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

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Key Words

Leading Change, Adding Value; Unwarranted Variation; triple aim outcomes; Framework; process evaluation, Five Year Forward View

Key Points

- Leading Change, Adding Value (LCAV) is a framework for nursing, midwifery and care staff;
- LCAV supports nursing, midwifery and care staff in demonstrating what they do on a daily basis – to showcase the quantifiable contribution nursing, midwifery and care staff make to the delivery of health and social care;
- This was a process evaluation of the first 10 months of LCAV; a qualitative approach to evaluate how the LCAV framework has been disseminated in its early stages. The quantifiable metrics of successful dissemination will be analysed as the framework advances;
- The principles embodied within the LCAV framework emphasise the importance of working across traditional professional boundaries, sharing good clinical practice and empirically measuring the value added by those improvements in practice;
- The continued emphasis on the engagement of frontline staff across health and care is vital. For nursing, midwifery and care staff to be empowered to fully engage with the principles of LCAV, the implementation of LCAV needs to be accessible for all nursing, midwifery and care staff.

Reflective Questions

- 1) 'Everyone can lead change, whatever their role and wherever they work' is the ethos of the LCAV framework. How can you ensure that nursing, midwifery and care staff are positioned to directly lead and influence the transformation work occurring across health and care?
- 2) Is there something you do every day that makes you think 'we could do this differently'?
- 3) Can you identify and address unwarranted variation in your workplace?

Abstract

Background: *Leading Change, Adding Value: a framework for nursing, midwifery and care staff* (LCAV) is a national framework to support transformational change across health and care. LCAV positions all nursing, midwifery and care staff as leaders, wherever they work, whatever their role. LCAV is aligned to the *Five Year Forward View* and builds upon the value base of *Compassion in Practice*.

Design: A qualitative approach of semi-structured interviews was used to capture information on how LCAV had been disseminated in its early stages from the perspective of key stakeholders and partners. This also included looking forward towards how it might be embedded into everyday practice as business as usual.

Methods: Data collection took place over a three-month period between January 2017 and March 2017. Twenty semi-structured telephone interviews were conducted with key LCAV partners and stakeholders from across health and social care. Perceptions were sought as to how LCAV has been, and may be, used by front-line staff following initial dissemination and any potential barriers and enablers to taking the framework

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forward. To offer a practical illustration of the translation of LCAV into practice by frontline staff, a series of examples ('case studies') were provided by the LCAV Operational Team to contribute to the demonstrable examples of nursing, midwifery and care staff putting LCAV into action in its first year.

Findings: A thematic framework analysis of data identified a three-theme paradigm to evaluate LCAV: 'Past – where has this come from? Themes here acknowledged how LCAV fits into existing work, its value and impact and other aspects. Looking towards situating LCAV in its current context, themes were grouped under the heading of 'Present – where is it now?'. Themes here include dissemination strategy, understanding of potentially new terms such as 'unwarranted variation' and the inclusivity of the framework. The 'Future – where is this going?' was conceptualised by themes including LCAV being viewed as enhancement, not additional work, a culture change, leadership, embedding LCAV and potential barriers to this.

Conclusion: A programme of dissemination events and examples of good practice in the form of case studies has been valuable tools to engage nursing, midwifery and care staff across health and social care. Continuing to establish networks of front-line staff engaging with LCAV and supporting each other will help facilitate best practice sharing, multi-professional and cross boundary working. Highlighting LCAV in action in such a manner may enhance the understanding of the framework and encourage translation into practice. Demonstrating nursing, midwifery and care staff leadership in many different settings and roles will help provide direction of how LCAV can be implemented as business as usual and become a standard way of working.

Introduction

'Leading Change, Adding Value: a framework for nursing, midwifery and care staff' (LCAV) is the national framework for nursing, midwifery and care staff within England (NHS England, 2016a).

LCAV builds on *Compassion in Practice* (Cummings & Bennett, 2012) from which one of the strong legacies is the 6Cs (care, compassion, courage, communication, competence and commitment). These remain the foundation of the value base, and inherently central to identifying and addressing unwarranted variation in practice. However, stakeholder consultation requested a different approach to a new professional framework, to clearly demonstrate the key contribution that nursing, midwifery and care staff are bringing to the 'transformative change' work occurring across both health and care sectors within England. LCAV supports nursing, midwifery and care staff in demonstrating what they do – to showcase the quantifiable positive contribution nursing, midwifery and care staff make to the delivery of health and social care.

Launched in May 2016, LCAV supports nursing, midwifery and care staff to consider how they can narrow the three gaps described in the *Five Year Forward View* (NHS England, 2014); health and wellbeing, care and quality and funding and efficiency (Berwick, Nolan & Whittington, 2008). Integral to the LCAV framework is a focus on identifying and reducing unwarranted variation, in a bid to achieving the triple aim outcomes of better outcomes, better experience, and better use of resources. Not all variation is unwelcome; however 'unwarranted' variation is described as disparities in

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health and care outcomes, individuals' experience, and use of resources which cannot be justified by reasons of geography, demography, or infrastructure.

The principles embodied within the LCAV framework emphasise the importance of working across traditional professional boundaries, sharing good clinical practice and empirically measuring the value added by those improvements in practice. Within LCAV the positioning of nursing, midwifery and care staff as leaders is intrinsic. This evaluation marks the end of the first year of LCAV and focussed on exploring how well the framework had reached nursing, midwifery and care staff so far, how it had started to be embedded and the journey towards becoming 'business as usual'. The emphasis on providing evidence to quantify the contribution that nursing, midwifery and care staff make towards meeting the triple aims is important as it provides a vehicle for demonstrating what has been achieved so far.

LCAV is underpinned by 10 aspirational commitments developed by staff and individuals who use health and care services. These commitments help align efforts to areas where unwarranted variation is identified and supports nursing, midwifery and care staff to translate LCAV into practice (Table 1).

Table 1: Aspirational commitments of *Leading Change, Adding Value*

1	We will promote a culture where improving the population’s health is a core component of the practice of all nursing, midwifery and care staff.
2	We will increase the visibility of nursing and midwifery leadership and input in prevention.
3	We will work with individuals, families and communities to equip them to make informed choices and manage their own health.
4	We will be centred on individuals experiencing high value care.
5	We will work in partnership with individuals, their families, carers and others important to them.
6	We will actively respond to what matters most to our staff and colleagues.
7	We will lead and drive research to evidence the impact of what we do.
8	We will have the right education, training and development to enhance our skills, knowledge and understanding.
9	We will have the right staff in the right places and at the right time.
10	We will champion the use of technology and informatics to improve practice, address Unwarranted Variations and enhance outcomes.

(NHS England, 2016a)

Background

A scoping exercise was conducted to set the context of the evaluation using the search terms ‘*Leading Change, Adding Value*’. The following databases were searched in October 2017: CINAHL Complete; Internurse; PubMed; and Proquest Journals. No empirical studies were available which specifically focussed on LCAV. The available literature is primarily descriptive in nature as may be expected when the framework is

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in its infancy. However, the available literature provided contextual examples of LCAV (Longhurst, 2016a; Practice Nursing, 2016), its essential features (Evans, 2016a; 2016b) and how it might be utilised within specific specialities (Beckford-Ball & Evans, 2016; Harrison, 2016; Mann, 2016).

The emphasis within LCAV on engaging and supporting frontline staff has been acknowledged (Blakemore, 2016; Longhurst, 2016b). Furthermore, professional associations positively welcomed LCAV (Care England, 2016; Royal College of Midwives [RCM], 2016; Royal College of Nurses [RCN], 2016).

The British Journal of Healthcare Assistants published a short series on LCAV, highlighting its key features in addition to providing examples of case studies illustrating how LCAV is being put in to practice (NHS England, 2016b; 2016c; 2016d; 2016e; 2016f; 2017a). LCAV featured in several journal editorials introducing the framework as well as considering its potential impact (Blakemore, 2016; Brown, 2016; Scott, 2016; Stephen-Haynes, 2016). The importance of the 6Cs within *Compassion in Practice* has been recognised as a continued basis for the values base of LCAV (Barchard et al, 2017; Baille, 2017); where work is driven and led by the frontline (NHS England, 2017b).

Aim

The aim of this process evaluation was to explore how LCAV has been received by key stakeholders from across the nursing, midwifery and care sector in its first year. Important aspects of establishing transformational change included how the framework had been disseminated, understood and embedded.

Data collection

Twenty qualitative, semi-structured, telephone interviews were conducted, with key stakeholders involved in the co-development of the LCAV framework, to explore perceptions of the progress of LCAV to date. This phenomenological qualitative approach allowed the authors to investigate experiences and initial thoughts, as well as explore associated challenges (Holloway & Galvin, 2016) and as such aimed to identify and describe the subjective experience of the respondents (Holzemer, 2010). Semi-structured interviews were used to afford the opportunity to ask specific, but open-ended questions to allow fluid responses from participants (Tappen, 2010). Such a style permits interviewers to address relevant themes whilst also allowing scope to probe avenues of inquiry started by the interviewees. The limitation of telephone interviews is far outweighed by the many advantages, such as: reducing financial implications of travel; being more time-effective; and extending the geographical range of access to potential participants (Oltmann, 2016).

The interview schedule was informed by the background literature, and was piloted twice, once internally and once externally, to add rigour to the pre-interview process and to refine interview questions. Two members of the evaluation team conducted the interviews, which were recorded with a digital audio recorder and transcribed verbatim. Discussion topics included: the participant's role and involvement with the co-development and implementation of LCAV; context and narrative of LCAV; communication and dissemination strategies; and reflections on the barriers and enablers in implementing LCAV as business as usual. These topics are the basis for landing organisational change (Balogun et al, 2014).

Research Governance

This evaluation was a service evaluation, exempt from ethical approval. Letters to confirm this were granted by Information Governance, at NHS England and the Chair of the Faculty of Health and Social Care Research Ethics Committee at Edge Hill University.

Participants

A purposive sample of thirty-eight eligible interviewees were identified, comprising LCAV regional leads; the leads of national programmes of work (identifying and addressing unwarranted variation in practice) which had been referenced in the original LCAV framework; members of arms-length body partners, professional organisations, and trade unions. These individuals were proposed for their knowledge and experience of both strategic and operational dissemination and implementation of LCAV. The interviewees reflected representation across health and social care with a range of perspectives and experiences. The LCAV regional leads reflect the national approach to cascading LCAV to frontline staff. All participants were invited, via e-mail, to take part in a telephone interview lasting approximately 30 minutes. Information sheets and consent forms were provided. All 20 participants who volunteered were interviewed, with their verbal consent being taken at the start of the interview. Interviewees represented many disciplines across health and care, including public health, provider and commissioning organisations, maternity, care sector, mental health nursing, learning disabilities, safeguarding, community and primary care nursing. However, given that LCAV had launched only eight months previously the participants interviewed were at a senior level within key stakeholder bodies rather

than front-line staff as the process of dissemination was still in its infancy. This has been reflected on within the limitations section.

Data analysis

The interview transcripts were analysed by two members of the evaluation team independently of each other using a Thematic Framework Analysis method (Ritchie, Spencer & O'Connor, 2003). Transcripts were read in their entirety to remind the analyst of the interview content or for them to become familiar with the transcript if they had not conducted the interview. The transcripts were read and re-read to ensure familiarity with the data. The interview transcripts were independently analysed by two of the authors [SAS & JF], to add rigour. Participants were given a unique identifier made up of a number (from Analyst 1) and a letter (from Analyst 2) e.g. '*Participant 1-B*'. The two analysts then manually undertook focus coding, a process whereby key quotations are identified in the data. Themes were identified through an iterative process and each analysts' themes and sub-themes were mapped onto each other, and collapsed where necessary. To further enhance the credibility (Noble & Smith, 2015), the analysts came together with the Principal Investigator [JB] and the lead interviewer [KZ], to establish a thematic framework. On discussion, it was decided LCAV spanned across three stages in time: 'Past – Where has this come from?', 'Present – Where is it now?', and 'Future – Where is this going?' Identifying these stages within time, encompassing a temporal perspective, and organising the themes within them was viewed as useful as it gave recognition to the origins and context of LCAV together with how it might move forward.

Findings

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Analysis of the qualitative data identified three overarching themes: 'Past – Where has this come from?'; 'Present – Where is this now?'; and 'Future – Where is this going?'. Each theme contained sub-themes and are illustrated in the analysis by a selection of representative verbatim quotations.

'Past – Where has this come from?'

'Existing Work'

The LCAV framework was viewed as showing some continuity and development across health and care, for instance building in part, upon the former 6Cs value base. Interviewees welcomed LCAV as a reference point for all nursing, midwifery and care staff to identify and address unwarranted variation and to showcase the translation of this into practice:

"I'm really enthusiastic to see unwarranted variation really across all our areas of work and *Leading Change, Adding Value* has really provided that benchmark for us all to work towards." (Participant 6-G)

The focus of frontline staff in social care service provision is a progressive principle of LCAV, reflecting the integration of health and social care across the system:

"What we're seeing in the framework is consistent with the *Five Year Forward View*, it's consistent with a much more people orientated design and delivery of service and that should find linkages across the whole of the NHS and for some social care..." (Participant 16-P)

‘Value & Impact’

The value LCAV is having on identifying and addressing areas that will benefit from change, led by nursing, midwifery and care staff, was exemplified by interviewees commenting on the timely nature of LCAV to support staff in these times of service delivery pressures:

“...it’s very much a document of its time... because of the way the NHS is at the moment, and the pressures that we’re feeling we need to do different things, in the Five Year Forward View I think currently *Leading Change, Adding Value* absolutely fits into that” (Participant 2-H)

Building on commentary above, LCAV was praised as being a framework that integrated the care sector right from inception. However, there was recognition the alignment of social care with acute sectors requires continued co-development:

“...social care has always had less prominence than nursing in the sense of being seen as less professional, less organised, less qualified, and it’s good that social care is seen as being up there with nursing care, with similar kinds of standards and similar kinds of expectations.” (Participant 16-P)

‘Framework Positives’

LCAV was in principle well-received with interviewees commenting on the potential to help facilitate care, placing individuals at the centre of care delivery and quantifiably evidencing the impact that nursing, midwifery and care staff are making. Participants recognised LCAV moved away from a traditional strategy-style document to a

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framework, which supports frontline staff in what they are already doing although often not recognising that they were actually doing so:

“I welcomed the framework, as opposed to a strategy type document, it allows us to use the framework in terms of the triple aims that we’re trying to achieve, particularly interesting to me is how it directs us around the reducing variation in practice...” (Participant 4-S)

“It’s a framework, it’s not a strategy, I think it builds on the previous strategy the 6C’s and obviously Compassion in Practice, and so I think it sits well, I think it has a good reception, and being received well across most sectors...”
(Participant 18-A)

Taking an overview of the responses of the stakeholders interviewed, LCAV has been recognised as being developed to have relevance to practice for frontline staff, as well as having strategic and professional importance. This has also further highlighted the supportive mechanism of the framework for leadership; whatever your role, wherever you work and by doing so demonstrates the key contributions of the professions within the system.

‘Present – Where is it now?’

‘Dissemination Strategy’

There was an appreciation by interviewees that national pieces of work can be difficult to cascade to frontline staff. Best practice examples in the form of ‘case studies’ (see Table 2) proved to be fundamental in “spreading the word” to frontline staff. These

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short narratives showed how LCAV has, in part, already been implemented as “business as usual” to improve clinical practice by identifying and addressing unwarranted variation, to meet the triple aim outcomes:

“...one of the ways in which we’re trying to communicate information like this is through case studies and through real examples, and because I think when people can see things in action they can relate more to it; so I think what we’ve tried to show good case studies with exemplary practice...” (Participant 12-D)

‘Levels and Meaning of Unwarranted Variation’

LCAV has started to bring the subject and understanding of unwarranted variation to the fore for nursing, midwifery and care staff. Interviewees offered current examples of unwarranted variation in clinical practice. These provide context for how, where, and why LCAV is proving to be a useful tool for making changes to narrow the three gaps described in the FYFV and to quantify the impact made to outcomes, experience and use of resources and to translate this into practice:

“...we know that we deliver services very differently with very inconsistent outcomes across England..... we need to learn from where it is done well and spread that if at all possible, the NHS is really very poor at spreading what it knows well” (Participant 9-R)

‘Inclusivity’

Participants reported LCAV as a framework which helps to enable and encourage cross-institutional and multi-disciplinary working:

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“Ultimately I think ... what it enables people to do is have conversations with each other from different areas of the sector.” (Participant 18-A)

“...I think that the framework should be applied for everybody, everywhere..... it’s about cultural change and system change and I think if the framework is to be accepted, it has to embrace cultural change, cultural change within an organisation.” (Participant 8-I)

‘Future – Where is this going?’

‘Enhancement, Not Additional Work’

LCAV builds on the success of *Compassion in Practice*, further strengthening the core professional standards, by embedding these core values to help become ‘business as usual’ for nursing, midwifery and care staff:

“I think Compassion in Practice was a really good baseline for which we could demonstrate the values of the nursing profession, I think where Leading Change, Adding Value is stronger is because it’s addressing, it embeds the values, and I think the underpinning sort of compassion that nurses need.”
(Participant 5-C)

Participants reported LCAV to be facilitative in nurturing a positive ethos driven by individual needs, for all staff providing care:

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“...I think the Commitments about working in partnership with patients and their families and that whole element of co-production to ensure that whatever we are developing and promoting is ultimately informed and grounded with the patient experience and what the patient needs, and not in someone’s job title”

(Participant 20-F)

‘Culture Change’

Interviewees provided examples of how frontline staff need to be engaged in order for LCAV to be embedded as ‘business as usual’. Whilst discussion revealed that ‘how’ frontline staff are to be engaged was important, there was also dialogue regarding ‘why’ LCAV would be important to individuals in the nursing, midwifery and care sector and a responsibility to help explain this message to frontline staff:

“I believe that everybody should be inextricably linked with practice and therefore every person, all parts of the system have a responsibility for ensuring it reaches the hearts and minds of practitioners at the coal face and indeed people that we provide services to.” (Participant 8-I)

Whilst participants understood LCAV had been written as a national framework for nursing, midwifery and care staff, there was an appreciation that for it to be adopted in everyday practice, it is required to be relevant and respected by colleagues outside of these professions too:

“...this is a really important framework because we are also focusing quite heavily on the workforce and how the whole health and care workforce that’s

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not exclusive to nurses, or midwives, or care staff, but across the whole sector, so pharmacists, GP's, allied health professionals, local colleagues and various professional groups that work in the health and care system.” (Participant 13-J)

‘Leadership’

Interviewees recommended frontline staff could only be inspired to fully engage in LCAV principles, if there was strong, national, and identifiable leadership:

“I think what it needs is also clear, visible, articulate leadership..... And I think we need a leadership nationally that really positions this well and really is strong and visible.” (Participant 18-A)

LCAV was praised in interviews for being a true co-development piece of work, not only horizontally across sectors, but vertically between policy drivers and frontline staff, and suggested this ethos should remain:

“I think it needs to be driven within a collective leadership style throughout the system and everybody should be able to contribute...” (Participant 8-I)

“...if we're going to empower patients then we're going to have to empower staff, I think people who don't feel that they are empowered as frontline staff are not going to feel enabled to empower patients and carers...” (Participant 16-P)

‘Embedding LCAV’

Whilst the potential for LCAV was evidenced in the interviews, some expressed a need to consider the longevity and credibility of this national framework:

“...it’s a very good framework, and I think we have to hold on to it and use it in our communication, in our language, we have to make it part and parcel of the conversations that we’re having, what I think would be fundamentally wrong, would be to sort of sweep this one away and bring in another policy document, or another policy framework to replace this...” (Participant 20-F)

There was the sense among interviewees that given an appropriate amount of time, LCAV could become fully embedded for the nursing, midwifery and care staff professions and provide real positive change for individual and population care, driven by frontline staff:

“I think there’s a current suggestion that Leading Change, Adding Value currently has a life span of three years or so, and actually that really is the wrong approach, so this is almost an ongoing journey which we need to develop...”
(Participant 13-J)

‘Barriers to Embedding LCAV’

One of the challenges for LCAV is establishing an awareness of the framework, across nursing, midwifery and care staff and making sure the framework reaches frontline line staff, recognising the current pressures in the health and care environment:

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“I think most would feel it’s quite complex for front level staff to understand..... NHS England has done some fantastic cartoons before where they’ve used infographics to introduce quite complex problems.”

(Participant 6-G)

A further approach to embed the framework presented an opportunity to take a multi-disciplinary approach led by the nursing, midwifery and care sector; as well as incorporating colleagues of all levels from other professions such as doctors, pharmacists, and allied health professionals:

“...it requires multi-professional work. Cross-professional boundary working. And so, I think there’s maybe a question, or a challenge to the evolution of Leading Change, Adding Value along with other strategies or programmes of work...” (Participant 13-J)

Best Practice Case Studies

Valuable exemplars of LCAV being translated into practice were illustrated by vignettes of quality assured ‘case studies’. These examples of work led by frontline staff were summarised by two members of the research team [SAS & JB], aligned to the 10 Commitments and their impact on the triple aim outcome presented. These case studies demonstrate regionally led examples of LCAV in action. These case studies (which will continue to be collected by the LCAV Operational Team) showcase how nursing, midwifery and care staff across the system have led and contributed to the Five Year Forward View (NHS England, 2014) and other national programmes and initiatives. Their inclusion in this evaluation provides some

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examples of how LCAV has been utilised by nursing, midwifery and care staff to date. Full descriptions of LCAV case studies are available at

<https://www.england.nhs.uk/leadingchange/lcav-in-action/videos/>

Table 2: Best Practice Case Studies

Best Practice Case Study	Synopses
The Five Point Huddle – Cuckoo Lane	Nurses at a nurse-led practice identified and addressed unwarranted variation in staff communication across the practice. They introduced twice-daily briefings discussing clinical, operational, and practical issues, which aims to keep staff aware of initiatives, promotes excellence and minimises risk, whilst reducing complaints.
Flexible Visiting – Aintree	Nursing staff from a University Hospital Trust identified and addressed unwarranted variation in visiting hours and subsequent experience. The visiting hours changed from fixed 1-hour visits at set-times to a core-hour system from 1:30pm-7:30pm across the Trust. This sought to reduce pressure on carparks, whilst improving experience for patients, relatives, carers, and staff.
Respiratory Futures – Leeds	Two practice nurses identified unwarranted variation in respiratory care locally and introduced educational resources for healthcare professionals via setting up a Leeds Respiratory Network. The nurses set up free educational meetings, a mailing list, and use of social media. This aimed to provide much greater and up-to-date knowledge and training, to deliver more consistent care and reduce variation using the NHS Atlas of Variation. They used technology to share knowledge and good practice for new guidance to attempt to reduce costs to patient and practice and improve quality of care.
Small Improvements, Big Impact – Berkshire	The ‘small improvements, big impact’ project was a collaboration between three older adults wards at this Berkshire mental health inpatient service. They provided authority and autonomy to staff to deliver service to patients on older adult mental health inpatient wards, to try and improve patient care.

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<p>Care Navigation and Social Prescribing- Central Gateshead</p>	<p>Health Care Assistants were trained as Primary Care Navigators to advise and support patients and carers with any social needs that may be affecting their health. The primary care navigators help connect vulnerable patients with care and support in the community, and provide direct non-medical support. The role has improved patient outcomes and experiences significantly and removes the need for a GP appointment when social prescribing is appropriate.</p> <p>Health Care Assistant roles were evolved to reflect a “Primary Care Navigator” role to ‘Communicate’, ‘Guide’, ‘Support’, & ‘Develop’ with carers of patients with dementia, improving screening to try to reduce staff burden and support patients to receive the right care, at the right time.</p>
<p>Weight Management Group – Durham</p>	<p>Having identified unwarranted variation in their weight management ‘treatment options’, nurses at a remote practice developed a programme, collated resources, and ran an evening group for weight management to offer a structured, accessibly programme in the evenings. This contributed to better adherence to weight management regimes and better reported experience by patients in remote settings.</p>

Discussion

Leading Change, Adding Value has a clear policy context which builds upon existing strategies such as *Compassion in Practice* (Cummings & Bennett, 2012) and is directly aligned to the *Five Year Forward View* (NHS England, 2014) and other national programmes such as *All Our Health* (Public Health England, 2015), the *Shape of Caring* (Health Education England, 2015) and *Getting it Right First Time* (GIRFT; NHS Improvement, 2012). This has meant that rather than being viewed as a further change in ways of working, it can be embraced as a progression, which complements ongoing work. This supports frontline staff to consider the outcomes of their work and question whether there is always a measurable positive difference achieved in experience, outcomes and the use of resources. Indeed, it has been recognised that the 6Cs which underpinned *Compassion in Practice* have been embedded as the value base of LCAV

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(Baille, 2017). LCAV is seen as *enhancing* rather than *adding* to workloads, which is an important distinction when striving to support frontline staff in their roles.

Given that the LCAV framework is aimed at all nursing, midwifery and care staff it is important to recognise the current context of the challenges within the health and care system. Indeed, part of this evaluation was to gauge whether the framework has the potential to be embedded as 'business as usual' for frontline staff. Moving forward, this involves considering appropriate dissemination strategies in order to reach frontline staff. It also offers the opportunity to reflect on the current context and whether this could act as a potential barrier to the framework being embedded and recognising the environment for nursing, midwifery and care staff.

One of the important aspects of LCAV is the emphasis it places upon providing evidence to support best practice. Showing the value added by evidence based changes in practice ensures LCAV can help staff support and sustain these changes in the face of sometimes competing demands. However, in order to do this it is important that staff have the knowledge and skills to be able to produce, record and evaluate this evidence. LCAV can be used to transform care for the better, ensuring it is more efficient, reducing unwarranted variation and preventing ill-health and quantifying the impact of this work and the way it is translated into practice. Nursing, midwifery and care staff are well-placed to be leading that transformation agenda. Such findings and commentary highlight important parameters for landing transformational change in an organisation where front-line staff are integral leaders (Balogun, Hailey, Stuart, and Cleaver, 2014).

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In terms of disseminating the key messages of LCAV it is important to be able to illustrate its application and value to frontline staff. Indeed, it has been argued that for LCAV to have any impact on care, outcomes and experience; an understanding of the merits of the framework from nursing, midwifery and care staff at all levels is essential (Blakemore, 2016). One of the key ways to do this is by using best practice case studies to illustrate how LCAV has been used to encompass and enhance good practice. As provided in this manuscript, a number of 'case studies' aligned to LCAV have highlighted good practice led by frontline staff to tackle unwarranted variation. These have been shared and aligned to the 10 Commitments showing a variety of ways groups of staff across settings are working. Understanding and commitment to change is increased when it builds on previous experiences through case studies of successful transformational change across settings helps to increase adoption and embedding of the change in practice.

A particular strength identified in LCAV is the inclusion of the care sector, which has also been identified as an area for continued development as LCAV evolves through additional engagement and inclusion. Although the care sector is represented within the LCAV national Partnership Board and helped co-develop LCAV for nursing, midwifery and care staff working in social care (NHS England, 2016g); sustained appreciation of the varied needs of the care workforce will be essential.

Developing and harnessing leadership amongst frontline staff is central to LCAV. In doing so, LCAV highlights the potential of nursing, midwifery and care staff to shape the future of care delivery. The fact LCAV has been written for all nursing, midwifery and care staff to be the figureheads of leading change and adding value to patient

care, was seen as a major positive by interviewees. The need for staff to feel included as drivers for change at a regional level or within their own areas of practice is imperative (Serrant, 2016). One of the parameters of the continued evaluation of the LCAV framework will be to identify whether the framework can be embedded as 'business as usual' given the pressures on the health and care environment. LCAV is not a mandated strategy, rather a support tool for nursing, midwifery and care staff to take the lead on change by identifying and reducing unwarranted variation in their workplace to demonstrate the triple aim outcomes.

Limitations of the evaluation

Twenty interviews were performed as part of this evaluation. These twenty interviewees were key LCAV stakeholders who were engaged strategically with LCAV and who had knowledge and understanding of LCAV. This does introduce a selection bias, together with a possible social desirability bias, given the participant's strategic involvement in disseminating and implementing LCAV. This participant sample was selected as LCAV had only recently been launched and was in the early phases of dissemination. Therefore, it was viewed that meaningful data on the current situation of LCAV would be best obtained from those involved in its development and to glean both their strategic and operational perspective as dissemination is rolled out. Notwithstanding this limitation, it does give a useful starting point and trajectory for the ongoing work needed to embed this framework in the health and care system. A further limitation was that only one data collection method was used. Only using interviews means that triangulation of data methods cannot be performed. A further potential limitation was that the evaluation of year one was conducted only 8-9 months after its

inception, which may have been premature, something on which multiple interviewees commented.

Conclusion

Enhancing understanding and translation of LCAV amongst nursing, midwifery and care staff is important as it reinforces the principles within LCAV and demonstrates its value. Therefore, the continued emphasis on the engagement of all staff across the health and care sector with LCAV is vital. National events for frontline staff have been received positively and future events will include more formal conferences and workshops, but also more informal, webinars, and networking opportunities at a local level. These events will be evaluated as a part of the narrative of the Year 2 evaluation moving forwards. The ability of staff to access these events must be considered in terms of time, location, and feasibility of attendance.

The ethos of LCAV is that *“Everyone can lead change; no matter what their role and wherever they work”* (Aitkenhead, 2017). This has been welcomed, demonstrated in some settings already, and should certainly be supported and encouraged. For nursing, midwifery and care staff to be inspired to fully engage with the principles of LCAV, the implementation of LCAV needs to be applicable for all nursing, midwifery and care staff. Capturing examples of this leadership in action provides opportunities to portray a clear vision of how LCAV can be subsumed as ‘business as usual’ by frontline staff, in addition to ensuring equitable standards of care for all. This, in turn, aims to fully showcase the immense contributions that the professions bring to a period of unprecedented change and challenge across the healthcare system.

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Text Box 1 (to be included with article publication):

The end product of the formal three year programme of LCAV will be the bringing together of an '**Atlas of Shared Learning**'. The Atlas of Shared Learning will aim to demonstrate how nursing, midwifery and care staff across the system have strongly led and contributed to the *Five Year Forward View* (NHS England, 2014) and other national programmes such as *All Our Health* (Public Health England, 2015), the *Shape of Caring* (Health Education England, 2015) and *Getting It Right First Time* (GIRFT, NHS Improvement, 2012). The Atlas of Shared Learning will enable colleagues to source and implement learning on where unwarranted variation in care was identified and addressed through nursing, midwifery and care staff leadership and the resulting improvement of outcomes, experiences and use of resources.

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