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Evaluation of the health care services well-led framework

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1 Executive summary

The purpose of the well-led framework (WLF) is to assess, support and develop health and care leadership (including management, culture and organisational systems) and thus to enable better care for patients, and a more sustainable health and care service. This evaluation addressed the following questions:

- How does the framework operate to ensure that organisations and services are well-led?
- What are the improvements happening as a result of it?
- How relevant are the key lines of enquiry?
- How useful and helpful are the well-led CQC inspections?
- How useful and helpful are the developmental reviews?
- How is the framework applied to the wider health and care system?
- How can the framework be developed to meet the needs of systems leadership?

A mixed methods and realist synthesis approach was taken to understand, in depth, the impacts and the potential of the framework. More than 400 people were reached through either responding to the survey questionnaire, agreeing to a phone or face to face interview, participation in a focus group, or attendance at a workshop. Respondents included public representatives, leaders and managers of regulatory and oversight bodies, provider trust leaders, healthcare commissioners, system provider partners, and academic and policy experts.

The main findings were:

1. There is an intrinsic value to the WLF. There was strong agreement that the framework is clear about what a well-led organisation looks like and that it covers most aspects for managing health and care services. The framework enables leaders to reflect on and change leadership practices that impact the quality of care. There is widespread support for a framework that includes a focus both on culture and leadership and systems and processes. The use of the WLF has led to improvements in leadership and governance.
2. It works well when applied with an appropriate balance between culture and leadership, and governance and processes. Experiences of inspections and developmental reviews are variable. Inspection teams need increased capacity and capability to assess culture and leadership aspects. Peer reviewers are an under-utilised resource in inspections and developmental reviews.
3. The framework is a powerful tool; it matters to organisations and to the individuals working within them. The rating given by CQC hugely affects them. The culture among system oversight and regulatory bodies (and the use of the WLF) is sometimes skewed towards assessment rather than support and development. System oversight and regulatory bodies generally lack the requisite capacity to support providers to improve their leadership.
4. The framework works well when context is taken into account. Not all key lines of enquiry are equally pertinent in all situations. The focus on a number of areas, including culture, diversity, service user and patient engagement could be more explicit. The applications of the framework don’t always give significant attention to system context. The framework sits within a wider landscape of structural instability.
5. There is scope to broaden the use of the framework across systems. It doesn’t address the importance to patients of joined up care across primary, community, mental health,

acute and social care providers. Where there is little evidence of positive and collaborative relationships in the local system, it is not seen as appropriate to award a rating of Outstanding to a provider.

6. The framework could be useful at all levels, from ward/department to board, but the application of the framework is too board-orientated at present.

The main recommendations are:

Content

1. Organise the WLF under two broad headings: governance and processes, and culture and leadership.
2. Refine the culture and leadership elements of the framework, including more on measures and prompts for assessing organisational culture.
3. Expand and consolidate the documentation available surrounding the WLF to include good and excellent practice for each KLOE.

Application

4. Use peer reviewers differently, more inclusively and sustainably, in CQC inspections and developmental reviews.
5. Vary the frequency of CQC inspections according to explicit criteria, up to three-yearly intervals.
6. Clarify the purpose and interconnectivity between the various applications of the WLF including self-assessment; developmental review and the inspection approach

Future

7. Consolidate, clarify and expand guidance on system leadership.
8. Encourage the use of the WLF for and by CCGs and ICSs to promote a single definition of high quality leadership.
9. Ensure that the application of the WLF takes into account both leadership of individual organisations as well as the extent to which leaders of an organisation effectively operate and input across the broader system.
10. Supplement the current application of the WLF in individual organisations with consideration of whether governance, processes, leadership and culture are effective across a system. This could take the form of either a local system review, and / or reviews across specific pathways of care.
11. Apply reviews of the WLF to system regulatory and oversight bodies, with key findings made publicly available.

In conclusion, there is unrealised potential of this framework, which mainly relates to how it is applied. Providers neglect to use it as a developmental tool, regulators sometimes prioritise the systems and processes areas over the culture and leadership aspects, and oversight bodies pay too little attention to providing the support to improve what has been signalled as needed by a well-led assessment.

2 Context and introduction

2.1 Introduction

The NHS National Improvement and Leadership Development Board (NILDB), representing the collective leadership of the national bodies which govern the NHS in England, commissioned an independent evaluation, in the autumn of 2018, of the implementation and impact of the healthcare services well-led framework (WLF), from Alliance Manchester Business School at the University of Manchester, in association with Deloitte. This is the final report of that evaluation.

The purpose of the WLF is to assess, support and develop health and care leadership (including management, culture and organisational systems) and thus to enable better care for patients, and a more sustainable health and care service. It was first introduced in 2014, with amendments to its scope and application introduced in 2017. It is intended for use by leaders, inspectors, regulators, commissioners and external facilitators. This evaluation is specifically framed for the attention of health and care regulatory and oversight bodies, although it is constructed in such a way as also to be of wider interest to health and care organisations and policy makers.

For ease of reference, the key lines of enquiry (KLOEs) in the latest version of the framework (NHS Improvement, 2017), are reproduced in figure 1 below.

Figure 1 Overview of the WLF

Are services well led?
1. Is there the **leadership capacity and capability** to deliver high quality, sustainable care?
2. Is there a clear **vision** and credible **strategy** to deliver high quality, sustainable care to people, and robust plans to deliver?
3. Is there a **culture** of high quality, sustainable care?
4. Are there clear responsibilities, **roles** and systems of accountability to support good governance and management?
5. Are there clear and effective processes for managing **risks**, issues and **performance?**
6. Is appropriate and accurate **information** being effectively processed challenged and acted on?
7. Are the **people** who use services, the public, **staff** and **external partners engaged** and involved to support high quality sustainable services?
8. Are there robust systems and processes for **learning**, continuous **improvement** and **innovation?**

2.2 Origins and development of the well led framework (WLF)

The well-led question was one of five conceived by CQC for its assessment of the quality of providers, the others being safe, effective, caring, and responsive. The five key questions and the detailed assessment frameworks for the different sectors, along with the comprehensive inspection approach, were introduced from 2013-14, following the Francis Inquiry report in 2013 into the failings in care at Mid Staffordshire NHS Foundation Trust (Francis, 2013). CQC developed the first iteration of the WLF with providers, public, experts and others including TDA and Monitor. Michael West and the Kings Fund were commissioned to support this work, and there was also public consultation.

Later on, the framework developed into a single framework across CQC, TDA and Monitor, being clear on the alignment between the approaches of the different organisations. The guiding purpose behind the framework is to uphold leadership that enables high quality, sustainable care, and builds patient, public and stakeholder confidence in the health and care sector. Culture and leadership as well as systems and processes were incorporated in the first iteration of the WLF in 2014, which had five key lines of inquiry under the headings of vision and strategy, governance arrangements, leadership and culture, patient and staff experiences, and continuous learning and improvement. The latest version of the framework (from 2017) has eight key lines of enquiry under the headings of leadership, vision and strategy, culture, governance, management of risks, issues and performance, information management, engagement, and learning continuous improvement and innovation.

A number of risks were identified at the time that the framework was first developed in 2013. These, included a danger that a deficit rather than an appreciative approach would be taken by the regulatory bodies, and that a limited understanding amongst inspectors and others about organisation culture, collective leadership and associated behaviours, might limit its deployment and lead to a lack of balance, respectively, between attention paid to systems and processes, and attention paid to culture and leadership. Some of these risks are reflected in the focus of the subsequent WLF guidance for governance reviews published in 2015 by Monitor which comprised four domains for boards and their external reviewers to consider: vision and strategy, governance arrangements, capability and culture, processes and structures, and measurement.

The origins of the WLF lie earlier, in the tools used as part of the authorisation process for NHS foundation trusts as mandated by their regulator, Monitor, in particular the risk assurance framework (RAF), the quality governance assurance framework (QGAF) and the board governance assurance framework (BGAF).

Monitor has, in turn, been influenced by guidance issued over the years by the Financial Reporting Council in the Combined Code on Corporate Governance for London Stock Exchange listed companies (for example in 1992, 2006, 2008, 2010, 2016 and 2018). The Code now has at its heart an updated set of principles and requires companies to ‘comply or explain’. It is supported by guidance on board effectiveness. In addition to sections on board leadership and company purpose, division of responsibilities, composition, succession and evaluation, audit, risk and internal control, the latest version of the Code is clear about the role of the board in relation to organisation culture: *The board should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the company’s purpose, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board’s activities and any action taken. In addition, it should include an explanation of the company’s approach to investing in and rewarding its workforce.* (Financial Reporting Council 2018:4).

2.3 Current context

The complex backcloth against which the WLF now operates in the NHS has been rehearsed elsewhere (for example in outputs by the Kings Fund and the Health Foundation). Challenges include workforce shortages, financial constraints, pressures on social and residential care, and deepening political uncertainties. Flux in the system, which presents new opportunities, has been initiated by the restructuring of national NHS bodies, and the creation of new local health organisations, the publication of Long-Term Plan & the Interim People Plan. This last, in particular, signalled the importance of putting leadership and culture at the core of how the performance of providers, commissioners and systems is assessed. The Interim Plan also calls for ensuring that the WLF used by the Care Quality Commission and NHS England/NHS Improvement (NHSE/I) is sufficiently focused on leadership, culture, improvement, and people management as these factors are often identified as the root drivers of quality and efficient use of resources.

Meanwhile, disappointingly, there is continuing evidence of persistent variations in quality of patient care, staff morale and in leadership amongst providers. There is, equally, growing evidence of the links between better leadership, better staff morale and better patient experiences of care. Further, there is a greater recognition of the part that organisation culture plays, that is the attitudes, beliefs, values and behaviours that are displayed, articulated and enacted by the people who work in that organisation.

There is a somewhat crowded landscape of other tools and interventions for improving leadership in the NHS and the wider health and care system. Some examples: first, there is the suite of programmes for leaders at all levels, commissioned or run by the national and regional NHS Leadership Academies, including the large scale Elizabeth Garrett Anderson Masters level programme for aspiring senior managers, and the Nye Bevan programme for aspiring board directors, which is informed by the Healthcare Leadership Model published by the national NHS Leadership Academy (Academy, 2013). Second, there is a stream of work, also led by the NHS Leadership Academy on building leadership for inclusion (BLFI). Third, supported by NHSI, and also involving the Kings Fund and Centre for Creative Leadership, there is the well-regarded culture and leadership programme, which draws from Michael West's work and is being implemented in around 60 trusts, as well as also being introduced in NHSE/I. It focuses on developing collective, compassionate and inclusive leadership in trusts. Fourth, there are the programmes supported by NHSI which centre on service improvement, including the QSIR College, and the leadership for improvement board development programme. Fifth there are the long-standing open programmes offered by the Health Foundation (for example GenerationQ) and the Kings Fund. Last, there is the new 2019/20 NHS Oversight Framework, to which we understand further refinements are being made for deployment from April 2020.

Within this broader picture, this evaluation examines the contribution made by the WLF to assessing, supporting and improving NHS leadership, including the impacts of the WLF, in practice, in terms of its content and its applications. This includes the detail of the framework, CQC's well-led inspection regime, the developmental well-led reviews, as well as the use of the framework by organisations to support improvement. Together, according to the theory of change for the WLF (NHS 2018), reproduced in Appendix 1, these arrangements represent a programme of action designed to ensure better quality of care, because of services that are better led. In relation to other relevant recent research, eight regulatory impact mechanisms were identified in research undertaken by Alliance Manchester Business School and the Kings Fund in 2018 on the impact of the CQC on provider performance. That study shows that impact can occur before, during and after inspection and through interactions between regulators, providers and other key stakeholders (Smithson et al 2018).

Drawing on the theory of change, and the eight regulatory impact mechanisms, the scope, focus and the following questions were shaped in the initial phase of the evaluation with input from a broad range of stakeholders:

- How does the framework operate to ensure that organisations and services are well-led?
- What are the improvements happening as a result of it?
- How relevant are the key lines of enquiry?
- How useful and helpful are the well-led CQC inspections?
- How useful and helpful are the developmental reviews?
- How is the framework applied to the wider health and care system?
- How can the framework be developed to meet the needs of systems leadership?

3 Methods

The approach adopted for the review is a mixed methods realist informed evaluation to understand the broad impacts of the framework. The purpose of this approach is to identify mechanisms that explain how the WLF achieves impact, then to test these mechanisms in various contexts to understand the different circumstances in which the mechanisms work or don't work, who they work for and why they work (Pawson, 2013). In this way, we understand not only the positive impact of the framework, but also the times when it does not work and there are unintended consequences.

The evaluation incorporated scoping discussions with 11 representatives from national bodies which govern the NHS between January and April 2019, with whom we engaged to understand the impact the WLF was intended to have, and to understand the context within which the WLF was introduced. We also drew on existing literature particularly the Developing People Improving Care (DPIC) strategy (2016); Long Term Plan (2019), Interim NHS People Plan (2019) and Impact of the Care Quality Commission on Provider Performance (2018). This enabled us to develop a set of testable propositions about the WLF; to develop qualitative interview research questions, and to develop a survey instrument for providers and clinical commissioners. The survey instrument was pre-tested and discussed with a range of stakeholders. This enabled us to revise the instruments.

Evaluation team members then interviewed representatives from across 30 provider organisations as well as facilitating conversations with seven NHS provider boards between January and July 2019. A copy of the interview topic guide is provided in Appendix 4. The purpose of these activities was to test our set of propositions. Each interviewer noted and summarised the responses and shared them in regular monthly meetings with each other, informally on weekly calls and from time to time with the NILDB representative. The results were analysed inductively into a set of themes.

A survey was sent to providers (see 9.2 for a copy of the survey questionnaire). It opened on 21 March 2019 and closed on 30 May 2019. A total of 3,023 emails were sent out using a commercial database of NHS leaders from Wilmington Healthcare (previously Binleys). This database, which is illustrated in the Appendix, contained 68 chairs or deputies,169 non-executive directors, 73 chief executives, 197 finance officers, 259 medical directors and several other roles. Medical directors were a significant proportion of the roles represented. Two reminder emails were sent. There were 390 responses which represents a response rate of 12.9%. Of these, 190 responses representing 6.3% of the total sample were complete and retained for analysis.

A second survey was sent to clinical commissioners. The survey was opened on 21 May 2019 closed on 31 July 2019. A total of 353 emails were sent out using a commercial database of NHS leaders from Wilmington Healthcare. The list included executive and non-executive board members and other executives who work for clinical commissioning groups. Two reminder emails were sent after the first email which helped secure 22 complete responses (6.5%).

Comprehensive results from the survey, including charts, were provided separately in an earlier briefing report. The results of the surveys were analysed using descriptive statistics and compared with the data from the interviews. This comparison enabled us to refine the initial theories which we then prepared for further testing. Focus groups and workshops were held with 47 attendees, including patient representatives, inspectors, and leaders from national bodies, trusts and organisations supporting the ongoing development of the NHS between March and July 2019. The refined themes were shared with these groups to solicit additional insight for further refinement. There were additional focus group sessions organised with 15 trust board secretaries in October 2019, representatives from eight

commissioning organisations and local government bodies and at three CQC workshops which included a range of executive reviewers and specialist advisers.

In total, we solicited the views of about 400 people in the following ways:

- 11 telephone or face to face interviews with representatives from national bodies that govern the NHS, including five senior CQC leaders
- 30 individual and group telephone interviews with leaders from a range of provider organisations
- 190 complete responses from a national survey of members of NHS provider boards
- 22 complete responses from board members of clinical commissioning organisations
- 7 NHS provider boards
- 59 attendees of focus groups and workshops, including meeting of the CQC Hospital Directorate Leadership Team (around 15 attendees) and Mental Health Directorate Leadership Team (three attendees)
- representatives from eight commissioning organisations and local government bodies
- input from 15 trust board secretaries
- attendance at three CQC workshops.

Whilst the evaluation team maintained their academic independence at all times, there was also a significant element of co-production with representatives from NILD throughout this study. This was deemed to be important for the development of the research questions, in discussions about the meaning of the emerging findings and in developing the recommendations arising from the findings.

3.1 Limitations

The objectives of the research are to understand whether the WLF is having the intended outcomes and impact and to understand any unintended consequences of it, to support the further development of the WLF, to look across all regulatory and oversight organisations and the wider health and care system to understand gaps and opportunities for the use of the WLF in achieving its aims. This suggests that the evaluation should consider the views from across the system. Whilst the evaluation solicited the views of representatives from national bodies which govern the NHS, leaders from a range of provider organisations, members of NHS provider boards, board members of clinical commissioning organisations, patient and public representatives and representatives from commissioning organisations and local government bodies, there was greater focus on the views of NHS providers. This was a pragmatic decision to focus resources on areas where the framework is likely to have most significant impact.

The evaluation provided a mixed set of data. For example, the survey provided quantitative as well as qualitative data. Collecting and mixing two data types in one survey can be challenging. For example, respondents may use survey responses to provide summary responses and use comments in the survey to highlight negative instances of a programme. This can lead to the analysis of comments aligning to the lowest scores found in the quantitative data (Boussat, Kamalanavin and François, 2018). The qualitative comments collected in the survey were somewhat discordant with the overall scores of the survey and the themes of the interviews. However, they were useful in understanding weaknesses of the programme and were retained specifically for discussing the unintended consequences. The low rate of completed responses retained for the surveys for providers, 190 in total (6.3% response rate) and clinical commissioning groups, 22 in total (6.5% response rate) limits the generalisability of the findings across the system. We have therefore qualified our report with discussions about the contexts in which our recommendations work.

4 Findings and analysis

The findings are presented under three headings of content, application and future of the framework. Content is related to understanding the aspects that enable the framework to work – for example the relevance of the key lines of enquiry or the manner in which the framework achieves change. Application is concerned with the manner in which the framework is used by trusts themselves, in CQC inspections and developmental reviews and the resulting impact. The future of the framework section addresses questions aligned to its potential application and development in order to meet wider system needs. Together, these headings cover the main questions posed by the NILDB in the initial scope for the evaluation, principally: is the framework working; how can it be developed further; can it be applied to the wider system, and what can we learn from other related efforts?

4.1 Content of the WLF

4.1.1 Findings

How does it work to ensure that organisations and services are well-led?

The survey results indicate that the majority of the respondents agree that the WLF is clear about what a well-led organisation looks like and covers most aspects for managing healthcare (see survey statement #1 in Table 1 in 9.3). It is viewed as being underpinned by the correct principles and the KLOEs are clearly described. This sentiment was further supported by the majority of interview and focus group participants who commented on the positive extent to which the framework provides clear and helpful guidance around what well-led means. Comments in this area included:

- "*The KLOEs are good, sensible headings. Why would you want to change them*?" (acute trust chair)
- "*The length is about right; it isn't overbearing and the examples of good practice are helpful*". (acute trust secretary)

The majority of provider interviewees also commented on the usefulness of having a framework which outlines expectations around governance and leadership, against which boards know they will be assessed. Some went further, describing the value that the framework brings in providing a model for self-reflection:

- "*We as a board would struggle to self-assess without this now*" (acute trust CEO)
- "*The framework enables a discipline by which the Board can review its performance across a range of areas and determine where focus and action is required*" (mental health trust CEO)
- "*We used this as a drumbeat*" (community trust CEO).

A number of participants also noted that the WLF is more helpful than the predecessor guidance relating to governance and leadership, such as the Board and Quality Governance Assurance Frameworks in that it provides a more holistic approach to leadership and governance arrangements within an organisation.

Whilst recognising these positive attributes of the framework, a number of suggested improvements were also made regarding the content. These are outlined under 4.2.1.

How relevant are the key lines of enquiry?

While the content of the framework (described above) is broadly viewed as positive, there was divided opinion on the relevance of all KLOEs to all organisations. For example, there was some discussion concerning whether a standardised model is appropriate given the diversity of different providers' scale, context and performance across the sector. One respondent commented "*A one size fits all is unlikely to be appropriate across such a variety of providers, both in terms of magnitude and services*" (executive director).The survey also found divided opinion on whether some sections of the WLF should be removed or reduced (survey statement #4), and there were a number that considered some sections are more important for a well-led organisation than others (survey statement #3). Finally there were also comments from some interviews that it would be helpful if the content of the framework could more easily facilitate greater challenge and stretch for stable and high-performing organisations, for example though the indication of evidence of levels of good, excellent and exemplary practices, rather than lines of enquiry that seek binary assurance. Equally organisations with lower ratings expressed an appetite for more tangible and real-world examples of good practice (such as case studies) to support their improvements required.

Comments provided in the survey, as well as interview and focus group feedback further illuminated this breadth of opinion. While some think that the WLF *'contains the necessary sections'* and that all are important, others posited that some sections '*can be situational on localities' (*clinical director*)*. Some also felt that there is duplication throughout the WLF and some questions could be merged or removed, such as KLOE 6, relating to the use of information. A minority also challenged the validity of some aspects of the framework, such as expectations around organisational values: '*the writing of a vision, a mission statement and listing abstract nouns has no proven benefit'* (NED).

There was a consensus among interviewees that the framework should maintain a strong focus on both leadership and governance, and we heard significant levels of support for the enhanced focus on leadership since the 2017 refresh of the NHS Improvement guidance. Some stakeholders expressed a view that leadership and culture could be part of the same KLOE (whereas these are currently under two separate ones), with clearer guidance provided regarding expectations and outcomes of a healthy culture at all levels, and the role of leaders in setting, leading and monitoring this.

Other areas that were identified as warranting greater emphasis included:

- Medical and clinical engagement, including the extent to which leaders at this level are fully engaged in shaping the quality of patient services
- The emphasis on patient involvement, which at present, doesn't fully address levels of engagement i.e. consultation vs co-production
- The role, contribution, capacity, impact and empowerment of middle managers, including a focus around the quality of their development and succession planning
- Staff experience, including greater levels of clarity on how this should be measured;
- Equality, diversity and inclusion, particularly in relation to the Workforce Race Equality Standard; unconscious bias training and insights into the different experiences of black and minority ethnic staff, patient and carer groups
- Innovation and creativity, including clearer guidance on what works well in this area and the culture which is required within an organisation to effectively support the implementation of continuous quality improvement.

Finally, there were a number of views, particularly from workshop and focus group participants, that the focus on service user and patient engagement could be more explicit. This included a need to more clearly articulate the benefits of a range of different levels and approaches to meaningful service user and carer engagement and co-production activities, and ensuring a focus on the extent to which the culture of an organisation supports staff at all levels in undertaking these activities. Workshop delegates also tended to agree that the focus on patient outcomes in the framework is not explicit, despite this being the aim of high quality leadership. They also emphasised that the language and jargon currently used within the WLF is potentially alienating to patients and the public.

4.1.2 Analysis

Both the survey and the qualitative evidence show that the framework is a sensible and useful tool that provides an authoritative, shared definition and understanding of what well-led means. It works by calling the attention of leaders to key aspects that can influence improvements in effectiveness. This enables boards and their leadership teams to reflect on and change leadership practices that impact the quality of care. All stakeholders engaged in the evaluation agreed that the existence of a framework emphasising the importance of governance and processes, and culture and leadership is in itself, helpful. The WLF is also seen to emphasise the latter more than its predecessor guidance, which is supported.

The KLOEs of the WLF are clear, systematic and comprehensive. They provide clarity and structure, and most are in agreement that the eight KLOEs are all relevant. There is broad agreement that the framework makes clear what a well-led organisation looks like and is useful for setting benchmarks. The framework is therefore a tool for structured reflection that informs practice and drives improvements.

The survey showed that some KLOEs are considered more important than others and that, in some contexts, some KLOEs should be omitted or reconfigured, otherwise there is duplication and over-emphasis in particular areas. This was supported by interviews with providers, during which a strong view emerged that applications of the KLOEs should be flexed according to organisational context in order that, without diluting standards, assessment and improvement resource can be deployed most effectively.

The framework is particularly strong on technical matters, such as governance and processes, and stakeholders agreed that expectations in this area are set out clearly. Recognising the increased emphasis on culture and leadership in the most recent iteration of the framework, interviewee and focus group participants emphasised the need to continue to refine and strengthen the content in this area. Reasons behind this include a need to keep pace with policy priorities (such as just culture, diversity and inclusion and enabling the delivery of compassionate care) but also to ensure that the organisational culture enables and supports the delivery of a robust governance structure.

A number of respondents also noted that there is scope to expand the statements of good practice currently included within the framework to reference examples of good practice and case studies. It was felt that this would further assist in facilitating a culture of learning and support across the NHS.

4.1.3 Recommendations

1. Organise the WLF under two broad headings: (1) governance and processes, (2) culture and leadership. The intention of this amendment is to prompt a more equitable focus across these two areas both within the content of the framework itself as well as its application in practice.

2. Refine the culture and leadership elements of the WLF to include greater levels of detail on:
   (a) Measures and prompts for assessing organisational culture(s), including signs and symbols, and patient and staff experiences, that indicate displayed and enacted values, attitudes, beliefs and behaviours (examples: existence and embeddedness of Schwartz rounds; Arnstein levels of patient involvement)
   (b) How the extent of focus on quality and other types of improvement work will be assessed
   (c) Evidence of the encouragement and management of talent pipeline and succession planning for key leadership roles
   (d) Assessment of capacity, capability, empowerment and development of middle managers
   (e) The development of further lines of enquiry around equality, diversity and inclusion (for example, the use of reverse mentoring)
   (f) Extent and penetration of clinical and, specifically, medical leadership engagement

3. Expand and consolidate the documentation available surrounding the WLF to include further examples of good and outstanding practice for each KLOE, along with the use of case studies. This should be aimed at encouraging shared learning and improvement, as well as to provide further stretch and guidance for higher performing and more mature organisations. It would be helpful to draw from competency frameworks such as the Healthcare Leadership Model which uses this stepped approach. In addition, where relevant, case studies and examples of best practice from outside the NHS should be sought.

4.2 Applications of the WLF

4.2.1 Findings

What are the improvements happening as a result of it?

The provider survey shows that WLF has enabled improvements in relation to some areas of its scope. These were most evident in relation to risk management (survey statement #27), which supports evidence in feedback from focus groups and interviews, that provider organisations' governance arrangements, structures and processes are improved as a result using the WLF. One trust secretary stated that "*before the WLF, the overall state of governance across the NHS was very poor. Things are much improved over the last five years or so*".

To some extent, the WLF is viewed as having led to improvements in the capacity and capability (survey statement #23), organisation's culture (survey statement #25), the sense of responsibility, roles and systems of accountability (survey statement #26), engagement with patients and public (survey statement #29) and systems for processes for learning, improvement and development (survey statement #30). Many of these categories could be described as more pertinent to the culture and leadership elements of the framework. Through our interviews and focus groups, providers described the WLF as having driven a focus on leadership at board level, for example in determining board development priorities. However, many noted that there is scope to more consistently engage divisional, departmental or operational staff in the application of the WLF in order to understand the focus on leadership across an organisation.

Improvements were less evident in the vision and strategy of the organisation (survey statement #24), in information processing (survey statement #28) and developing positive relationships with system partners (survey statement #31). Interviewees from provider and

regulatory bodies further described the WLF's expectations in relation to strategy and system working as more 'nebulous' and harder to assess with a 'tick box' approach.

Besides these more tangible improvements, many providers described an indirect benefit in the framework as a tool for self-reflection. We heard of many trusts, for example, using the WLF to annually assess themselves against the guidance to determine improvement priorities and direct resource accordingly. Those who reported gaining more benefit from the framework tended to use the guidance more proactively, for example, by embedding it into the board's cycle of business (particularly in relation to Board development sessions), rather than waiting for the formal CQC self-assessment process to begin.

How useful and helpful are the well-led CQC inspections?

Most of the organisations represented by survey respondents had been through a well-led inspection since June 2017. While our evaluation scope is to assess the impact of the WLF in all of its application methods (inspection, developmental review and self-assessment), when reading this section, it should be noted that, most stakeholders focussed on the application of the WLF by the CQC, for reasons which are outlined in further detail under 4.2.2.

Survey findings showed that elements of the CQC well-led inspection process are indubitably reliable and helpful. In particular, the use of the WLF significantly helped leaders to identify gaps in their current arrangements (survey statement #19), benchmark their organisations (survey statement #18) and inform ongoing work practices (survey statement #20). Further, providers often referred to a poor rating as an important catalyst for change, with one stakeholder commenting that a rating of 'requires improvement' can be very helpful to an organisation when it ignites a change in attitude.

Survey respondents generally agreed that the CQC inspections were conducted in a supportive and collaborative manner (survey statement #5), that the CQC has a coherent approach (survey statement #8) and that there was clear feedback soon after the inspection (survey statement #6). Interview and focus group feedback in this area was more nuanced and varied. A selection of comments showing the breadth of views in this area is shown below:

- "*I couldn't fault our recent inspection. Conversations felt mature, open and contextualised. I think the open nature of our relationship with the local team really helped us make the best of the inspection*" (specialist trust chair).
- *"Our inspection team have taken the time to get to know us which has fostered an open relationship" (*mental health trust CEO*).*
- '*The senior inspector was very good…they came to the senior leadership team to talk…not defensive; relaxed and confident, considered, measured. Talked us through the report and gave various examples. The staff started to understand and accept what they were being told…I felt s/he was on our side'* [chair of trust in special measures]

And conversely,

- "*The well-led inspection doesn't feel developmental, it feels punitive. There can be serious consequences for individuals… people are really scared of it*" (acute trust CEO).
- "*I've had really negative experiences in which I've openly shared some concerns with the CQC, which were then played back in the public report as if the board wasn't aware. We were told this absolutely would not happen.*" (acute trust chair)
- *"The well-led inspection was reasonably searching but could have been more probing…"* (NED of Outstanding trust).

- *"The inspection team made an assessment about the effectiveness of the Board without ever seeing it in operation. It wasn't clear how some of the conclusions had been reached, and therefore it was unclear what actions needed to be taken as a result"* (acute trust CEO)

There was also a recognition from both providers and representatives from the CQC that a more consistent methodology and approach to inspections needed to be applied in practice.

Survey respondents were clear that the emphasis of the CQC's approach was somewhat stronger on processes than on styles and behaviours. Some commented '*whilst I agree it covers both [governance and leadership], it feels more process driven' (*divisional director*)*. Again, we found greater strength of feeling regarding this through interviews and focus groups, during which participants unanimously agreed that the CQC's (and indeed the wider regulatory and oversight system's) focus on culture and leadership should be much stronger. A key comment in this area included:

"*When I arrived at this organisation, I knew that improving the culture was key to our long-standing financial and performance issues. Yet in all of my conversations with regulators, none of them were telling me to do this. They were all focussed on process*." (CEO of a challenged acute trust).

The survey data indicates some agreement that the CQC inspection team had the appropriate expertise to conduct the inspection (survey statement #7), although there was differing opinion on this. A high number of respondents were unable to give their opinion in this area, and a further significant number of respondents were in disagreement, particularly around the recurring theme that a lack of appropriate skills was hampering the ability to provide the necessary focus during the inspection process. The latter view also came through strongly in provider interviews, during which board members often described a perceived lack of capacity and capability in inspection teams to robustly assess leadership. In particular, some trusts questioned the seniority and lived experience of some inspector teams in order to be able to credibly assess leadership and board effectiveness. One executive director commented that "*The credentials of the inspection team do not always reflect the levels set by the CQC".*

Aligned to this finding, during focus groups and interviews, providers frequently underlined the importance of the role of peer reviewers in the inspection process (both specialist advisers and executive reviewers). This cohort of the inspecting team are perceived to lend significant and valuable challenge and credibility to the process, and in particular are believed to increase the quality of questioning around the more qualitative aspects of the framework.

CQC stakeholders engaged throughout this evaluation agreed with the importance of peer or executive reviewers and specialist advisors but described the challenges in building a large enough pool of resource which the CQC can leverage. Peer reviewers themselves often articulated a need for improved training in order to undertake their role effectively, as well as a desire to be engaged more meaningfully at all stages in an inspection, particularly in relation to greater inclusion in the preparation for an inspection, as well as greater involvement in the synthesising and reporting stages. Key comments from peer reviewers included:

- *"Training was almost non-existent… I also had very little briefing on the trust beforehand. It all felt rather disorganised".*
- *"I felt uncomfortable… as if the CQC had made their mind up about the trust beforehand. They could have shown more respect to those working in the organisation".*
- *"I would have welcomed greater involvement at the triangulation and feedback stages... I didn't get a chance to comment on the report."*

How useful and helpful are the developmental reviews?

The key finding arising from the survey is that developmental reviews are helpful (survey statement #14). Respondents found that they are consistent with their own views (survey statement #13) and those of CQC inspections (survey statement #15) and that they added value (survey statement #16).

Providers also described an additional benefit to developmental reviews in that it is felt that there is greater autonomy in the process in order to flex the scope according to areas of greatest need, usually arising from the self-assessment. One acute trust CEO commented that "*My review felt like a partnership… a collaborative process. I also received a lot of help in identifying good practice and co-developing my action plan off the back of the review.*"

Some providers also described a more thorough staff engagement process in their review, as well as more attention given to the action planning following the diagnostic stage, such as the provision of advice, examples of good practice and access to learning from other sectors. Some providers also described being able to select the supplier based on their levels of experience aligned to the areas of focus for the board, such as risk management. Elsewhere, we heard of a lack of clarity regarding how to procure an independent reviewer. A small number remarked that the market choice seemed too narrow and that NHS Improvement sometimes oversteered to certain development review providers. In the opinion of these interviewees, this has potentially led to problems with value for money for the public purse and blind spots from this lack of diversity in procurement.

Many stressed that the added value of developmental reviews is contingent on the quality of the supplier selected and the experience of the team that is then deployed. Those who reported more negative experiences of their developmental reviews tended to focus on three key points, in which there is some overlap with findings in relation to CQC well-led inspections, outlined above:

- *Extent of focus on leadership*: Some providers felt that their developmental review had focussed largely on board effectiveness, to the detriment of wider culture and leadership matters. "*Our review didn't tell us much about the culture of the organisation. Acknowledging our dispersed geography, I would have liked to have heard more of their independent view in this area*" (community trust CEO).
- *Use of peer reviewers*: Not all providers were aware of the supplementary guidance regarding the potential to engage peer reviewers, and expressed an appetite for greater clarity in this area to make the most of shared learning and networks. As one Trust Secretary commented, "*There is nothing to stop peer review from happening more frequently and it would be good to normalise learning from each other in this way.*"
- *Extent of challenge from the review provider*: A minority of stakeholders described their developmental review as too "reassuring", which consequently identified little in the way of new information for the board to act on and take forward. "*I don't feel like our review told us anything new. Perhaps they were a bit in awe of us*?" (teaching hospital trust chair).

The provider survey found that the combined approach of the developmental reviews and CQC inspections works reasonably well (survey statement #22). Stakeholders were generally clear on the purpose of developmental reviews, with non-executive directors in particular often comparing the process to similar expectations set out in the Combined Governance Code for listed companies. A minority, however, expressed an appetite for the requirement for both an inspection and a developmental review to be more clearly articulated including the intended purpose of each approach.

Most stakeholders also agreed that the annual well-led inspection process alongside the (typically) triennial expectation of a developmental review should be reviewed, with a view to

developing more flexible guidance in this area. This was particularly the case for high performing organisations. While the guidance only says that a developmental review is "strongly recommended every three to five years", there were examples of trusts (even one rated outstanding) who had felt obliged by the regulator to have one immediately after their well-led inspection, despite only having had a developmental review three years prior. *"Why do we need a developmental review if we have just had a positive CQC well-led inspection? It feels like poor value for money" (*community trust CEO).

4.2.2 Analysis

There is broad agreement from providers and regulatory representatives that the existence of the framework itself has provided a valuable tool for self-reflection which can enable leaders to make improvements in relation to governance and leadership. Those who reported improvements as a result of the WLF were more likely to describe having routine self-assessment processes, subsequent action plans and a clear strategy for using the framework, for example through board development and independent review processes. They often described the value of the framework as being "post-review" or "post-inspection" and saw the assessment as part of a wider continuous improvement process, rather than an end in itself.

Interviewees were clear that having a framework and the associated inspection regime has led to improvements in governance. Providers find the clarity of guidance contained within the framework helpful, and that expectations in relation to systems, structures and processes are clearly defined. Many providers warned against losing this rigour and clarity in any future iterations of the framework. While some stakeholders reported improved board effectiveness as a result of the framework, its impact at divisional, departmental and team level remains unclear. One acute trust chair challenged this aspect of the framework: "*Is it really clear what good leadership looks like at all of these levels?"*

The emphasis on culture and leadership throughout inspections was an area requiring a more consistent approach. This view was communicated to us on multiple occasions by the CQC, with one senior leader in particular stating that "*we're not good at looking at the culture… the tangible versus the intangible*". Providers agreed that the inspection processes places less scrutiny in these areas, and underlined the need for increased capacity and capabilities within the CQC in order to robustly and credibly assess these areas. Peer reviewers are seen to bring significant potential in this space, when used fully and meaningfully throughout the inspection and developmental review processes.

Focus group and interview participants stressed that the WLF has an influential rating system and is backed by a regulator that has the authority to affect the organisations and people working within them. The benefit of this 'weight' is that it can expedite change where required. An unintended consequence is a fear of the inspection process, of which the WLF is a key part. Senior leaders frequently described the personal and emotive response which organisations, their boards and staff have towards well-led ratings; board members, and executive directors in particular, feel that a poor rating can have a huge negative reputational impact on their career in the NHS.

During workshops with cross-sector attendance, delegates described this context as deterring potential future leaders from aspiring to executive level roles, due to concerns around being held personally responsible for entrenched, long-standing and system wide issues. There was a strongly held belief that, as a result of this climate, the most challenged organisations are unable to attract high-performing, experienced leaders, which further disadvantages these trusts and their local populations. A view emerged, particularly from the two workshops in July, that the framework and its application could do more to actively promote the rotation or dispersion of high-quality leadership across such challenged

organisations. This view was further supported by interviews with senior regulatory and provider leaders who commented on the often "punitive" climate in the NHS and the potential problems of appointing the same safe pairs of hands to more than one board by way of mitigation (a development which the Financial Reporting Council in the Corporate Governance Code in 2018 warns against) *"We are in danger of over-boarding people. Are we supporting the right people with the right skills to do the difficult jobs*?" (senior CQC inspector).

Conversely, inspections are seen to add more value when there is a history of positive working between the Trust and the CQC, or work has been undertaken to build an open relationship with regular dialogue. This enables ongoing monitoring of performance, contextualisation of issues, and sharing of good practice where appropriate. While care must be taken to maintain both impartiality and independence, providers frequently described a lack of support from oversight and regulatory bodies in order to make required improvements.

Developmental reviews on the other hand, when undertaken by an appropriate and high-quality provider, are seen to have potential to fill some of this need, without compromising independence. For them to add value, however, the supplier selected must be the right fit for the organisation; peer reviewers will usually be beneficial to the process, which should focus sufficiently on development, and not just an upfront diagnostic. Finally, a developmental review is more likely to add value when its focus is truly developmental, rather than be directed by a regulatory body.

In light of the perceived imbalance between assessment and support described within this section, there is strong feeling among providers that an annual well-led assessment is often inappropriate. In addition, as outlined above, there was a view from across the various activities that inspections could be more tailored to take into account provider context and to focus on particular areas of risk. Survey questions survey statement #11 and survey statement #12 also show high levels of variation of views in this area. Reasons given against frequent inspection including that changes, particularly in relation to leadership and culture, will have had insufficient time to embed in under 12 months, increased regulation will detract resource away from more direct patient care, and frequency should be context-specific, aligned to local intelligence and risk factors rather than at fixed points.

A number of providers also noted that there needed to be more interaction across regulatory bodies to share insight around a provider and the context within which they are operating. This was felt to be of particular relevance when preparing for an inspection, as well as ensuring that key findings arising from a review were both pertinent and consistent across both CQC and NHSI/E.

4.2.3 Recommendations

1. Use peer reviewers differently, more inclusively and sustainably, in CQC inspections and developmental reviews. This should include ensuring that further training, support and briefings are provided to those undertaking these roles, as well as more consistent levels of inclusion in the analysis of findings stage.
2. Vary the frequency and focus of well-led inspections according to explicit criteria, which could include a range of metrics such as:
    a. Significant changes to the composition of the Board and leadership teams within an organisation
    b. Indicators of changes to staff experience such as through: Freedom to Speak up Guardians; national and local staff survey results; whistleblowing cases; feedback from minority staff groups such as BME and junior doctors; and

c. Quality metrics, such as Never Events and incident reporting.

This process should also include a more joined-up approach across regulators in order to collectively share insight and intelligence in order to determine the timing and approach to reviews and inspections.

3. Clarify the purpose and interconnectivity between the various applications of the WLF including self-assessments, developmental reviews and inspections.

4.3 Future of the WLF

4.3.1 Findings

How is the framework applied to the wider health and care system?

Respondents to the provider survey agreed that there were opportunities to improve leadership across the wider healthcare system through the broader application of the WLF (survey statement #32). This view was supported by interviews with providers, integrated care system (ICS) representatives and commissioners, who agreed that a single definition of high-quality leadership is needed to promote effective relationships across a system and to support the delivery of system-wide objectives. A small number of commissioners also expressed surprise that different leadership frameworks are being used in provider and commissioner settings, and called for a single framework to promote coherence. This view was echoed by workshop delegates, who agreed that there is a need for the NHS as a whole to adopt the framework, including regulators and oversight bodies; *"we can't stand in judgement if we are not applying the same principles to ourselves. Inspectors need to know how it feels to be assessed".*

Overall we found low levels of awareness of the WLF outside of the NHS provider sector. Few commissioners we spoke to were aware of its content, and there was low uptake to the commissioner survey issued as part of this evaluation. Some commissioners were generally aware of the WLF via the published CQC ratings for their local providers, but acknowledged a low awareness of its purpose and content. Where there were greater levels of awareness, there was a sense that insufficient use is made of the views of commissioners, with some noting that they had not been invited to participate in assessments happening in their area. Our engagement with CQC inspectors also found inconsistencies in how external stakeholders' views are sought in well-led inspections.

Those with greater levels of familiarity with the framework tended to agree that, while the content of the framework is helpful, its application is at odds with the national strategic direction of travel towards whole-system working and leadership. We found limited examples of the impact of the WLF on the broader system level. Further, it was emphasised that national targets and standards designed for individual providers can directly conflict with those which would benefit a system. Some key comments in this area included:

- "*It [the WLF] doesn't discourage tribalism in its current form*" (acute trust CEO).
- "*We have matrices coming out of our ears at the moment, but until the regulators start to treat us like a system, it's very hard for us to act like one*" (ICS leader).
- "*I could do nothing for the benefit of the system and still be rated outstanding per the framework as it stands. This runs counter to all the national messaging*" (community trust CEO).

Both survey and interview participants acknowledged the complexity of remedying these issues, not least where social care and wider system partners fit into the framework. Stakeholders gave credit to the CQC for implementing system reviews in some areas, but

encouraged this to go much further. For example, ratings are not currently given, and while commentary is made on the quality of relationships between leaders, some felt that there is not enough focus on outcomes. One community trust chair commented that "*Relationships are great but if they're not making a difference to patient outcomes, then what is the point*?"

Nonetheless, there is an appetite for regulation to be able to assess in some form across an integrated system over time. As a minimum, providers called for both the guidance and its various forms of application to take into account a much more explicit consideration of their wider operating environment, and the impact of this on an individual trust's performance and outcomes. In particular, local demography, population health needs, system-level financial position and performance of neighbouring providers and commissioners are all deemed to be key to the holistic and credible judgement of a single organisation.

How can the framework be developed to meet the needs of systems leadership?

Responses in this area were some of the most mixed of the evaluation overall, with divergent views and levels of ambition about the future of regulation in this area. In particular, we identified a paradox between those who advocate for single organisation well-led inspections given the legislative context, to those calling for system-wide regulation as soon as possible in order to drive change at this level.

Aligned to the latter, there was a spectrum of views about who the WLF should apply to, particularly if part of its future purpose is to encourage effective system leadership. All stakeholders felt that it should apply to all NHS bodies, but most cautioned against seeking to broaden its scope beyond this at this stage given the breadth of other work already ongoing in this area (for example in relation to the local government peer reviews).

Most agreed that the WLF should continue to be applied to individual organisations, but that this should also be supplemented by an additional focus across entire ICS' in order to drive more inclusive working. Many participants were clear that unless there is a more consistent focus on the quality of leadership, culture, system and processes within a system it will be difficult to fully enact change at this level. As regards how this could be achieved, stakeholders suggested a number of methods, including:

- Ensure that the context within which a provider is operating is given greater prominence in inspections and developmental reviews in order that any system wide issues which impact on the WLF rating for an individual organisation can be clearly understood and articulated.
- Seek the views of other system leaders as part of a provider inspection on a more consistent basis, and consider applying the WLF to other NHS bodies.
- Align the timings for the inspections of providers within an ICS so that aspects of the WLF (such as the extent of strategic alignment with key partners) can be undertaken concurrently. This would also allow for common themes within an area to be highlighted and reported jointly.
- Continue to undertake broader local system reviews to determine how services are working together. As part of this approach, include a focus of leadership and interaction along particular pathways, so that the patient perspective is put at the centre of the inspection methodology.

In each case, the majority of stakeholders agreed that the WLF in its current format provides a helpful starting point for developing guidance on system leadership. Many underlined the findings described under evaluation question (1), i.e. that the framework itself has been well-received as guidance by health providers, and cautioned against excessive changes or a wholesale review. However, it was generally felt that the framework could more clearly describe expectations in relation to system leadership, such as including partnership

working, monitoring of shared outcomes, use of community assets, multidisciplinary teams and encouraging innovation.

4.3.2 Analysis

It is clear from our interviews that the WLF currently sits in a cluttered policy environment, and applications to a wider system setting are complicated by the statutory context within which NHS providers and the CQC currently operate. Nonetheless, there is a strong appetite for the WLF to be adopted more broadly across the health sector in order to provide a single definition of high quality leadership which can provide a fulcrum for required leadership behaviours. Views as to how the framework could be rolled out more widely across systems lacked consensus, and we identified a range of appetites for this.

As a minimum, the WLF has the potential to be used and applied more broadly than within its current remit of NHS trusts. Its use as a tool for developing leaders could be exploited further (for example by extending its scope to CCGs and ICS's) to promote a shared definition of 'well-led' and expectations within this. It is expected that this would enable faster progress of system-wide priorities by driving a shared set of leadership behaviours. Much greater awareness of the WLF outside of NHS provider bodies is required to begin this journey.

Providers, patient representatives and commissioners concurred that the WLF should be used as a tool to promote and enable the delivery of wider NHS strategy, and as such, there is a need to align it more closely to the Long Term Plan and People Plan. This view contrasted with that held by some regulatory representatives who underlined the current legislative constraints within which regulators hold their mandate.

There is, nonetheless, agreement among providers that a more explicit consideration of a trust's operating environment and context would start to move the inspection lens towards a wider system focus (such as system wide financial position, demographics and the performance of neighbouring providers). It is currently felt that in looking solely at a single organisation, reasons for particular areas of underperformance for example may be missed. This can have the unintended consequence of recommendations being made which focus on the presenting problem, rather than the underlying issue, context and nuance.

Conversely, providers, commissioners and senior regulatory personnel agreed that increasing consideration of whole-system performance will drive a greater focus on outcomes and the interdependent nature of a system's financial position, performance, and in turn, quality of care provided. There remains a view that some trusts have been rated outstanding, despite little evidence to suggest productive relationships with system partners. This is felt to reduce the credibility of the well-led rating system, as well as the impetus for providers to more actively play a role in addressing the objectives of the Long-Term Plan.

4.3.3 Recommendations

1. Consolidate, clarify and expand guidance on system leadership, to include as a minimum:
    a) A definition of what is meant by a 'system' and attributes of effective leadership of a system, including the importance to patients of joined up care
    b) Expectations regarding prevention, population health and working with the wider determinants of health
    c) Evidence-based hallmarks of effective system leadership
    d) Processes to support (c), such as co-development of strategic plans, system-level monitoring of outcomes and joined-up use of digital technologies

e) How regulators will encourage system working through inspection processes, including the consideration of a provider's local operating context (such as demography, system financial position and partners' key performance indicators)

2. Encourage the use of the WLF for and by clinical commissioning groups and integrated care systems to promote a single definition of high quality leadership.
3. Ensure that the application of the WLF takes into account both leadership of individual organisations as well as the extent to which leaders of an organisation effectively operate and input across the broader system. Consider whether it is appropriate to award a rating of Outstanding to a provider where there is little evidence of positive and collaborative relationships in the local system.
4. Supplement the current application of the WLF in individual organisations with consideration of whether governance, processes, leadership and culture are effective across a system. This could take the form of either a local system review, and / or reviews across specific pathways of care.
5. Apply reviews of the WLF to system oversight and regulatory bodies, with key findings made publicly available

5 Discussion

As described in the chapter on methods above, the approach adopted in this evaluation is realist informed, in order to understand the broad impacts of the framework. The purpose of this approach is to identify mechanisms that explain how the WLF achieves impact, then to test these mechanisms in various contexts to understand the different circumstances in which the mechanisms work or don't work, who they work for and why they work (Pawson, 2013). In this way, we understand not only the positive impact of the framework, but also the times when it does not work and where there are unintended consequences.

A synthesis of open comments from the survey of providers, using realist evaluation methodology in Table 1 overleaf, offers more detail, particularly about how the approaches to the application of the framework affect the impact. This synthesis leads us to a proposition that an important impact of the WLF lies in the quality and consistency of how it is applied.

Table 1: Synthesis of open comments from survey of providers

If	Then	However	Which leads to
The WLF is applied proportionately	There will be an understanding of the effectiveness of leadership processes, systems and styles and behaviours	There is less of a focus on culture and quality improvement in practice and more of a focus on systems and processes	Focus on only a limited area of leadership
The inspection regime is triggered at the right frequency and with little duplication	There will be time for changes to take place	The frequency of inspection is too high in some cases	Ineffective short-term actions and over-inspection in certain areas
Executive reviewers who are chairs or chief executives, or have board experience themselves, use a structured interview process and are allowed open follow up questions	The provider board will be able to respond in a focused manner by providing evidence about culture and behaviours which would lead to a more comprehensive review	There is a lack of appropriate skills and experience in some of the inspection teams	A regulatory burden without maximising benefit
There is an additional KLOE on how well Public Health, Primary and Secondary care services communicate with each other and share their expertise	The framework will be more complete		
The framework has a developmental slant to it	It will be able to suggest improvements		

If	Then	However	Which leads to
An organisation self-assesses	They will perform better in the well-led aspects of an inspection		
The content of the framework and information is clear and well-balanced	It will be more effective as it will be easier to understand key objectives and goals	There is too much emphasis on certain areas and not on others	Failure to uncover relevant issues
The WLF takes greater account of the nature of the organisation	The reviews will be more relevant	The use of the framework is sometimes based on less relevant metrics	An invisibility of key metrics and compromised performance assessment
A developmental review is undertaken in a timely fashion using a "board to ward process"	Then boards will be motivated to make fundamental cultural, strategic and operational changes		
The WLF focuses on the performance trajectory of the provider	There will be greater alignment between review expectations and results	There is lack of recognition of the continuous journey	Frustration with the process
The WLF report provides actionable advice on the negative aspects of the review	The providers would know what to do	When the focus on negative aspects contains no proposed solutions	The providers feel less supported and more demotivated
The WLF explicitly reflected the changes set out in policy documents including system leadership requirements	There would be a better system approach and enhanced system impacts		

Previous research on the impact of the Care Quality Commission on provider performance identified eight regulatory impact mechanisms (Smithson *et al.*, 2018). These were developed from the literature on the impact of regulation in health and other sectors to evaluate whether and how inspections and ratings impact providers of care. The mechanisms were tested and refined with providers and patient groups to understand how the mechanisms operated in practice. Together they describe how the regulatory regime impacts organisational behaviour (see Table 1).

The mechanisms are, effectively, theories about how CQC regulation affects providers, or eight ways in which regulation has an impact. Whilst the WLF has other uses beyond assessment by the regulator, we can draw on these mechanisms to sense-check the findings of this evaluation, and to build on them. They also contribute to explanations about how and why the WLF works well, and circumstances in which it does not work so well.

Table 2: Eight regulatory impact mechanisms (from Smithson et al, 2018)

Anticipatory	The regulator sets quality expectations, and providers understand those expectations and seek compliance in advance of any regulatory interaction.
Directive	Providers take actions that they have been directed or guided to take by the regulator. This includes enforcement actions and, at the extreme, may involve formal legal repercussions such as prosecution or cancellation of registration.
Organisational	Regulatory interaction leads to internal organisational developments, reflection and analysis by providers that are not related to specific CQC directions. This leads to changes in areas such as internal team dynamics, leadership, culture, motivation and whistleblowing.
Relational	Results from the nature of relationships between regulatory staff (i.e., inspectors) and regulated providers. Informal, soft, influencing actions have an impact on providers.
Informational	The regulator collates intelligence and puts information about provider performance into the public domain or shares it with other actors who then use it for decision-making (e.g., commissioning, patient choice).
Stakeholder	Regulatory actions encourage, mandate or influence other stakeholders to take action or to interact with the regulated provider.
Lateral	Regulatory interactions stimulate inter-organisational interactions, such as providers working with their peers to share learning and undertake improvement work.
Systemic	Aggregated findings/information from regulation are used to identify systemic or inter-organisational issues, and to influence stakeholders and wider systems other than the regulated providers themselves.

Several mechanisms of change were identified in the data that relate specifically to the application of the WLF on provider organisations. They are summarised below in Table 3 and placed alongside the regulatory impact mechanisms identified in the work of Smithson and colleagues.

Table 3: Comparing the mechanisms of change with the regulatory impact mechanisms (RIMs)

Mechanisms of change	RIMs
1. The WLF calls the attention of organisation leaders to key aspects that can lead to improvements in effectiveness. This enables leaders to reflect on and change leadership practices that impact the quality of care.	Informational
2. The WLF provides assurance for what well-led looks like and therefore enables leaders to benchmark their practice. This supports the leadership in their delivery of quality health care.	Anticipatory

Mechanisms of change	RIMs
3. The WLF has an influential rating system and is backed by a regulator that has the authority to affect the organisations and people working within them.	Directive
4. The WLF adds more value when there is a history of positive working between the Trust and the CQC, or work has been undertaken to build an open relationship with regular dialogue. This enables ongoing monitoring of performance and sharing of good practice.	Relational
5. The WLF can be extended to the wider system to promote a shared definition of 'well-led' and expectations within this. This will enable faster progress of system-wide priorities by driving a shared set of leadership behaviours.	Systemic
6. The WLF works when applied to consider how leadership and governance are functioning at all 'tiers. This promotes consistency and a system of leadership practices which impact the quality of care provided.	Organisational
7. Assessments by CQC lead to interventions by NHSI although these are not always seen as supportive	Stakeholder
8. Peer reviewers, for example board members of Good and Outstanding Trusts, report beneficial learning for their own organisations from their experiences of supporting CQC inspection teams. They also report that their contribution could be enhanced and extended into facilitation of developmental reviews.	Lateral
9. Consistent, credible and high-quality application of the WLF, with system and organisation context taken into consideration, leads to greater acceptance and uptake of recommendations from inspections and developmental reviews.	Application

Apart from theme/mechanism number 9, the mechanisms of change can all be broadly mapped onto the regulator impact mechanisms as identified in the work of Smithson et al. For these, we can therefore draw on and add to the descriptions and examples used previously and we do so in Table 4 below. Mechanism number 9 is new and exploratory. It is concerned with the approach that the regulator takes during inspections and with the pitch and focus of attention of external facilitators in the course of developmental reviews. Our findings suggest that emphasis varies according to the capability of the team, their interests, processes and habits, In this regard, it is similar to the relational regulatory impact mechanism, but is particularly focused on the quality of the review. Mechanism 9 is therefore proposed as an application mechanism, an addition to the eight regulatory impact mechanisms.

Borrowing from the framework of Smithson and colleagues, and drawing from the findings from this evaluation, Table 4 below summarises the main impacts of the WLF, including the effects of some of the weaknesses that have been identified in its current applications. Given its use by CQC, not surprisingly the impacts of the WLF have much in common with those identified by these authors.

Table 4: The WLF impact mechanisms including unintended consequences

Anticipatory	The WLF sets quality expectations about leadership and governance, and provides detail about what a well-led organisation looks like. Providers understand those expectations as a benchmark and seek compliance in advance of any regulatory interaction in order to improve their chances of a good rating. However, if it is relatively weak on matters such as such as leadership qualities, culture and engagement, it may fail to motivate the implementation of a number of policy priorities, including a learning and just culture, team working and compassionate leadership.
Directive	Providers take actions that they have been directed or guided to take by CQC and by NHSI. Credibility of the team and supportiveness of regulators, influence how recommendations are received.
Organisational	Interacting with the WLF leads to internal organisational developments, reflection and analysis by providers that are not related to specific regulatory interventions. This can lead to changes in areas such as policies, systems and processes, internal team dynamics, leadership, culture, motivation and whistleblowing across the organisation.
Informational	Inspectors collate intelligence and put ratings based on the WLF into the public domain or share it with other actors who then use it for decision-making. It is a powerful tool. In order to avoid being 'named and shamed' providers therefore improve their performance and profile or 'game' the system and work only on a limited set of items to maximise their chance of a good rating.
Stakeholder	Well-led ratings encourage, mandate or influence other stakeholders to take action or to interact with the regulated provider.
Lateral	The WLF stimulates lateral learning, such as through the experience of peer reviewers, and a growing system level understanding of what well-led looks like.
Systemic	Aggregated findings or information from inspections using the WLF are used to identify systemic or inter-organisational issues, and to influence stakeholders and wider systems other than the regulated providers themselves. They can have a ripple effect across the system and promote a shared set of leadership behaviours. However, extending the scope of the framework without increasing capacity within regulatory and oversight bodies also risks losing the depth of assessment and assurance currently provided.
Application	The WLF is operationalised by the inspectors and by external facilitators of developmental reviews, who emphasise certain aspects of it. Their emphasis, which arises from the issues that the organisation may be facing or the characteristics and interests of the team, influences the acceptance of regulatory assessments.

6 Conclusions

This evaluation has found that there is intrinsic value to the WLF. It works well when applied with an appropriate balance of attention to culture and leadership, and to governance and processes, respectively. It is a powerful tool; it matters to organisations and the individuals working within them.

We have also identified a number of areas where the framework could be improved. Its application in practice is weighted more towards assessment than to support the development of good quality provider leadership. The framework would work better if organisational context were taken into account. There is scope to broaden its use across whole systems, and to deepen its reach down into organisations to all levels, from board to ward or department, and to the front line.

There is cause for optimism about the potential for better leadership which this framework can influence. We have identified the conditions in which it can be used to achieve positive impacts. Despite the crowded landscape of interventions, and policy developments, the framework is bedding down and has significant traction. There is unrealised potential of this framework, which mainly relates to how it is applied. Providers neglect to use it as a developmental tool, regulators sometimes prioritise the systems and processes areas over the culture and leadership aspects, and oversight bodies pay too little attention to providing the support to improve that has been signalled as needed by a well-led assessment.

There remain concerns about the national circumstances in which this framework operates, including the relentless pressure on services, and on finances, and the increasing workforce shortages. The paradox of the double use of this framework, as an assessment and as a developmental tool, is not yet resolved. This evaluation has also shone a spotlight on the capability, culture and behaviours that exist, in some places, in the national regulatory and oversight bodies. These can sometimes work against the overall objective of improving leadership and governance, and better patient experience of care.

7 Summary of recommendations

We reproduce here in one place, for convenience, the recommendations outlined in chapter 4 above, which are drawn from our findings and analysis under the three headings, content, applications, and future.

7.1 Content of the framework

1. Organise the WLF under two broad headings: (1) governance and processes, (2) culture and leadership. The intention of this amendment is to prompt a more equitable focus across these two areas both within the content of the framework itself as well as its application in practice.

2. Refine the culture and leadership elements of the WLF to include greater levels of detail on:

(a) Measures and prompts for assessing organisational culture(s), including signs and symbols, and patient and staff experiences, that indicate displayed and enacted values, attitudes, beliefs and behaviours (examples: existence and embeddedness of Schwartz rounds; Arnstein levels of patient involvement)

(b) How the extent of focus on quality and other types of improvement work will be assessed

(c) Evidence of the encouragement and management of talent pipeline and succession planning for key leadership roles

(d) Assessment of capacity, capability, empowerment and development of middle managers

(e) The development of further lines of enquiry around equality, diversity and inclusion (example: existence of reverse mentoring)

(f) Extent and penetration of clinical and, specifically, medical leadership engagement

3. Expand and consolidate the documentation available surrounding the WLF to include further examples of good and outstanding practice for each KLOE, along with the use of case studies. This should be aimed at encouraging shared learning and improvement, as well as to provide further stretch and guidance for higher performing and more mature organisations. It would be helpful to draw from competency frameworks such as the Healthcare Leadership Model which uses this stepped approach. In addition, where relevant, case studies and examples of best practice from outside the NHS should be sought.

7.2 Applications of the framework

4. Use peer reviewers differently, more inclusively and sustainably, in CQC inspections and developmental reviews. This should include ensuring that further training, support and briefings are provided to those undertaking these roles, as well as more consistent levels of inclusion in the analysis of findings stage.

5. Vary the frequency and focus of well-led inspections according to explicit criteria, which should include a range of metrics such as:

a. Significant changes to the composition of the Board and leadership teams within an organisation;

b. Indicators of changes to staff experience such as through: Freedom to Speak up Guardians; national and local staff survey results; whistleblowing cases; feedback from minority staff groups such as those from BAME backgrounds and junior doctors;
and

c. Quality metrics, such as Never Events and incident reporting.

This process should also include a more joined-up approach across regulators in order to collectively share insight and intelligence in order to determine the timing and approach to reviews and inspections.

6. Clarify the purpose and interconnectivity between the various applications of the WLF including self-assessment; developmental review and the inspection approach.

7.3 Future of the framework

7. Consolidate, clarify and expand guidance on system leadership, to include as a minimum:

a) A definition of what is meant by a 'system' and attributes of effective leadership of a system, including the importance to patients of joined up care

b) Expectations regarding prevention, population health and working with the wider determinants of health

c) Evidence-based hallmarks of effective system leadership

d) Processes to support (c), such as co-development of strategic plans, system-level monitoring of outcomes and joined-up use of digital technologies

e) How regulators will encourage system working through inspection processes, including the consideration of a provider's local operating context (such as demography, system financial position and partners' key performance indicators)

8. Encourage the use of the WLF for and by clinical commissioning groups and integrated care systems to promote a single definition of high-quality leadership.

9. Ensure that the application of the WLF takes into account both leadership of individual organisations as well as the extent to which leaders of an organisation effectively operate and input across the broader system. Consider whether it is appropriate to award a rating of Outstanding to a provider where there is little evidence of positive and collaborative relationships in the local system.

10. Supplement the current application of the WLF in individual organisations with consideration of whether governance, processes, leadership and culture are effective across a system. This could take the form of either a local system review, and / or reviews across specific pathways of care.

11. Apply reviews of the WLF to system regulatory and oversight bodies, with key findings made publicly available.

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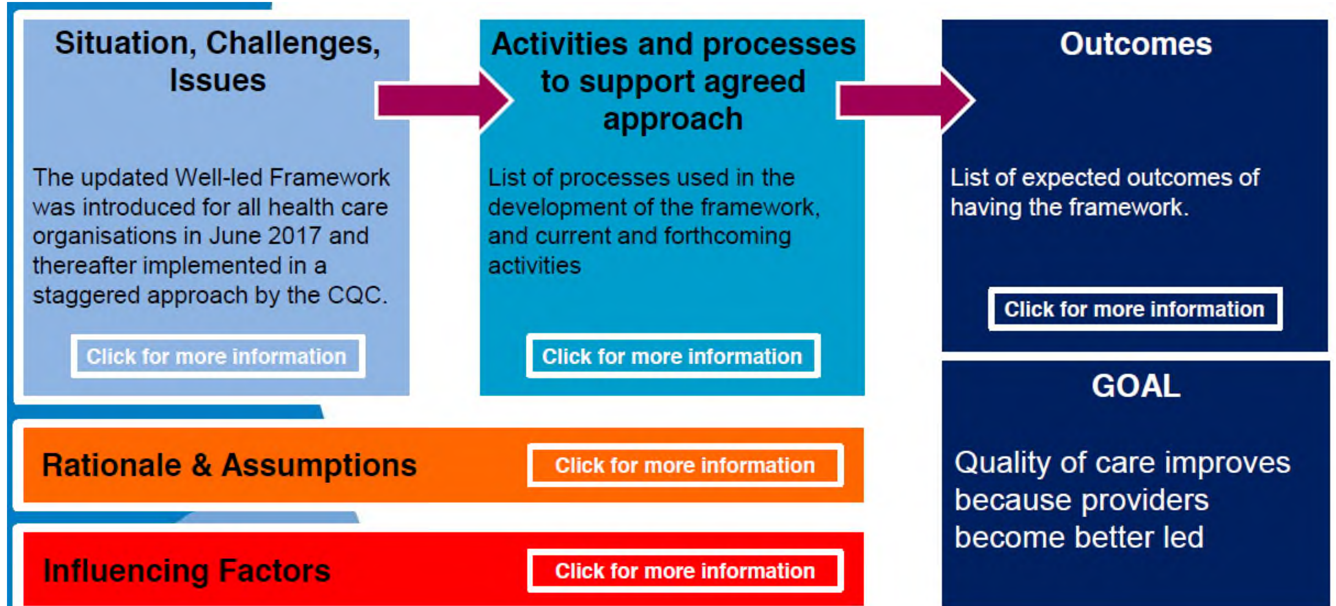
9 Appendices

9.1 Theory of change for the WLF (summary)



9.2 Survey questionnaire

As part of the evaluation of The Health Care Services WLF (for short WLF) jointly developed by NHSI and CQC, this survey is being organised by Alliance Manchester Business School at the University of Manchester. We would be grateful if you could complete a brief, anonymous online survey which will help us to assess the effectiveness of the framework and the impact that it is having on services.

You will be presented with some choices and set of statements. Please make your choices using the options provided and rate each statements according to the extent to which you agree. We understand that in some instances, you may be unable to provide a response. Please do add comments in the boxes provided after the statements to explain your answer, where you think this would be helpful to us. Your individual responses will remain confidential and will not be attributable to you in any verbal or written report.

The survey should take no longer than 10 -20 minutes to complete.

The survey is arranged into four main sections; the design of the WLF; CQC well-led inspections; developmental well-led reviews; improvements resulting from the WLF; and the WLF in the context of the wider system.

		Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Cannot say
General information							
1	Please select your role in the trust	DROP DOWN OF ROLES: e.g. CEO, CHAIR, OR NEAREST EQUIVALENT					
The design of the WLF							
2	The WLF makes clear what a well-led organisation looks like						
	Any further comment?	TEXT					
3	I understand the approach that CQC has to undertaking reviews against the WLF						
4	Some sections of the WLF are more important for a well-led organisation than others						
	If you have agreed with this statement, please expand on your answer	TEXT					

		Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Cannot say
5	There are some sections of the WLF which should be removed or reduced						
	If you have agreed with this statement, please expand on your answer	TEXT					
CQC inspections							
6	Has your trust had a well-led inspection since June 2017?	BUTTON YES/NO					
7	Have you been involved in other well-led inspections since June 2017 (i.e.at another Trust)?	BUTTON YES/NO IF YES, THEN Q8 ELSE Q9					
The following questions relate to your most recent CQC well-led inspection.							
8	My trust has not had a CQC well-led inspection						
9	The inspection was conducted in a supportive and collaborative manner						
	Any further comments?	TEXT					
10	The inspection team provided clear feedback						
	Any further comments?	TEXT					
11	The CQC inspection team had the appropriate expertise to conduct the inspection						
	Any further comments?	TEXT					

		Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Cannot say
12	The CQC inspection team had a clear, coherent approach.						
	Any further comments?	TEXT					
13	The focus of the inspection was appropriately balanced between 'processes' and 'styles and behaviours' of the trust						
		TEXT/ IF DISAGREE THEN 15 IF AGREE THEN 16					
14	If not, the inspection focussed more on:	PROCESS			STYLES & BEHAVIOURS		
	Any further comments?	TEXT					
15	The CQC inspection team adequately covered each KLOE on the inspection						
	Any further comments?	TEXT					
16	The Trust has been given the appropriate support following the inspection						
	(IF agree) Support was given by:	DROP DOWN BOX – WITH CQC/NHSI/CCG/OTHER (etc)					
	Any further comments?	TEXT					
17	The frequency with which inspections happen is appropriate						
	Any further comments?	TEXT					

		Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Cannot say
18	Some elements of the WLF are unnecessary to inspect with the same frequency as others						
	If you have agreed with this statement, please expand on your answer						
19	The CQC's assessment of leadership at our Trust was aligned with our own assessment						
	Any further comments?	TEXT					
Developmental reviews							
20	My trust has not had a developmental well-led review						
21	Has your trust had a developmental well-led review since June 2017	YES/NO					
22	Have you been involved in other developmental well-led reviews (at this or other trusts)?	BUTTON YES/NO IF YES, THEN Q23 ELSE Q24					
	Any further comment?	TEXT					
23	The developmental review was undertaken for:	CHECK BOX: As part of trust-led continuous improvement To prepare for an upcoming CQC inspection Board development To inform internal plans and communications To be used as directed by NHSI or commissioners Other					

		Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Cannot say
24	The developmental well-led review was useful for:	DROP DOWN BOX: As part of trust-led continuous improvement To prepare for an upcoming CQC inspection Board development To inform internal plans and communications To be used as directed by NHSI or commissioners Other					
25	Where relevant, the findings of developmental well-led reviews have been consistent with the findings of the CQC well-led inspection						
	Any further comment?	TEXT					
26	Developmental well-led reviews are value adding						
	Any further comment?	TEXT					
How the WLF drives improvement							
27	Use of the WLF on a CQC inspection, development review, self-assessment or more broadly as part of the Trust's practices, has helped our Trust to make improvements						
	IF AGREE: Please select what helped make the improvement	DROP DOWN BOX: Our own self-assessment Trust practices Inspection Developmental review Other use of the WLF					
	Any further comments?	TEXT					

		Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Cannot say
28	The WLF has helped us to benchmark our trust against best practice						
29	We have used the WLF to identify gaps in our organisation						
30	We regularly use the WLF to inform our ongoing work practices						
31	The WLF helps to share best practice across the wider system						
32	The combined approach of developmental reviews and CQC inspections works well						
	Any further comments?	TEXT					
In which of the following areas did the WLF help you to improve as a Trust							
33	Leadership capacity and capability						
34	Vision and strategy						
35	Culture						
36	Responsibility, roles and systems of accountability						
37	Processes to manage risk, issues and performance						
38	Information processing						
39	Stakeholder engagement						

		Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Cannot say
40	Systems and processes for learning, improvement and development						
Using the WLF across the wider system							
41	The framework helps to facilitate a positive relationship with system partners (commissioners, STP/ICSs, oversight bodies)						
	Any further comments?	TEXT					
42	The wider healthcare system could improve by making better use of the framework						
	Any further comments?	TEXT					
43	Please use this space to comment on ways you consider that the WLF could be improved	TEXT					
44	Please use this space to add any other comments	TEXT					

9.3 Summary of survey responses

The following section presents the responses to the questions regarding the WLF. A summary of the results is presented based on the analysis of responses as ordinal data using the median (Mdn) and interquartile range (IQR) to define a response which represents a typical opinion. The median describes the breadth of opinion by indicating how far along the scale the typical opinion is: from strongly agree (Mdn=1) to strongly disagree (Mdn=5). The IQR describes how widely held the opinion is amongst the respondents: from no divided opinion (IQR=0) to strongly divided opinion (IQR=2). The IQR estimates the quality of the opinion. Thus, an opinion with Mdn=1 and IQR=0 suggests that typically, a respondent strongly agrees about an issue and her opinion is similar to most other respondents. In contrast, Mdn=3 and IQR=2 suggests that typically, a respondent neither agrees nor disagrees on an issue. However, there is significantly divided opinion. A number of respondents are likely to share this typical position, but a notable number will not. In the results that follow, the typical opinion (median) is presented as the view of the respondents.

Table 5 presents the summary of the responses to the main questions excluding the responses to the complementary questions. The summary is described in terms of the median and inter-quartile ranges. Eighteen median responses fall within the range of “agree” (Mdn=2) and fifteen within the range of “neither agree or disagree” (Mdn =3). None of the median responses fall in the categories of “strongly agree”, “disagree” or “strongly disagree”. “Cannot say” was excluded from this summary but is included, where relevant, in the descriptive summary to each question. The interquartile ranges indicate that there is slight disagreement on most statements (IQR=1) though there are some statements where there is divided opinion (IQR=2) and one where there is agreement (IQR=0).

Respondents agreed with the use of the WLF to identify gaps in the organisation (Mdn=2). This was a widely held opinion (IQR=0). The questions where the typical opinion is not widely held are highlighted in grey in Table 5 (IQR=2). These highlights show that the typical opinion is “neither agree or disagree” with regard to whether sections of the WLF should be removed; if the CQC has the appropriate expertise to conduct an inspection; the frequency with which inspections take place; if the WLF helps share best practice across the wider system; if the WLF leads to improvement of the vision and strategy process and of information processing, and if the WLF helps with developing a positive relationship with system partners (for the forgoing questions, Mdn=3). The highlights also include the question where the typical response agrees that the CQC team had the appropriate expertise to conduct the inspection (Mdn=2). However, all these typical opinions are not robust, widely held positions (IQR=2). Opinions were relatively widely held (IQR=1) on the rest of the questions. On these questions, the typical response was to “agree” (Mdn=2) or “neither agree or disagree” (Mdn=3).

Table 5: Summary of responses to the main survey questions

Survey statement	Median		
	Agree	Neither agree or disagree	Inter-quartile range
#	Mdn=2	Mdn=3	IQR
1. The WLF (WLF) makes clear what a well-led organisation looks like.	●		0
2. The CQC's approach in undertaking reviews against the WLF is clear.	●		1
3. Some sections of the WLF are more important for a well-led organisation than others.		●	1
4. There are some sections of the WLF which should be removed or reduced.		●	2
5. The CQC inspection was conducted in a supportive and collaborative manner.	●		1
6. The CQC inspection team provided clear feedback soon after the inspection.	●		1
7. The CQC inspection team had the appropriate expertise to conduct the inspection.	●		2
8. The CQC inspection team had a clear, coherent approach.	●		1
9. The CQC inspection team adequately covered each KLOE on the inspection.	●		1
10. The Trust has been given the relevant support following the CQC inspection.		●	1
11. The frequency with which inspections take place is appropriate.		●	2
12. It is unnecessary to inspect some elements of the WLF with the same frequency as others.		●	1
13. The CQC's assessment of leadership at our Trust was aligned with our own assessment.	●		1
14. The developmental well-led review was helpful.	●		1
15. Where relevant, the findings of developmental well-led reviews have been consistent with the findings of the CQC well-led inspection.	●		1
16. Developmental well-led reviews add value.	●		1
17. Use of the WLF on a CQC inspection, development review, self-assessment or more broadly as part of the Trust's practices, has helped our Trust to make improvements.	●		1
18. The WLF has helped us to benchmark our organisation against best practice.	●		1
19. We have used the WLF to identify gaps in our organisation.	●		0

20. We regularly use the WLF to inform our ongoing work practices.	●		1
21. The WLF helps to share best practice across the wider system.		●	2
22. The combined approach of developmental reviews and CQC inspections works well.		●	1
23. The WLF led to the improvement of our leadership capacity and capability.		●	1
24. The WLF led to the improvement of our vision and strategy.		●	2
25. The WLF led to the improvement of our organisation's culture.		●	1
26. The WLF led to the improvement of our sense of responsibility, roles and systems of accountability.		●	1
27. The WLF led to the improvement of our processes to manage risk, issues and performance.	●		1
28. The WLF led to the improvement of our information processing.		●	2
29. The WLF led to the improvement of our stakeholder engagement.		●	1
30. The WLF led to the improvement of our systems and processes for learning, improvement and development.		●	1
31. The WLF helps with developing a positive relationship with system partners (commissioners, STP/ICSs, oversight bodies).		●	2
32. The wider healthcare system could improve by making better use of the framework.	●		1

9.4 Topic guide for telephone and face to face interviews and focus group discussions

Design of WLF

What does it address well?

What doesn't it address well?

What should be included that isn't (if anything)

What shouldn't be included (or focused on less) that is?

How does the balance of KLOEs within WLF affect your organisation?

How well does the WLF balance between processes and behaviours (culture) serve your organisation?

What is your understanding of the aims of WLF? (addressing communication). Do they align with those of your organisation? (Is WL achievable as based on WLF?)

How does the frequency of inspections impact your organisation?

How does WLF support diversity and inclusion? What can be done to improve this (if anything)?

Impact of inspections

How well do CQC inspect? Are inspectors adequately trained?

What are the common aspects to good inspections (if any)?

What are the common aspects to poor inspections (if any)?

What is the aim of inspections?

Do inspections achieve their aim? (and why/how?)

How do inspections impact your organisation?

How do inspections impact the system?

What are your views around use of specialist advisors? Could this be improved?

Impact of Developmental Reviews (DRs)

To what extent are DRs useful for your organisation?

What aspects of the DR are useful?

What aspects of the DR are less useful?

Is the way DRs are commissioned effective (in terms of helping the Trust – e.g. when instructed by NHSI)?

How do DRs impact your organisation?

How do DRs impact the system?

Are there ways in which peer reviewers could be included / used in DRs to better effect?

WLF for systems

To what extent does WLF apply to the new model of leadership (for systems?)

How does WLF fit within the 10 year plan?

What aspects of system working does WLF address well?

What aspects of system working does WLF not address well?

What improvements can be made to WLF to improve system working?

Should WLF apply to system partners as well as to provider organisations? (Does it map well? - if not why not? -if not should there be a universal approach to leadership across the system)

To what extent is there a common leadership approach across the NHS? Where are the gaps? What can be done to align the different organisations involved?