2004), (Spilsbury, et al., 2011), (Choi, et al., 2016). There is therefore significant opportunity to develop the NHS workforce using coaching.

2.2 Lean

'Lean' is the umbrella term for a number of variants of improvement methods stemming from the car manufacturing industry and includes amongst others Lean Six Sigma, Lean methodology, Lean manufacturing and the Toyota Production System (TPS) (Melton, 2005). Lean is based on 5 key principles known collectively as 'Lean Thinking' and is essentially about improving productivity through eliminating waste and improving flow (Hall, 2004), (Campbell, 2009). Lean is acknowledged as the system that made Toyota the world's largest car manufacturing company and was first described in the 1990 book 'The Machine That Changed the World' (Womack, et al., 1990), although had been in practice in Japan since the early 1930's (Teich & Faddoul, 2013). Much of the success of TPS and Lean has been from a simplistic core of standardising work and developing workers capability for problem solving (Hall, 2004).

2.2.1 Impact in manufacturing and journey to healthcare

There is strong evidence that Lean has enabled many organisations to make significant operational and process improvements thereby improving overall performance and efficiency (Yang, et al., 2011), (Belekoukias, et al., 2014). The benefit in manufacturing with positive impact on inventory turnover, quality, waste, defects and product lead times all contributing to overall organisational performance improvement is also well documented (Demeter & Matyusz, 2011) (Taj & Morosan, 2011), (Albliwi, et al., 2015). Melton describes the opportunities presented by the Lean system as revolutionary and subsequently many industries are keen to adopt principles to aid them in achieving their organisational goals (2005).

Popularity of Lean outside of manufacturing is growing rapidly with the healthcare industry one of the leading adopters (Proudlove, et al., 2008). Lean in healthcare has been described as having enormous potential to help save lives, but writers acknowledge the adaptations needed to help transfer the success of the system from making cars into a healthcare setting (Fillingham, 2007). The rising popularity of Lean in healthcare can be associated with its great success in manufacturing and other process driven industries, the simplicity of its core principles (eliminating waste and improving processes) and their relevance to the challenges of the modern VUCA healthcare environment (Campbell, 2009).

Evidence of Lean interventions in healthcare is increasing rapidly (Henrique & Filho, 2020), but as Campbell and Fillingham state, it requires adapting to the healthcare environment in order to be effective, safe and sustainable (2007), (2009). The opportunities to use Lean to help improve processes and eliminate waste are clear and its rising popularity therefore unsurprising (Teich & Faddoul, 2013). Lean works in manufacturing but cannot simply be plonked into a hospital and left unattended with the expectation of the same results in healthcare (Drotz & Poksinska, 2014). Lean is not the panacea for all the difficulties in modern healthcare but an important contributor to improvement necessary to meet these difficult challenges (D'Andreamatteo, et al., 2015).

2.3 Model for improvement (MFI)

The MFI is a proprietary system for improvement developed and owned by Associates in Process Improvement (API) and is widely adopted in healthcare (API, n.d.). It is the preferred framework of the Institute for Healthcare Improvement (IHI) for supporting organisations accelerate their improvement activities (IHI, n.d.). It brings together two fundamental elements into a single simple system: the PDSA cycle, and the “three questions” which are described below in brief detail (Langley, et al., 2009, p. 24).

2.3.1 Three Questions and the principles of improvement

All changes do not lead to improvement but all improvements require change.
(IHI, n.d.)

Langley describes 5 fundamental principles of improvement that influence three questions summarised in the table below:

5 principles of improvement (Langley, et al., 2009, p. 15)	Three fundamental questions of improvement (Langley, et al., 2009, p. 24)
1) Know why you need to improve 2) Have a way to tell if the improvement is happening 3) Develop an effective change that will result in an improvement 4) Test changes well before trying to implement 5) Know when and how to make the change permanent	• What are we trying to accomplish? • How will we know that a change is an improvement? • What changes can we make that will result in improvement?

Table 1 - Summary of the 'Three questions' adapted from Langley et al

The purpose of the questions is to guide improvement work and although presented (and sometimes described) sequentially they can be addressed in any order (Langley, et al., 2009). The questions work by guiding managerial process and can be effective in helping give more definition to assignments and tasks; and therefore their usefulness is not limited to improvement efforts but can be applied effectively in everyday work (Crowl, et al., 2015).

2.3.2 Plan – Do – Study – Act: the PDSA cycle

PDSA (sometimes also referred to as 'PDCA': Plan–Do–Check–Act) was heavily influenced by improvement science from the early 1950's and went through several evolutions before Deming published his 1993 cycle that went on to become one of the most popular models in change management and improvement disciplines (Cleary, 1995), (Moen & Norman, 2006), (Taylor, et al., 2014). Its application in healthcare environments has been widely reported and several systematic reviews of impact report significant improvement in healthcare outcomes (Christoff & Pharm, 2018)

As with Lean, there is enthusiasm and energy for the potential of tools successful in other industries to apply in a healthcare setting and return similar benefits (Melton, 2005). There is encouraging evidence of positive impact of PDSA in improving outcomes in healthcare including reduction in surgical infection rates, improved efficiency in primary, secondary and specialist care, and systems-wide improvements in operational effectiveness and efficiency (Nicolay, et al., 2011), (Donnelly & Kirk, 2015), (Leis & Shojania, 2017), (Knudsen, et al., 2019).

Similarly once again to Lean there should be some caution here. There is likely to be weakness in the evidence base due to a number of methodological issues briefly described below:

- **Positive bias.** Projects with positive findings are more likely to be reported than those with neutral or negative findings; therefore impacts and benefits of interventions are at risk of being overestimated (Bamberger, 2009). In one study of 120 QI projects, 98% reported positive outcomes (Knudsen, et al., 2019) and 27% achieved their original stated quantitative aim. There is therefore risk of positive bias in the evidence base for QI.
- **Oversimplification.** Failure to invest in rigorous evaluation has led to oversimplification of the approach and information being lost (Reed & Card, 2016). This is consistent with findings of later studies where key methodological features are present in only 4% of studies (Knudsen, et al., 2019). Both writers are concerned about the veracity in intervention and evaluation.
- **Lack of methodological rigor.** Nicolay, et al identified 1595 published articles in their study of QI interventions; however only 1 methodologically sound randomised controlled trial (RCT) was conducted (2011). Low methodological rigor was observed in Knudsen, et al study also (2019). The evidence base is therefore considered to be sub-optimal at this point (Nicolay, et al., 2011).

Use of MFI as a tool for QI is widespread in the NHS and other healthcare organisations. It is reported in a broad range of settings with clinical, process and systems impacts positively described across a number of specialties and conditions (Taylor, et al., 2014). There is evidence of clinical impact across mental health services including both at micro-level and macro-level and inpatient and outpatient settings, for example increased adherence to screening for involuntary movements thereby improving patient outcomes (Singh, et al., 2013), (Boland, 2020). Improvements in patient care outcomes in highly specialised services such as intensive care and paediatric nephrology are also widely reported (Mascarenhas, et al., 2018), (Gaudreault-Tremblay, et al., 2019).

2.4 Perform

'Perform' is a proprietary operational management methodology of Pricewaterhouse Cooper (PwC) that claims productivity improvements of between 15-25% within 12 weeks through building capability in leadership and management tiers (PwC.au, n.d.). Relatively little academic research is published on the impact of Perform and a pseudo-systematic review conducted as part of this literature review found no peer-reviewed studies or published evaluations. There is therefore a gap in the empirical understanding of the impact of Perform.

Perform is described by several similar but differing terms in its own marketing material therefore existing simultaneously as an approach, a methodology, a system, a management system, a model and a 'way of working' (PwC.au, n.d.), (PwC.nz, n.d.), (PwC.pl, n.d.), (PwC.uk, n.d.), and consequently could be considered to have something of a crisis of identity.

2.4.1 Evidence base and impact

PwC are confident of Perform's efficacy and quote a number of figures in their material about possible operational improvements, however often fail to make source data available for scrutiny. The figures published are presented in rounded numbers with a wide and varying range and therefore understanding likely impact or the validity of the data is difficult (Cole, 2015). This practice would breach a number of guidelines for reporting in peer review journals and limits the power of this data in comparison to that which has been peer reviewed (Lang & Altman, 2013).

Claim of impact	Duration	Location	Reference
"releases capacity of between 20-30%, while also increasing staff engagement"	12 weeks	New Zealand	(PwC.nz, n.d.)
"15% – 25% productivity improvement"	9 weeks	Australia	(PwC.au, n.d.)
">100% improvement in management time spent on 'value-adding' tasks"	16 weeks	Poland	(PwC.pl, n.d.)
'typical results' from "a large hospital"	unstated	UK	(PwC.nz, n.d.)

Table 2 - Summary of stated impact of Perform, collated from various PwC sources

There are strong headline claims of improvement and impact in healthcare settings; however deeper analysis leaves some questions unanswered. Let us review the claims of theatre utilisation for example:

'Theatre Utilisation' is broadly defined as the proportion of available time that was put to use in performing procedures and is usually measured in minutes (Nadig & Kamaly-Asl, 2017). The nationally accepted standard of efficiency for operating theatres is 84% (Audit Commission, 2003). Many factors influence utilisation and this can be down to starting late, finishing early or delays between cases. Case mix, surgeons' skills and technical factors all play a role in determining productivity (Nadig & Kamaly-Asl, 2017).

Theme	Improvement claim	
Theatre Capacity	28% reduction in costs	A Large Hospital Theatre and Ward Flow Efficiency Large scale transformation to improve operation and financial performance, whilst delivering quality care Location: UK The challenge A globally renowned hospital which is one of the UK's largest teaching hospitals was faced with a number of clinical, operational and financial difficulties. PwC supported a transformation to improve its short term financial and operational performance, with a particular focus on delivering quality working alongside PwC teams from Business Recovery and Strategy. Consulting focused on the Theatre Turnaround Programme and the Ward Flow Efficiency Programme. Our approach PwC worked across surgical and medical pathways. In theatres, they worked collaboratively to deliver interventions across the surgical pathway, and across the rest of the hospital. They supported the organisation across bed management, acute surgical and medical wards, specialty wards and discharge co-ordination to address operational difficulties. Interventions included: - Operational rhythm: Daily operational meetingboard rounds to review performance, ensure prioritised patient planning, time action and ensure a problem solving mind set helped to drive the introduction of standard aspect of working. - Planning & Capacity Management: On the wards, better planning and visibility of capacity and discharges were put in place. In theatres visual scheduling boards were developed to help plan for the next 2 weeks of day surgery, maximise theatre utilisation and increase accountability amongst clinicians, service managers and admission clerks. "It's the start of a brand new dawn here. It's perfect!" - Consultant, Surgery THEATRE CAPACITY 28% reduction in costs THEATRE UTILISATION 25% of leaders' time now spent on activities that drive performance PATIENT CARE 50% reduction in on-the-day surgery cancellations DISCHARGES 40% increase in planned discharge accuracy
Theatre Utilisation	25% of leaders' time now spent on activities that drive performance	
Patient care	50% reduction in on-the-day surgery cancellations	
Discharges	40% increase in planned discharge accuracy	

Table 3 - Summary of Perform impact in healthcare - adapted from PwC New Zealand

(PwC.nz, n.d.)

The headline statement of "theatre utilisation 25%" would seem to suggest an increase in theatre utilisation of 25% - hypothetically a move from 70% efficiency to 87.5% efficiency. The qualifying statement of "25% of leaders' time now spent on activities that drive performance" is confounding. This does not tell us a number of things: How much time were they spending before? How effective are they with that time now? Does this additional time drive any outcomes? Do these outcomes represent an improvement and for who?

The data presented relies on assumptions of improvement but could represent a department where their productivity has decreased, but only the manager's activity is reported so therefore it is impossible to say whether Perform can impact positively on theatre utilisation. Similar questions can be asked in relation to the 58% increase in patient throughput at 'a large hospital' (PwC.nz, 2017) - Who are the patients and in what departments? What was the baseline and how does this compare to expected levels?

Significant emphasis is put on the sustainability of Perform in the marketing material (PwC.au, n.d.), however there is no follow-up data presented, and therefore the evidence in relation to Perform's effectiveness and sustainability is limited. High quality evaluation would benefit understanding of this system.

2.4.2 How is Perform delivered?

Perform is described as a series of 10 operational elements that are delivered to teams sequentially with each element building on the last. The system is presented in a model known as the Perform 'wheel' which represents an integrated and powerful tool for improvement (PwC.nz, n.d.). Delivered to teams through a "coaching approach" where PwC practitioners would define the new way of working and make sure this becomes business-as-usual. This is described as "a tried and tested approach that delivers benefits through both behavioural change and process improvement" and is "far more effective than any other solution in the market" (PwC.nz, n.d.).

Although described as a series of 10 elements sequentially building on each other in a weekly cycle (PwC.ca, n.d.), there appears to be variation in how the elements are presented and in what order one should rotate the Perform 'wheel' (see table 4). For example, presented below are 4 variants of the wheel. If the wheel were to start with 'vision' as element 1 there appears to be conflict about which element should occupy the 5th slot – standards & confirmation, problem solving, planning and control, or routines and practices? This variation in order as well as absence of intuitive flow to the system appears to undermine attempts to present the Perform Wheel as a robust model or framework for improvement (Abend, 2008), and therefore more work needs to be done to understand which model is the most effective system for healthcare improvement.

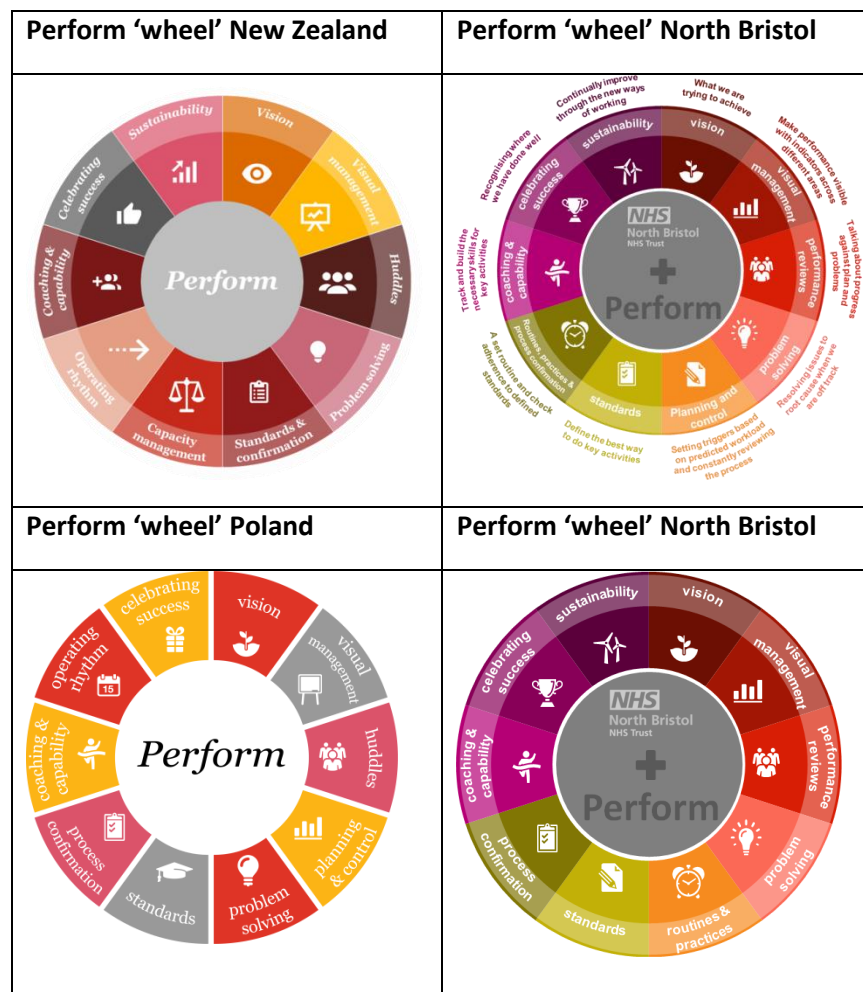


Table 4 - comparison of 4 Perform 'wheels' obtained from web sources

2.5 Conclusion

There is great potential in Lean, MFI and coaching as tools and approaches for improvement in the NHS and some evidence to support their effectiveness. However issues around methodological rigor and positivity bias in evaluation means that we don't have the full picture. Proprietary models such as Perform are becoming popular but as yet lack robust critical evaluation and so their effectiveness relies on anecdote and perception rather than robust empirical data. Initial anecdotal data appears promising, however there is a clear need for rigor and routine high-quality evaluation if the value of activities is to be understood and decision makers able to make evidence-based decisions. As described by Nicolay, et al, there is some work to do to "bring evidence-based management into the same league as evidence-based medicine" (2011, p. 324).

3 Methodology

The need for transparency, detail, and clarity in terms of position, approach and methods to research is well documented in literature and is considered a central tenant of social inquiry (Bryman, 2008). This chapter will state the philosophical position, research approach, and research strategy for this Master's thesis providing also a critical discussion of the literature pertinent to each subsection. The rationale in relation to choices made and positions taken during this evaluation research piece will be stated throughout.

3.1 Introduction and background

Traditionally, research paradigms (that is approaches to, and philosophies of) have been considered to live in different houses, with positions and perspectives deeply entrenched and never to mix without compromising the perceived quality and validity of study (Saunders, et al., 2007), (Slevitch, 2011). There is growing acceptance of alternative approaches to epistemological and ontological positions such as pluralism and pragmatism (Healy, 2003), (Burke-Johnson & Onwuegbuzie, 2004).

Furthermore there is increasing awareness of the need for alternative study designs which help bridge the gap between theory and practice, allowing evidence of what is effective and in what circumstances to be considered in order to enhance the decision making process (Murtagh, et al., 2007), (Khalil, et al., 2012). This study will present an evaluation research piece using mixed methods to investigate any organisational impact associated with coaching and improvement activities, but also to explore more deeply perceptions of the programme from a range of stakeholders (Steckler, et al., 1992), (Burke-Johnson & Onwuegbuzie, 2004), (Hammarberg, et al., 2016).

3.2 Research Paradigms

Paradigms are described as a philosophical way of thinking and in research this statement of position is known as the 'research paradigm'. The term 'paradigm' is felt to communicate a set of common assumptions and orientations shared by members of a research community (Given, 2008), and research paradigms therefore describe the perspectives, school of thought and beliefs that influence the researcher. The research paradigm defines the nature of inquiry and will guide researchers of the methods and design most appropriately suited to their investigations (Kivunja & Kuyini, 2017).

A research paradigm will commonly contain 4 components: ontology, epistemology, methodology and methods that should be clearly identified and stated in order to inform the consumers of the research as to the philosophical positions of the research or "how the knowledge was attained" (Rehman & Alharthi, 2016, p. 51). This transparency enables fuller appraisal of the study, allowing readers to make judgements on the appropriateness of design and methods of the research for themselves, as well as being a marker of higher quality scientific research (Martensson, et al., 2016).

3.2.1 Ontological position

Ontology is a philosophy of the assumptions made about reality and existence. It is the branch of philosophy that helps us make sense of reality, asking us whether phenomena exists and is observable to others, or is a construction in our own minds and a result of our own thoughts, biases, and ideas (Bryman, 2008), (Kivunja & Kuyini, 2017). This research piece will adopt a primarily constructionist position, seeking to understand the perspectives of participants, sponsors, and practitioners allowing a 'generation of theory' – or greater understanding of the perceived value of coaching and improvement in relation to their individual, team, and organisational goals (Bryman, 2008).

3.2.2 Epistemological position

Much like Ontology, Epistemology relates to our understanding of truths (Rehman & Alharthi, 2016), however Epistemology is distinct from Ontology in that it helps us articulate “how we know what we know” (Blair & Robertson, 2005, p. 269). Kivunja & Kuyini refer to 4 sources of knowledge: intuitive, authoritative, logical, and empirical knowledge, which describes the forms researchers rely on during their investigations (2017). Primarily this research will take a position of empirical epistemology which favours understanding of experience and sensing, however in the next subsection we will review a growing movement towards pluralism in Ontology and Epistemology and what this means for the methodological approach of this evaluation.

3.2.3 Pluralism

Qualitative and quantitative research methods are considered by some to be from opposing paradigms (Bryman, 2008), however they are both important and useful methods of inquiry – a belief central to the principles of pragmatism which aims to “draw on the strengths of each approach and minimise the weaknesses” (Burke Johnson & Onwuegbuzie, 2004, p. 15). This study will adopt a pragmatic position and inductive reasoning, seeking to draw on the strengths of each method of inquiry as described above.

Pluralism has been criticised for encouraging ‘poor science’ by promoting subjectivism and a lack of standards, thereby lowering overall quality of research (Patomaki & Wight, 2000). Indeed Glauco also believes that the duality of mixing methods distances each methodology from their original intended goals, thereby reducing quality (2015). Other writers such as Pawson, for example, have adopted a more measured approach describing how even in studies that appear methodologically weak there can be good evidence and so whilst academic rigor is important, the most important quality is transparency (2006).

3.3 Research Design

Research design is often described as the overall structure for research as opposed to just a statement of methods and procedures used to collect and analyse data (Marczyk, et al., 2005). The research design forms a strategy or plan of work that helps detail how the differing parts of the research piece will come together in well-structured and coherent manner, enabling researchers to more effectively state how they will investigate their chosen research topic (Bryman, 2008).

The nature of the research topic will form the basis of the research designs most appropriate to use, and several writers have cautioned against using research design to drive or influence the research topic (De Vaus, 2001), (6 & Bellamy, 2012). Bryman describes 5 types of research design which can use qualitative or quantitative methods: experimental, cross-sectional, longitudinal, case study and comparative (2008). Although further investigation shows the above list doesn’t appear to be exhaustive (Marczyk, et al., 2005).

3.3.1 Evaluation research

Evaluation research is concerned with the systematic collection and analysis of empirical data judging the achievements and effectiveness of programmes and interventions (Patton, 1990). It is increasingly common in healthcare and social sciences research and primarily focussed on generating understanding of the outcomes of a policy or programme, but may also be used to investigate the validity of a new approach or treatment (Maudlin, 2020). It is part of a move since the late 1990’s for social sciences and public bodies to be more explicit about the effectiveness of their work, but also aligns with a medical model of reporting that focusses on evidence-based practice and accountability (McQueen, 2001).

Evaluation research shares many similarities with other forms of social research. Indeed according to Clarke, evaluation research involves the application of the techniques and methods of data collection and analysis used in social research (1999). It is only differentiated from other research designs by its purpose; primarily being “conducted to determine value or impact of a policy, programme, practice, intervention, or service with a view to making recommendations for change” and therefore being considered predominantly action orientated (Clarke, 1999, p. vi).

The growing need for evidence-based practice in public sector organisations is increasingly acknowledged in literature due to its potential to support and improve practice and the decision making process – be it from clinical or management perspectives (Profetto-McGrath, 2005), (APA, 2006), (Baldwin, et al., 2016). Public organisations rely on key stakeholders for important decisions including commissioning intentions and Clarke cites 3 main factors that influence decision making process: the values of decision makers, resources available, and evidence of good and effective practice (2001).

Accountability in public sector organisations is important and there is rightful expectation from stakeholders that resources are used well – in the right ways, and on the right things (Davies, et al., 2000), (Aarons, et al., 2009). Although it may be assumed evidence plays a key role in decision making Clarke observes that in practice in public sector organisations it is primarily values & resource driven and subsequently is predominantly “opinion-based” (2001, p. 4). Data is clearly important in the decision making process; and there is therefore debate as to whether without due consideration of data there can be confidence resources are being allocated in the right way (Williams, et al., 2008).

In spite of the broad consensus supporting the need for robust evaluation, many researchers continue to observe a lack of evidence of high-quality evaluation being routinely undertaken – particularly in healthcare improvement and coaching practice (Clutterbuck, 2008), (Hill, 2010). This may be a primary driver for opinion-based decision making and therefore there is a critical need for effective evaluation of performance to enable evidence to play a greater role in decision making (Wimbush & Watson, 2000). It could be argued that due to the absence of robust evidence required to support decision making this drives decision makers towards opinion-based decisions

This study will use Evaluation research design as the most appropriate strategy to investigate the chosen research topic. This design helps gain understanding of the effectiveness of the programme and therefore will challenge an unmet need in relation to evidencing the impact of coaching and organisational performance. The methodology best enables the senior decision makers in the Trust to understand the impact of the programme, assign a value to the outcomes, and enable a decision in regards to future commissioning intentions to be made using evidence as well as their values and beliefs, and judgements around resources (Clarke, 2001), (Bryman, 2008).

3.4 Methods

There is much discussion about what makes ‘good science’. Some distinct themes emerge around the requirement for clear description of methods and materials as well detail around procedures and protocols enabling the study to be reproduced (Bryman, 2008). Repeatability is an important a criteria considered essential in good science (Risch & Krestel, 2019). Detail of methods is critical for researchers to demonstrate in order to produce research viewed as credible (Creswell & Miller, 2000).

Mohajan believes reliability and validity are the foundations of good research and key in promoting trustworthiness in the data, and in their view the methods should allow us to reproduce the study with consistent, stable and reliable results (2017). Practically speaking the methods should be clearly

described and materials required detailed, as well as a enough details so that other researchers could replicate the study with similar results (Gupta, 2018).

The following subsection provides detail of the methods of data collection and analysis used as well as sharing the methods for sampling. A discussion of ethical considerations followed by a brief critique of the limitations and strengths of this study design will conclude the chapter.

3.4.1 Qualitative component

3.4.1.1 Sampling and data collection methods

Participants will be selected for participation using purposive sampling – a form of non-probability sampling that allows collection of cases that will inform the researcher most about the intervention being reviewed (Etikan, et al., 2016). Purposive population samples (and qualitative studies more widely) suffer criticism that results may not be generalisable as they are not necessarily representative of whole populations (Higginbottom, 2004), (Schreier & Flick, 2017); however investigation of critical cases will give light to experiences that might be typical for specific populations (Palinkas, et al., 2015), and therefore provide useful insight into future applications of the research subject intervention.

Aligning sampling methods that best fit with the goals of the study is an important step of the qualitative research process (Bryman, 2008). Better understanding the experiences of the Multi-Disciplinary Team (MDT) in relation to coaching and improvement methodology, and the factors associated with success or not from participants' perspective is an important goal of this research. The evaluation seeks to explore the efficacy of coaching and ward-based improvement initiatives with an aim of understanding 'what works' from an MDT perspective, with a view to helping organisations and teams share best practice; therefore a strategic approach to sampling is considered valid.

The evaluation seeks to understand participants lived experience and the subsequent impact of the coaching and improvement initiatives, therefore in-depth interviews are considered to be the best method of capturing rich data in a small number of participants (Gill, et al., 2008), (Khan, 2014), (Thanh & Thanh, 2015). Highly structured interviews and questionnaires can result in unexplored perspectives of the participants and can be limited by the views of the researcher and therefore prone to bias, whilst unstructured interviews are considered to lack some methodological rigor (Peters & Halcomb, 2014); therefore, a semi-structured approach is considered most effective (Adams, 2015), (Pathak & Intratat, 2016), (Kallio, et al., 2016).

A convenience sample of 5 participants from the programme delivery team was selected and the researcher gained written informed consent (which detailed their right to withdraw at any stage). Interviews were recorded and transcribed using Otter digital recording software with full texts reviewed and analysed using the framework described below. Each participant has the right to access the audio recording, transcription, and interviewers field notes which were be made available from the date of collection.

3.4.1.2 Quantitative

Exploring the performance impact of the intervention will require statistical analysis of data collected from ward teams. The original strategy sought for key data pertinent to the teams business to be extracted from relevant sources including the hospital patient administration system (PAS), ward teams KPI boards, and anonymised and imported to MS excel subsequently being analysed in SPSS with tests for statistical significance. Owing to constraints related to covid-19 a pragmatic sample of quantitative data was obtained for triangulation purposes. This evaluation is observational and therefore will evaluate data already existing that is considered to be impactful for inpatient

ward teams in the hospital. No new quantitative or experimental data was collected for this study. This data serves to triangulate with the qualitative data.

3.4.2 Data analysis

3.4.2.1 Thematic analysis

Thematic Analysis is a method of identifying patterns or themes in qualitative data that helps researchers understand & explain phenomena. It shares principles and ideas with methods that are often viewed as more complex such as Grounded Theory (Glaser & Strauss, 1967) and Content Analysis (Berelson, 1952), but has found increasing favour in the last 15 years owing to its flexibility and perceived accessibility, as well as the growing view of its worth since Braun & Clarke's proposal of a 6 step framework in (2006).

Thematic Analysis is subsequently one of the most popular approaches to qualitative data analysis (Bryman, 2008) with some strong arguments to support its value in mixed methods research (Moore, et al., 2015), (Clarke, et al., 2015), and evaluation research (Patton, 1990). Using Thematic Analysis in this evaluation research piece and adopting Braun & Clarke's 6 step model (2006) will help identify interesting or significant findings from the data, using recurring motifs in the participants' perspectives to enable the categorisation (or organisation) of data into subthemes and emergent themes (Maguire & Delahunt, 2017).

The purpose of quantitative data analysis in this evaluation research study is to explore likelihood of a relationship between hospital performance and an investment in coaching for specific teams. This is not looking for causality, but looking for patterns or trends in performance and understanding to what extent performance differs from what was expected. In larger datasets statistical testing can tell us whether findings are likely to be spurious or not (Bryman, 2008). No statistical testing was applied to findings as the dataset was very small and only used for triangulation purposes.

3.5 Ethical considerations

The UK research community has made great efforts to improve the quality, rigor, and integrity of academic research undertaken in the UK. In 2011 the representative body of UK Universities published a concordat agreement outlining 5 high-level commitments member organisations signed up to in order to ensure that the rigor of academic research in the UK is considered beyond reproach (Universities UK, 2011).

An underpinning principle of the agreement is the duty of all conducting research to consider how "the work they undertake, host or support impacts on the research community and on wider society" (Universities UK, 2012). Benefits of this rigorous approach to research integrity are demonstrated by a recent Research Excellence Framework (REF) review citing 76% of submitted works as world-leading or internationally excellent (Universities UK, 2019). The concordat was revised in 2019 with further signatories committing to the refreshed standards (UKRI, 2019).

It is a requirement of all research conducted in collaboration with or under the auspices of the University of Wales Trinity St David's to comply with requirements outlined in the concordat (2012) and for each investigation to demonstrate careful consideration of the ethical implications of the study (UWTSD, 2017). This research piece will be conducted in line with its obligations under this agreement.

Research involving qualitative methodologies further describes ethical considerations and risks to participants which include distress, misrepresentation, and identification (Richards & Schwartz, 2002), (Ponterotto, 2010). Reflecting on the ethical issues and applying appropriate strategies (such as gaining informed consent prior to participation) are part of a rigorous research process (Byrne,

2001) as well as the submission of a detailed application to the university Research Ethics Committee (REC) prior to commencing the project (UWTSD, 2017).

There is consensus that 'good science' will carefully contemplate the ethical considerations brought about by any research piece and abide by any requirements and practices throughout the duration of the project (Sanjari, et al., 2014), (Arifin, 2018). Not all studies will require approval from a research ethics committee prior to commencing; however it is an expectation that they will make a statement about any potential issues from an ethical standpoint (Health Research Authority, 2017). In the NHS it is the position of the National Research Ethics Service (NRES) that evaluation research is classified similarly as service evaluation and is therefore not required for submission to an NHS REC.

Although REC submission is not required in evaluation research it is a decision of the author to commit to ethical standards in this piece. It could be argued that committing to standards of ethical research even though approval is not required is a strength of this work and demonstrates how the important methodological principles described in this chapter such as transparency are applied in practice to enhance the overall quality and credibility of this piece. Below outlines the steps taken in this study to address important ethical concerns during this evaluation research:

- obtaining prior written informed consent and being clear that participation is voluntary with option at any point for the participant to withdraw their consent without challenge
- ensuring anonymity and confidentiality by using particular strategies throughout the collection, analysis and reporting
- obtaining ethical approval from the appropriate UWTSD office prior to starting the project
- compliance with obligations of data protection and GDPR regulations

This chapter has described in detail considerations for research methodology and a critical review of the relevant literature. The choices and positions adopted are stated explicitly and a rationale for each is provided and so any decisions considered subjective can be reviewed in context with full disclosure from the author. It is argued that this detailed description of methods provides the roadmap required should future researchers wish to replicate this study (Marczyk, et al., 2005), (Bryman, 2008), (Gupta, 2018). Subsequent sections will present the findings followed by a detailed discussion of the results with implications for practice also reviewed.

4 Findings

4.1 Presentation of results

Perform was perceived to have a number of benefits to the organisation including the development of staff, therefore bringing new capability to the organisation. Some changes in relation to performance outcomes were also observed and will be described throughout the results section. Investigating the perspectives of key stakeholders including coaches and coachees in relation to benefits of the programme adds value by giving a rich understanding of how the programme is experienced within the organisation, and therefore gives insight into some of the more intangible benefits of the programme.

Also reviewed were a range of internal sources such as 'visual management boards', QlikSense dashboard, PowerPoint presentations to the steering group and 'sprint' documentation including any write-ups or summaries. NBT is happy for headline data to be reported on in this paper however does not consent to any contractually sensitive information being documented or source data appearing in the appendices, therefore this section will comment on the findings using field notes of the researchers observations as triangulation.

4.2 Delivery of Perform

Perform is delivered utilising both an interventionist project approach (known as 'sprints') and an open access simulation based training session (known as 'bootcamp'). Perform sprints usually occur as part of a planned programme approach and many of the clinical areas of the hospital has experienced a sprint.

My team, most of them have said, what is really important from the boot camp, what they've learnt, is how we upskill people. (Matron, Neuro & Stroke)

There are ten elements, we roll out one a week, starts with vision and then moves on to visual management and performance reviews, which is where teams come together to track their performance, and talk about what could be improved and then try and solve it together, and I think it's really that's improved. So, actually we are getting people talking about how they are performing as a team and people really understanding what their role is, and how it contributes to the performance of the team. (Programme Lead)

Governance is through a robust structured approach with individual coaches feeding back to lead coaches and a programme lead who subsequently report back to a steering group utilising a 'huddle' format once a week. Membership of the steering group contains both the executive SRO and executive sponsor (Dixon, et al., 2018).

Initially delivered in partnership with PwC the Perform programme has achieved recurrent funding and is part of an attempt to embed a culture of continuous improvement across the whole organisation as well as to support with large scale transformation work. The view at senior level in the organisation is that Perform has provided good value for money to date and will be a key part of achieving ambitious aims stated in the new 5 year strategy (NBT, 2019). This section will describe in further detail some of the key reasons the senior decision makers in NBT believe that "Perform works" (Medical director/Exec sponsor).

Perform has more than washed its face (Director of People & Transformation/Exec SRO)

... it's a commitment of ongoing investment in all staff across NBT (chief executive at bootcamp opening speech)

4.3 Summary of themes

Participants described their work and the intervention in rich detail and the analysis of transcripts and other data sources revealed 3 emergent themes from the data in relation to impact, and 1 in relation to success factors:

- Growth and increase in capability,
- Performance improvement, and
- Perform as an investment in sustainable improvement.
- Drivers for success and future directions

Presentation of the findings by theme will be described below in further detail with presentation of participant quotations as raw data pertinent to the theme.

4.3.1 Personal development and building capability: Growth for coaches and coachee's

The opportunity to pursue personal development goals was cited as a key motivating factor for new coaches joining the Perform team

I had this opportunity from Perform come through. And I thought it's, it's a very good opportunity for me. I could learn more skills, and also I can use my learning in my masters and put something in practice and try. So that was the motivation for me to join Perform. FN

So I came to Perform to fill a skills gap that I had in coaching... I've done a lot of programme management and network management, I had never done coaching. So I was hoping to pick up some skills from here. AM

coming to Perform for me was about taking the next step in how to affect change within the organisation and try and learn from a team that were the crème de la crème of performance management and change management, and quality improvement. CAR

But as coaches grew more experienced in the role they felt the opportunity to bring in other skills, ideas and techniques really enhanced how they delivered the programme and brought benefits to themselves and their coaches. A number of coach's spoke about the satisfaction they had from seeing coachee's put learning into practice.

...the actual things that we had discussed and the conversations we had were actually coming to fruition. You know, the team was starting to realise that they could make changes do different things and worked in a different way to work better and smarter..... That's quite satisfying. AM

And others were pleased of how their coaching practice had improved with experience, in spite of the role throwing up the odd challenge.

So, I think, flexibility, being more patient, and then working around the team was the key for me to bring in those changes in that area. That's what I learn, how to do that when it's busy. FN

... coaching has been really useful as a style. And again, there is skill in knowing when to coach the person that you are with or the team that you are with.... If you're generally asking a coaching question you want someone to think about the response and get them to explore all avenues... you have to be adaptable to the situation as it presents to you. CAR

When asked what they thought may be the drivers for the most effective improvement conversations they were having coaches described how evolving the original Perform approach and tailoring it to their own style was important. Moving away from terminology of sprints and the original corporate style of delivery was felt to be a good future opportunity and likely to be more effective. Coach's spoke powerfully about facilitating deep reflections in their coachee's that enabled them to develop some sustainable enhanced capability.

(it) can be more beneficial to sow the seeds of an idea or change methodology, and then picking those back up and having dedicated coaching time with key people, and can be a bit more beneficial. CAR

But actually, you know, plant the seeds in the autumn and, you know, the bulb in the autumn and out they've come in the spring. You know, they've sort of done it naturally they've sort of gone away and discussed it and whether it was just planting that seed and not realise the seed was planted, and they brought it up in a meeting or, you know, they've had a conversation with another team you know the seeds there. And it's just about having that influential conversation that they didn't realise was there. And then them adapting into that and taken on to a later date. AM

4.3.2 Elevating performance and achieving goals

In 2017 NBT experienced one of the most challenging winters in the organisations history. Perform was commissioned to support NBT develop a sustainable solution to its persistent difficulties in managing patient flow. In the subsequent annual report of 2018/19 Perform is cited as a key driver in unblocking some of the major issues around reducing delays for patients, improving discharge experience, improving quality (through timely availability of correct specialty beds) and ensuring that lifesaving hospital beds are available to the emergency department every morning (NBT, 2019a).

Key benefits to the organisation included a reduction in the length of stay across specialties including in the maternity wards where the impact for mothers and babies was significant, enabling them to start their new lives at home together much earlier rather than spending precious time waiting in hospital.

...what it helped was like the team could work more efficiently, their communication was good. So they, that means like they work more effectively. The mothers were seen like before midday or the mothers and babies. And also patients or mothers were discharged bit early. FN

...reducing length of stay was important, we improved the pathway right through from ED, the AMU, and to the short stay medicine ward so the team got really slick at managing those type of patients. Rarely did patients spend more than 72 hours in hospital on that pathway, everyone knew what they were doing – it was seamless. JT

The ICU department worked hard to drive at underlying cultures that influence performance such as poor communications and helplessness, hindered by a hierarchical structure and historic practices

I think what you could say we did achieve in ICU is we gave the team permission to ask questions and challenge the status quo...(we) gave the team more of a voice ...so I think that was the biggest win in ICU is just giving a voice to people at all levels team, how to challenge in an appropriate way. CAR

The performance benefits were felt quite widely across the organisation. Short stay medicine, neurosurgery, and maternity teams all agreed goals to help them increase the number of discharges of patients per week which subsequently helps reduce the number of beds needed to run the hospital properly

...they changed the fundamental way ways of communication. There was an 18% increase in discharges which could be attributed to earlier TTA submissions. FM

34a were great, when I went they baseline average was 41 discharges a week, we agreed a 10% goal – so 45 per week, they achieved 53 per week average for the time I was there! And in the year since they have sustained 50 per week, so whichever way you look at it they've done well...JT

...just helping the team to cope without those 10 bed spaces. FN

When pushed to describe the impact of the programme on the department the coach was keen to describe this as a long term project, but also candid enough to admit the original goal set out at the beginning of the sprint was not achieved

So although we didn't get the outcome that they initially invited us in for, and we didn't achieve the goal we initially set out, we actually still got a positive outcome from it because they're now in a better place, and they understand as a team, what their challenges are, to the next time that they ask for support or help, they will have a better understanding of what that involves, and what that support will look like. CAR

When working with areas in sprints all the coaches described the importance of agreeing a relevant and achievable goal with the key stakeholders. Going forwards it is a strong collective recommendation that Perform programme and the Perform coaches be able to take a less corporate task-focussed approach to goalsetting. Coaches expressed a desire to engage teams in meaningful dialog that explores targets that would be powerful and motivating for each team rather than feeling corporately mandated. Some coaches have described it as feeling like they were there to 'do Perform to' wards/teams, preferring instead to be viewed as supportive and facilitative which is thought to offer some really powerful benefits down the line

That's not the message I wanted to take. Yeah, we're not here to do Perform we're here to support teams achieve form goals. Yeah, and I think that was very much a directive. AM

...also I believe in changing people developing them, which actually through Perform you can't see... It's just mainly talks about what to be done at that time it's like a fixing a problem.... I think we had some very good success. But I think now we need to think about changing our strategy, and adapt to the new things, and the new challenges. So I think, Perform is a very good base. And then we have to move on now, and evolve and change the approach and change how we bring in change and understand a little bit more about the people's behaviour and focus on that and we could bring in a good change. FN

When I first went into the admissions unit I tried to meet the ward sisters, I would've been their 3rd Perform coach in under 12 months – they must have a complex or something! Initially they were a little wary of me, we had a conversation and it boiled down to being afraid of being made to do loads of 'stuff' that wasn't relevant or helpful in their role, like they had this board that literally took 2 hours to complete, by the time it was done it was out of date, but at the time they were told "you must have a visual management board!"... they described it to me as feeling a bit like foie gras – with Perform being shoved down their throats until they were choking... in the end we decided to work in a different way and on what was going to be transformative for them. It worked really well and a year down the line we still meet up and they're going from strength to strength. JT

4.3.3 An investment in sustainable change

Senior leaders invested significantly to take the trust in a radically different direction with a new approach, and so something many people have described is the importance of building energy and momentum, and keeping it going!

We spent years going down a process of telling people what to do and then wondering why it doesn't work. (Medical Director)

I was personally quite keen that any investment that we made in a program of change should be embedded, and it should be long lasting. (Consultant Neurosurgeon & Clinical Lead)

Procured originally as a problem solving initiative with a strict focus on patient flow, the perception of the programme has evolved. There is understanding that like a well landscaped garden, trees planted in the spring may flower in the autumn. Consequently there is will to move Perform from a 'patient flow project' to an embedded system within NBT.

I think we are seeing Perform as not just an initiative anymore, I think this is the way forward. (Programme Lead)

I think people quite quickly got the message that there was something in this that they could really understand and help them to do their day to day work. (Medical Director)

The sustainability was important also for coaches and teams, and there signs that teams had adopted their own ways of working following their initial support from a Perform coach

It's nice to go back and speak to some of the team that you've already worked with, and then start seeing them using those tools and practices for their next project that they are leading with and we haven't been involved with. So intensive care for example, to key people that were in intensive care and are running their own projects and using some of the tools and techniques that I was helping them to understand in their new project which we've not been involved with at all. So it shows that they listened to learn and taking something on and either applying it themselves. CAR

While there is initial enthusiasm for what appears to be a very powerful change tool with lots of staying power, some of the coaches were a bit more reflective, describing how it was important not to celebrate success too early and think the war was won on the basis of one battle

...It was challenging to really ascertain - because the team was going through some other changes as well. I think it probably needed a longer assessment period to really see how the team was changing their service. But it certainly helped to support a new way of working, and has facilitated in what appears to be embedding any practice. FM

4.3.4 Why does it work and what is the future?

There was strong feeling in the senior management and executive teams that Perform had worked for NBT. The winter of 2017 had been extremely challenging and the 'feel on the ground' was that in 2018 and 2019 the trust was more resilient, performed better, and staff were happier. There were more positive scores in the NHS staff survey for both years and an improved CQC rating and while it is difficult to imply cause and effect there is feeling in the executive board that Perform was a real driver for this change. Part of the strength was felt to be that teams were aligned with dedicated coaches who could focus on their development with them

Because it is a coaching approach, it's not asking people to take time out of the day job, it's very much sitting alongside them. It's about working with people and allowing them to find the answer, rather than us giving them the answer. (Programme Lead)

One coach reflected on their differing experiences being asked to be quite structured in how they delivered Perform to Maternity teams quite early on, and later being given more freedom to identify meaningful goals and be more flexible with Neurosurgery

...because of the different approach. It was about identifying key stakeholders that were then able to find daily influencers within their teams to really drive forward change. So that was an element of coaching, mentoring and MDT working. FM

Another coach was really reflective about the impact of the bootcamp training on participants, and the effect their positive experience had on their motivation to go away and make some change happen

By the end of the day, the buzz in the room is tangible, you can cut the air. We have had people from all works and services, catering, cleaning, everybody has learned something, has got something to take away with them, and really think about how they can make a difference on the ground day by day. CW

Heavily referenced as a 'coaching programme' there is recognition from the coaches participating in this evaluation that the approaches and techniques they use to convey ideas and tools go well beyond pure executive coaching style. All had completed an ILM level 3 coaching certificate as part of their induction to the role, however in practice it was their ability to be fluid, resourceful, and flexible that really drove change in their teams

...in reality, you're, you are there to support teams... neurosurgery appeared to understand that it was about trying to improve performance. FM

Yeah, I think, yeah, I think you have to sort of definitely pull on some other skills. Okay. You know, when we weren't coaches when we went out... we had no real coaching experience. AM

So switching to a different type of style is more beneficial there. Also because we're dealing with clinical teams, having dedicated time for coaching can be quite tricky, you have to be adaptable to the situation as it presents to you. And so using things like motivational interviewing and brief intervention can be more beneficial to sow the seeds of an idea or change methodology, and then picking those back up and having dedicated coaching time with key people, and can be a bit more beneficial. Having coach in the title. Sometimes I feel restricts the team from exploring other ways of communicating or getting ideas out there. It's quite handy to allow the person to realise when to coach and when not to coach. CAR

Ultimately coaches were humble in their assessments. Coaching practice is predicated on the basis that the coachee has the potential to unlock their best solutions. The most important aspect of success in this programme appeared to be about identifying the talent in the organisation and helping them to drive their changes in their teams – the daily influencers: people on the ground that care about their services, being empowered to lead and influence change on a daily basis.

... these are what I'm calling your daily influencers the people who are there on a day to day basis that can carry forward ideas and notions and encourage early adopters to new ideas, people that are keen and enthusiastic, know the day to day running, and can generate energy and enthusiasm for something new. The people that are on the ground on frontline, doing the jobs, ones that know how to find those small little differences, or those subtle differences to the current processes that can get you those real wins. FM

Often it wasn't about the big tangible stuff that people felt made the difference, but the intangibles related to organisational culture. During the interview process it was apparent that coach's weren't

overtly familiar with describing results in relation to outcomes and impact, oftentimes citing it was difficult to measure 'some of the qualitative stuff' or that data and reporting was not there

*I think the reality is it's hard to provide any data or demonstrate any real change.
It's much more of a qualitative reporting mechanism. FM*

*Some of the other more complex stuff like readying ICU to change and for the
next step is more along the qualitative than quantitative side. CAR*

*It was really hard to, like, we wanted to have some KPIs and we wanted to
measure them, and it was really hard to see, and measure directly what impact
we could bring into the case managers and so the measures like the quality
measures are really difficult, especially working with Perform, and the
dashboards we have we could measure all the KPIs but anything to get the direct
impact was really difficult so it does make it hard to see what the impact we are
creating with the team. So that was all of the difficulty we had measuring. FN*

But coaches were keen to emphasise strongly that they felt something positive was going on here; this was step one on a long journey to a meaningful shift in culture and while measuring and reporting tangible benefits was difficult they were sure that the impact of their work would be felt a little further on down the road

*All the conversations we're having about change and how things could work
better was sort of not welcomed in all cases all the time. And so some of the
bigger changes that we wanted to see, or we thought would help didn't actually
come at the time of the sprint. But it was more about having those conversations
and almost planting the seed at the time. And we didn't realise this until sort of
three months old and that actually some of those seeds that we planted have
now grown. You know people are actually starting to see that these were ideas
that they could use and starting to really adapt to. AM*

*Going forward, this is the first step in the journey. So think the outcome we got
from intensive care with it, change their mind-set and step them onto a different
path to be ready for future change and future challenges, and future
adaptations... CAR*

4.3.5 Quantitative measures

4.3.5.1 Impact on performance including patient flow

Measures that influence patient flow include occupied beds, length of stay, AM discharges, and total discharges. These metrics are measured on a bespoke dashboard utilising data from the hospital patient administration system (PAS) and are available for individual specialty teams to access. Individual teams sometimes make arrangements to track specific measures or KPIs that are important to their service goals. Consent was not granted to present source data in this evaluation; however permission was given to reference headline values that were in the public domain for triangulation purposes.

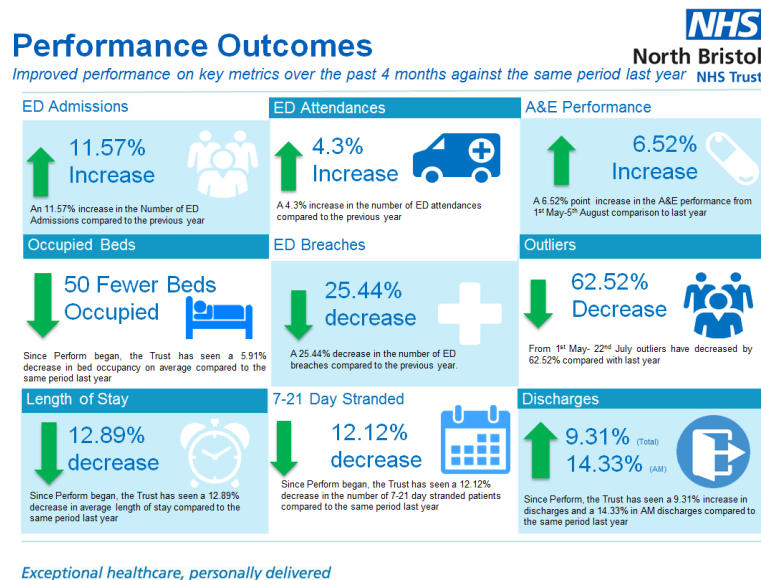
The following summary is a replication of headline data from an internal board report prepared in late 2018 describing operational performance in comparison to the same period in 2017.

- An improvement in the number of occupied beds at midnight from a 2017 baseline of 851 to a target of 808.
- An improvement in total weekly morning (AM) discharges from a 2017 baseline of 182 to a target of 224.
- An improvement in the total number of patients with a length of stay of 7 days or greater from a baseline of 468 to a target of 312.
- An improvement in average length of stay (excluding 48-hour or less stays) from 10.5 to 9.5.

Table 5 - Summary of headline data of Perform impact in NBT comparison of 2018 v 2017

4.3.5.2 Narrative summary of performance outcomes

Further cited in a submission for the HSJ partnership award in 2019 was an 18% improvement in ED performance in 2019 vs 2018, and a process outcome that over 2000 staff had accessed the bootcamp training course – close to 25% of the workforce.



7

Figure 1 - replication of summary slide as prepared in part of submission for HSJ partnership award 2019

4.3.5.3 Financial impact & return on investment (ROI)

Permission was not granted for detailed documentation of financial impact owing to commercially sensitive information related to the contract with PwC, however NBT consented to sharing their estimated ROI value and actual forecast financial improvement as a result of their Perform work.

- Estimated ROI – 1.74
- Estimated forecasted financial improvement is £2.82m

5 Discussion

This evaluation presents a number of useful findings in relation to this important field of practice. Using mixed methods with qualitative exploration of the perspectives of key stakeholders in relation to the impact of the intervention gives an important insight into what about the Perform programme works, why, what the areas for improvement are and what opportunities are there to influence future practice.

Most findings were generally reported as positive, however there is a difficulty articulating these in relation to outcomes and impacts. Presentation of data in a systematic way using a model such as a results chain may be beneficial for the Perform programme (Funnell & Rogers, 2011). Results chains are a form of logic model that help clearly display the inputs, activities, outputs, outcomes and impacts of simple interventions (OECD, 2017). Consequently there is clarity to stakeholders on the activities and associated outcomes of an intervention which helps senior managements to make evidence-based decisions about their effectiveness, impact and value (Picciotto, 2014).

Results chain



Figure 2 - Visual of an example results chain logic model

There was little evidence of practice reported in the programme being evidence-based. This doesn't mean it is ineffective; however without robust data collection and measures it is difficult to understand which bits of practice drove the improvements and which bits had less impact (Clutterbuck, 2008). Whilst the programme material describes the approach as 'coaching-based' in reality the improvement interactions were highly complex and required practitioners needing to use a broad range of skills in 'helping activities' (Garvey, 2004). Therefore Perform should work further to understand the skills required to be effective in the practitioner role and make investments to enable workers to develop appropriately.

There is some encouraging evidence to suggest that Perform was effective in NBT at supporting improvement in a number of important operational outcomes such as length of stay, occupied beds, financial position, patient-flow metrics and patient discharges. Consequently executives were happy to go on record and describe Perform as demonstrating value for NBT. Without access to datasets a deeper more robust interrogation was not possible, however there is opportunity in the future for Perform to identify reporting mechanisms that will allow more systematic monitoring of the programme against a set of defined success criteria.

There was evidence of development in relation to some valuable skills and capability in the organisation that will help drive sustainable improvement beyond the lifespan of a working relationship with a coach. In VUCA times the agility and resilience gained from a highly-skilled and capable workforce is a prized commodity, and the challenge for Perform is to develop methods and systems to capture some of the improvements described as qualitative and intangible (Clutterbuck, 2008), (McIntosh & Layland, 2019).

5.1 Discussion of strengths, limitations and mitigations

I'm honest about my dishonesty. Derren Brown

5.1.1 Methods

This evaluation has a number of limitations that are important to describe. Openness and transparency are critical qualities in academic reporting (Martensson, et al., 2016). While there are limitations and some opportunities for improvement in this work a key strength is the candour and realist perspective with which this is presented (Pawson, 2006), (Bryman, 2008). There is room for improvement in methodological design and execution, however the realist perspective dispels the myth of perfect inquiry and proposes that many studies diminish their value by chasing methodological purity and design to the detriment of the relevance of their evaluations in a practical setting (Pawson, 2013).

This study makes an important contribution to the evidence base despite some limitations; however it is argued that this work may encourage more widespread evaluation activity of coaching and improvement in an NHS setting. The literature review finds that much of the coaching and improvement activity in a healthcare setting goes unreported (Phillips & Phillips, 2005), (Clutterbuck, 2008), (Hill, 2010), (Lindsay, et al., 2019), (Woodnutt, 2018), and many of the improvement studies published suffer from significant methodological flaws including positive bias, lack of transparency and overestimation/reporting of an effect (Nicolay, et al., 2011), (Reed & Card, 2016), (Knudsen, et al., 2019). 'Poor science' in this field should not be encouraged (Nicolay, et al., 2011), however there is urgent need to engage clinicians and managers in the NHS in evidence-based improvement practice and therefore an opportunity for new approaches to evaluation (Banerjee, et al., 2012).

Many programme evaluations in a healthcare setting will be completed by internal teams with varying degrees of expertise, time, budget and experience (Tourmen, 2009), and therefore methods for agile and responsive evaluation able to deliver results and insight at pace present a significant opportunity (Twidale, et al., 2014). The 'quick and dirty' evaluation paradigm is described as a "lightweight method for heavyweight research" (p. 343). It is implied that this approach releases the researchers from expectation of the definitive judgement about a topic (Pawson, 2006). Therefore acceptance of the "good enough" evaluation is something that potentially encourages more evaluation activity to take place (Durose, et al., 2017).

5.1.2 Scope and the role of the researcher

You can't track everything (Patton, 2008, p. 202)

This study committed to a 16 week deadline in the research proposal and made detailed plans for review at key milestones using a Gantt chart. Recommended parameters for a masters dissertation project state that the earliest submission is at 12 weeks, and projects can take up to 2 years to complete (UWTSD, 2019) with 2 semesters being another commonly cited timeframe (Bailey & Scarrow, 2010). Oftentimes qualitative projects can be subject to slippage with difficulties in data collection and access to participants (Vanstone, 2017). Postgraduate researchers have experienced a difficulty in balancing competing demands for time and unexpected events can put significant additional demand on a research process (Wellington, 2017).

The planning stage of a thesis should build in contingencies to allow for unexpected events (Brett Davies, 2007). The UWTSD MBA dissertation guidance advises pragmatism in both planning and scope with the "need to focus in to find a narrow and specific topic that will be manageable within the time and resource constraints of the Masters Dissertation" (UWTSD, 2019, p. 8). The initial study design made plans for 15-20 semi-structured interviews with a range of stakeholders, many of whom

will hold senior or operational responsibilities in the hospital. Due to the unprecedented covid-19 pandemic there is a huge requirement on healthcare staff to prioritise clinical duties, therefore the sample size and approach was changed to become a convenience sample and opportunistic interviews with fewer participants. Availability of quantitative data also became restricted.

There is an argument that the study could have been postponed, or another research topic investigated (UWTSD, 2019), however in the current VUCA climate it has never been more important for the healthcare sector to understand what's working and why in an improvement context before being replicated and more widely deployed (Parry, et al., 2013). There is recent evidence to say that research adaptable enough to continue despite unexpected events can benefit with richer findings and more empirical sensitivity and therefore potentially add value alongside studies with stricter deductive designs (Pultz, 2018). The decision to continue the evaluation and report using a modified protocol does not diminish this work, but provides important findings that are practically useful and rapidly available to senior leaders and service managers and is therefore a key strength.

This study has presented a significant body of evidence underlining why this topic is important as well as identifying considerable gaps in the evidence base. Evaluation is a difficult and specialised activity (Kessler & Tanburn, 2014) and although rapidly becoming professionalised as its own discipline can often fall as part of the expected responsibilities of service managers to complete evaluation (Tourmen, 2009). Several important factors can constrain the ability to effectively evaluate interventions including expertise operational pressures, lack of data/monitoring mechanisms and limitations of programme design and planning (Banburger, et al., 2016).

Patton's work on situational factors describes why some interventions may go unmonitored and there is a risk that in increased operational pressures in the VUCA world that evaluation takes a back seat as something that is nice to do, rather than an essential part of daily routine (Patton, 2008). This study has presented additional learning about the capacity of NHS programme managers to complete evaluation of important activities using new methodologies to high academic standards in the face of significant operational pressures and competing demands, and therefore makes a useful contribution to knowledge.

5.2 Conclusion

This study has made an important contribution at an important time in field where there is a significant level of activity taking place that however remains underreported. Absence of effective evaluation means that many stakeholders and decision makers are unsighted and therefore unable to consider evidence in their decision making processes (Clarke, 2001). Subsequently there is a risk that highly effective models, approaches and practice are not widely shared and implemented, yet approaches that are not effective remain more widely deployed (Parry, et al., 2013).

At a time where resource is stretched somewhere close to absolute capacity and yet demand is increasing at unprecedented levels the need for understanding of the most effective approaches to improvement has never been greater. The evidence-based medicine movement (Sackett, et al., 1996) is accepted to be a significant driver in the improvements in healthcare outcomes for many patients and there is will in the clinical community to engage in improvement activities providing the discipline commitments to evidence-based management practices (Nicolay, et al., 2011). There is therefore a need for more improvement practice, and more investigation into its impact.

Improvement science has seen great success in other industries yet is relatively new to healthcare (Drotz & Poksinska, 2014); subsequently there is great enthusiasm about the opportunities to meet organisational goals using these approaches (Melton, 2005). There are fundamental differences between industries and the willingness to adapt approaches to healthcare will likely be a key success factor in driving improvement in a complex sector such as healthcare (Campbell, 2009). Recognising

the skills and experience required to develop effective healthcare specific improvement approaches may need some external support there is a role for the private sector and proprietary systems for improvement, however also a critical need to ensure practice is both evidence based and evidence generating (Parry, et al., 2013), (Banburger, et al., 2016).

This pragmatic narrative evaluation has reviewed available data and using mixed methods analysed the perspectives of a small sample of coach practitioners to help understand the organisational impacts of the Perform programme and its role in improvement. Some valuable initial results have been shared however it should be recognised the intervention is in the 'innovation and testing phase' (Parry, et al., 2013). Causation cannot be implied due to gaps in monitoring and reporting processes (Cairney & Oliver, 2017). Without published results and robust data it is difficult to substantiate any claims made in the marketing material which therefore be could be considered unreliable (Eccles, et al., 2003), potentially weakening the understanding of the impact of Perform.

More should be done to understand the precise mechanics of improvement using Perform and the conditions associated with this before being more widely deployed (Dixon-Woods, et al., 2015). It is also too early to say that Perform doesn't work either. The need for effective approaches to improvement in the NHS is great and so there is value in monitoring the Perform programme more closely within a robust framework. The 'results chain' logic model (Funnell & Rogers, 2011) is presented as a potentially helpful evaluation framework for the Perform programme and it is a recommendation of this study that robust monitoring in line with this model is completed as routine part of future practice.

5.3 Summary of recommendations and considerations

5.3.1 Primary recommendations:

The following primary recommendations are made based on the findings of this evaluation. Given the scope of this research project the recommendations are specific for the Perform programme in NBT; however there is applicability in these principles for other improvement approaches in a healthcare setting.

- Ensure practice in the use of Perform is **evidence based**, acknowledging its observed potential but also the need to understand more critically the approaches and elements most successful and in what situations.
- Ensure practice in the Perform approach is **evidence generating**, using an appropriate outcome-focussed model such as a result chain logic model to clearly demonstrate and differentiate between activities, outcomes and impact.

5.3.2 Considerations:

Following on from the recommendations above there are a set of supplementary questions which programme management may wish to consider as part of the findings of this study. This study was primarily focussed on the impact of Perform at organisational level and so did not fully investigate the components described below as the scope would have become too broad and dilute. These questions may be appropriate for further future research.

- **'Wheel'**. Consider work to make the Perform system more intuitive, re-labelling the Perform 'wheel' to something that describes its mechanics and applications in a more appropriate manner, such as toolbox/kit for example.
- **Deployments**. Consider adapting the deployment of the Perform 'wheel'. As opposed to sequential prescription in delivery *is there a diagnostic that can happen to see which elements would be most transformative for teams and how they would be supportive to their goals? Does every team need to do every element of the wheel in order?*

- **‘Coaching’.** Consider the skills taxonomy of skills required to be an effective ‘coach’. Is the Perform approach genuinely predicated on a coaching approach, or is the skillset required much broader and therefore further investment in its practitioners required?
- **Holistic approach.** Should Perform be conducted in isolation and does this strengthen or weaken the approach? Could elements of other methodologies (such as PDSA) be complimentary alongside Perform?
- **Conditions for success.** What role do human factors including motivation, confidence and self-efficacy play in being a successful coachee? How will Perform adapt so that readiness for change is not a barrier to access or a determinant of outcomes? Particular consideration of established psychological theory such as SDT and TTM can help establish ‘winning conditions’ (Audet, et al., 2012).

5.4 Final word

This study was completed during the covid-19 global pandemic and evaluated the improvement activities in the largest acute hospital in southwest England at the height of preparations. It has never been more evident of the VUCA conditions within which the NHS is required to operate in, nor the value of a highly resilient and skilled workforce with significant change and improvement capability more recognised. How NBT will fare in the covid outbreak is unknown. As this dissertation is being finalised there are 301 acute beds equipped ready now to receive patients – a bed occupancy of 42%.

Do more of what works and less of what doesn't. Steve Clark

The basis of this preparedness is in the foundations of improvement. There is not time for defects, duplication, over-processing, waiting and waste. The value-adding functions of the hospital are self-evident, and the opportunities for improvement in others becoming clearer. It is the conclusion of this dissertation that improvement is therefore an essential activity, and consequently it is essential that improvement activities appropriately document their inputs and outcomes so that impact can be felt and understood by all in healthcare. With escalating demand and finite capacity the advice to the NHS is as clear as Clark’s advice to his interns (2012, p. 283), and the role of improvement in this and its responsibility to itself is equally clear.

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7 Appendices

7.1 Research Proposal

Research Proposal – final draft

Evaluating the impact of executive coaching on the performance of inpatient teams in an acute hospital trust: a mixed-methods review of the Perform Programme

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● Research Rationale Background

Healthcare in the UK is provided universally and free at the point of access by the National Health Service (NHS), the largest publicly funded healthcare provider in the world. Demand for the service is increasing year on year due to an aging population, higher patient acuity, population growth, growing patient expectation, and advances in medicine (thereby increasing the number of conditions, or treatment options open to patients). Funding the service has been the subject of

much contestedness, with many observers claiming there is a significant budget deficit squeezing commissioners and providers and limiting their ability to meet demands.

Politically the NHS is a high value commodity with scrutiny of its performance being central to many parliamentary wrangles and regularly the basis of electoral campaigns. Subsequently there is both political pressure to (and an internal recognition of the need for) change the way care is delivered to meet the growing demands on the service. Transformation and change management are therefore high on the agendas of many NHS organisations with change in culture and behaviours of the workforce seen as a key opportunity to drive improvement in performance.

Despite a lack of a strong evidence base executive coaching remains a popular developmental intervention and a key mechanism used by organisations to drive improvement activities. North Bristol NHS Trust has invested in a partnership improvement programme which delivers coaching to teams with the aim of driving increased operational performance. This evaluation research piece will investigate NBTs' 'Perform' programme, examining the operational impacts and participants experience using a mixed-methods research to understand the effectiveness of the project and any potential benefits and drivers, with the aim of supporting decision-making for the organisation about future commissioning intentions.

- **Aims**

This Evaluation Research project aims to critically evaluate the Perform programme in North Bristol NHS Trusts' specialty of Neurosurgery with the aim of understanding its impacts at an organisational level, but also the participants experience to illuminate key drivers for any outcomes (or lack thereof). Findings from the Evaluation Research will help inform the Trust of the programmes efficacy, as well as provide useful intelligence to support decision making around the future of the programme.

- **Objectives**

- **Primary Objectives**

To provide North Bristol NHS Trust with robust information to assess:

- What was the impact of the programme?
- How was the implementation of Perform received and what drivers were identified in the observed outcomes of the programme (positive or negative)
- and therefore establish, Was the programme 'worth it' and why?

- **Secondary objectives**

- To make a contribution to the evidence base for executive coaching, aiding better understanding of
 - participants experiences of coaching in a healthcare setting
 - NHS Trusts approaches to improvement activities and how these are received by frontline teams

- **Academic focus/Lit review**

Executive coaching is a developmental tool that encourages coachee's to find solutions to goals through structured conversations. Coaching has gathered support in literature for the benefits reported by participants such as increases in self-efficacy (Leonard-Cross, 2010), confidence (Parker-Wilkins, 2006), and motivation (Jones, et al., 2016) and the subsequently assumed organisational improvements this yields. The consensus on tangible organisational outcomes is less clear, with a

lack of robust evaluation routinely embedded in coaching practice and measures of organisational achievement less frequently reported than personal goal achievements (Phillips & Phillips, 2005).

Executive Coaching is extensively reported in the literature and has a growing body of research dedicated to describing its benefits (Levenson, 2009). Many of the evaluations focus on benefits for the coachee's personal development, for example improving coachee's self-efficacy (Leonard-Cross, 2010), however they fail to link this to any organisational outcomes or describe a positive performance impact (Jones, et al., 2016).

Phillips and Phillips (2005) acknowledge that data is not collected routinely, or with sufficient rigor as part of the coaching process, but contend that demonstrating return on investment (ROI) from Executive Coaching should be straight forwards and happen more frequently. Some studies do make efforts to describe ROI, with figures of up to 689% reported in some cases (Parker-Wilkins, 2006). This could be considered a highly attractive return of close to \$3million from a \$19,000 investment and go some way to challenging perspectives that coaching is primarily a learning and development tool rather than an activity that represents a value for money investment or a vehicle for driving improved operational performance.

There is a surprising lack of robust research reporting benefits of executive coaching at an organisational level given the fairly frequently reported perceived benefits to the coachee. At this stage the benefits to an organisation appear to be theoretical or assumed, therefore this evaluation research piece seeks to investigate the value of executive coaching in line with specific business objectives, which if met will go some way to meeting expectations of senior leadership (Parker-Wilkins, 2006) *and help us to better understand the value to the organisation of executive coaching investments.*

● **Research Method**

● **Epistemological, Ontological, and Methodological approaches**

Transparency of design and clarity of position and approach to research are central tenants of social inquiry (Bryman, 2008). This short subsection will detail the philosophical position, research approach, and research strategy for this Master's thesis.

Traditionally, research paradigms (that is approaches to, and philosophies of) have been considered to live in different houses, with positions and perspectives deeply entrenched and never to mix without compromising the perceived quality and validity of study (Saunders, et al., 2007), (Slevitch, 2011). More recently however attitudes have softened somewhat and there is increasing acceptance of pluralism in epistemological and ontological approaches (Healy, 2003).

Evaluation research is concerned with the systematic collection and analysis of empirical data judging the achievements and effectiveness of programmes and interventions (Patton, 1990). The purpose of mixed methods evaluation research is to add value to the process of inquiry through a greater understanding of why phenomena occurs as well as enabling investigation into questions traditionally answered through a positivist paradigm (Steckler, et al., 1992).

Mixed methods evaluation research can generate useful findings that help answer important research questions that purely positivist or interpretivist approaches may struggle to investigate fully (Burke-Johnson & Onwuegbuzie, 2004), (Hammarberg, et al., 2016). More recently in medical research the Randomised Controlled Trial (RCT) has become more accepting of incorporating qualitative components to study design due to its ability to illuminate findings of interest or

significance that enhance the overall power of the research piece (Murtagh, et al., 2007) (Khalil, et al., 2012).

This Evaluation Research will use mixed methods to investigate any organisational impact associated with improvement activities, but also to explore more deeply the participant's experiences of the programme. The qualitative element of the evaluation will give an understanding that goes beyond a reporting of numbers, and allow exploration as to what drivers may have been for particular phenomena or outcomes. This evaluation research will be a useful contribution to the knowledge base and will help healthcare organisations to understand the relative value of coaching to support improvement activities, its likely impacts at team and organisation level, as well as the key factors that influence outcomes and experience. Essentially hospitals will have a better understanding of what/doesn't 'work' when it comes to improvement initiatives in an inpatient setting.

● **Data Collection**

Participants will be selected for participation using purposive sampling – a form of non-probability sampling that allows collection of cases that will inform the researcher most about the intervention being reviewed (Etikan, et al., 2016). Purposive population samples (and qualitative studies more widely) suffer criticism that results may not be generalisable as they are not necessarily representative of whole populations (Higginbottom, 2004), (Schreier & Flick, 2017); however investigation of critical cases will give light to experiences that might be typical for specific populations (Palinkas, et al., 2015), and therefore provide useful insight into future applications of the research subject intervention.

Aligning sampling methods that best fit with the goals of the study is an important step of the qualitative research process (Bryman, 2008). Better understanding the experiences of the Multi-Disciplinary Team (MDT) in relation to coaching and improvement methodology, and the factors associated with success or not from participant's perspective is an important goal of this research. The evaluation seeks to explore the efficacy of coaching and ward-based improvement initiatives with an aim of understanding better 'what works' from an MDT perspective, with a view to helping organisations and teams share best practice; therefore a strategic approach to sampling is considered valid.

The evaluation seeks to understand participants lived experience and the subsequent impact of the coaching and improvement initiatives, therefore in-depth interviews are considered to be the best method of capturing rich data in a small number of participants (Gill, et al., 2008), (Khan, 2014), (Thanh & Thanh, 2015). Highly structured interviews and questionnaires can result in unexplored perspectives of the participants and can be limited by the views of the researcher and therefore prone to bias, whilst unstructured interviews are considered to lack some methodological rigor (Peters & Halcomb, 2014); therefore, a semi-structured approach is considered most effective (Adams, 2015), (Pathak & Intratat, 2016), (Kallio, et al., 2016).

A sample size of 15-20 participants from the programme including delivery team, executive sponsors, and frontline staff in ward teams will be selected and the researcher will seek to gain written informed consent (which will detail their right to withdraw at any stage) and record the interviews using a digital audio recorder. Interviews will be transcribed verbatim and imported to QSR Vivo for analysis using the framework described below. Each participant has the right to access the audio recording, transcription, and interviewers field notes which will be made available from the date of collection.

Exploring the performance impact of the intervention will require statistical analysis of data collected from each ward team. Key data pertinent to the teams business will be extracted from relevant sources including the hospital patient administration system (PAS), ward teams KPI boards, and anonymised and imported to MS excel subsequently being analysed in SPSS with tests for statistical significance. This evaluation is observational and therefore will evaluate data already existing that is considered to be impactful for ward teams in the hospital. No new quantitative or experimental data will be collected for this study.

• **Methods of Analysis**

Thematic Analysis is a method of identifying patterns or themes in qualitative data that helps researchers understand & explain phenomena. It shares principles and ideas with methods that are often viewed as more complex such as Grounded Theory (Glaser & Strauss, 1967) and Content Analysis (Berelson, 1952), but has found increasing favour in the last 15 years owing to its flexibility and perceived accessibility, as well as the growing view of its worth since Braun & Clarke's proposal of a 6 step framework in (2006).

Thematic Analysis is subsequently one of the most popular approaches to qualitative data analysis (Bryman, 2008) with some strong arguments to support its value in mixed methods research (Moore, et al., 2015), (Clarke, et al., 2015), and evaluation research (Patton, 1990). Using Thematic Analysis in this evaluation research piece and adopting Braun & Clarke's 6 step model (2006) will help identify interesting or significant findings from the data, using recurring motifs in the participants' perspectives to enable the categorisation (or organisation) of data into subthemes and emergent themes (Maguire & Delahunt, 2017).

This evaluation research piece seeks to explore the organisational outcomes from investment in coaching interventions and will therefore analyse quantitative data to help understand the impact of the intervention, see what has changed, and enable judgements around whether this change is an improvement. All organisations exist with a defined purpose (Atrill, 2009), for example to create a customer, maximise profits, or serve customers (Drucker, 1954), (Denning, 2014). The primary goal for the NHS is to provide healthcare for patients (its customers), therefore exploring performance metrics relevant to specific functions in the hospital will help us understand to what extent more value has been created for the customer (Hillman & Keim, 2001) .

The purpose of quantitative data analysis in this evaluation research study is to explore likelihood of a relationship between hospital performance and an investment in coaching for specific teams. This is not looking for causality, but looking for patterns or trends in performance and understanding to what extent performance differs from what was expected. Statistical testing can tell us whether findings are likely to be spurious or not (Bryman, 2008), and following univariate analysis the appropriate statistical tests are to be applied.

• **Ethical consideration**

The UK research community has made great efforts to improve the quality, rigor, and integrity of academic research undertaken in the UK. In 2011 the representative body of UK Universities published a concordat agreement outlining 5 high-level commitments member organisations signed up to in order to ensure that the rigor of academic research in the UK is considered beyond reproach (Universities UK, 2011).

An underpinning principle of the agreement is the duty of all conducting research to consider how "the work they undertake, host or support impacts on the research community and on wider

society” (Universities UK, 2012). Benefits of this rigorous approach to research integrity are demonstrated by a recent Research Excellence Framework (REF) review citing 76% of submitted works as world-leading or internationally excellent (Universities UK, 2019). The concordat was revised in 2019 with further signatories committing to the refreshed standards (UKRI, 2019).

It is a requirement of all research conducted in collaboration with or under the auspices of the University of Wales Trinity St David’s to comply with requirements outlined in the concordat (2012) and for each investigation to demonstrate careful consideration of the ethical implications of the study (UWTSD, 2017). This research piece will be conducted fully in line with its obligations under this agreement.

Research involving qualitative methodologies further describes ethical considerations and risks to participants which include distress, misrepresentation, and identification (Richards & Schwartz, 2002), (Ponterotto, 2010). Reflecting on the ethical issues and applying appropriate strategies (such as gaining informed consent prior to participation) are part of a rigorous research process (Byrne, 2001) as well as the submission of a detailed application to the University Research Ethics Committee prior to commencing the project (UWTSD, 2017).

● **Resources and Time Management**

Proper Preparation Prevents Poor Performance – James Baker III

Postgraduate research is a significant undertaking and the appropriate management of resources such as time are crucial factors in the pursuit of a successful project (Levin, 2005). Key management strategies in successful postgraduate projects include effective planning and forwards visioning of important tasks, accounting for ‘Murphy’s Law’ and identifying contingencies, realistic assumptions on the time required for key stages, and anticipating appropriately the time required for items outside of the researchers control – such as ethical approval, and feedback responses (Levin, 2005), (Brett Davies, 2007), (Swetnam & Swetnam, 2011).

Significant other resources required in postgraduate research can include computer access and appropriate software (such as NVivo or SPSS and MS Word/Excel), an audio recorder, travel, and library access (Brett Davies, 2007). All costs associated with the project will be covered by the researcher and provision made for ensuring access to IT systems with appropriate backup capabilities.

Managing the project and all its required resources is the responsibility of the student researcher, although the University of Wales (UWTSD) makes provision for 15 hours of supervision to support the student throughout the research project. To ensure most effective use of supervision requests for feedback and meetings must have clear, specific requirements detailed. Students are advised to use the time of the supervisor wisely throughout the project considering which is the most value-adding way (UWTSD, 2018).

A high-level project plan (fig 1.) has been produced detailing the time required to achieve each step of the programme. A further schedule (fig 2.) has been documented showing the plan on a day by day basis, including significant milestones, expected outputs, and a trajectory to track progress against plan. The plan details a project starting in earnest week commencing 16/12/19 with an expectation of completing an ethics submission by 23/12/19 prior to any data collection. Concurrently to the ethics application a literature review will be completed prior to data collection and analysis commencing.

The dissertation module handbook describes a recommendation to students of 528 hours of independent learning required for the dissertation, including reviewing materials and completing activities for learning research methods (UWTSD, 2019). The project plan commits a minimum of 249 hours currently allocated to the project with a contingency of 100 hours unallocated at this time. The goal of the project is to have received supervisory feedback on the submitted drafts by 23/3/20 with a view to making amendments and submitting for the 14th April deadline for consideration of the April exam board.

Understanding the conditions in which students achieve regular production of work is essential to producing a successful project, and what produces 'optimum flow' will vary from researcher to researcher (Swetnam & Swetnam, 2011). Drawing on the experiences of previous projects is a useful exercise in benchmarking expected outputs (Queen & Squires, 2011). Successful postgraduate research including qualitative and mixed methods evaluations has been achieved using similar project planning methods and timelines in previous academic endeavour. There is therefore demonstrable evidence of the researcher being able to meet the deadlines described in this research proposal (Taylor, 2012), (Taylor, 2014), (Taylor, 2014(a)).

Figure 3 - Dissertation Project Plan

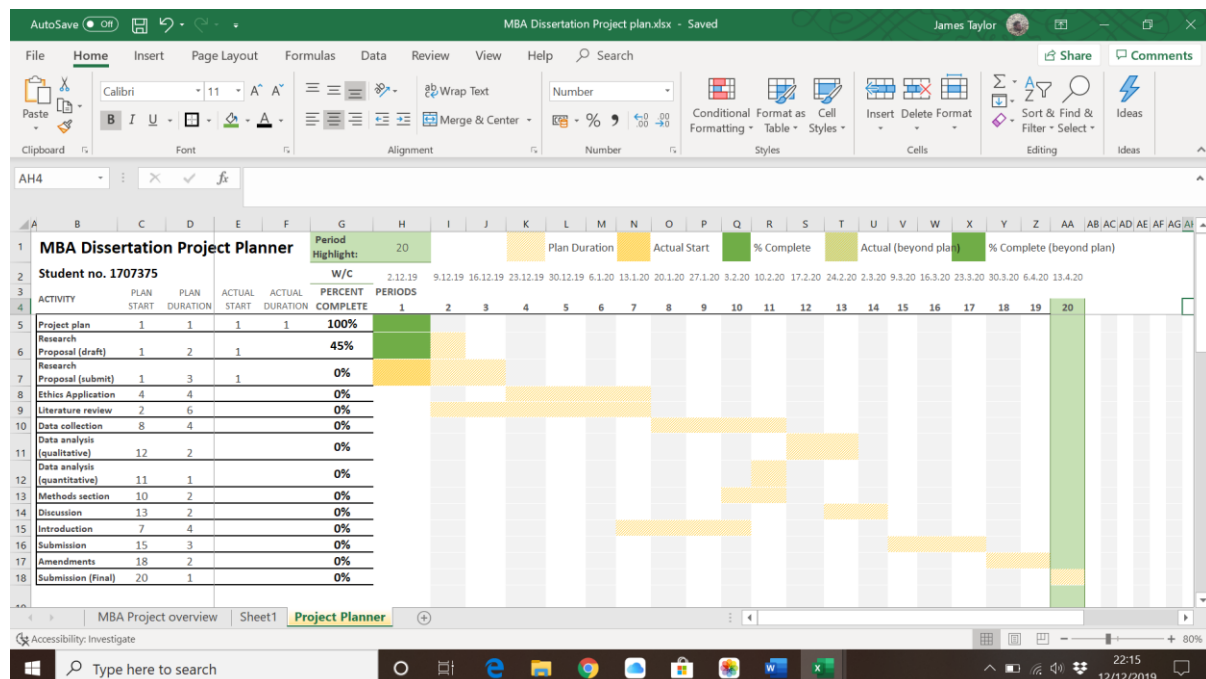
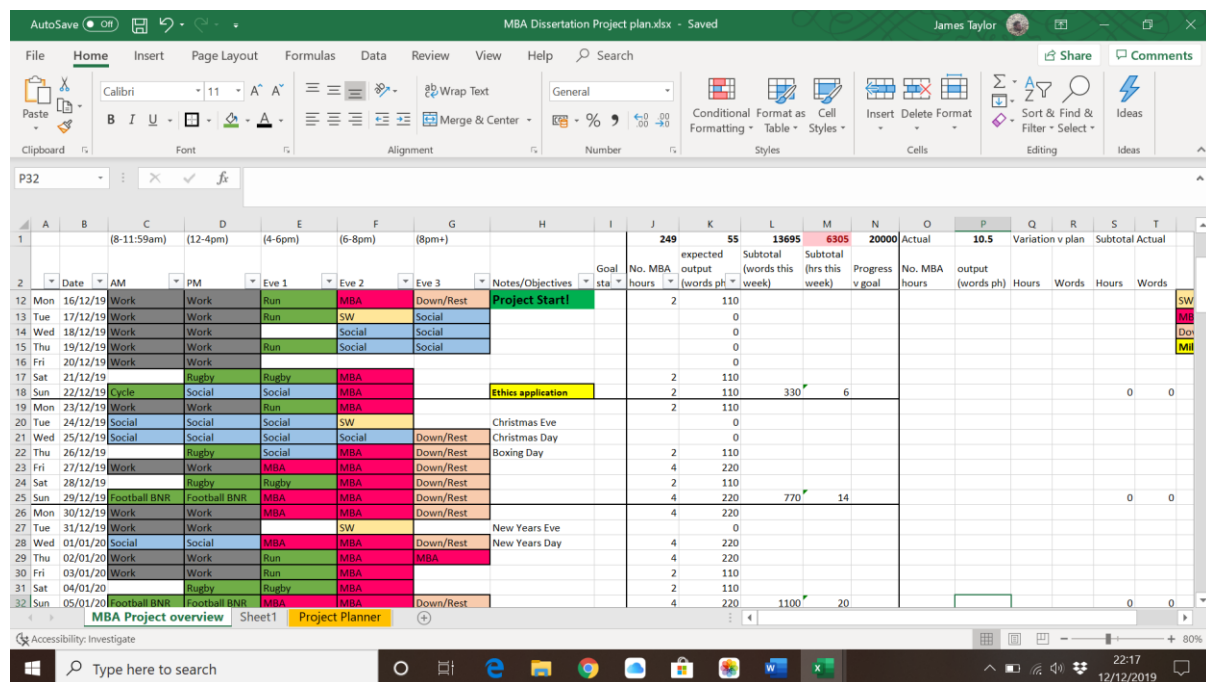


Figure 4 - Dissertation plan: day by day plan



• Summary of aims, design, methods

Question:	What is the impact of executive coaching on the performance of teams in an NHS trust (and how does this influence operational outcomes?)	
Aim:	Understanding of: • Impact • What works/doesn't work • Why	
Methods:	Mixed-Methods Evaluation Research Design	• Semi-Structured interviews w/participants from the MDT, commissioners, and delivery teams (n 15-20) • Thematic Analysis • Statistical Analysis of quantitative outcomes • Review of ROI
Expected delivery time:	12-14 weeks	
Potential outputs:	Submission for peer review journal article	
Rationale:	• Essential public service with increasing demands • Lack of evidence of effective change practices • Change programme delivered	

	but no understanding of impact • Potential to influence/inform future commissioning decisions • Contribution to the evidence base • Contribution to the debate on evaluation practices in executive coaching	
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7.2 Interview 1

AM

Wed, 4/8 10:33AM • 36:40

SPEAKERS

jt, AM

jt 00:05

Just to speak.

AM 00:09

Just speak.

jt 00:12

Um, I know that we know but just tell me about your background and why you ended up. And before. So I

AM 00:21

came to perform to fit a skills gap that I had in coaching. Some radiographer my background. I've done a lot of programme management and network management, I had never done coaching. So I was hoping to pick up some skills from him.

jt 00:41

How long is it now 18 months. 18 months. And what was your exposure to coaching before you came in.

AM 00:50

Nothing,

jt 00:53

or anything similar.

AM 00:56

Not really. They're the closest I probably got to coaching was anything to do with the human factor stuff because it was an understanding of human behaviour. With processes and design. And, you know, remember there is a human at the heart of everything we do, and coaches, is a allows that to.

jt 01:18

So, last week it just taught me for your. So when you arrived there. Talk me through your thought your journey. What were you, what were they getting you to do, and. Yeah.

AM 01:32

So, in terms of word Simon I had 27 been. I didn't have much coaching from my mentor. I think after probably two or three weeks I was left alone, and was told, you're doing okay but there was no sort of reason behind why I was doing okay. As in sort of names or mates, I suppose, as you know, this was done while and that was done while it was doing okay so you're on your own, but even in those four to three weeks there was no real level was really shadowing me in, in what I was doing.

jt 02:22

So it sounds it's difficult to know what you're doing well and what you needed to work on.

AM 02:26

Yeah. You know, I don't know how someone cuz I'm doing okay. There was no overview of actually what I was doing, no process confirmation.

jt 02:36

So just to summarise that that's really helpful just to summarise where we are on that. Clinical background, loads of good skills around. Human Factors canes for some coaching experience, set up on a challenge in our spiritual ward in winter, and three weeks and your mentor says you'll find off your game is that roughly Well,

AM 02:56

yeah, in those three weeks there was no process confirmation. Yeah, there's no input, other than a couple of the drivers that individual came to nothing on the board whatsoever.

jt 03:11

So I guess just on what I'm talking about how you were asked to roll out what you were doing. So from day one day one. Here we go. Go and do. I was performed. Was it.

AM 03:30

Yeah, I think the initial training, we had that first week of doing stuff. And we were introduced for awards, it was almost just to go and get on with it you need to go and get a vision out of them and we'd already done a bit of training on vision, and then let loose to say, go and find all these people and get them together on a board and make a vision.

jt 03:56

So how was that approach described to what did they say that they like if you've got a clear understanding that and about what form is or what is there to do or.

AM 04:07

I have a much better idea now i don't think that that that was explained at the very beginning. Obviously we all had some idea of what form was and what it was going to do. But I don't think anyone really introduced us to their prior experience on sort of wave one and two other than.

jt 04:30

So it's sort of hinted that there's a coaching programme. You come in with limited coaching skills, and someone gives you a task today, and says, vision other. Yeah. And then week two, they say, go and get them to do. Vision management. So it's quite touch driven.

AM 04:49

Yeah, I think, I think the way you're introduced to the world is very task driven thing with no idea of an idea of how to approach it so they're not coaching you to coach you to direct you to go and cultural teams

jt 05:10

and circus just direct question How's that feel as a new

AM 05:14

coach. I don't think it's ideal. Okay. I don't think it's an ideal introduction. I think that goes back to sort of the human factor side of things that there needs to be more understanding about processes and learning.

jt 05:38

So, that's really helpful. Thank you. How did you survive. So you're in here for. So you started October, and into the end of January. Wrapping up your albums your original deployment Was it 12 weeks

05:57

old. Yeah, yeah.

jt 05:59

How did they describe that to what did they call it. Sprint. So it's divided into Sprint's 12 weeks.

AM 06:08

12 week Sprint's, it was it was, I think it was described as a 10 week sprint but actually when they realised we needed to extend twice during that that wasn't planned at the beginning.

jt 06:22

So yeah, so how did you keep afloat. And in those 10 to 12 weeks. I think

AM 06:27

a lot of personal resilience. There is yeah we had, we had a good team at that point, as well, learning from others.

jt 06:38

So your development is driven by your own initiative, really. And in terms of, like, delivering the tasks, how would you say that you love Would you say that you're effective at doing that or

AM 06:56

I think once I was up and running, I think once you know you sort of gathered momentum and knew you were onboarding, the team that you're working with. And I think it was better. And it's quite hard to go into an area and say week one I've never met you before but here we go we're going to start with this. There was no sort of introduction, really, a bit of, you know, you don't. You just perform doesn't allow fine you leave and time often people are having days off, you know, it just says right you're gonna roll this out over this period of time. If you're off or they're off it's tough shit you've got a deadline for it it's tough that you've got to carry on. Yeah. So if you're a person that you need to liaise with on the board Isn't there any particular point in particular at the very beginning, you've got a lot of

jt 07:52

catch up to do so. The sprint, and the perform.

08:00

They call it a whale.

jt 08:02

So perform well on each week, then you go on to another bit and it doesn't allow you to. So, it's quite rigid, is that,

AM 08:10

I think it's I think it's uh yeah i think it's rigid. There's only. This probably to age, maybe three ways around it that the Sprint's get extended way or the rollout gets extended to allow for key people to be off, including yourself. And also, or the other way would be to have a team of people that you actually chosen to be able to roll stuff out because there's a lot of managers that like to be in charge and people won't make decisions without them being there, and they can be a real hindrance to how successful that rollouts gonna be. If key that key individual. As it turns out, isn't there to say, Well, what can and can't happen. Then you sort of fell before you started so have a team of people that are trusted to make the decisions. And also I think the understanding of what for me is and allowing whichever individual to make some, some changes and test changes within their workplace, you know that understanding needs to happen as well because I think that isn't understood when we're trying to get people to problem solve on their own and not escape manage to their leaders. So I think there's a bigger bit of work to be done prior to any rollout. So there's understanding amongst the team that we're working with about what could or couldn't happen.

jt 09:50

So the bit you think needs to happen is someone needs to scope it and say either do the conditions exist for change. Is that right,

AM 09:57

yes, conditions exist for change and, you know, what are the like the three top three, three things that really need to be allowed to happen. As in, you know, if the leader isn't there, the manager isn't there. Who's the second in charge or third charge. Or can we just make changes as the team sees fit because it's an area that can that that can happen to without there being any effect on patient care.

jt 10:33

It sounds like there was. It was quite rigid and structured, but then you felt that you still managed to achieve some results from doing it.

AM 10:44

Yeah, I think it's more than that.

jt 10:46

And it relied on more like your personal skills that we're sort of saying,

AM 10:52

Yeah, I think you have to be quite resilient. I think my deployment deployment to the area was quite resilient. Yeah, I think they might base that on my band background. I can't be sure of that. But I think that might be what happened.

jt 11:09

Yeah, okay. But with hindsight you're looking back and thinking it was potentially a challenge and a challenge in time.

AM 11:16

Yeah, new manager. Yeah.

jt 11:21

Okay. So, what would you say, how would, how would you have been asked to report results, or what would it would it be clear on whether you're succeeding or not because I know you said you weren't getting much feedback from your line manager at the time. Yeah.

AM 11:44

So in terms of results from line management. There's probably no real reporting back about how I was doing other than you're doing okay you're good or whatever but there was nothing to substantiate them. In terms of reporting back tasks that we had to complete, you know, we had those key or the call now the TPM, which we have to get to.

jt 12:27

So they would set you like weekly objectives.

AM 12:30

Yes, objectives that we had to achieve. Okay.

jt 12:33

So in the original Sprint's, you're saying that. Maybe it wasn't entirely clear what you were setting out to do. But then you were given a weekly list of objectives and tasks lined up to this before we ought to go off and do it is that fair yeah

AM 12:48

yeah i think that i think that's true. And, however, you know, one or two of those wasn't completed. I personally would feel bad but then they'll go, Well don't worry about it you're like well.

jt 13:02

What was the point of setting I was quite

AM 13:03

setting these things in the first place, you know, or who do we hold to account for they're not being achieved you know you sent me the task to go and do it. I haven't done it, or I'm going to get it done. Two weeks later because of various things that are going on, but actually then no one held you to account and I think that's quite disturbing. And it's not it's not about holding the coach to account, it's about holding some of the teams to account as well. Best under less authoritative way.

jt 13:38

Do you think so the mechanism you stand in front of an objectivist board, and everyone say yeah we've done it oh yes we haven't you sort of said that you would say occasionally, I haven't moved that forward. What was your gut feeling about the self reporting of everybody else we that the confidence that everyone. Do you think that people were overestimating what they have achieved Is that what you're saying.

AM 14:02

I think there was some,

14:06

some

AM 14:11

reporting I think that some people may have come back with some of their results a little bit. False. Okay. I do

jt 14:21

show the mechanism for week one says go out and do a vision, the 10 people in a room and 10 of them would say we've got a vision.

AM 14:31

And I would be there three weeks later say I said I've got a vision.

jt 14:34

Okay. So, self reporting. It might be that people are more inclined to tell a positive story. Yeah. So how long, how long were you originally supposed to be informed for that system six months. So what happened so now we're in February, what, what happened

AM 15:01

was asked to stay by terraform for another year just to keep

jt 15:05

you on.

AM 15:06

They ask him for 12 months. Yeah. That wasn't for my request that was theirs.

jt 15:12

To do what so. So what are your journey now.

AM 15:15

So I would start really 12 months because, again, nothing substantial but they like the word that I was doing and perform what it means to stay. I went back to have this conversation with radiology radiology denied the extension denied. Didn't want, they wouldn't agree to the extension. I then went and spoke to the ball come back to speak to Malaysia. Before we set up some meetings with the divisional, Director of Clinical, who I told my story to who I work with in the past. She agreed that radiology had no justification for keeping me at that point because radiology was okay and staffed.

jt 16:09

And the benefit was to keep you doing this perform Yeah,

AM 16:11

she saw that this was being a benefit to me and my skill set and actually felt she felt that my skills gain skill set could be used to support their division more in a year's time doing clinical clinical governance.

jt 16:29

Okay. So, moving on. We've discussed that the forms had to roll out this perform well. And the results are off your set objectives that align to this wheel and the results are sort of self report to the team managers, what are the types of things that you're asked to go and do with barriers. Are you satisfied, are you set objectives and say we're, we're setting out to change this we are you tasked with going to deliver this perform well.

AM 17:10

How'd you mean. Send the first, our first wave. Yeah, we're tasked to go and do things, I think the the objective thing dropped off somewhat in. In our second wave.

jt 17:31

So we're not. We're not entirely clear on whether that were set to help a team achieve an outcome. But we're going to do perform to them is that,

AM 17:45

yeah. That's not the message I wanted to take. Yeah, we're not here to do perform we're here to support teams achieve form goals. Yeah, and I think that was very much a directive.

jt 18:00

So directive Annamarie please go and do perform to these areas. Is that pretty much how I came across.

AM 18:08

Yeah, I think so. Okay.

jt 18:10

Taught me talking about the strengths and or other aspects of that approach. Does it work i

AM 18:24

don't think i don't think it works. I like, I like this all it is a coaching approach but I don't think that works because it's an element of being to Softly, softly approach and actually is up, you know, people achieve things in different timelines with a very softly, softly approach whereas actually if you've got a bit, a bit of a timeline or a deadline towards things. Yeah. I think that will help people know that, you know, things have to be achieved by a certain date. And

jt 19:05

you said it was like that. Sorry, but he said it was like you like the coach and approach. Sounds like it's quite direct you're asked to be quite directive so how much of real coaching Did you feel that you were able to do.

AM 19:19

I think when it comes to shaves outlined in the, the objectives that we've been set. Set particularly that first sort of wave that we did. It was you know very much at each time that I had each week, I would say, this is what we need to achieve by this week. And then I would target my conversations around that with people on the ward, but actually it was the sort of the board manager at that point that had to actually achieve the chief the goal because of the way that was set up. So, you know, and he wasn't always available.

jt 19:56

So you're saying rather than a pure coach and approaches much more around using other skills as a practitioner to get stuff done.

AM 20:04

Yeah, I think, yeah, I think you have to sort of definitely pull on some other skills. Okay. You know, when we weren't coaches when we went out. We were shadow coaches or junior coaches or whatever you want to call us but we had no real coaching experience. We all came from different backgrounds, so I share that. That's very difficult to think, to say we're coaches or shadow coaches when they're in supervising. I think is quite dangerous. Okay. What about wasn't dangerous but where's the consistency and everyone has a different style of doing things but where's the consistency in what we're doing, you know, we've got band twos threes, fours five sixes and sevens going out, you know where's all the was on the skills they're putting on say they're all doing the same thing.

jt 21:01

So to be effective been involved in perform relies on polygon other skills just then. To coaching and development. Yeah, thanks. I'm so the new thing that needs to be some consistency in the skill set that people have gotten when they come in.

AM 21:19

Yes, I do agree that doesn't mean say no one should not be allowed to come, but I think there needs to be an element of making sure people have got the skills that are required. Not everyone can coach. And not all of our work is around coaching. I mean, though there's a thing about resilience, you know we're one of the team leave quite early on was our stance resilience, I think it was down to, probably a bit of lack of support, probably the wrong individual for the role. But how did you test that

jt 22:02

you spoke about about process confirmation earlier in the, in the chat so maybe, maybe that's a way. So just thinking about wrapping up this self reporting that coming back on objectives. Would. How would you sort of describe the objectives that were written for you, or that you're asked to deliver.

AM 22:27

I think in some ways are pretty basic. Okay, I think, I think it's to two things really early on when they were probably too basic on the internet. There could have been unachievable not well written,

questionable whether the some of them were objectives. Please don't ask me to give an example I just remember reading again.

jt 22:55

But that

AM 22:57

doesn't sound like an objective.

jt 23:00

So, some are too basic and some are real estate, and you sort of mentioned earlier that there was any accountability, if, if they weren't delivered so you're sort of saying that some of them sort of lacked any value.

AM 23:14

Yeah, if, if you're not accountable for achieving something. And it's not about saying you haven't done. It's about holding on to. If there's no the objectives were achievable, and they wanted them within that week, and we've got an achieve them then there should have been almost like a, an outstanding action. Yeah, has to still be done has to be done but after that we they were rubbed off. They were never written down.

jt 23:42

Okay. So it was almost activity for activity sake. Yeah.

AM 23:48

Yeah, probably. Probably. Probably not valuable. Perhaps, as an individual. Coach, we don't mentorship achieve that would rather than thinking one size fits all.

jt 24:01

Okay, so they weren't necessarily aligned to the goals of the team that you're working with. Yeah. So just wrap up with a bit of appreciative inquiry, and 18 months down the line, what do you think other. So what do you think are the biggest things that you've learned what do you think are the best things that you sort of achieved, and what do you think that they were based on.

AM 24:33

Thanks, but one is children's being difficult. Do you think that going back up three months after the sprint had finished, and having an evaluation meeting was quite key to actually the success of the whole rollout. Hearing that, the actual things that we had discussed and the conversations we had were actually coming to fruition. You know, the team was starting to realise that they could make changes do different things and worked in a different way to work better and smarter. Maybe the, maybe it was so progress but actually, you know sometimes things, if they happen too quick. They're not gonna work. Okay bits change that obviously but.

jt 25:30

So you're saying that slow progress is better than no progress. Yeah, no progress is no progress, because that sounds like what you're describing with the objectives. When you're new in the sprint term monitoring sounds like it was quick. Yeah, but what you're saying to me is that the objectives were just written up, which stand and say, Yeah, they're achieved when it's questionable. And then even if it wasn't achieved, it doesn't matter anyway because you've got a different one next week. So would you say it's easy to. Would you say it would be easy to go back and say, Did we make a difference in all the areas like do you think that you made a difference, like across the team, I think,

AM 26:14

probably not the difference at perform what it makes me think that they realised there was a bigger picture outside of their Ward area. And how each action is something we discuss quite regularly, while I discussed with the individual team members you know your action. You make for this patient has a knock on effect elsewhere, and a bit of realisation. I think for them. You know that they are a part of a bigger team, you know, and therefore blames each, each other's wards. No, actually, don't blame start collaborating and working a bit more cohesively with other departments but better. So I think there's other changes that they had such a big staff turnover was almost impossible.

jt 27:10

That's really helpful. Thank you. So think about just wrapping up, and I'll summarise some stuff back to you and then just a sense check. Yeah. So most of the, the work that we had given was task focused and they weren't necessarily considered against what was it was kind of a one size fits all prescription not considered against the benefits for each individual area. And sometimes the progress against that was self reported so it's difficult to know whether that that was achieved, as a whole programme or not. The. Sometimes the objectives are unrealistic and lacking value for the teams, and so is there a question about whether the any objectives that were achieved by the war teams have they been sustained.

AM 27:57

There was no evidence anything's been sustained. There is evidence to say the stuff hasn't been sustained in terms of like am discharges and, okay.

jt 28:09

So some of the objectives us have a quite arbitrary. You are under pressure to go and vote in a coach and approach.

28:17

Yeah, but

AM 28:19

he needs to slow

jt 28:20

it probably became more directive, and then when the support fell away from teams at the end of the sprint. So did that align with that sustainability. But in spite of that thing you're saying that you achieved some good successes with some areas. And that was built on pulling on skills that you previously had and aligning. What work you're going to do with individual teams needs. Yep. And then having honest discussions about actual progress, and being realistic about timeframes Is that fair.

AM 28:57

Yeah, I think that's fair. Okay.

jt 29:01

So last two questions. One is just a. What other type of areas I should have asked at the beginning, what are the type of areas or specialties across the hospital you that got involved there So you mentioned my spirit tree. Women's and Children's anything else that you got involved in or is it a bit. So you you were asked to work across quite a board abroad area of the trust and so some strategic plans, some stuff in EDI and some stuff. Without good or bad being given that broad remit or.

AM 29:33

I was quite, I was quite happy with it. I think I was probably if I'm honest less happy with. Being partnered with an individual at one point. Okay. So, some don't think it pull out relationships. Yeah. Don't think allow people to individuals to that particular individual allow people to shine and do their best.

jt 29:57

Okay, So I have quite a prescriptive way of working,

AM 30:02

totally different. Okay. Think pop some people's agendas, were different.

30:19

That's really helpful. That's not you.

jt 30:22

So the last, I guess the last thing. Overall, if you looked at the whole programme from your perspective as a coach in the comments. And if you just had to give it a good, bad or ugly rating, or something really, really simplistic rating, what, how would you describe it and why. And do you think it would be worth keeping them bought that they need to keep doing or change.

AM 30:47

I think the idea is great. And I don't think that the way we've worked is probably best. I think it still got many iterations to go before we've sort of achieved what it needs to be. And I'd hate for it to have the funding pulled from it, because it didn't. Perhaps work the way that the probably sold to the trust. Initially, I think we're doing the right thing by getting more tools in for the each element. So I think it's the right thing for teams to do and to think differently about the way they work but we have to be mindful of, you know, frontline teams that are incredibly busy. And I think there's a lot of free work to be done before you actually roll out anything. And it has to be that we have, we have been mindful of both the actual achievement, you know what the outcome or objective of us being in each area is before we go there. I think that's something that the total team leadership here need to outline you know in a sort of a six month build up, maybe, you know, on to any sort of all.

jt 32:24

That's great. That's really helpful. And then just to pick up on something that we've just said before, I think you were describing it before the recording went on, around the a bit similar to gardening.

AM 32:36

Okay, so, um,

jt 32:37

so a bit more about that, if that's okay.

AM 32:41

So, think when we were implementing children's, we were finding it quite difficult because of the type of teacher working with a type of what they were doing. And the layout of the department. That probably communication that was with each department. And all the conversations we're having about change and how things could work better was sort of not welcomed in all cases all the time. And so some of the bigger changes that we wanted to see, or we thought would help didn't actually come at the time of the sprint. But it was more about having those conversations and almost planting the seed at the time. And we didn't realise this until sort of three months old and that actually some of those seeds that we planted have now grown. You know people are actually starting to see that these were ideas that they could use and starting to really adapt to.

33:47

Yeah, some of the changes.

jt 33:51

How does that feel in comparison to the setting objectives, because you've planted the seed How's it feel now that you see the, the green shoots of growth, three months down the line.

AM 33:59

That's quite satisfying. Actually, there was some good work done and it was just going to take, you know we just had this realisation, it was going to take a little bit longer to get there. But actually, you know, plant the seeds in the autumn and, you know, the bulb in the autumn and out they've come in the spring. You know, they've sort of done it naturally they've sort of gone away and discussed it and whether it was just planting that seed and not realise the seed was planted, and they brought it up in a meeting or, you know, they've had a conversation with another team you know the seeds there. And it's just about having that influential conversation that they didn't realise was there. And then them adapting into that and taken on to a later date. Great.

jt 34:53

Sounds fantastic. So if it was going to continue, and you've got a choice of approach that you were given when you started, or the approach that you built, towards the last bits of where, which one would you choose and my

AM 35:09

I'd choose the sort of latter way of working, but more defined objectives,

jt 35:17

so just describe that mean really succinctly. So you think you prefer. I think more autonomous way of working in Yeah, so just describe that for me really succinctly and then we'll wrap it up. Nice. The

AM 35:46

second way of working was better. It was more autonomous, and the only difference I would make is that you any sort of objectives were made with the team that you were working with. not described by the leadership of perform unless there was something critical that needed to happen, in which case you'd still go back and discuss that with the team that you're working with. Perform shouldn't be descriptive it should be

36:19

named. Yeah. Amazing.

jt 36:24

Thank you for your time. I gotta stop my thing that says I've got to stop my thing but I said, I'm gonna. Okay.

7.3 Interview 2

Cal

Wed, 4/8 11:45AM • 21:46

SPEAKERS

jt, Cal

jt 00:02

Third time Okay,

Cal 00:04

so my background is the acute medical unit is about full price. Working EDI is a healthcare system and everything else we will start with crew always been involved in quality improvement projects I've been a strong dimension champion and dimension lead for the trust as well as on the wards and coming to perform for me was about taking the next step in how to affect change within the organisation and try and learn from a team that were the creme de la creme of performance management and change management, and quality improvement. Cool.

jt 00:37

Where did your cue background come from.

Cal 00:40

So that was mainly just spotting things as always on the wall and thinking actually I think this could be done a different way this could be improved on and speaking to lots of people within the team about how I would go about that. When I was in the trust the quality improvement team were kind of just starting out, as it were, and so eventually I got linked in with Dan with Barton moraine, and who basically start to show you the structure that they were using to roll out quality improvement projects. As part of the grief, system practitioners you do a whole module on quality improvement. And so it linked in quite nicely. And then I started to do my performance improvement work, aligning to the same structures and processes that they were using just I was speaking and using the same language in the trust, as everyone else. Cool.

jt 01:30

And why did you What do you like about QA, why did you go and do it in the first place.

Cal 01:37

It's nice to see where you're at, what the current situation is where you think it could get to so making that prediction of actually if we could make this change or if we could make this improvement, we could get it to this stage, but QA kind of gives you that structure to hang something on of what steps you took and how we kind of got there, and then also helps you link in with others so that they can see the value in what you're doing. So I find that really useful to be able to showcase not only what I was doing that then make it useful for other people to use again in the future as well so it was a continuous thing.

jt 02:18

So I told her a bit about how long you've been in, and what types of teams you've been, and the type of work you've been involved in. Okay,

Cal 02:26

so in perform I've been here for just over six months. Starting on intensive care and working with the team they originally invited in with the task of looking to make some improvements around flow and patient discharge from ICU back to the wards, and we work through that with the team of me and for the coaches, which was quite interesting. It was kind of my first project within perform. And my first exposure to using the performer methodology. And then from that I went on to the neuro team and started working with stroke teams specifically with a very big ask at the beginning of redesigning the whole patient pathway, but then working with key stakeholders in stroke to actually tailor it down to what I could support with and what was realistic and to draft a plan, basically, and then use

the key stakeholders to really drive it forward and be more of a same board about how to use the methodology, and how to implement performing an effective way to felt was a bit more structured than the original ICU work.

jt 03:39

You said how to use perform in an effective way.

Cal 03:42

Yes.

jt 03:44

Can you say more.

Cal 03:45

Yeah. And so perform in my view is a set of tools to be used by teams to enable them to affect change. And as with any tool it's only as good as the person using it. So you need to have an understanding of how to use the tool, and when to use tool appropriately. And essentially, if you take any of them, like visual management. It's like giving a team a hammer and saying, here's a box of screws now go and put everything up on the wall. If you don't know how to use the tool appropriately. It won't have the same effect or efficiency that if you use it correctly. And I think that's the role of the PERforM coach really comes in and shines with a really good coach, from what I've witnessed and other people in the academy as well. It's knowing how and when to use the tool and describe how the tool is used effectively with the team gets your biggest result, just giving people the tools with no explanation or guidance on how to use it. And with teams feeling a bit lost or not seeing the value in the worth is the tool.

jt 04:51

How'd you feel about the description of perform wheel

Cal 04:57

useful and non useful, and I think it's good that it does follow a structure so from the very basic element, it does walk you through it, but having the structure is great, but the flexibility of the wheel means that sometimes people don't appreciate that jumping back and forth, or actually having multiple elements running at the same time, is what teams need, and sometimes it can focus teams too much on this week is visual management, so they focus completely on visual management, but they're actually raising some really good things that might be come later on the line into routines and practices, and some of the coaches sometimes in observation can shut conversations down or shut opportunities down because the focus isn't on that element that week when actually that's the

prime time to really explore that and run the team together. And as a coach you need to spin multiple plates. Understand, when to keep one's going and when to stop ones or pocket, which is a skill.

jt 05:59

So you say the way that it's described as a wheel that must be done sequentially isn't particularly helpful you need the idea to be able to spin the wheel around like a wheel of fortune.

Cal 06:10

Yes, spinning so when you need it, and recognise when you need to switch back and forth,

jt 06:21

think that's a great way of describing it it's really helpful. So talk to me about your approach because it's described in the literature as a coaching approach, and we spoke about coaching, in particular a couple of times, what's your experience occasion, what's your experience of coach development here. How much coaching Do you think you've done and how much other improvement type stuff Have you had to do to make it work. Okay, so think

Cal 06:55

coaching has been really useful. Coaching has been really useful as a style. And again, this is skill in knowing when to coach the person that you are with or the team that you are with. If you're working individually one to one coaching can be really useful and beneficial. If you're working within teams or groups or meetings, which you often do as a perform coach, trying to coach, a mass of people can sometimes actually be more complex and brings more problems. If you're generally asking a coaching question you want someone to think about the response and get them to explore all avenues. If you're in a group situation, it's quite common that someone will try and jump in and get to the answer quickly, which when you're coaching isn't necessarily what you want to happen. So switching to a different type of style is more beneficial there. Also because we're dealing with clinical teams, having dedicated time for coaching can be quite tricky, you have to be adaptable to the situation as it presents to you. And so using things like motivational interviewing and brief intervention can be more beneficial to sow the seeds of an idea or change methodology, and then picking those back up and having dedicated coaching time with key people, and can be a bit more beneficial. Having coach in the title. Sometimes I feel restricts the team from exploring other ways of communicating or getting ideas out there. It's quite handy to allow the person to realise when to coach and when not to coach.

jt 08:39

That's really helpful. You're the second person to describe it. So in the seats. So I think there's something in that the. Tell me what you think. work that you've seen, and why.

Cal 08:54

So for me it's always going with what did they want to achieve, even if we have an idea of what he needs to do or if we've been asked by someone. Senior in the organisation to go in and help them implement something, or we start by going to ask the team, what do you want to achieve and what's realistic for you to achieve and nurture that idea. And it gives you buy in from the team, it shows that you're interested in what they have to say what input they've got, and then build off that to eventually align to what you're also trying to achieve. So rather than forcing a team to say right you have to work on this target will this go. If that's not the target we'll go, they want to work on, it'll feel like it's being forced upon them, and they will reluctantly do it, which also mean eventually they won't stick to doing it. As soon as you step away they'll go back to what they want to. If you use the hook as, I'm here to work with you to achieve what you want to do, that's realistic and we've got a timescale and it's to showcase you your team and your skills and not what I'm up to, you're more likely to work together and get them asking you and involving you in what's going on. So you find yourself then getting invited to meetings and conference calls CCE even to emails that necessarily you might not have before. So opens up more avenues and improvement work generally eventually everybody wants to improve everyone comes to work to do a good job. So you can align what you want to try and achieve what they want to achieve, because at some point, a lead or a lag KPI will eventually join together in some way or form. So if you've got to do a little project with them first to get buy in. Do that and then that should align to the, the bigger goal the bigger project.

10:39

Lunch

jt 10:43

lunch. So lunch again. That's wicked. So talk to me about the types of results that you've seen come from, where or what you mentioned ICU, what do you think you guys achieved in ICU,

Cal 10:59

the ICU, they were a team that initially invited us in. But I think, you know, NICU Vera team that initially invited us in to do some work with them, but it became quite apparent quite quickly that they weren't ready for what the process involves, and they saw invite as a team that was going to come in and do things for them, rather than it being a two way street and they would actually have to contribute to the process as well and be prepared to deal with the process. So it kind of an earth ICU internal things within the team that they needed to achieve. First, but I think what you could say we did achieve in ICU is we gave the team permission to ask questions and challenge the status quo. And they require a hierarchical team to start with, and things that they were using to express an ease or difficulties in processes were being shut down by senior management quite quickly and not addressed in an appropriate strategy or way as being very encouraging conversations and encouraging structure to how you raise a problem and deal with the problem, gave the team more of a voice in an appropriate way so we turned. Essentially what was moaning into constructive feedback, and allowed people of all grades to structure what they wanted to say to the senior team. That should have given them a way of driving results without it being unproductive. So I think that

was the biggest winning ICU is just giving a voice to people at all levels team, how to challenge in an appropriate way. Okay.

jt 12:43

What benefits you saying that boards.

Cal 12:46

So I think as a team that thing with as a team. I think that enabled ICU to take the first big step in their journey. So I think, perform, we generally have talked about working with teams as sprints and using a 1213 week window to work through the tools and programme, with the teams that actually should probably be a lot longer journey with you start with perform but then actually there are touch points, going forward, this is the first step in the journey. So think the outcome we got from intensive care with it, change their mindset and step them onto a different path to be ready for future change and future challenges, and future adaptations. Without us going in. They might have been six months a year down the line, and those moans would have carried on as loans not being constructive. So although we didn't get the outcome that they initially invited us in for, and we didn't achieve the goal we initially set out, we actually still got a positive outcome from it because they're now in a better place, and they understand as a team, what their challenges are, to the next time that they ask for support or help, they will have a better understanding of what that involves, and what that support will look like.

jt 14:09

Just saying when leaving them with some change capability. What was the original goal that you were setting there today,

Cal 14:17

original goal was to instigate them using flow. Okay. And standardising the process for a patient to leave ICU go into.

jt 14:28

Okay so quite sort of task focused

Cal 14:31

very task focused. Okay. And something that had come from the senior team Dan Rather than the bottom up approach from the team. The team is actively involved in a discussion, or you're

jt 14:44

involved in. What, what would you have used any models or theories in terms of how you were going out to do stuff or were you just relying on other perform methods or to perform well to guide you through.

Cal 15:02

So my face started in intensive care. When I first started in intensive care. It was my first project within the form and me and the coaches were all using just the PERforM elements and and using the performer tools. But, in hindsight and reflection and actually using different tools and different approaches at the start, might be more beneficial. So rather than sticking to just what form dictates should happen. Having a more flexible approach and not sticking to element by element week by week. Understanding actually at certain points different members of the team, different teams are at different stages. So using things like the forming norming storming forming teams and categorise we teams where people within their teams for the readiness for change would have helped us tailor our approach to make them more effective and more efficient, as opposed to just coming in and presuming that he was at the same level in the same stage and same understanding of what was being asked

jt 16:19

will be found to be the case for six months.

Cal 16:22

It's been interesting to see the different approaches that people take, and it's been really an energetic and energising to see how much the teams out there really want to make a big impact to their daily lives. Everybody in the trust wants to make an improvement. Their knowledge of how to go about that improvement in a structured way is where they seem to get the first, third or pitfall, and it's been really nice. As a coach to actually see how we can help them get over that first hurdle, and teach them some of the skills along the way so that each new hurdle that presents itself, they can start to get over it and start putting the plans in place, and it's nice to go back and speak to some of the team that you've already worked with, and then start seeing them using those tools and practices for their next project that they are leading with and we haven't been involved with. So intensive care for example, to key people that were in intensive care and are running their own projects and using some of the tools and techniques that I was helping them to understand in their new project which we've not been involved with at all. So it shows that they listened to learn and taking something on and either applying it themselves.

jt 17:49

So, if we have two questions. Overall, would you say to the programme make a difference. And do you think you'd be able to quantify what that difference is because you've spoken about some really powerful stuff which feels great. But like X Factor stuff is tangible. How do you measure change capability, but doesn't mean it's not worthwhile. So, overall, I think the programme made a

difference. And would you say that there's any measurables that you could identify that helps you say that.

18:29

So, overall.

Cal 18:33

Overall, programme has made a difference. And to the overall organisations I do have what changes and how we go about it. And I think we're still at very early stages within the organisation we're quite a big organisation. Perform has touched base with a lot of people, but we have only touched base, and I don't feel like the performance elements, tools, and way of working is fully embedded in the organisation, because of the size of organisation and our staff turnover. It always needs to be a constant thing for this to be embedded in all areas of the organisation. Performance just starting to leak into other areas as well rather than just being a standalone almost product in the trust, and for us to have real lasting impact if you like it doesn't need to leak across all divisions, all areas, all communications it's consistent and a trust approach, as opposed to a standalone thing to look at. It's useful to do the standalone approach to start with people grasp the base ideas. Some of the things that we set out to measure in business analysis and things is really obvious, length of stay being an example, and turnover of patients turnover of staff, but they are quite easily identified as quick wins when you first go in and try and identify improvements with teams. Some of the other more complex stuff like readying ICU to change and for the next step is more along the qualitative than quantitative side. And so staff feedback can make it measurable looking at things that they use like the happy app and the comments that they're using. You can pick up the language and see the difference of before we went in and after we went in and the moment to be using as a change in behaviour, that makes it quite difficult to quantify it measurably, and that the staff attitudes and behaviours. I think you can measure as being a different before intervention after intervention. But recognising that actually what we went in and said we were going to start measuring flow as an example. As a quantitative measure. Great. We didn't achieve that. But what we did achieve was a qualitative measure instead. And recognising that a long term journey. Those are the things that will have a bigger impact. But you're not going to get your quick wins from all of it and working with some of the divisions and like I'm doing at the moment, it's quite interesting to actually see the mix of the two. And recognising when you're talking to teams that what you can achieve as a quick win. And what are going to be long term goals, and how you're going to measure those separately.

jt 21:28

Great. That's really helpful. Thank you. Sorry about that. For interruptions at the beginning. Yeah, anything else that's helpful to share ledge.

7.4 Interview 3

Farukh

Wed, 4/8 12:50PM • 16:35

SPEAKERS

jt, FN

FN 00:00

Okay,

jt 00:01

yeah. So just tell me really briefly about your background. Any, any sort of experience of coaching and stuff before. And what you came to like when you came from, how long you been on. And what you came for satellite.

FN 00:15

Yeah, okay. I joined NVT in 2017 so the reason I joined Nbd. My background is hospitality. But I wanted to change my career, and wanted to do a monster so I chose monster MBA. And that's the reason I joined MBT, and my plan was to work at NBT gain some experience and do my learning as well, and at the same time, I had this opportunity from perform come through. And I thought it's, it's a very good opportunity for me. I could learn more skills, and also I can use my learning in, in my masters and put something in practice and try. So that was the motivation for me to join perform. And they also heard of the great success perform pad at NBT and was really excited to be part of the team. So that's the reason I joined. Before I joined in 2019, end of March. So yeah,

jt 01:31

great stuff, how long, how long have you been in now about a year.

FN 01:36

So yeah, it's been yeah it was one year second starting in April until April 2020.

jt 01:44

Perfect. And just anything in your background about your skills relevant perform before.

FN 01:53

So the skills relevant to perform, like myself, I've got great years experience managing and leading bigger teams in hotels and I always came across, change it real time because the time I started in hotels in 2007 and eight we had the credit crunch and we have to do a lot of changes so I was really keen, and I really enjoyed change at the time and actually gave me opportunity to grow as well

because I could think differently bring in changes. So it was very exciting time for me and I thought I could apply the same here as well, and try and bring in some change so that was my motivation.

jt 02:47

Awesome. So moving on very briefly just describe the type of areas that you've worked in and perform.

FN 02:58

So when I joined. And I was deployed in women and children's unit. And we worked as a team of four coaches so we had two experienced coaches and two of us were new. So, basically, above we worked as a team. And I predominantly worked in the amended birth centre and the word postnatal ward in medicine women and children.

jt 03:29

Good stuff. And you've worked in other areas like ICU.

FN 03:35

So that was my first spring so it was for three months and after that, we moved on to help in nickel and from Nick who I worked a couple of months in ICU as well. And then I've worked with the medicine division and help with the ideas team, bringing in some change and bring in some performance petrology to the team so these are the areas. I worked in the hospital.

jt 04:10

Good stuff. Thank you man, and so on that broad range of teams you work with, what are the types of goals that you are sort of sent to was it Did you have a clear goal for each of those that you were sent to do.

FN 04:26

The goal or the objective. We have set objectives what we wanted to achieve. So, basically, it was the outcomes what we wanted. At the end of the sprint. So when we went into mandate, basically. Our goal was to save like 10 bed spaces in console So, and just helping the team to cope without those 10 bed spaces. So that was one objective. And also, another goal was to discharge patients or reduce the length of stay, and to mostly aim discharges so the patients go home. Before midday. So, these are the main objectives or goals or outcomes we wanted. With the sprint. So yeah, we work towards that using the performance methodology delivery loads those 10 elements.

jt 05:28

Okay. Talk to me a bit more about the your understanding of the PERforM methodology.

FN 05:36

So the before methodology. It actually is a mix of, like, all different methodologies like the concepts are taken from the different improvement methodologies like continuous improvement Linson Lean Six Sigma so the concepts all taken from those, and put together as a group of 10 elements working in a cycle. So for me, it's a very systematic approach to going into an area, and then bringing in some change, which uses the coaching style as well. So yeah that's that's the performance methodology, but a lot of things are coming from, like, the continuous improvement and lean. Lean Six Sigma so how to problem solve and improve improve the staff, so it's got like 10 elements and it's very systematic approach. In my opinion it takes a bit longer time because you are supposed to deliver each element it's more like. It's more structured that we don't want to change. So, as coaches when you go in, you are strictly set like first week vision second week, visual management, third week visual management board. And so, it's, it's like more like a. What do you call like like a military, it's all set like and you do according to that. So for me, more flexibility would be would be nice doing different elements in different time. And mainly perform users coaching style, but to bring in, bring in any change, you need to first understand the human behaviours, which is very, very important if you see, Kurt Lewin's Model Model of profound knowledge, if you see human behaviour or human factor is the main thing, apart from the other three elements as well understanding the process theory of knowledge on that so for me, that's where I think of, for lack of a bit because it tells about introducing all those 10 elements, but it doesn't give you that knowledge about how you understand those human behaviours and bring in that change so that's where I think it fit in. In actually delivery. So, yes,

jt 08:38

that's really helpful. Thank you. So you mentioned that a bit more flexibility would be nice so. And you said that it's very structured. Talk to me about the type of results that you achieved

08:56

FN 08:59

the results. You see the first deployment, working with mended. I did you perform methodology we tried. And then we successfully went through all those 10 elements. The difference what I could bring in was like the team came together. And then, what, what it helped was like the team could work more efficiently, their communication was good. So they, that means like they work more effectively. The mothers were seen like before midday or the mothers and babies. And also patients or mothers were discharged bit early. So these were the little changes which I could bring in. So, it was challenging, while working because just to go and introduce all these changes. We had a massive resistance from the midwives, the midwives, are really challenging. They said they are always busy and they are always busy because they take care of mothers who are basically giving

birth a new life. So they always busy safety's massive challenge to change their behaviour mainly. So it was a challenge and how I did overcome the challenge was to be very patient and look for those little opportunities to speak to them and, and then make them realise like how they could do better and showing them like things could be better, and the advantages of it. So once they started to realise that they understood the value, and then the change was a bit easier. So, I think, flexibility, being more patient, and then working around the team was the key for me to bring in those changes in that area.

jt 11:23

Fantastic. Thank you, mate. I'll just start wrapping up. But I think that overall. would you say the programme made a difference.

FN 11:45

I'm not the person to say that we made a difference. This programme. So, basically. Like, if you see performance elements. The main thing is about, like, going through all those 10 elements, but all those things working together, it didn't happen. Actually, it was like, making them things for me, continuous improvement is more, more powerful because it's about bringing making some brief interventions, finding something which could change. And also I believe in changing people developing them, which actually through perform you can't see. Doing that much. It's just mainly talks about what to be done at that time it's like a fixing a problem. But we need to think beyond I think bringing in more like continuous improvement is also about innovation bringing new ideas and how you develop those so I think we missed a lot on developing the people there. Like if the biggest challenge I had was the leadership so they really lacked leadership. So I think those are the things which probably. We might have to focus more. That will bring good change and the sustainable change. So what we did with performance, like effect at that time. But if you think beyond the future and bringing in some sustainable change it has to focus a bit more on the people developing them, and the leadership and looking into innovation and new ideas so I think it should be a little bit different to how, but I could say we did bring in change through performance, it was a small change for that time. Like, during their huddle meetings, which improved and made them work a little bit efficiently.

jt 14:05

Thank you, man. That's really helpful. I'll Um, I'll let you get on because I know you're really busy. Is there any sort of last comments around like whether that you think that there was anything that you couldn't measure that you knew was effective.

FN 14:24

Yeah, like with the recent deployment in ideas like with the case managers. It was really hard to, like, we wanted to have some KPIs and we wanted to measure them, and it was really hard to see, and measure directly what impact. We could bring into the case managers and so the measures like the quality measures, or really difficult, especially working with perform, and the dashboards we have we could measure all the like KPIs but anything to get the direct impact was really difficult so it does

make it hard to see what the impact we are creating with the team. So that was all of the difficulty we had measuring.

jt 15:21

Thanks, Mike. So, overall, and in a word or not any good or not

FN 15:33

good performance. Good. I think we had some very good success. But I think now we need to think about changing our strategy, and adapt to the new things, and the new challenges. So I think, perform is a very good base. And then we have to move on now, and evolve and change the approach and change how we bring in change and understand a little bit more about the people's behaviour and focus on that and we could bring in a good change.

jt 16:13

Awesome. Thank you, man. And while I let you get on with the rest of your day but I really appreciate you taking the time to give me a shout. Okay. All right. Thanks, right, and I'll see you. Maybe tonight or tomorrow. Okay. Perfect. Have a good day.

FN 16:30

Thank you. Thanks.

7.5 Interview 4

Freya

Thu, 4/9 5:48PM • 25:25

SPEAKERS

jt, FM

jt 00:03

Between, like, it doesn't like him. People talking immediately so like give it like one second after I finished talking to register Yeah. Is that all right. So

FM 00:38

we tried a couple of different approaches in different areas with varying degrees of success. One was more of a structured approach. One was more of a supportive approach. Do you want me to elaborate.

jt 01:13

Yeah, so...

FM 01:14

I think, on my first deployment, it was a children's that was much more of a rollout for methodology in a structured on to 10 step. And there was an expectation that this would follow a cyclical process. And it was a new area that hadn't previously experienced before. Whereas, I had another deployment within neurosurgery where a more flexible way of working, was adopted that facilitated more of a supportive approach, acknowledging previous support by other members of the team.

jt 02:13

What do you reckon. So, key differences between the two what would you say,

FM 02:27

same agenda. But this last one was quite a structured approach, without consideration for deviation. And the second one was much more of a flexible approach to a situation, say, in neurosurgery approach appeared to work better because it was about assessing current needs and the service and more support in them. To bolster postable and already been done. Whereas, women's and children's objective seems to roll out as a page to a targeted task or objective. I guess the main differences the objectives seemed more ambiguous in women's and children's, whereas the flexible approach in neurosurgery allow for more honing of ideas and more focus.

jt 04:06

So how would you say that they were received by each area. I think

FM 04:14

the virgin children's approach, left everyone, a little bit confused probably isn't the right word. And. But if you're asking people how you can help them you can support, but they don't know what you can help them support when it comes. So if there's not a clearly defined objective early on. It's hard to gather momentum and build wealth, whereas the neurosurgery approach, very much, looked at previous work that had taken place around discharges and recognise previous attempts and use that to capitalise on the needs of the service sector work with the surgical team to see the advantages for them. It was much more of a holistic MDT approach, as opposed to focusing on one specific team. I think previous attempts have largely been directed towards nursing teams, as opposed to taking in a more multidisciplinary approach.

jt 06:03

How would you recommend the teams received. Compare and contrast. So compare and contrast the two approaches how'd you recommend the team, the teams that you were there with received each bit.

FM 06:23

Save I think the teams were very different. Whereas the children's have named previous exposure to before, and what it may or may not offer and didn't have some of the IoT technology that is available within the main building, which perhaps change things slightly. But don't think there wasn't a lack of will for engagement, but I think there was uncertainty around what was on fun. And what could be expected. I think in neurosurgery. having had prior exposure. That was already an understanding. Knowledge Base of what it was about. I think there was fatigue, from nursing teams who felt that they had been quite targeted with a new approach. The incorporated medics page to rejuvenate the process.

jt 07:54

And so, just in terms of results from that alternate actually talked to me about the types of activities that you might have got up to where those dudes.

FM 08:07

Say, I think deployments were around kitchen. Before women's and children's was more ambiguous because nobody really had a clear objective from the start. Whereas, that was an objective in neurosurgery. It wasn't particularly a new objective. But because of the different approach. It was about identifying key stakeholders that were then able to find daily influencers within their teams to really drive forward change. So that was an element of coaching, mentoring and MDT working.

jt 09:28

So when you come into form your title form coach, a lot of emphasis on coaching. How much did you experience being asked to be a coach. Did you find that the most useful approach or. It sounds like you developed your own pluralistic approach, approach. I think

FM 09:57

the conception of coaching is generally still quite misunderstood. People still yet to understand what fax offers more back means people think, by having the word perform there is an assumption that will lead to performance manage. And, in reality, you're, you are there to support teams. But you know, that performance manage, and I think that's quite an important difference in distinguishing between the two women to children felt very much like they will be performance managed. Whereas neurosurgery appeared to understand that it was about trying to improve performance, which I think was a key difference.

jt 11:10

Start over. Okay. So, I thought that Damien is interested in Tim, you say a bit more about that.

FM 11:25

Largely methodology and principles are management and leadership, techniques. And to recognise that teams already function with people in those roles is key. As a leader, or a manager of an area or department. One of the jobs of that person would be to identify members of their team, who have certain skills and attributes to to delegate responsibility and to act on their behalf. Say, these are what I'm calling your daily influences the people who are there on a day to day basis that can carry forward ideas and notions and encourage early adopters to new ideas, people that are keen and enthusiastic, know the day to day running, and can generate energy and enthusiasm for something new. The people that are on the ground on front, doing the jobs, ones that know how to find those small little differences, or those subtle differences to the current processes that can get you those real wins.

jt 13:08

So they're really super connected motivated,

FM 13:20

- skilled influencers who do stuff on a daily basis and get it moving are already – they're embedded in the job. They, they do it, they know it, they can see why things may need improvement. And perhaps they've not previously felt that they had the ability or support or encouragement tackle some of the long standing challenges of an area or department junior doctors, a classic example they will be on a rotation placed, so they will come and go. And often they feel like they just have to adopt ways of working within that area. Because actually to implement the change, they're probably not Bellona. Whereas someone I could read strong he was trading a specialty, who has vested interest within that area, who wishes to develop and progress in that specialty or field. They are the people that I think would have been the people I've been looking for for your daily influences the people that are kind of already invested in that service. So, in terms of nursing it might be your, your band sixes or your or super keen band fives those aspiring, the next level. I think would be my daily influences people who have credibility, within the team. People with ideas and innovation. To take stuff.

jt 15:42

So if you're going to look at perform as a whole. And then you've got two different experiences, would you would you say it worked.

FM 16:01

I think there needs to be better understanding around fundamental principles and elements of before I think there was a lot of superficial understanding, rather than deep understanding of what a gentleman meant, and the wicked nature of those. Say, I think perhaps Jiu Jitsu the structure. Some of these key fundamental principles theories etc and they have been diluted during the prior year 18 months before my arrival. I think a solid understanding would create the best foundation.

jt 17:12

What's your opinion, the best way to get that solid understanding

FM 17:25

recognising that they are leadership management principles is a good starting place.

jt 17:35

Lots of

FM 17:37

reform is not new. I think it's about the delivery of what it is. I think Dowell form could go under the radar and you wouldn't know. you would recognise it as good leadership and management. In order to develop it. I think it's about looking for those aspiring individuals who wish to arrest. These people are made to baited and want to have a real genuine desire to improve things. By helping them to develop their management and leadership skills.

jt 18:57

So last question then. In terms of tangible results from the overall your overall experience of two quite different specialties. What would you have measured or what would you be able to report back and say, Actually I think we achieved this, because you spoke about some cultural stuff which is around. Facilitating some goals but what would you say that you achieved in each bit.

FM 19:32

Women's and Children's I think the reality is it's hard to provide any data or demonstrate any real change. It's much more of a qualitative reporting mechanism. Whereas, neurosurgery this appears to be simple quantitative data that is supported supporting the new ways of working.

jt 20:12

What would be an example of your data that supports your neurosurgery way of working.

FM 20:20

So during the time where they changed the fundamental way ways of communication. There was a 18% increase in a discharges which could be attributed to earlier TTA submissions.

jt 20:40

So one in five increase. How did that go down with the team was that seemed to be useful or thought to be useful. It was

FM 21:03

challenging to really ascertain. Because the team was going through some other changes as well. I think it probably needed a longer assessment period to really see how the team was changing their service. But it certainly helped to support a new way of working, and has facilitated in what appears to be embedding any practice.

jt 21:48

So the main changes in both would appear to be cultural, maybe easier to identify some quantitative measures that were helpful to sort of onboard some people in neurosurgery. And I guess if we're just going to wrap it up and say, as a whole, do you think the programme made a difference. How would you sum up

FM 22:20

sporadic patching. I think it comes down to it comes down to building report showing levels of commitment. Demonstrating flexible ways of working.

jt 22:46

So pockets a good stuff and then pockets of stuff we don't know whether it's good or not.

FM 22:55

Yeah, I think more needs to be there needs to be more robust data. Understanding around what has worked and what hasn't. That's cool.

jt 23:19

Well did you. I should have asked at the beginning but your clinical and you've been there yet. what, what did you come for perform for originally. While you're doing that.

FM 23:37

And I'd like to think I recognised that it was effective leadership and management skills. That could be transferable to any area. Say I felt that I was in a position where I had a couple of options, where I could choose to stay and develop within my current working environment, or come and work with an elite team who may have a different set of skills, knowledge, and background. Say to pick up a set of transferable skills that I could take back to an outpatient area.

jt 24:34

How much of that original goal Do you reckon you achieved.

FM 24:48

That's been learning. I've learned things that I perhaps didn't expect to learn and learn stuff that I thought I would have. I think a lot of it. In theory, sounds lovely. But there's a difference between theory and practice.

7.6 Interview transcript 5 – video

Perform Programme Lead

I think, as there are always with these things, there is a little bit of anxiety, not quite knowing what to expect.

CW - Perform Coach

What do we think about it, probably apprehensive, but equally recognising there was a huge amount of will out there to make some changes.

V D - Quality Improvement Practitioner

I went on my first boot camp, probably April time, and by then a few other people had been, and if I had any reservations they had all disappeared.

CW - Perform Coach

By the end of the day, the buzz in the room is tangible, you can cut the air. We have had people from all works and services, catering, cleaning, everybody has learned something, has got something to take away with them, and really think about how they can make a difference on the ground day by day.

EA - Perform Coach/Matron

My team, most of them have said, what is really important from the boot camp, what they've learnt, is how we upskill people.

Perform Programme Lead

We started this program and, kind of, adopted 'Perform' with a view to improving the hospital. As it went on, and actually quite early, we realised that this tool is really powerful, it can be applied to anything.

Consultant Neurosurgeon

I was personally quite keen that any investment that we made in a program of change, should be embedded, and it should be long lasting.

Medical Director

We spent years going down a process of telling people what to do and then wondering why it doesn't work.

Perform Programme Lead

Because it is a coaching approach, it's not asking people to take time out of the day job, its very much sitting alongside them. It's about working with people and allowing them to find the answer, rather than us giving them the answer.

There are ten elements, we roll out one a week, starts with vision and then moves on to visual management and performance reviews, which is where teams come together to track their performance, and talk about what could be improved and then try and solve it together, and I think it's really that's improved. So, actually we are getting people talking about how they are performing as a team and people really understanding what their role is, and how it contributes to the performance of the team.

CW - Perform Coach

At the end of the day, we are all part of one NBT. We are all part of making the patient journey successful, a good experience for them, but actually part of that is about making it good experience for the staff as well.

EA - Perform Coach

People are happier, every member of the team, down to the housekeepers, domestics, everyone knows what's happening so they feel part of the team.

UR - Perform Coach

With the Perform, definitely there has been a significant change.

AG - Sister

Our morale on the ward was happy. We are heard now. We are part of the trust. We are part of one NBT.

Medical Director

I think, people quite quickly got the message that there was something in this that they could really understand and help them to do their day to day work.

CW - Perform Coach

Once you've experienced Perform, then it's there and it's what you do, and that's how you make your day work.

Perform Programme Lead

I think, we are seeing Perform as not just an initiative anymore, I think this is the way forward.

CW - Perform Coach

It is within our life blood, it is how NBT works, and that will be part of what makes it a great place to work, and a great place to deliver healthcare. Making that one NBT vision, a little bit more real, and that's a real success.